

MCP²

Multidisciplinary
Collaborative Primary
Maternity Care Project

Projet de soins
primaires obstétricaux
concertés



Multidisciplinary Collaborative Primary Maternity Care

Focus Group Report

Guidelines for Model Development

Discussion Paper

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Multidisciplinary Collaborative Primary Maternity Care

Focus Group Report¹

1.0 Introduction

The Multidisciplinary Collaborative Primary Maternity Care Project received funding from the Primary Care Health Transition Fund to “*reduce key barriers and facilitate the implementation of national multidisciplinary collaborative primary maternity care strategies as a means of increasing the availability and quality of maternity services for all Canadian women*”.

This paper reports on one of the methods being used to develop multidisciplinary collaborative maternity care models. The first in the series of background research papers – a literature review – was prepared in December 2004 (Anderson, 2004). An interview report has also been prepared and a subsequent paper will present findings from an e-delphi process conducted with key informants from across the country (Anderson, 2004).² It is very important to emphasize to the reader prior to reviewing this paper that its content must be seen as nested within an iterative process; the model development is ongoing, and the input presented here from the focus groups contributes to this process.

A final report synthesizes all the findings from the data collection of this phase one initiative, the purpose of which is to develop a model of multidisciplinary collaborative primary maternity care that can be used in a range of different contexts across Canada.

The paper begins with a discussion of conceptual framework used in this research (section 2). Section Three reports on the approach used for this phase of data collection from the focus groups. It describes the process employed, and the range of focus groups from across the country. Section Four reports on the findings. These are clustered under the prevailing themes to emerge from the group discussions.

¹ The analysis and conclusions presented in this report do not necessarily reflect the views of the members of the MCPMCP or their partner associations. Funding for the research was provided by Health Canada as part of the Primary Health Care Transition Fund. The views expressed herein do not necessarily represent the official policies of Health Canada.

² Other research is also being conducted as part of the overall MCPMCP. For more information please go to www.mcp2.ca

2.0 Conceptual Framework

It is important to situate the development of collaborative maternity care models based on an underlying rationale that quality care is comprised of a range of expected, fundamental outcomes. Figure 1 (next page) reflects the integration of two complementary frameworks for the development of collaborative models; the Donabedian framework for quality (1966, 1980, 1982, 1985, 1988) and the framework for understanding and applying change in organizations (Pettigrew et al, 1992).

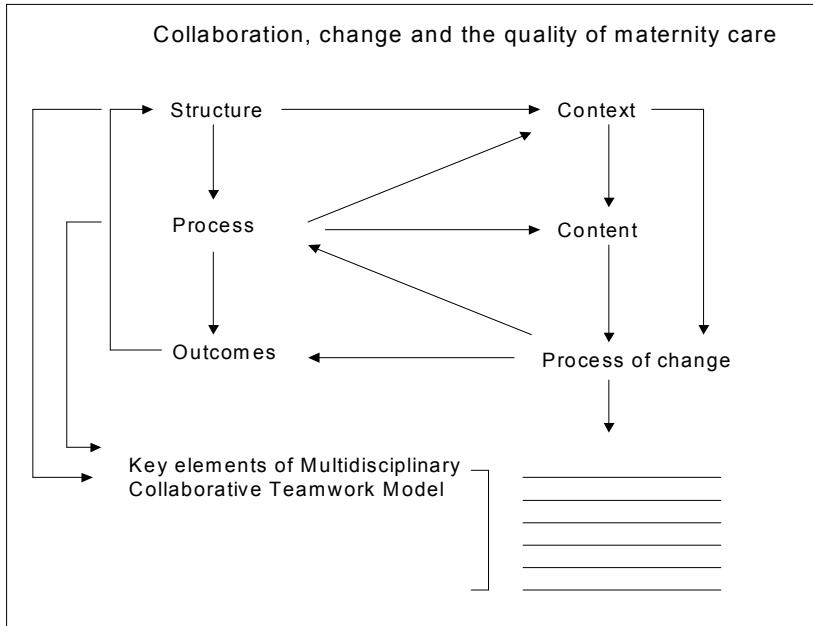
The logic of the integration is as follows: The ultimate goal of developing collaborative primary maternity care models is to improve the quality of care through more effective and efficient work processes and the realignment of increasingly scarce human resources. There are several key elements in a collaborative model that affect, and are affected by, the structures and processes in place in respective areas providing maternity care. To move towards collaborative models requires effective changes in what and how services are provided.

Thus developing guidelines for models has an explicit '*change*' dimension as organizations and professionals either independently or collectively move from one way of providing care to another. Change is multidimensional. Any changes introduced in organizations will be understood in terms of the *context* in which it is introduced (i.e., internal and external contexts), the *content* that is the focus of the change, and the *process* by which change is introduced.

The inter-relationships among Context, Content, and Process form the framework for introducing change, managing expectations and enhancing uptake and further knowledge transfer. In operational terms it provides the foundation for implementation – for developing guidelines for model adoption. Schematically this is represented in Figure 1 (next page).

The key elements of multidisciplinary collaborative teamwork models (MCTM) are integral for improving outcomes, and in fact, lend themselves well to subsequent formative evaluation of the new models that may emerge. Thus in the bottom right-hand quadrant, the key features of a MCTM can be agreed upon and used as a basis for further model development.

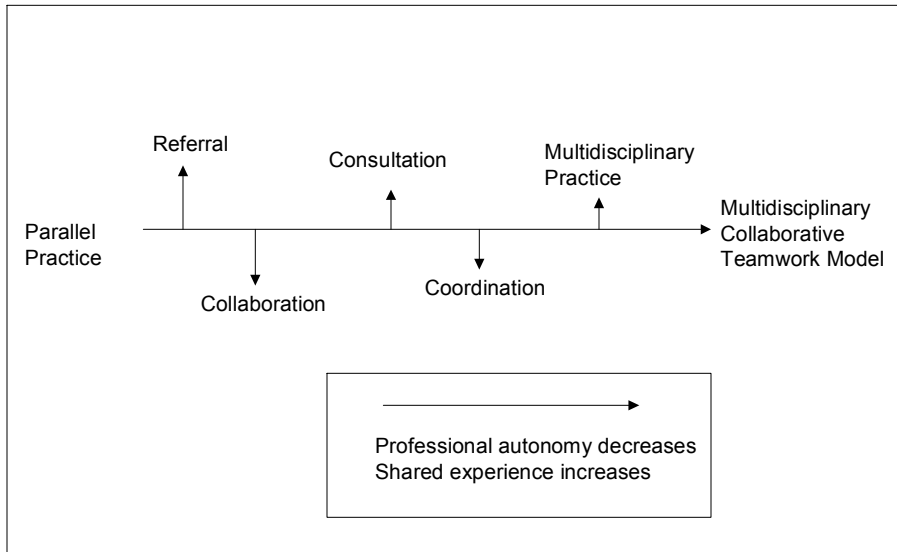
Figure 1: Collaboration, change and the quality of maternity care



In Figure 2 the multidisciplinary collaborative teamwork model (MCTM) is shown to clearly move beyond simply focusing on parallel practices, and is presented at the other end of the continuum – and is much further developed than models based around referrals and consultations. Various models of maternity care exist at any point along the continuum, including ‘collaboration’ as a distinct and separate entity.

This is partly because many providers feel they *do* collaborate even though they do not have any formal ongoing structured means of doing so, but rather on an ad hoc case-by-case basis. And that, to them, is collaboration. Ultimately it is assumed that new models will improve care on a range of expected outcomes.

Figure 2: Continuum towards a Multidisciplinary Collaborative Teamwork Model (MCTM)



Adapted from King and Shah (1998).

3.0 Method

Focus groups were conducted between April and May 2005. Initially it was determined to conduct 10 focus groups with a range of stakeholders from across the country in the first few months of 2005. This, however, proved extremely challenging for a variety of reasons. We ended up with eight focus groups, including several with existing collaborative models.

When organizing the focus groups every attempt was made to represent all professionals. Early on in the process of contacting participants for the focus groups it was evident that it would be somewhat difficult to recruit participants from specific professional groups. As an alternative we elected to construct some focus groups with specific professionals groups and others with professionals working within existing collaborative models.

Notwithstanding this, the focus group representation falls short in the areas of family physicians, obstetricians and nurses. We attempted to contact these professionals with assistance from the Model Development working group of the steering committee, the broader national committee members themselves, and through the SOGC contact lists.

Despite this it was still very difficult to reach these professionals, often having to "sell" the concept of participation to medical secretaries managing very busy schedules. This was the case even when physicians were referred to us by other physicians.

Based on this lengthy and disappointing response and recognizing time constraints with the project, we determined that conducting additional interviews would be more effective than attempting to get these professionals to participate in focus groups. Three interviews were therefore conducted with family physicians and two with obstetricians in lieu of focus groups participation. In any case to supplement the focus group data this report is also based on the additional five interviews conducted with family physicians and obstetricians.

Fortunately, the focus groups with current models included representation from nurses, family physicians and obstetricians. Participants in the focus groups also included administrators, midwives, those in training in specific professions, and consumers. In total there were 65 professionals and consumers from five provinces who participated in the eight focus groups. We conducted three of the focus groups face-to-face (Manitoba) and the remaining five by telephone. The two Nova Scotia focus groups were scheduled to be conducted face-to-face, but at the very last minute our plane flights were postponed indefinitely. Instead the groups were conducted by telephone. A matrix describing the breakdown of focus group participants is provided below.

Focus Group Participants

Province	Midwives	Family Physicians	Nurse/NP	OB/GYN	Consumers	Models
Manitoba (FtF)	X (8)					2X (18 & 10)
Nova Scotia					X (6)	X (8)
British Columbia						X (7)
Ontario	X (6)					
Alberta						X (2)

4.0 Findings

“You must trust that the others you work with know what they’re doing. We all have our own skill sets”.

“There is an assumption that collaborative model of practice will be better for practice”.

“Somehow or other, we can’t lose sight that giving birth is not a medical event – it is a birth event – a family event”

The findings resonated strongly with those obtained from the 40 interviews conducted in the first part of 2005. This section identifies the key themes to emerge from the focus group data.

What Women Want From Primary Maternity Care?

Women want the best for their babies. They want the choice to be able to deliver in the hospital, birth centre or home. They want to be respected and provided with good, friendly care. Moreover, they want the appropriate use of technology rather than blanket assumed use (e.g., IV, ultrasound, inductions). Importantly, women want to be treated as individuals. It was also noted that women are not looking for a collaborative model; it is the professionals who are looking for a collaborative model of care.

Women want convenience – they should not have to be going all over town (and the country) and waiting for hours and hours. Being in control is also important, especially when giving birth. Post-partum care is also highly valued, and comments were expressed noting that visits from public health nurses are very important. Needed, however, is further support re: nutrition, and other lifestyle behaviours such as stopping smoking?

Consistent pre-natal care is important to women. There is a need to educate people in this stage. Women also need someone they can trust, who is willing to help and accommodate their needs, and who is respectful towards mothers and fathers. Midwives again, were recommended, as there is the belief that they provide better continuity of care and support throughout.

The consumers’ focus group discussed the role of a Doula in primary maternity care. *“A Doula is a great thing as she will be there for you. My Doula came in before the birth, introduced herself, said she was there from the head-up and wouldn’t interfere anywhere else”.* This particular individual’s experience also included a meeting of the Doula with her physician – and the subsequent collaboration, *“went really well”.* In British Columbia meanwhile, doulas are seen as proven and valuable team members of collaborative models of care. Although doulas are very supportive of the fathers, some consumers expressed concern that the Doula could take over the role of the father.

The consumers group recommended a number of improvements to the current system of primary maternity care. Expecting mothers need to make sure that the professionals have access to their files *“so they know what you want/need”.* There needs to be a birth plan. This can be a standard approach for women and their families, and a road map for

the health professionals with women at the centre. Regardless of who is seeing the woman, they *“just want to have them recognize you – a common focus and with a smile on their face”*. More and more support for men *“would be wonderful”*.

Being informed is *“a huge thing”*. It was suggested that this should begin at the school level. *‘Reproduction workers in the community would be ideal’* as this would contribute to preventative health care. There needs to be more emphasis on breastfeeding, especially in prenatal classes. Breastfeeding is also important in post-natal care, as it helps to prevent post-natal depression.

There should be more opportunities for women to sit down together and discuss what they want and the type of care they need. A consumer’s focus group very strongly supported the development and use of drop-in centers where recent mothers can go and share experiences with others, use resources and in general have a place to reduce stress and build relationships with others who have, or are, experiencing the same thing.

Similarly, another woman commented that she *“found it hard to have a doctor who would even listen to me. The doctor did clinical work...In prenatal – didn’t have discussion on choice/options. Midwife care is the best. Its very inclusive of [my] daughter, family etc”*.

One physician noted and indeed reflected the views of women that what is important is a safe and healthy baby, and the need and desire for women to have developed a relationship with the provider they are seeing, preferably 1-2 physicians, and not 5-6. Women also want to see that the team is clearly working together to address the woman’s needs. They would like a system that looks for risks and proactively offers things to prevent that.

Recent mothers were strongly supportive of the role of midwives; *“it should be the first thing we have. ...It’s where it’s at.”* They also agreed that there is definitely a place for physicians working with midwives. As one of the mothers noted, *‘It comes down to information. If you don’t know, how do you know what to ask?’ “Cyst on your placenta” – he [the doctor] didn’t take the time to answer. “You have a right to know what’s happening with your body. I find the doctor is always looking at the clock.” When you don’t answer the question properly, it may even be more dangerous – mom might blow it all out of proportion with half answers”*.

Key Features of a Successful Model

There were a number of key features identified by the focus group participants. Overriding it all were successful outcomes and safety for the expected mothers.

It was suggested in some of the focus groups that a population health approach is important – that there can be a positive birthing experience with healthy babies that will then contribute to healthier children (e.g. breastfeeding). A collaborative model will benefit from the input from a different range of providers, plus additional input from the community.

Considerable support was given to the use of OSCAR – the electronic medical record that assists maternity care providers to increase their effectiveness as a collaborative model (i.e., used for scheduling, messaging, billing functions with secure access). One

collaborative model, for example, noted it was moving to having everything being electronic, although there are no plans as yet to use personal digital assistants (PDAs) such as Palm Pilots or Pocket PCs. Initially there had been some degree of duplication with paper based record entry but over time the shift occurs to have everything electronic.

Key elements of the collaborative model identified by focus group participants include:

- Woman centered
- Egalitarian relationships
- Effective communication
- Continuity of care.
- Women want 1) voice (being heard), 2) choice of partners in their care, 3) control.
- “Trust” in sharing the information (from other professionals)
- Call rotation – takes the burden away, addresses work-life balance.
- Clear boundaries need to be established (e.g., when is it high risk etc).
- Respect. Appreciations of the values of each team member, as they all contribute. It should not be that one health care provider has the final say
- “Team” care plans are developed (defined by the woman’s care needs, individualized for the client, where information, psychosocial especially, is important, not just purely medical information).
- Education of students and continuing education very important. It was noted that medical students and residents need to be encouraged to work in collaborative care and have good role models.
- Creating and building relationships important
- Understanding each other is a central element.
- Shared care, on-call shared.
- Decision-making autonomy and flexibility with professional choices.
- Need freedom to choose to be in the collaborative model.
- Need to maintain standards of Midwives
- Common understanding of women centred care.
- Think of care on a continuum of interests, skills sets and expertise
- No hierarchy or power relationships
- Acceptance of expertise in pregnancy continuum
- Recognition that the care team is broader than nurse, midwife, doctor
- Equity of Finances. People need to feel they are fairly compensated. Importantly, they should be compensated fairly for actual collaboration (e.g., OB consultants could be paid for both the delivery and being available over a set time for collaboration related activities).
- Different philosophies of all professionals have to be respected – and the client needs.

Further comments from participants support these elements:

“You can collaborate well with those who have a shared philosophy”.

“With women centered care you have plan and follow it and get team to fit into this”.

“We forget that PTs and OTs are instrumental in helping woman deal with labour and post partum depression. Health educators also have plenty to offer with pre, intra and post natal care, as do Doulas”.

“Existing institutional models don’t work – little accountability. Nobody reports to the woman – who can’t provide feedback”

“When things go wrong... need to talk through what happened – do a review. How to do it better next time. This helps to avoid “bad blood”. Say what is on mind and how to avoid next time”.

“If I trusted the organization I’d be fine. It was good having a Doula attached to me. 1st baby – “It’s beyond the medical, it’s emotional.”

There was criticism in the focus groups about the overly medical model of maternity care, and a call for care being much greater choice for women. One focus group observed that there are a lot of assumptions about what ‘collaborative’ means, for example, *“I’m in charge” (OB) and everyone reports to me ...I’ll decide”*. In fact, to that focus group (with midwives), the definition of collaborative is *‘contested territory’*.

Importantly, collaborative team members need to know each other on some level. It is difficult for family doctors or obstetricians, for example, to trust someone they do not know. Midwives observed that different professionals hold true to essence of their type of care – Midwives, for example, are able to do informed choice – continuity of care. They work together in a non-hierarchical relationship. One focus group observed that recognizing each other’s strengths, and working in teams can address problems much better than outside team structures.

Also important, and something not to lose sight of is the need to know the patients ahead of time. This enables providers to recognize situations before they develop. Being patient centred – working towards best care for patient, and respecting their wishes will lead to higher success with collaborative care.

Being in close proximity to one another is important for building relationships and collaboration. With regard to accountability, one group felt it was important that there always has to be one primary *“most responsible”* physician (care provider) – this has to be really clear and documented as to who is the person in charge. This needs to be clearly communicated. Others, however, felt that one person did not have to take full responsibility – which this rests with the core team more generally.

Benefits of a Collaborative Model

There were numerous benefits of a collaborative model cited by focus group participants. An important benefit is being able to break down the barriers between midwives, family physicians and other doctors. In one collaborative model, participants noted that they simply sat down as a group and looked at what their prototype looked like. They are now breaking down the silos. There are no egos but rather passion and caring. The team is *“connecting together”* as are the women who receive care and support from the model. In prenatal care, support, post-partum, etc. the team gets the group of women all together, and raises awareness of what others in the team do.

There is a belief that a collaborative model provides better care, and enables team members to see what skills other professionals bring (e.g. physiotherapists). As one team member commented, *“when you work in a model, it’s amazing how much better it becomes”*. Nevertheless, as with the interviews conducted it was noted that developing and maintaining a collaborative model takes time. *“You need to iron out the kinks first before getting the physicians to come into it”*.

One of the advantages of a collaborative model is that professionals can specialize and improve upon their skill-sets through a greater volume of patients. As this family physician observed, *“in clinic we do get to do a lot of deliveries, which increases confidence and competence compared to our own practice”*. Other family physicians in the broader community meanwhile have become very comfortable referring. Like other collaborative models they make sure the patients return to their own physician at the end of the pregnancy.

For nurses the collaborative model is *“wonderful”* as the nurse gets to be a nurse and also gets to be a teacher. The two nurses in one model, for example, ensure that continuity is maintained, which makes the patients feel more comfortable. As a nurse commented, *“from a population health approach as a nurse you have a huge opportunity to influence – to make a big impact”*.

Challenges and Suggestions for Developing a Collaborative Model

Several challenges were identified for proponents of collaborative model development. First, it was noted that family physicians are doing fewer and fewer births at hospitals. And with fewer numbers providing maternity care, the pressures increase for those who have greater on-call commitments. As one participant observed, women were heard to say *“So much care from so few people”*.

The challenge is that *“others not in [a collaborative model] have a sense of what they do is the way it should be”*. To then assume because a collaborative model exists and that professionals will gravitate to it is a risky thing. That is why further education and awareness of the models will be important

Funding of those in the model was also an issue, especially as many physicians are on fee-for-service, which encourages volume of encounters as opposed to spending longer periods of time with women. In contrast, midwives are paid on a different basis (per woman) and are committed to their clients in accordance with their clients’ own perceived needs. The differential approaches to remuneration would need to be addressed in model development regardless of jurisdiction. In some jurisdictions, however, there are no midwives operating as part of the formal health care system, so to assume that a model would require their participation may be foolhardy without recognizing the various different contexts in which potential models could be established.

‘Clients’ [women] have different perspectives than providers. This needs to be understood in any model formulation. For example, clients have concerns as to what they disclose. *“There’s no space to build trust here...it’s pure business.”* [referring to an electronic medical record]. Interestingly, and important in regards to model development, an electronic medical record rightly was not seen as an essential element in a collaborative model by those working without it. Yet to those who do have an electronic

medical record, they are firm advocates for its use as a strong enabler for a successful collaborative model.

One of the barriers to collaborative models is education. Indeed, as a midwife from Ontario commented, *"We still have hospitals 10 years after the introduction of Midwives who are quite ignorant of what we do"*. Education starts in the colleges and universities but should continue into the professional years as well so that all professionals become familiar with the various respective practices of others. The Ontario midwives felt that liability was a major issue that would need direction and resolution if considering midwifery as part of a collaborative model.

There were a number of suggestions for things to consider when starting a collaborative model. The community needs to be able to provide input. The model development also needs upfront investment, and champions. There should be some degree of payment for time spent on non-clinical time spent with the collaborative model. Importantly, the model has to be sufficiently funded to enable a start up to occur. One focus group said that funding should be committed on a longer-term basis as opposed to merely start-up because this would show commitment and enable longer term planning for models to proceed.

The model cannot be imposed if no one wants it. The collaborative model has to be needed. The development of the model needs to occur in small steps, as there is more likelihood that there will be greater uptake this way rather than massive changes. Professionals are less likely to adopt a model if massive, or perceived drastic changes are required. This is especially the case in the absence of evidence about what can work in a given context. Although collaborative care may be seen as new, *"we're not inventing the wheel on this. There are actually few differences in the care"*.

There is a need to select the group of professionals very carefully. They need to have similar philosophies. *"You need to get everyone on the same page"*. As a collaborative team we are *"strong when we stand together"*. Team members must be open to feedback in new areas, including what the community needs are. Team members must be prepared to spend a lot of time team building, and be able to work through emerging issues. Team members must be willing to make compromises. Differences need to be resolved, including looking at the evidence, and what's not there in the evidence. One focus group stated they would like to see support tools for how to collaborate, and how to engage others in the model (such as peer counselors, public health nurses),

A commitment to the model is important. More important perhaps is a passion for what the team members do. As one collaborative team member observed *"Passion is really important – to get the best possible care for women and their families."*

It was also noted that the new generation of professionals coming through *"want a life, a better balance"*. Indeed, flexibility is also important in the model, as there are many different ways in which it can work. There have to be choices available for the professionals in the model, especially for the new professionals. Continuity of care is also important among and for the team members.

Communication is the big thing – in one collaborative group they document in the charts as well as communicate when switching on-call – a telephone exchange of information – and they also have daily progress on charts. There is a high level of trust among the

team, comprised of family physicians, nurses and obstetricians. As one of the physicians noted, *'And we can call each other even if not on call – shows a sense of commitment to one another'*.

Building trust takes time. In one community the collaborative model noted that they *"knew each other in the community – and got to know who you would want to work with"*. A new physician asked about joining the model but they said they didn't know him so he'd have to wait.

In Northern and remote areas care is always provided in a collaborative way (with physicians and nurses). "We have to involve others – we have no choice". Physicians in the North have to collaborate and cannot provide primary maternity care without collaboration. One northern physician noted that "We have many female patients with very low self-esteem – they will not share with doctors but will share with other professionals. Moms may not come in if they don't have community connection" (i.e., a public health nurse). In fact, he sees more high-risk coming in than if they do not have that "community connection". "There is a fair amount of effort to get them [the high risk] in – to find them – bring them in – and try different strategies".

In northern areas the more medicalized procedures such as c-sections, epidurals, and operative procedures are not available. There has to be a risk assessment – the bar is lower – and physicians and nurses must make a decision earlier in prenatal care. Given the context, primary care nurses, in fact, often function as nurse practitioners. If transfers to the south are required once in labour, then air transfer is fine even though there may be the time in transport. At the hospital in the meantime while they are en route they will set up the operating room in preparation. If 40 minutes or less there is no time lost in transfer as it takes this long to prepare the room anyway. Also, as emergency technicians – doctors can fly with patients. Although physicians have access to provincial air ambulances they typically will use bush planes as these are much more responsive.

There is not much difference between urban and rural areas in terms of mortality and morbidity. There is actually a lower risk in people delivering closer to home in rural areas due to the earlier and ongoing risk assessment. The professionals themselves, the physicians, are often from other countries, and go into rural and northern areas as a way to get established in the Canadian system.

The other thing to consider in northern areas is that the actual number of births is relatively small and so physicians themselves often prefer to deliver the babies to keep their levels of experience up. They may potentially be reluctant to allow other professionals to deliver babies as a result.

Finally, there needs to be some proof of concept with a collaborative model. *"It needs to be demonstrated that the models are better than what I'm providing to my clients now"*. Midwives noted that there needs to be some flexibility with the models and that they be voluntary and phased in.

Midwifery Perspectives

Midwives participating raised a number of key points. Midwife philosophy is ‘*solid continuous care*’. “Models”, however, erode what midwives believe for women.

There must be desire by the professionals to forge into personal relationships, to get to know people on a personal level.

Midwives observed that women are looking for a relationship with their providers, and midwives and nurses provide just that. Physicians have it at times but the relationship building is not as strong as it is with midwives and nurses. Midwives also believe strongly in relationships – and this must begin with respect for women’s ability to make decisions. Women also would like continuity of care. They want to know that all providers are ‘*on the same page*’ – gelling with consistent advice and philosophy.

Another important point made by midwives is that there should not be an assumption that midwives always work well together. They, like other professionals, also have their own preferences as to how to work with women. So although philosophically they may start from the same place, on a day-to-day basis they may view the provision of care quite differently. Similarly, like other professionals, some may prefer to work in a collaborative model while others may not.

An important point to emerge from the focus groups with midwives was the explicit clash between professional autonomy and underlying philosophy (and loss of this in a collaborative model) and the growing concerns that the call system is placing too much stress on midwives and leading to burnout and loss of midwives from the system (which a collaborative model may be able to address through better, shared on-call systems). Thus to some, the current maintenance of midwifery autonomy and philosophy may eventually lead to fewer midwives, whereas involvement in a collaborative model may stem that flow but potentially compromise the existing midwifery autonomy and philosophy.

“Over the last 50 years we’ve done a really good job of medicalising child birth. A “relearning” for consumer is required. Classes should go beyond just prenatal and birth and go into post natal. It takes time to do this – but it is changing (e.g. home births).”

“We are not little girls here, we are equal professionals.”

“Nothing happens in isolation, it’s a system.”

“This is our choice; it’s a really exciting time.”

Some midwives feel that they are “*suffering from disconnection*”. They feel alienated from the rest of the system. “We pick and choose our consultant now, but we’d be concerned, that we wouldn’t have [that kind of] choice in the collaborative model”. Their fear is that maybe they wouldn’t be able to collaborate and still do as they had trained. The concern is that they would lose their midwifery uniqueness. A related fear is that nurses would become the preferred critical mass. And if they had to extend their scope

of practice that may in fact lead to loss of interest and even loss of the midwifery role over time. As one midwife put it “We are vulnerable still”.

Midwives noted that the Midwife can practice autonomously and give woman choice. If there is an issue that requires transfer, midwives want to work with family physicians or obstetricians that respect midwives and can have respectful joint discussions.

If midwives were in a collaborative model it was felt they should be salaried, and not funded through a fee for service arrangement. It was noted by midwives that they would work well in rural areas with physicians but there would still need to be a system to ensure specialist care was always available.

Processes Required to Develop a Collaborative Model

Clarity over accountability needs to be determined. One participant observed that if there was a poor maternity outcome then accountability for the results needs to be shared. Others, however, noted that little should change from the current context as all professionals have to accept responsibility and potential liability based on the extent of their involvement regardless of organizational structure.

An important feature is to try and educate and encourage every discipline to collaborate. It is hard to put processes together when people simply do not want to be engaged. In some cities there is extreme reluctance to “go there”, and collaborate.

Funding

“Be very open and aware about financial arrangement – be above board, know how stand, clearly communicated”

Finances were identified as a major issue. Importantly, the model needs to be properly funded. The different focus groups observed that a range of funding options is possible. It would be instructive to pilot the different options as collaborative models emerge. These could include blends of FFS, course of care, salary and sessional fees, shared positions (even for obstetricians), paying more for night work, and different options for the pooling of on-call remuneration. The important point is to ensure that equity is achieved some way and that time spent ‘collaborating’ is not assumed to be unpaid time.

Optimum Size of the Model

This was discussed briefly in the focus groups. The general feeling, however, was that a model with between 4-8 professionals that could share the on-call system would be the most effective. The numbers are low which also means that women would be able to meet all providers in the model through the course of their pregnancy. Just as important as the number of team members is the type of professional and other key attributes, including language spoken and willingness and commitment to working in a collaborative model. It does not suit everyone (e.g., some physicians prefer to be at the birth of their patient whether they are on-call or not, which may be counter to a policy in a collaborative model. Or it may not be, depending on what a respective model’s team decides works best for everyone).

Risks

There are always the ongoing concerns regarding risk-management and who best decides on this. Sometimes, it was felt that certain professions take a higher risk than they should. Risks become cumulative, not additive. Patients see this, and can see the tension between different professions. Ultimately it is about making judgment calls, but those calls are less likely to be detrimental if there is a willingness and openness to freely communicate thoughts regarding risk that may differ among team members and other professionals outside the core team.

Other Discussions

There was some discussion in different groups about the role of Nurse Practitioners (NP). NPs are generalists by training. So if they were to be part of a model they would likely work alongside the family physician. This would be very different from a specialist NP (e.g. neonatal). Also, they could be specialized in Maternity Care, but doing more than an extended obstetric nursing role. NPs could fill in the current gaps, including intrapartum care. *"You could have an NP whose focus is women's health or have a blend"*. They could have a huge role in the call schedule. *"They need to be savvy, and have sound clinical judgment"*.

Obstetricians working in a collaborative model felt that they were pleased with how it was working for them – they still maintained their remuneration levels through an alternative payment plan and enjoyed the benefits of closer working relationships with other professionals. Another obstetrician interviewed meanwhile, observed that *in her heart* she knows she should not be doing primary maternity care, but *"I love doing primary care"*. Coverage of Obstetricians is a problem for everyone.

5.0 Summary

The viewpoints expressed by the participants in this phase of the project reaffirmed earlier points made in the interviews. There were some frustrations with the focus groups. First, despite considerable effort and the best intentions we were unable to have full group discussions with some of the professional groups. Second, although we had a template for examining key themes, discussions often got sidetracked to other issues that were clearly more important to the focus group participants. This, in and of itself, was not a disaster, but it did mean that we often did not have enough time to address all we had hoped for.

On a much more positive note it is clear there are many dedicated professionals in a range of contexts who willingly participated in this information exchange. There is clear interest in the development of collaborative models and there is also concern about what it may mean for respective professional groups.

There are collaborative models in place, each with similarities and yet differences. No one size of model fits all but that is the attraction. There can be some core 'fixed' features of a model to which can be added 'variable' elements that provide the flexibility that will be required for interested parties to join in a model. In terms of this larger project, the product – the model – is well underway, but that by itself will be insufficient without the appropriate processes in place to effect a positive change in the way primary maternity care is provided. Addressing the process challenges and necessities is the purpose of phase two of this research.

Finally, what the focus groups showed was clarity again in the needs of women, and the importance of placing women at the center of any model. The birth of a child is much more than a medical encounter. We have seen through the primary data collection and the literature in this initiative that the development of a collaborative model offers considerable opportunities to respond to needs and to reacquaint providers, women and their families with the social and very human face of primary maternity care.

Appendix 1: Focus Group Protocol – Theme Areas



For the professional focus groups

1. Type of model currently in place
2. Intrapartum care
3. On-call system
4. Communication and Exchange of information – especially communicating among team and with regard to client records.
5. Funding model(s)
6. Type of site (single or multiple sites)
7. Optimal size (i.e., number of clients/patients with # of providers and which types)
8. Special populations (do they need special models or ...)
9. Differences between rural and urban

Note: Not all these theme areas were covered in the respective focus groups. The content areas depended very much on the specific participants and indeed, where they preferred to place their emphasis and were able to draw on their knowledge base.

For Consumer Focus Groups

1. What are the most important things that you would like and need from the health care system's provision of maternity care?
2. What are the differences in your experience between your first pregnancy/ birthing experience and subsequent birth experiences?
3. Differences with care between rural and urban areas?

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Primary Maternity Care Model Development Project, April 2005