

# When the midwife-woman partnership breaks down – principles for ending the relationship

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## ABSTRACT

New Zealand's unique Lead Maternity Carer (LMC) midwifery model of practice is a privilege for both women and midwives. Underpinning this model of practice is the concept of partnership. The midwife-woman relationship has been identified as the key sustaining element of one-on-one midwifery care. However practice experience reveals the potential for this key relationship to break down. This becomes a particularly complex and conflicting challenge when the midwife recognises that for her own professional safety she needs to unilaterally end the midwife-woman relationship.

Of paramount importance to a healthy functional partnership is mutual trust, respect and reciprocity. There is a taken for granted assumption that trust can be established and maintained, that there is willingness for sharing on both sides and a reciprocal respect. When trust is eroded or irretrievably breaks down, the health and survival of the relationship are threatened, and the alliance has the potential to become unstable and unsafe. Consequently the midwife may decide to end the relationship. A framework, to help navigate and support the midwife who is experiencing this distressing challenge, does not exist.

A case study, explored through descriptive interpretive analysis, is used to present one of the author's experience of a breakdown in the trust relationship. Analysis of the experience reveals the intuitive process this midwife utilised, to ensure she upheld her professional responsibility as well as maintaining her self-worth and integrity. Implications for practice arose from the discussion and principles were distilled. These may provide an appropriate and professional process for midwives on the rare occasion they need to end the partnership.

## KEY WORDS

Midwife, woman, relationship, trust, breakdown of trust, guiding frameworks

## INTRODUCTION

Challenging situations in midwifery can be many and varied - small and easily resolved or so large they feel insurmountable, threatening the emotional and professional well-being of the midwife (Pelvin, 2010). This is particularly applicable to Lead Maternity Care (LMC) midwives who work autonomously within the community, some more isolated than others, all without the equivalent of an institutional hierarchical structure to turn to for guidance and support let alone protection. A particularly complex challenge comes when the midwife recognises that, for her own professional safety, she needs to unilaterally end the midwife-woman relationship.

This paper presents a challenge related to the "cornerstone" and very essence of New Zealand (NZ) midwifery care: partnership. The intention is not to challenge the concepts of partnership, but to provide an opportunity to reflect on what Cox and Smythe (2011) suggest is a paradox, in that by truly upholding this concept, complex challenges will occasionally but inevitably manifest for midwives which threatens that very partnership. Significant conflict will exist for midwives as they struggle to maintain self-worth and professional integrity in a partnership which they recognise cannot continue whether or not their 'partner' (the woman) shares this view. This paper seeks to articulate suggested values and strategies to guide a midwife who decides to be pre-emptive (avoiding the risk of more serious deterioration) and end the partnership relationship.

## BACKGROUND

While the midwife-woman relationship has been identified as the key sustaining element of one-on-one midwifery care (Sandall, 1997; Engel, 2000 & 2003; Cassie, 2004; Wakelin & Skinner, 2007; Hunter et al, 2008; McHugh, 2009; Doherty, 2010; Leap et al., 2011) practice experience reveals the potential for this key relationship to break down (Smythe, 1998). The New Zealand College of Midwives (NZCOM) describes the nature of this partnership relationship as being based on trust, mutual sharing of knowledge, informed decision making and reciprocity (Gulliland & Pairman, 2010). There is a taken for granted assumption that trust can be established and maintained, that there is a willingness for sharing on both sides and a reciprocal respect.

Pelvin (2010) states "the midwife takes a leadership role in establishing the partnership, sustaining it throughout the life of the partnership and negotiating its completion" (p. 305). LMC midwives provide care to a wide range of women and require significant skills to modify and adapt the principles of partnership so that it becomes an individually negotiated and workable relationship. Of paramount importance to a healthy functional partnership is mutual trust, respect and reciprocity (Gulliland & Pairman, 2010; Anderson & Pelvin, 2010). However skilful a midwife may be in working in partnership, when trust is eroded, the health of the relationship is threatened, and can become unsustainable and therefore unsafe.

## THE NATURE OF TRUST

Trust is difficult to define and is described as an 'invisible assumption' most of the time (Simpson, 2012, p. 550). Trust plays a central part in our lives, forming the basis of all relationships (Pask, 1995), but as a concept is 'difficult to pin down' (Honey, 2004, p.11). Baier (1994) suggests that to trust another is dependent on goodwill from that person, but this is clearly subjective. The 'trustee and truster' may have different ideas on what goodwill is.

Goodwill is generated by behaviours that foster a feeling of trust. It is equally true that there are behaviours that contribute to distrust. This may be as a result of misread assumptions (based on past experiences), that relate to expectations about the 'standard and sphere of trust' (Henaghan, 2012, p. 16). Henaghan (2012) goes on to suggest trust will always entail risk as a result of the discretionary elements that exist and that ongoing clarification regarding expectations is required to nurture the trust relationship.

The development of trust in any relationship, including the midwifery partnership, entails reciprocal respect, goodwill, feelings of safety and reliance (Baier, 1994). The trust relationship becomes unstable when behaviours and attitudes do not warrant or provide evidence for the trust (Purtilo & Haddad, 2007). Although the midwifery partnership is based on reciprocity, it is the midwife who has the responsibility to facilitate the development of mutual trust as the relationship establishes, by demonstrating evidence of, or role modelling, her own trustworthiness. Even with particular attention to this, if reciprocal behaviours of trust from the woman are ambivalent or absent, breakdown of the trust will occur for the midwife, and the relationship will become based on fear, with potential for negative outcomes (Secundy & Jackson, 2000; Henagan, 2012).

When a woman chooses a midwife to be her LMC, a registration form is signed by both parties. This essentially becomes a 'contract of care'. Bilateral contracts consist of one promise being exchanged for another which could be perceived as a form of guaranteed mutual goodwill, trust, respect and reliance (Baier, 1994). The Maternity Services Notice (section 88) (Ministry of Health (MOH), 2007b) is explicit in identifying what the midwife provides in terms of service specifications, with all provision being based on "partnership, information and choice" (p. 1033).

If a woman distrusts the care she is receiving and the 'contractual promises' are not being delivered on, it is clear in both Section 88 related documents (MOH, 2007a; MOH, 2007b) and consumer information (Maternity Services Consumer Council, 2008; MAMA, nd; MOH, 2011) that the woman can simply break the contract at any time, by changing her LMC. Section 88 makes reference to the LMC not continuing care in two places (MOH, 2007b, p. 1053 & 1060) but unfortunately these statements fail to guide the midwife. They are confusing, and open to more than one interpretation. Anecdotal evidence exists in that some believe the Section 88 contract of care cannot be 'broken' by the midwife. This is simply not the case although there is no explicit reference to under which circumstances the midwife too can break her signed contract with the woman.

## WHEN TRUST BREAKS DOWN

Professional safety is a concept that is 'based on the sound development of the relationship with the woman' (Skinner, 2010, p. 75), with the essential attributes of strength, trust and reciprocity, that will facilitate appropriate safe decision making by both woman and midwife (Guilliland & Pairman, 2010). When a midwife recognises that the partnership is not working and probably will never work; when she lacks trust in the woman, and feels therefore 'professionally unsafe', she may unilaterally decide she must end the contractual relationship.

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## Relationships based on fear rather than trust become unsafe and unhealthy.

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How often this occurs in NZ LMC practice is unknown, although anecdotal evidence suggests most midwives have at least one complex experience of this kind approximately every five years. Such an infrequent rate of this development is supported by Schorn (2007) in her survey of American midwives unilaterally discharging clients when un-resolvable relationship breakdown is experienced. Many reasons were cited as contributory to the midwife's decision to end the relationship but underlying factors of lack of trust and loyalty existed.

Guilliland (2004) tells us "love and fear are the two strongest feelings for both a woman and a midwife" (p. 5) and that a strong, trusting, reciprocal partnership will contribute to balancing these emotions. Partnership cannot be practised and will become morally inappropriate (Baier, 1994) if either party acts through fear of repercussions. When the midwife perceives the trust relationship has broken down, fear of an unjustified complaint from the woman may become overburdening and precipitate defensive practice (Surtees, 2010). Relationships based on fear rather than trust become unsafe and unhealthy. Henaghan (2012) suggests the human spirit becomes sapped when one lives or works in fear for long periods. Ending the relationship must be essential in these circumstances.

## METHOD

Case studies, such as the one presented in this paper, are used to offer 'detailed and intensive analysis of a single case' (Bryman, 2012, p. 66), examining contemporary phenomena especially where interrelated complex issues are involved (Pope & Mayes, 1995).

Descriptive interpretive analysis has then been used to further explore the case study. This method is ideally suited when the researcher wishes to hear the voice of a person/people, analyse the themes and present a thoughtful overview of results (Sandelowski, 2000; Smythe, 2011). The theoretical underpinnings do exactly what the name implies: describe and interpret.

In order to examine the reality of unexpectedly ending the partnership relationship, Liz asked Debbie to describe a practice experience. Debbie has chosen this specific example because she believes it is one particularly important to share with colleagues. Liz listens and, with Debbie, makes sense of the data. The strength of this approach is its straightforwardness. The limitations of this method is that the analysis may not move beyond what Debbie has said, in order to explore deeper meanings. However the intention here is to provide an insightful exploration that culminates in the reader considering suggested practice principles if ever faced with a similar challenge.

## PRACTICE EXPERIENCE

Debbie was interviewed by Liz about one of her own experiences of a breakdown in the trust-relationship and what follows is part of the transcription of the interview:

*A red flag went up for me the first time we met. There was something about her manner that made me think she had the potential to be demanding and possibly unreasonable. That turned out to be the case on an occasion when she did not approve of something I did. The conversation that resulted was extremely unpleasant and I decided that it*

*was 'unsafe' for me to continue in the relationship. I felt really upset by the whole thing as it was the first time in 10 years of practice to have this experience. But partnership and trust became non-existent and I felt she would be 'out to get me' regardless of the standard of care I provided, at some point or another. Even though I tried, it eventually felt too hard to turn the relationship around when I was feeling so battered. And a fear was growing that if I remained in the relationship I felt at risk for having my reputation undermined unfairly. Thus I decided to withdraw from her care, but found there was nothing to guide me.*

In reflecting on this experience it is clear that right from the beginning Debbie felt this relationship was going to be difficult. There was not the easy, open warmth and sense of mutual goodwill that normally comes with the first meeting. Rather there was distance and formality. When the woman made the complaint, Debbie felt it was unjustified. From her long experience in practice she knew other women readily accepted similar instances of such care. This woman did not seem to understand, or offer Debbie reciprocal respect. This encounter of tension revealed that the woman did not trust the midwife, and the midwife no longer trusted the woman.

Debbie initiated a conversation towards clarification of the misunderstanding in the hope of rebuilding trust, but this was to no avail. The woman was still dissatisfied with the manner of care and she exhibited behaviours that did not foster feelings of trust. At this point Debbie recognised that, for her own well-being and protection, she needed to terminate the relationship. Debbie was now faced with how to do this in a professional manner that would minimise the potential risks for both her client and herself.

## GUIDING FRAMEWORKS FOR MIDWIVES

A framework to support NZ midwives, and help them navigate their way through this challenge does not exist. How should the midwife manage the situation in the most professional way for both the woman and herself? How does the midwife release herself from the LMC contract (MOH, 2007a) that the woman has signed with her? Although an 'exit' clause exists for the woman, there is no equivalent for the midwife should she find herself in the uncomfortable, and unsettling situation of wanting to end the contract of care.

When a woman declines a referral, consultation, transfer of clinical responsibility, emergency treatment or emergency transport, the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) (Ministry of Health, 2012) directs the LMC midwife how to fulfil her professional responsibilities. Steps are outlined to support the LMC with continuing care in this challenging situation. Additionally steps are provided should the LMC decide to discontinue care. However no specific midwifery guideline exists to support practice in a non-clinical situation that necessitates the unexpected and unilateral end to the midwife-woman relationship.

Midwifery Council New Zealand (MCNZ) "Code of Conduct" booklet (2010) refers only to ending the "professional relationship with women at

the appropriate time as communicated with each woman in a professional manner" (p. 3). This refers to the natural ending of the partnership usually four to six weeks into the postnatal period.

Anderson and Pelvin (2010), in their chapter on ethical frameworks in the textbook *Midwifery: Preparation for Practice*, present a scenario of a difficult midwife-woman partnership. They pose questions for consideration, but provide no answers or guidelines, particularly in the context of a partnership becoming unworkable. Surprisingly midwives may find the most guiding document to be that of NZCOM's "Unexpected Outcome? Legal & professional information for midwives" (nd). The 'unexpected outcome' in this booklet is never identified as such, so could cover a range of possibilities, including the unplanned for, and rare, need to terminate the partnership. Certainly the advice offered regarding the question "I've been involved in a case which may result in a complaint - what should I do?" (p. 2) could apply to the stressful challenge of terminating the midwife-woman relationship as there is a strong likelihood the woman will feel aggrieved with her midwife's decision, and make a complaint. However, amidst the experience of living through the tension of ending the partnership because of reciprocal lack of trust, with or without an 'unexpected outcome', Debbie would have valued clear, specific steps to guide her.

## GUIDING FRAMEWORKS USED BY OTHER PROFESSIONS

Nursing Council of NZ provides guidelines on professional boundaries for nurses (2012), but, like MCNZ's Code of Conduct (2010), the statement on concluding professional relationships is related to a positive and natural end. However Cole's Medical Practice in NZ (St. John, 2011) guides the medical profession in terminating the professional relationship when there is a breakdown. Paterson (2005) discusses this scenario in depth and refers to the relevant statement in the NZ Medical Association's Code of Ethics (2008) that acknowledges the right to withdraw from providing care in certain situations and lays out the steps that are required. Paterson (2005) qualifies this course of action by saying it must be "handled with care" and "calling it quits should be an option of last resort" (np)

The NZ Association of Psychotherapists (NZAP) and NZ Association of Counsellors (NZAC) discuss in their handbooks (NZAP, 2008; NZAC, 2002) the mandatory role of professional supervision, citing the challenging client-practitioner relationship as an issue that will benefit from the insight, support and guidance gained from in-depth discussion with the practitioner's supervisor. Facing this issue, in addition to the support received from practice colleagues, midwives would similarly benefit from the opportunity to take stock and reflect with a skilled midwife 'mentor', as described by Smythe and Young (2008) and Lennox, Skinner and Foureur (2008). Concepts of self-care, staying safe and sustaining practice all spring to mind as key concepts influencing the midwife fielding this challenge.

When we looked further afield in the literature, we found that the National Association of Certified Professional Midwives (2004) and the American College of Nurse Midwives (2008) grant their members the right to discontinue care in 'unacceptable situations' resulting in lack of trust and partnership (Foster and Lasser, 2011). They discuss the ethics involved in this very serious matter. Inherent risks to the woman, such as abandonment, must be thoroughly considered (Paterson, 2005; Schorn, 2007; Foster & Lasser, 2011). Foster and Lasser (2011) acknowledge the importance of seeking collegial support, but also suggest establishing and following written guidelines "as these situations can be very difficult to manage ethically" and stress the aim that "dignity, autonomy and fidelity" are upheld for all involved (p. 141).

Midwives will experience conflict when they recognise a particular relationship cannot continue. Maintaining self-worth and professional integrity when faced with such a key concept as partnership not working, may produce a 'burden of moral stress' (Dann, 2007, p. 639). Surtees (2010) expresses this as "balancing the elements of risk within the realms of restraint and responsibility of partnership with women" (p. 81). A formal framework that facilitates a professional and safe way to unexpectedly end

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the midwife-woman relationship (albeit an infrequent occurrence) would be supportive to midwives in NZ and contribute to sustaining practice.

## GOING THROUGH THE EXPERIENCE

Debbie recalled what it was like to go through such an experience:

*I felt I was 'damned if I did' and 'damned if I didn't' get myself out of the partnership. I knew whatever I did, I was going to remain vulnerable. I didn't want to work with someone whom I felt would inevitably make a complaint about me, regardless of the care I provided. I found it really upsetting and would go so far as saying I found myself in a state of anxiety. I wouldn't want to have face too many of these situations especially as I consider myself to normally work very well in partnership! Thank goodness for my close midwifery colleagues. Together we nussed out how we thought it best to handle the situation....*

Withdrawing from a client relationship generates stress and anxiety and should not be tackled alone. Often the midwife is already dealing with an angry client. Ending the relationship professionally and safely is demanding and however 'well done', there is potential for repercussions.

At the very heart of coping with a challenge, such as this, must lie the availability of meaningful midwifery support (midwifery practice colleagues, mentors, and advisors) in order for the midwife to reflect constructively on the experience that has presented. The way forward for Debbie required thoughtful collaborative planning, of appropriate care and safety for both parties, whilst still enabling her to "maintain a secure sense of self" (Pairman, 2006, p. 93), as well as sustaining her practice and passion for midwifery.

## WORKING OUT OWN FRAMEWORK

Debbie described to Liz the strategies she developed for herself after unsuccessful attempts were made to rebuild the trust in the partnership. Liz unpacked the data Debbie provided.

### Support from colleagues

*I was disappointed that the situation wasn't able to be reconciled but felt relieved I had my close practice partners to carry on getting support from. They helped me establish 'where to next' with the difficult job of extricating myself from being the LMC.*

It is important to have close relationships with colleagues who already know and trust one's normal standard of practice. Their feedback is an important touchstone of the seriousness of the situation.

### Support from others

*I was so upset by the whole thing. It felt hideous. I worried about it so much I felt I needed to talk to key people outside of my practice as well, people I trusted in and out of the profession, just to check out other perspectives... like the consumer one I guess. I had great support around getting out of the partnership which was reassuring.*

To remove oneself from providing care to a woman is a big step. It is possible that the midwife herself is too close to see influencing factors that could be resolved. For Debbie, one important voice was that of 'the consumer'; a trusted woman who gave a perspective from having stood on the other side of the partnership relationship.

### Communicating with the woman

*Talking on the phone had become very difficult, impossible actually, as what I was saying wasn't heard or accepted...responses were really aggressive. In the end I wrote a letter clearly stating I was not her LMC anymore.*

Ineffective communication was the root of the problem in this situation. Therefore it was important that the midwife record her decision to withdraw care in writing. Debbie needed to know the outcome was clearly stated and heard, and that she herself had evidence of the wording of the message.

### Communication with others

*I actually felt I needed to make this action as formal as possible by informing the District Health Board DHB, (and Health Benefits) that I*

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*was not now the LMC. I didn't want the DHB to be phoning me in the middle of the night saying my woman had presented and I needed to come in. Section 88 provides no guidance/steps that should be taken to undo the LMC'ship. I had to make it up as I went along.*

Debbie was not sure whom she needed to inform, so she made sure every stakeholder who could end up in the midst of this situation knew she was no longer the LMC. It was important for the woman's safety that there was no confusion in her ongoing care about who was carrying clinical responsibility.

### Preventing a gap in care

*One of the things I was advised about was to send a list of alternative midwives/providers in order to minimise the sense of abandonment. I also got in touch with the manager of the DHB Community Team and told her the situation as I suspected this would probably be where care would be taken up. Not only did I get great support from this midwifery manager but I felt as if I was also doing a handover.*

It was difficult for Debbie to hand over care when she did not know who the woman would turn to for ongoing care. Nevertheless, Debbie's understanding of options helped her to recognise the most likely choice. She talks of feeling very supported in this difficult situation. Such support makes all the difference for both parties in the breakdown of a relationship.

### Documentation

*What I did was to make sure that I documented all our conversations very carefully. I had to do this on separate pieces of paper as the maternity notes were with the woman. I then wrote a letter to the woman. That meant that we both should have been very clear about where each of us stood.*

As an LMC Debbie already knew the importance of documentation. The difference in this situation was that she no longer held the woman's notes. However she recognised the need to establish her own file of all written communication, and to write an audit trail of events.

## EMERGING PRINCIPLES

Principles emerge from our reflections on what Debbie intuitively did. These are about:

### Meaningful midwifery relationships

Skinner (2008 and 2010) states that the development and maintenance of meaningful successful midwifery relationships are crucial in practice. Others agree that "the quality of relationships is fundamental to the quality of maternity care" (Hunter et al., 2008, p.132). Midwives require supportive reciprocal relationships (Kirkham, 2007; Pelvin, 2010) to underpin their practice so they can remain safe. Hunter et al. (2008) state provision of continuity of care is "conducive to relationship formation" (p.134) and this should equally apply to supportive midwifery relationships within midwifery practices.

Building links, cherishing and trusting each other, using the same principles of the midwifery partnership (Guilliland & Pairman, 2010), will not only

sustain midwives within a practice on an everyday basis, but will prove invaluable when challenges and dilemmas present. Although Smythe (1998) is essentially referring to the midwife-woman partnership, the trust and knowing generated in trusted midwifery relationships can free the midwife to “leap ahead, discerning what she perceives lies in the darkness” (p. 188).

Midwives supporting midwives will create a positive spiral/continuum (Kirkham, 2007). The value of time used to facilitate investment in developing such relationships cannot be underestimated. Jones (2000) suggests that midwives positively supporting midwives will generate generosity of spirit, reciprocity, and “as long as the circle of empowerment remains unbroken, it is self-perpetuating” (p. 167).

#### *Generation of wider collegial support*

If a midwife develops a trusting relationship with a ‘wise woman’ midwife mentor outside her practice, this will provide opportunity for her to gain perspective, advice and guidance, to reflect and feel empowered - all of which are required, but more at some times than others. Mentoring support is available through the Midwifery First Year of Practice Programme (New Zealand College of Midwives website) for graduate midwives but this should not be seen as only applicable to new graduates but to all midwives. Smythe and Young (2008) describe a more formal arrangement introducing the notion of paid professional supervision which would offer a “safe place.... to ponder” (p. 13). In addition professional advice and support, particularly when a dilemma presents, can be accessed from an NZCOM Midwifery Advisor.

#### *Remaining professional*

Frameworks for practice provided by MCNZ (e.g. Code of Conduct, 2010), NZCOM (e.g. Code of Ethics, Standards for Practice, 2008) and MOH (e.g. Section 88 including Referral Guidelines, 2007 & 2011) guide practice in most complex situations (Skinner, 2010). Facilitation of collegial support and collaboration and the delineation of professional practice boundaries are outlined in these documents and careful reading of them will support the midwife to remain professional and provide appropriate care in most situations where a midwifery dilemma presents.

However, within these frameworks, there are no specific guidelines that lay out an appropriate, safe and professional process to end the unexpected and premature conclusion to the partnership.

#### *Communication*

Hunter et al. (2008) suggest “the quality of relationships is inevitably linked to the quality of communication, and effective communication is essential for safe practice” (p.133). This applies primarily to the midwife-woman relationship but, equally, talking through practice challenges in depth with valued practice colleagues will help to clarify how to appropriately manage a complex situation, coincidentally keeping the midwife safe (Brodie et al., 2008; Foster & Lasser, 2011; Davies, Price, Edwards, & Beech, 2013).

Communication is considered by Foster and Lasser (2011) to “be the midwife’s most important tool” (p. 140), and the quality of communication reflects the quality of the midwife-woman relationship (Skinner, 2010). In irremediable situations effective verbal communication becomes difficult, if not impossible. Regardless, a decision to withdraw from the contract of care, and the reasons for this, must somehow be articulated to the woman (Paterson, 2005).

#### *Keeping the midwife safe*

Comprehensive and accurate documentation of the sequence of events ideally provide evidence of attempts to renegotiate the partnership, decision to terminate care, steps taken to avoid abandonment or gap in care, and where possible handover to next maternity provider (Foster & Lasser, 2011). By so documenting, the midwife is properly following her profession’s code of ethics and standards of practice (NZCOM, 2008) and thereby maintaining her own safety in this context (Skinner, 2010).

#### *Keeping the woman safe*

A midwife who decides to end the contract of care will be faced with her own sense of failure in terms of partnership, obligation and duty. This sentiment must not prevent her from acknowledging the woman’s potential experience of loss and abandonment (Forster & Lasser, 2011). Abandonment will be minimised by taking all actions to provide the woman with alternative care options - which admittedly will be harder in some geographical areas than others.

Although there are no legal issues regarding termination of the woman-midwife relationship, there are ethical considerations that include concepts of dignity, autonomy, fidelity, beneficence and non-maleficence. Foster and Lasser (2011) argue that, if the woman is denied clear communication, documentation, information on alternative maternity providers, and handover (if possible), then the gap in care and sense of abandonment that ensue will reflect badly, not only on the individual midwife but also on the profession as a whole. To minimise this happening they suggest that the ‘establishment of written guidelines for discharging clients....is advisable” (p. 141).

## DEVELOPMENT OF SUPPORT FOR PRACTICE

From the principles that emerged during Debbie’s discussion with Liz, an interim framework is offered to guide midwifery practice in similar situations (Table 1). It is hoped that this paper will stimulate further discussion from the wider midwifery community, particularly amongst those who have found themselves facing this experience. Should that occur, the potential for future development of a national consensus on formal guidelines, to replace this interim framework, is high.

**Table 1:** Framework for attempting to rebuild trust within the partnership:

- Maintain woman’s dignity throughout
- Generate support from midwifery colleagues
- Reflect on situation with an experienced midwife to clarify circumstances and plan appropriate ways to rebuild partnership
- Discuss the issue directly with the woman. Clearly explain why the partnership is not working for you as the midwife. Attempt to negotiate to maintain the partnership
- Document the discussion in the woman’s maternity notes
- Offer, if necessary, a mediated meeting, either through agency of paid professional mediator or through agency of NZCOM Resolutions Committee
- Seek professional support and advice from a midwifery ‘mentor’
- Write own personal documentation/reflection on the situation

#### *If no resolution:*

- Communicate clearly to the woman that the partnership has ended
- Minimize risk to woman; avoid sense of “abandonment” and a gap in care if possible by providing a list of alternative care providers
- Document each step
- Photocopy all notes
- Provide a “handover” to next LMC

*“Extensive feedback” may be received, via the Midwives Standards Review process (NZCOM), from the woman. If accepted by the woman this, too, may lead to a Resolutions Committee meeting. A formal complaint may still occur.*

## CONCLUSION

New Zealand’s unique LMC midwifery model of practice, as translated through our LMC system of delivery of maternity care, is a privilege for both women and midwives. Underpinning this model of practice is the concept of partnership. Even when truly upholding this concept, midwives may occasionally find themselves faced with the challenge of a partnership that has irretrievably broken down. As Debbie’s experience revealed, navigating the stressful situation of ending the midwife-woman relationship alone, felt unsustainable. Whilst trusted and meaningful support from practice colleagues and the wider midwifery community is essential for safe practice and the wellbeing of the midwife - and usually readily available to most midwives, there is a lack of ‘support’ in the shape of a ‘brass tacks’ formal guideline that maps a process reflecting a professional and responsible approach.

An interim framework based on practice principles has been presented for the midwife to consider if confronted with this situation. This offers

an interim navigational tool and intends to provoke a conversation and a process leading to formal guidelines for an appropriate, safe and professional (if not albeit unexpected and premature) conclusion to the partnership. National guidelines are essential for the midwife to maintain self-worth and integrity, and to be able to stand strong and true to her profession throughout this fraught but rare challenge.

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**Accepted for publication Feb 2014**

MacGregor, D., & Smythe, L. (2014) When the Midwife-woman partnership breaks down – principles for ending the relationship. *New Zealand College of Midwives Journal*, 49, 11-16.  
<http://dx.doi.org/10.12784/nzcomjnl49.2014.2.11-16>