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"When You Feel Like There is No Trust in the Profession"—Midwives and Obstetricians Facing Complicated Cases

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Abstract

This study examines how two collaborating professions, midwifery and obstetrics, are influenced by women requesting caesarean sections. The empirical material consists of semi-structured interviews with Swedish midwives (n=6) and obstetricians (n=6). Analysed through Tilly's terms, the categorical pair and triad, midwife and obstetrician function as complementary categories in a triad with the women they encounter. Midwifery is a profession with connotations of closeness, understanding, and a unique connection to birth. It is challenged when women reject support or the idea of vaginal birth as empowering. Obstetrics, as a profession, relates to medical expertise, distance, and overview. It is challenged when their knowledge and authority are rejected. Both professions rely on each other's complementary roles for support. The midwife draws on the obstetrician's authority, while the obstetrician draws on the midwife's empathic knowledge of the woman. When strongly challenged, they uphold their defined positions by questioning the woman's judgement and rationality.

Keywords

Professional roles, maternity care, midwives, obstetricians, categorical pairs, caesarean sections

Introduction

Midwives and obstetricians, the two primary professions in maternity care, have been argued to define themselves as each other's opposites. Midwives have traditionally been women and associated with female-coded values, such as intuition, care, and low-risk, "natural" births. Meanwhile, physicians have traditionally been men and associated with historically male-coded values of distanced professionalism, biomedical expertise, and use of instruments in complicated cases (Hildingsson et al., 2016; Reiger, 2008; Öberg, 1996). As we will show, these perceptions of the two professions are prevailing but not unchallenged. In Sweden, midwives have a comparably strong position, currently and historically. Still, maternity care has a hierarchical structure with the obstetrician as the authority (Hildingsson et al. 2016; Öberg, 1996). This article will shed light on how these two professions, midwifery and obstetrics, define and negotiate their roles in a context that provides unique challenges when they encounter women who request a caesarean section (CS). The request for a CS without a medical indication provides a scene to study the interplay between midwives, obstetricians, and patients when the roles and hierarchies of maternity care are challenged. While the roles of midwives and obstetricians in Swedish maternity care have been described in generic and rather consistent terms in previous research, focusing on a specific situation provides new perspectives.

Historically, midwives were women with an informal expertise in birth who lived and worked close to their patients. Thus, they also functioned as gatekeepers for the first provincial doctors when they entered the scene. By the mid-1800s, the balance had shifted, and physicians had a broadly accepted authority (Johannisson, 1990). This was also the time when the idea of physicians' using the best evidence in making decisions about the care of individual patients started to develop (Sackett, 1997). The professionalisation of educated midwives has its starting point around 1870. Initially, it re-strengthened midwives' positions, but by the early 1900s, physicians had control over midwife education as well as over their professional jurisdiction. Swedish midwives organised and strived for longer education with more theory, for less responsibility for nonmedical labour in the hospitals, and for the right to use instruments during complicated births (Öberg, 1996). Swedish physicians worked on keeping their own profession exclusive, keeping the number of active physicians low in comparison to most of Europe (Carlhed Ydhag, 2020; Öberg, 1996). Midwives were expected to handle acute complications in the physician's absence, especially in the sparsely populated areas of northern Sweden. If complications occurred in the physician's presence, the midwife stepped back. This may in part explain the strong position and independence of Swedish midwives and the fast hospitalisation of birth during the early 1900s, as it made it possible for physicians to be accessible for many births managed by midwives simultaneously (Öberg, 1996).

Research on midwives' professional position has taken different normative standpoints. Some emphasize the empowerment in close midwife-patient relationships (Hildingsson et al., 2016; Larsson et al., 2019; Wulcan & Nilsson, 2019), while others argue that midwives perserve their

subordination by toning down their professional skills, allowing obstetricians to claim technical expertise as their arena (Reiger, 2008). Swedish midwives do not have a history of readily accepting their niche. Still, physicians monopolised the expertise in complicated births over time, partly by controlling midwife education. Birth complications were initially something all physicians were expected to handle (Öberg, 1996), and obstetrics became a speciality only in the 1950s (Carlhed Ydhag, 2020). Öberg (1996) argues that, by then, physicians had won the battle over the birth clinic and were the widely accepted profession in charge. The two professions have since proceeded by carving out their respective niches in cooperation.

Women’s preferences have also shaped the development of birthing practices and reproductive healthcare. Öberg (1996) has argued that women’s preferences were an important factor driving the hospitalisation of birth around 1900 and an accurate measure of the quality of care. When the number of deaths was higher in hospitals, most women preferred home birth with a known midwife. When antiseptics were discovered and hospital births became safer, they also became more popular.

Viewed as a study of professions, this work examines the interplay between a classic profession built on basic, generally recognised, robust scientific knowledge that unites and standardises practices, and a semi-profession, with less autonomy and more emphasis on communicative methods (cf. Brante, 2013). Although the professions of midwifery and obstetrics have been studied individually and comparatively, negotiations of their roles in concrete, real-life situations remains less studied. A few studies have focused on how women requesting CS perceive their encounters with healthcare and are perceived by professionals. By investigating how professions interplay when encountering them, this study provides an important link between studies of the professions in maternity care on an aggregated level and studies focusing on patients.

Professional perspectives on birthing

In this study, the power dynamics between the professions in maternity care were analysed through interviews with Swedish midwives and obstetricians about working with women who request CS. In Sweden, a woman who wants a CS without a medical indication can apply for it on maternal request, which is called “by psychosocial indication.” The final decision is made by an obstetrician, but a midwife is involved in providing counselling and information for the woman (Svensk förening för Obstetrik och Gynekologi, 2011; Wulcan & Nilsson, 2019).

Research consistently shows that the power balance between midwives and obstetricians has a substantial impact on how birthing and maternity care is understood (Hildingsson et al., 2016; Panda et al., 2018a; Lyckestam Thelin et al., 2019). Obstetrician domination is associated with standardised, evidence-based maternity care where birthing is seen as a medical event, and risk and safety on an aggregated level are in focus (Reiger & Morton, 2012). Midwives are seen as involved in the longer process from pregnancy to motherhood, where giving birth is part of a transition in life, and as advocates for individualised, autonomy-focused care

and natural birth (Reiger & Morton, 2012; Öberg, 1996). Discussions on patient autonomy regarding mode of birth are an arena for expressing professional norms and ideals. In Sweden, there has been a heated debate on whether CS on maternal request should be added to the few exceptions from the ground rule that a patient cannot demand surgery, as stated in Swedish healthcare legislation (Health and Medical Services Act, 2017). If that were accepted, the third category, the birthing women, would step into the field where the two professions have divided their responsibilities.

CS is regarded as an exception in Sweden. The general levels have been slowly rising since at least the 1970s, but are still low by international comparison (National Board of Health and Welfare, 2015). The Swedish system, which is tax-funded and mainly a public healthcare system, has been shown to correlate with low levels of CS on maternal request (Loke et al., 2019; Panda et al., 2018b). The presence of a “normal birth culture” in the public and medical discourse has been argued to strongly influence professional decision-making about CSs and dominate in Sweden due to the strong position midwives hold (Hildingsson et al. 2016; Panda et al., 2018a). International research on the influence of maternal preference on CS levels is inconclusive (Begum et al., 2021; Panda et al., 2018b). In Scandinavia, 6–8 percent of women prefer CS to vaginal birth (Løvåsmoen et al., 2018). Women requesting CS challenge the Swedish discourse that vaginal birth in a hospital is the ideal mode of birth (Lindgren, 2006) and are thus considered difficult to work with (Eide et al., 2019; Johansson, 2023). Research on women giving birth shows that some experience vaginal birth as a rite of passage into true womanhood (Lyckestam Thelin et al., 2019) while others describe it as an expected rite of passage that creates unreasonable judgment when rejected (Lindgren, 2006).

This discourse is also present in Swedish research. A preference for CS is predominantly connected to fear of childbirth and presented as a problem in need of explanation and solution. Medical research has focused on fear of childbirth as a psychiatric condition related to anxiety and depression (c.f. Nieminen, 2016; Sydsjö et al., 2015; Zhang et al., 2021). Nursing studies have focused more on low self-efficacy regarding birthing, which has been related not only to mental health but also to a medicalisation that makes women expect a medical professional to take charge. This medicalisation is argued to harm women’s trust in their natural ability to give birth, which is in turn connected to a lack of bodily awareness and connection between body and mind in a broader sense (c.f. Larsson et al., 2019; Sahlin, 2020; Wigert et al., 2020).

Aim

The aim of this study is to understand how two collaborating professions, midwifery and obstetrics, are influenced by the patients they are working with. We study this in a critical context, where women request caesarean sections. It provides an example of how the two professions redefine themselves and relate to each other, as well as to the birthing women, in a challenging situation where general ideals and goals for the professions’ collaboration cannot

follow ordinary routines. This study will hence deepen the understanding of the intraprofessional dynamics. With the help of Charles Tilly's understanding of durable inequality, we discuss the results through his terms, categorical pair and triad. This framework provides a new lens to view the intraprofessional interplay in maternity care, compared to the more traditional organisational theories previously used to understand their positions in Sweden (see Öberg, 1996; Carlhed Ydhag, 2020). It is well-suited to understand how hierarchical relationships between groups—in this case, professional groups—develop over time.

Methods and materials

The analysis emerged from an interview study conducted at two clinics between April 2021 and March 2023. The clinics were selected through a purposive sampling method, based on three factors: the size of the clinic's catchment area, distance to the closest neighbouring clinic, and geographical placement. Clinic 1 serves a mid-sized region as its sole birth clinic in the mid-parts of Sweden. Clinic 2 is one of five birth clinics in a geographically small but densely populated southern region. The clinics represent the two most common combinations of the factors used. All interviewees but one midwife work in specialist maternity care teams for fear of childbirth, where all requests for CS on maternal request are processed. Most also work at the generic maternity ward concurrently. Request for CS is an exception, also in the teams for fear of childbirth, thus the professionals mostly meet women who prefer vaginal birth or are unsure of mode of birth. At clinic 1, two midwives and two obstetricians were interviewed, all women. At clinic 2, four midwives, all women, and four obstetricians, three women and one man, were interviewed. This mirrors the gender division of obstetricians and gynaecologists in Sweden (National Board of Health and Welfare, 2021), and male midwives are so few that they disappear entirely in the national statistics (National Board of Health and Welfare, 2024).

All participants were informed both verbally and in writing about the project, the confidential treatment of their information, and their rights as participants. The interviews ranged from one to two hours and were transcribed verbatim. Due to the COVID-19 pandemic, clinic 1 interviews were conducted over video link. Clinic 2 interviews were conducted at the clinic, except one, which took place at the university for practical reasons. The interviews were semi-structured and focused on the work with women who prefer CS. They were guided by questions from four themes: decision-making, professional perspectives on the women, cooperation with other professions, and organisation and practical circumstances.

At the outset of the thematic analysis, three key themes stood out in the material as the interviewees focused on them the most: the roles of the obstetrician, the midwife, and birthing women as patients. All text about these themes was extracted for further thematic coding. The theme *birthing women* was by far the largest but also the most homogeneous. A thematic analysis according to Hayes (2000) was used. The first three themes were coded into categories and sub-categories at three levels, also guided by the empirical material.

In Swedish, the literal translation of obstetrician (*obstetriker*) is rarely used; most interviewees used the general term for physician (*läkare*). For this article, the term obstetrician is used when participants clearly refer to obstetricians and physicians when a speciality is not inferred. When using quotes, participants are referred to with clinic (C1 and C2) and profession in order of interview (O1/M1 for the first interviewed obstetrician/midwife at that clinic).

Social categories in maternity care

The sociologist Charles Tilly's understanding of durable inequality and social categories constituted the starting point of the analysis. Tilly (1999) has argued that categories are connected primarily to social contexts and gain stability and durability when enacted in a consequent manner by interchanging individuals. While all categories are contextual, some are more local than others. For example, patients are patients in relation to healthcare, not in relation to their family, working group, or other contexts. In Tilly's conceptualisation, *patient* thus functions as an internal category, specific to the local context of healthcare. External categories are connected to wider societal contexts. The category *pregnant woman* stays relevant when the woman leaves the hospital; thus, it is an external category, possible to use in several contexts, with varying connotations.

Tilly (1999) goes further and shows how categories are connected by larger and smaller units. The smallest unit is the categorical pair. Categorical pairs are linked categories that gain relevance through each other by presupposing each other while also being clearly different and mutually exclusive. Physician-patient is a clear example. The physician has no role to play without a patient. Their interaction is directed by local knowledge about proper enactment of categories, concretised by scripts, that is established through repetition, attrition, and habit, which in turn construct expectations. The next unit for linked categories is a triad. It consists of three categories that are all linked to each other in similar ways. Tilly considers ties between categories as stable if the gain of the tie is larger than the cost to uphold it. For a stable triad, a certain symmetry is required, but all ties must not be equal. For example, if two categories have an equal and rewarding relationship, a triad with a third category is more stable if the first two have similar relationships to the third. A triad of two groups of physicians with different specialities of equal status and a patient who also holds them equal could be an example of a stable triad. In this study, we view midwives and obstetricians as a pair of professionals. They are colleagues, and they form a triad together with patients. However, their collegial relationship contains a difference in authority, which would also require somewhat different ties to patients for the triad to be stable. Hence, if birthing women relate differently to the two professions in a way that is compatible with the division of work the professions have agreed upon, this will ensure the stability of the triad. Using Tilly (1999), midwives' historical cooperation with physicians could be connected to sorting by gender and class as external categories, and ranking, where midwives have accepted a certain amount of subordination to uphold a niche that entails a unique, femininely coded role at the birth clinic. While historically contested by midwives, this hierarchical but complementary relationship

has been agreed upon between the professions over many years (see Öberg, 1996). In our analysis, we will focus on how the pair is constituted as a base for understanding how the third category, the birthing women, influences the categories in the pair when they are parts of a triad.

The three categories from the professions' perspectives

In the following three sections, we show how the three categories are involved in the interplay around birthing in general and the specific situation where birthing women want a CS. The empirical material shows how the interviewed midwives and obstetricians reason, which we argue is based on how they perceive the professional categories they belong to and collaborate with.

The midwives: Time, closeness and depth

When the midwives were discussed in the interviews, three assets in the borderlands between personal qualities and professional abilities were stressed consistently: time, closeness, and depth. When asked about their main task, most midwives talked about providing support and ensuring that the woman has a positive birth experience. The midwife was presented as someone who has important qualities that are hers both as a person and as a midwife. These two dimensions were rarely separated.

The first asset is time for emotion. Conversation was presented as the midwife's most important tool, and they stressed the importance of taking time to let women talk until they feel finished. In this context, listening was presented as a competence specific to the midwife profession.

> We get involved, a midwife and an obstetrician, with this woman, and she can have regular visits with the obstetrician but also see us because we often make time for longer conversations and talk more in-depth about, what is the fear about, do you have something lingering from previous births. (C1, M1)

Obstetricians also argued that midwives have more time to spend with the women. The time that midwives can give makes it possible for women to put words to their fear, which was framed as crucial for finding a solution, whether it is a birth plan for medical interventions or psychological support. Time is also a prerequisite for the midwife's second asset: an ability to form a close bond. A male obstetrician put it as follows:

> The midwife manages the greater part of supporting the women. They often have a better emotional connection to these women; due to their professional role, they somehow have a different connection to maternity care and, to being a woman, maybe. It sounds fuzzy but, midwives have a role like a mother or an older sister. Like a woman being there for other women, and for children too. (C2, O1)

Here, the closeness between the woman and the midwife was explicitly gendered, which was unusual. Still, the notion that the midwife can relate more to the pregnant or birthing woman’s situation was predominant in stories from both midwives and obstetricians, regardless of gender. The ability to understand on an intuitive level was sometimes described as a double-edged sword that makes it easier to break through to closed-off women, but more difficult to remain professional:

> To be very emotionally engaged can be a really good way to get these women to rethink things because you become very close on some sort of professional level. But it can also blind you; you get affected and have to say to yourself, “I have to get it together; she is scared, and she is worried, but a CS is not the solution.” (C2, M3)

From the obstetricians’ perspective, an important difference between the professions was that midwives can allow themselves to form opinions about what is best for individual women based on the close, interpersonal connection, without having to articulate strong arguments. The midwives were thus understood as freer in their professionalism:

> As a midwife, you don’t have to decide on CS, and then I think it might be easier to say that we won’t do a CS, or, for that matter, that this will never work; we have to do a CS. (C2, O3)

While expressing that midwives have it easier in this aspect, obstetricians also argued that having the midwife disconnected from the decision can promote continued work with women who are denied a CS. Some midwives also mentioned that not having to say no can serve the alliance with the woman, but they did not frame it as having less responsibility or easier tasks. Rather, they argued that they have a unique perspective: a deep understanding of birth and the meaning of the birthing experience on a universal level, which is the third asset. Midwives stressed the positive aspects of natural, vaginal births with as few interventions as possible as an important part of their profession:

> As midwives, we think more [than obstetricians] about the healthy and healing aspects of giving vaginal birth, no matter what a woman has experienced. /…/ We have a strong belief that it affects a woman to give vaginal birth in a very, very positive way. (C2, M2)

The meaning of vaginal birth is presented both as a midwife speciality and as something important to women, which could be seen as an expression of how the professional mission and self-perception colour the understanding of the patient and her needs.

In sum, the midwife was presented as someone who has time, the ability to form a close bond, and a unique and deep understanding of birthing. These assets were presented as both personal and professional, built on knowledge and intuition. Implicitly or explicitly, they were connected to the midwife, embodied as an experienced woman.

The obstetrician: Knowledge, distance and overview

When the obstetricians were discussed in the interviews, they were framed as consultants who enter the process of pregnancy and birth with specific medical knowledge and an unambiguously professional role. When described in general terms, the obstetricians' profession was understood based on three assets: knowledge, distance, and having an overview. Their competence regards the assessment of medical risk and safety. The first asset is scientific knowledge. Some argued that a CS is like any other intervention where a physician has knowledge about the human body and possible outcomes: "To become an obstetrician, you must do an internship where you have a basis in a lot of other specialities too, and you get used to thinking in terms of risk and consequence all the time" (C2, O2).

Nevertheless, obstetricians also stressed the importance of a good reception. While midwives presented interaction as a natural part of their profession, the obstetricians often described themselves as different from other physicians for endeavouring to form good relationships. Many of them had considered other specialities where interaction is important, such as psychiatry and paediatrics. Midwives also argued that "their" physicians are different as they are more sensitive to women's psychological needs and listen to the midwives when they advocate for them:

> We all agree that women should be helped to deliver their child in the way that is best for her well-being, and for a small proportion of women, that will always be a CS. /…/ There are physicians who don't share that point of view, but our physicians they listen to our assessments. (C1, M2)

Still, obstetricians presented listening and providing support as secondary to their primary role of providing medical expertise. They did not claim to strive for the deep connection and understanding that the midwives do. The second asset stressed is *professional distance.* Trust in the obstetrician was discussed as trust in the profession, not the specific person. The obstetrician's authority at the clinic can provide the women with a sense of security:

> I think trust is a sense of security, at least with me, to believe what I say. About what is best medically, but even more that what I say will be followed. If we decide to give vaginal birth a try and make a plan, they can trust that the plan will be followed. (C1, O2)

“When You Feel Like There is No Trust in the Profession”

In relation to women who wish for a CS, both professions emphasised the obstetricians’ role as decision-maker, arguing that a professional distance was especially important. Obstetricians often talked about this responsibility as demanding and difficult. They are the ones the woman tries to convince and becomes angry with if she does not get her way.

> Then, [after saying no] I am the mean doctor, and they want to see someone else. We had to deal with that /…/ that some women got a no, and then they wanted a second opinion within our team. (C2, O2)

As in the quote above, many described how women do not give up but try to get a second opinion. Having the decision connected to the obstetricians as a person is considered a problem, as they become “the mean doctor.” At both clinics, the decision is made within the team for fear of childbirth, either by the obstetricians or by representatives of both professions. While one person still makes the official decision, all described this routine as a source of support and security, as well as a strategy to disconnect the decision from the individual obstetrician. Being part of a team makes the decision part of a larger agenda which is managed by both a professional agreement and administrative rules. As a result of general medical knowledge and professional distance, the third asset of the obstetrician is an overview, where the individual patient is seen in the context of public health. It was argued that the obstetricians have more responsibility for looking at the bigger picture:

> In this profession, we know that performing CS randomly, allowing those numbers to skyrocket, isn’t good for anyone. For the individual, it might work out well, but we’ll end up with a lot of complications that might not be so beneficial for the population at large. /…/ I think about public health, and I believe that when working in healthcare, there’s a responsibility to strive for good public health in the long term. (C2, O3)

While obstetricians mainly stressed their competence in understanding public health, the closeness between the midwife and the woman came back as an argument for the same division of responsibility when presented by a midwife:

> To keep the statistics on CS down, it’s a pretty high goal that the obstetricians are really focused on. If you can give vaginal birth, you should be strongly encouraged to do so, and the obstetricians are more driven than the midwife, who is closer to the patient during labour. (C1, M1)

In sum, obstetrics as a profession is strongly connected to medical knowledge, professional distance, and a general responsibility for public health. Trust is presented as crucial for obstetricians. When trusted, they can more easily use their expertise and guide their patients towards a medically safe birth, and displaying the expertise is also a tool to create trust.

The fearful birthing woman presented by midwives and obstetricians

As this is a study of the professions, the birthing women themselves were not interviewed. Still, the women are present in the professionals' stories as they uncover how they perceive women wanting CS as well as their own view of ideal birthing. Both professions highlighted the norm of vaginal birth by talking about it as being medically best. They considered women's stern wish for CS as an expression of some form of underlying problem that they did not fully understand:

> We have, I think, an assumption that it's odd to want to give birth with CS. The woman wants to be cut, to have major abdominal surgery, to extract a child who could have come out another way. That it's irrational. (C2, O1)

While the medical arguments were the most frequent from both professions, many also argued that a vaginal birth can have a psychologically positive function for the woman's self-esteem:

> A woman with low self-esteem can generally be incredibly strengthened. If she is afraid of pain, maybe of the unknown, of losing control, and just generally of giving birth. Many women are, but especially those we meet, and they can be incredibly strengthened by finding the courage to give vaginal birth. (C1, M2)

Moreover, many also argued that vaginal birth could be empowering for women who have been abused and/or have more severe psychiatric conditions, but that there are often not enough resources to get to a point where the woman is ready. Relating to the assets of their respective professions, midwives were more prone to argue that there was not enough time, and obstetricians were more prone to argue that they did not have enough knowledge. From their different perspectives, their arguments take the starting point of CS being an abnormal way of giving birth that should be avoided.

When discussing decisions about birth mode, there was a shared ambition for a positive birth experience with as few complications as possible. Obstetricians focused more on the medical aspects and could view the experience as secondary. This position is most strongly expressed here, where the notion of the birth experience as important and transforming, often stressed by the interviewed midwives, is directly challenged:

> These days, there's this widespread idea that it should be so wonderful to give birth. I don't understand who came up with that or where it came from or why it has become so domineering because there're very few who actually think that it's this amazing experience. /…/ It hurts like hell, and it's sweaty, and there's blood and piss and poop and all of that, but that's secondary to what you get for your efforts. (C1, O2)

More often, both midwives and obstetricians said that a positive birthing experience is more important than vaginal birth. “The goal can’t just be vaginal birth. The goal must be a safe and secure woman and a good birth experience where we find a reasonable way by working together.” (C1, M1).

In conclusion, a positive birth experience is the main goal for both professions. In most aspects, they reasoned in similar ways. The shared professional perspective on women with a wish for CS is that it comes from psychological or psychiatric problems or from traumas like sexual abuse or an earlier complicated birth.

The categorical pair: Midwives and obstetricians as trusted colleagues

The midwife and the obstetrician can be seen as ideal types where contrasts are used to tease out their respective professional position as classical and semi-professions. When midwives and obstetricians work together, their different expertise functions as complements. The obstetricians’ science-based procedural knowledge is combined with the midwife’s knowledge and communicative skills in a well-established role division. Thus, they are a categorical pair, as Tilly (1999) described. The categorical pair is constructed by uniting two unequal categories with well-defined boundaries, where one is subordinated to the other. Tilly (1999, p. 84) has argued that categorical inequality is not necessarily bad. It can facilitate collective production. Still, the inequality also facilitates exploitation and produces differences in individual capacities. In the interviews, the professionals talked about how they relate to each other and work together. Many spoke of how the two professions complement and trust each other. Firstly, the midwives’ closeness to the woman and the insights gained from spending time with her make her an appreciated colleague. Obstetricians spoke of the midwives as colleagues who contribute new perspectives and whom they trust to provide a solid basis for decision-making. Trust was an especially evident aspect at the first clinic, where large distances were a reason to keep the number of appointments down. The obstetrician’s role as decision maker was sometimes presented as close to symbolic:

> If the patient is 250 kilometres away, it’s really unnecessary for her to come here to see me just to decide what she and the midwife have already talked about, for example, an induction. Then it can be like, a short note from the midwife in her medical record, “Is it ok if I set her up for induction?” and then I look at her records and be like, “Sounds good, let’s do that.” (C1, O1)

Midwives expressed that while the obstetricians need access to the midwives’ knowledge of the individual woman, midwives need the obstetricians’ more specialised medical knowledge:

> It goes both ways; the obstetricians can’t make good decisions without us, and we can’t make good decisions without them sometimes if it’s a complicated birth. We

> handle the normal births, but with the complicated births, we need each other. (C2, M1)

Obstetricians presented the midwife as an ally and source of support when making difficult or unpopular decisions. In these situations, having a midwife who has worked closely with the woman on one’s side was presented as a source of security. Midwives described a positive relationship in terms of obstetricians who listen to midwives and appreciate their perspective, but who can also take over when the relationship-based work has been unsuccessful, and more authority is needed. One midwife answered the question of when she involves an obstetrician:

> Most often, I have met with the woman, and maybe her partner, a couple of times, and I feel that I can’t get anywhere; she insists that she wants to see an obstetrician, and she wants a CS. Then I talk to the obstetrician first. /…/ and then the obstetrician can take over. Most often, we agree. (C2, M4)

The obstetrician’s professional distance can also be valued when the closeness between the midwife and the woman becomes too demanding. While the less emotional perspective of the obstetrician can be appreciated, midwives held engagement and care for patients as a standard for both professions. This was not taken for granted with all physicians, but many described the obstetricians in the teams as special*,* in that they think more about the holistic experience of birth and listen to the midwives:

> There are different factors that enhance the risk of CS. That you can’t spend enough time in the room, that you have too many patients, etc. I think the obstetricians who come here, they want to work differently; they come from these large clinics and don’t want to work like that anymore. If you involve them early, then we get on the same track and think more alike. (C2, M1)

Though midwives are excluded from explicit decision-making, they can influence the obstetricians by influencing them to take the midwife’s perspective to some extent. In contrast, midwives could describe interactions with other physicians who do not listen to midwives or patients.

Cooperation within the teams was presented in predominantly positive terms, as based on mutual trust. Obstetricians trust midwives to provide valid input and take responsibility for decisions based mainly on the midwife’s word. Midwives trust obstetricians to listen to and respect their competence. Both professions discussed cooperation with an awareness that the obstetrician can override both midwives and patients. Many of the midwives’ positive statements were expressions of trust that this option would not be used excessively. In sum, the two professions talked about their way of functioning as a categorical pair, revealing the obstetricians’ superiority without reducing the role of the midwives.

A complex triad: Midwife, obstetrician and birthing woman

When the categorical pair of professions works in relation to the birthing women, they form a triad. This triad can be related to the idea of evidence-based practice, where professional expertise is to be combined with the best available scientific knowledge and the influence of individual patients’ predicaments, rights, and preferences (Sackett, 1997). According to Tilly (1999), a triad is a social configuration that consists of three categories with ties to each other. Tilly (1999, p. 49) has argued that stable pairs tend to recruit third parties jointly, and as both professions are dependent on access to birthing women, they both include them in the triad. Yet, the birthing woman is a person, subordinated to both professions in this situation, as she is depending on the decisions made and actions taken. While the professions are internal categories in the context of the birth clinic, the woman is strongly coloured by external factors; her identity is not primarily formed by the clinic. The interaction between the professions and the women is formed by a desire to make her fit into the category properly, so that the triad can work in line with the script that is valid for the context. Within the script, the professions can improvise to position themselves and uphold their categorical identities.

When positioning themselves in the triad, obstetricians claimed to have a way of thinking in terms of risk and safety due to their medical training, a perspective that the midwives are argued to lack. Thus, they are both professions, but with different perceived competencies, which highlights that they are not one, but two categories. This was expressed by one obstetrician as follows:

> We are coloured by our other activities. When you must always weigh, if I do this, it can have these consequences, if I do that… We never have the option to do nothing. The patients only come to us when they need help, and it’s different for a midwife. (C2, O2)

As shown, midwives claimed to have a more holistic view, where giving birth is part of a longer process, and an existentially important part of a woman’s life. Some claim to be responsible for the experience and context of birthing to the extent that she can deny entrance to the obstetrician in certain situations.

> I think the midwife has a really important role as the protective shield in the room. To say: “No further with that kind of energy; you leave that outside.” /…/ If someone comes in with a stressful energy, and everyone has an adrenaline rush, then it will affect the woman and /…/ the labour wears off. (C2, M1)

Through their statements, they position both themselves and the other profession in the triad. When they reason about the third category in the triad, the woman giving birth, their professional roles can be manifested. However, it could also lead to professional disappointment if the script is not followed. In the ideal situation, the script is that the obstetricians’ medical assessment and the midwives’ expertise in supporting and encouraging are accepted

by the birthing women. From that, they can improvise in line with how the situation develops and uphold their professional roles. In the cases discussed here, the women did not always act in line with the script. This caused the professions to criticise the birthing women for not taking on their role in birth-giving properly, as they challenge the professional beliefs. The midwives talked about some women who are less willing to make sacrifices before, during, and after birth as challenging the conceptions of feminism and female strength:

> It’s about beauty ideals/…/ It’s good if you’re maternal and have children, but it shouldn’t be visible on your body. There is a young ideal for women, and I find it provoking, and that it generates wishes for CS. /…/ That you think it’s your right, like a misguided feminism. (C2, M4)

While these women challenge the midwives’ professional beliefs, others challenge the midwives’ profession more directly:

> As a midwife, you come into this profession with a fascination for birth and that there is something empowering and something important in a woman’s life, in the life cycle of a woman. And to meet these women who deprive themselves of that experience, of this growth potential that birthing offers, it’s difficult, emotionally. (C2, M2)

As in previous research on Swedish birth culture, giving vaginal birth is here viewed as a rite of passage that a CS cannot replace. For the midwives, this is at the core of their communicative profession, as they regard their role as facilitating a natural process. For obstetricians, their expertise and medical responsibility are challenged, and they described the persistent women in ways like:

> Those are the worst, who are just ice-cold decisive. When you feel like there is no trust in the profession or that we know what’s best, but the patient knows what’s best. They are the most difficult, who make you feel like just giving up. /…/ No patient would just walk into the surgery ward and say that “I want my gall bladder removed /…/” No surgeon would ever accept that. But when it’s CS, it’s some sort of grey area; patients have a lot of influence, and how we ended up here, I don’t know. (C1, O1)

When the women have psychological or psychiatric problems, the obstetricians present the interaction as demanding, as they cannot use their usual tools and professional role, and are forced to become more personal:

> There’s no established best practice when it comes to this patient group, but we are working with support at the borders of therapy but without the formal education. So, you must give so much of yourself. You have to use yourself as a tool when you don’t have any other tools. (C2, O2)

While the midwife’s professional role is challenged when women do not acknowledge the value of birth, the obstetrician’s professional role is challenged when their medical authority is questioned. Midwives more often described their reaction in terms of feelings while interacting with a specific woman, such as being angry with her or saddened on her behalf. Obstetricians more frequently describe feelings of exhaustion or being emotionally drained afterwards. Regardless, it is about the expected script not being followed, which makes it difficult to maintain professional positions, as they are affected personally.

Conclusion and discussion

The aim of this study was to understand how two collaborating professions, midwifery and obstetrics, are influenced by the patients they are working with. We have contributed by using a theoretical framework that differs from previous research and highlights the dynamics between the professions and birthing women. We have also furthered the understanding of the professional roles of midwives and obstetricians by showing how the ideal types are expressed and negotiated when challenged.

Women requesting CS challenges both professions, but in different ways. Midwifery as a profession involves closeness, understanding, and a unique connection to birth as an expression of female strength, which is also shown in previous studies. The woman giving birth becomes her ally when she can provide care and protection, sometimes against insensitive physicians. When women reject care, do not share fears or emotions, or reject the idea of vaginal birth as empowering, the midwife’s professional identity is challenged. When the same idea is embraced, the birthing woman and the midwife are considered mutually strengthened. Obstetrics as a profession is connected to medical expertise, distance, and the ability to see the bigger picture and take responsibility for public health at an aggregated level, again in line with previous research. It is strengthened when women seek and trust their knowledge and judgement. When the obstetrician’s medical knowledge and authority are not accepted, and when they need to venture into areas where they do not have expertise, their professional identity is challenged. Here, the distanced professionalism may also be shaken, and the work is perceived as emotionally draining. Decision-making in a team can recreate some of the distance.

In the triad, the midwife and the obstetrician function as complementary when the script is followed by everyone involved. While they argue for vaginal birth from different viewpoints and ascribe it different values, as an important life event or the medically sound choice, they are in agreement on how the categories within the triad should act and what the desired outcome is. The triad can then be seen as a hierarchical but stable model for evidence-based practice. The obstetrician has the highest authority. The midwife has a subordinate role but also an unthreatened niche as the professional that truly understands birthing women, and obstetricians are expected to respect and listen to them. This harmony contrasts with the conflict-focused narratives in earlier studies. The woman depends on both professions. If she

acts according to the script, she receives attentive care and medical guidance towards what the professions have agreed upon as a medically and psychologically safe birth. When she deviates, midwives and obstetricians sometimes find themselves in disagreement but more often in shared frustration. When challenged, they can recover by leaning on each other and the categorical pair they form. The midwife can lean on the obstetrician’s authority, for example, by sending women to them for an explicit “no” when persuasion is not enough. The obstetrician, in turn, can lean on agreement with the midwife and her empathic knowledge of the woman when they make unpopular decisions. The woman who rejects the midwife’s care and the obstetrician’s expertise with most force, by demanding a CS without accepting a dialogue with either profession, is rejected in return, as her rationality and relationship to her body are questioned. By doing so, the professions can uphold their defined positions as a pair, while the collaboration with the patient risks being lost.

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