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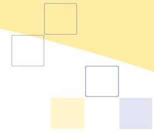
Multidisciplinary Collaborative Primary Maternity Care Project | Projet de soins primaires obstétricaux concertés



Assessing Knowledge, Attitudes and Beliefs

Towards Collaborative Primary Maternity Care

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Executive Summary

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Collaborative multi-disciplinary care is an important objective to achieve in maternity care in order to ensure that Canadian women receive access to high quality evidence-based health care. In addition, collaborative care is important for the efficient, effective functioning of health services and the quality of work life of health professionals. There are decreasing numbers of family physicians available to provide maternity care and the workforces in nursing and medicine are aging with projected increasing retirements. In addition, increasing numbers of midwives and nurse-practitioners are providing maternity care in some provinces. A baseline survey to assess attitudes, beliefs and knowledge about collaborative primary care was distributed to the members of the following national professional associations:

- The Association of Women's Health, Obstetric and Neonatal Nurses (Canada)
- Canadian Association of Midwives
- Canadian Nurses Association (Re Nurse Practitioners)
- College of Family Physicians of Canada
- Society of Obstetricians and Gynaecologists of Canada
- Society of Rural Physicians of Canada

There was a good response with 796 respondents who included: Family physicians (198), midwives (165), nurses (219), nurse-practitioners (52), obstetricians (150) and others (12). Response rates by professional association membership lists varied from 6% to 40% of the distribution lists. It should be noted that provincial lists and not national lists were used for midwives and nurse- practitioners and some lists included group and duplicate email addresses. Due to the large number of respondents and the multiple statistical tests a p-value of 0.0001 was required for statistical significance

Participant Demographics

A typical respondent in this survey was:

- Female (77%)
- In the 45-54 age bracket (38%)
- Providing maternity care for between five and nine years (33%)
- A member in the Society of Obstetricians and Gynecologists of Canada (43%)
- Working primarily in a hospital (61%)
- Working in an academic/ teaching institution (49%)
- Reporting that their environment mostly or completely reflected Health Canada's 2003 collaborative practice definition (39%)
- Worked in Ontario (39%)

Concepts That Should Be *Demonstrated* In a Collaborative Practice

A large majority (over 85%) agreed or strongly agreed that the following should be demonstrated in a collaborative practice:

- autonomy in scope of practice,
- consultation,
- cooperation,

- flexibility,
- shared documentation,
- competency-based roles and
- quality of work life

Only 45% and 37%, respectively, agreed or strongly agreed that **supervision** and **clear hierarchical structure** belonged in a collaborative practice.

For supervision and clear hierarchical structure, nurses and midwives were more likely to be at the disagree end of the spectrum compared with family physicians and obstetricians.

Importance of Components to a Collaborative Practice Model

Almost all respondents believed that mutual respect, mutual trust, professional competence and communication between team members were important or very important. Ninety to 95% also felt that shared goals, informed choice for women and families, women's enhanced access to care and collegial relationships among team members were important or very important. Fewer, 78%, thought that complimentary practice styles were important or very important. Assertiveness of individual team members and ultimate accountability of one health care provider were reported to be even less important with 42% and 52% respectively answering in the not to moderately important range.

Importance of Components to a Collaborative Practice Model - Comparison by practice group

Interestingly there were no differences in attitudes about the components according to type of hospital (level 1, 2 or 3). However, there were many statistically significant differences at $p < .0001$ between the professional groups when comparing the attitudes of family physicians, midwives, nurses including nurse-practitioners and obstetricians. The number of physicians in rural practices was too small to include as a separate comparison group. Mutual respect and communication between team members were statistically different by practice group and the trend was in the same direction for these components and for mutual trust and professional competence, with the nurses and midwives more likely to strongly agree and the family physicians and obstetricians more likely to agree. Informed choice for women and families and women's enhanced access to care showed the same response pattern Practice groups were significantly different regarding the importance of assertiveness of individual team members with nurses finding this most important and midwives, family physicians and obstetricians each finding this less important than the preceding group. These differences will be important to track over the next year to see if there are any shifts in attitudes.

Attitudes towards Health Care Teams Questionnaire

Few measures exist about the concept of collaborative care. After a review of eight published surveys, we selected the attitudes towards health care teams scale published by Heinemann in 1999. Two scales were used which included a quality of care process scale and a physician centrality scale.

Quality of Care/Process Scale: Higher scores reflect more positive attitudes about quality of care from teams and quality process in teams

Sixty-four to 96% of respondents answered each item positively. The least positive response was to the item “Developing an interdisciplinary patient care plan is excessively time consuming” and the most positive response was to the item “The team approach improves the quality of care to patients.”

Professional practice groups responded significantly differently on many of the items of this scale. In general the differences were that nurses showed the most positive attitudes to health care teams with midwives, family physicians and obstetricians showing progressively slightly less positive attitudes. Interestingly, there was one exception in that there was no difference by professional group to the item “developing a patient care plan with other team members avoids errors in delivering care” with agreement by 85%..

Physician Centrality Scale: Higher scores reflect an acceptance of high physician authority in the team

In general, responses do not indicate acceptance of high physician authority. Reponses about whether the physician has the ultimate legal responsibility for decisions made by the health care team were split with 45% in agreement. All items of the physician centrality scale show significant differences in response between the professional practice groups. Obstetricians show the greatest acceptance of high physician authority followed by family physicians and nurses with midwives having the lowest acceptance.

New items were constructed for nurses and midwives which were similar to three of the physician centrality items. Most respondents considered nurses to be team players (89%) and progressively fewer considered midwives and physicians to be team players. Only about a quarter of respondents thought that nurses and midwives had the right to alter the team’s care plans while 44% thought physicians had this right. Only a third thought midwives were natural team leaders and about half each thought physicians and nurses were.

Predictors of Attitudes.

There are several independent predictors related to scores of attitudes about health care teams. These include: Gender, age, practice group, region, type of workplace, whether they had heard about the MCP-2 survey and whether their work environment reflects collaborative practice.

Similarly, multiple independent predictors were found for the physician centrality scale which included: Age, practice group, type of workplace, whether they had heard about MCP-2 survey and whether their work environment reflects collaborative practice. Thus attitudes are influenced significantly by multiple factors and future efforts will need to be tailored to selected groups thoughtfully.

In an attempt to determine the independent predictors of who had already heard about the MCP-2 project before the completion of this survey, a multiple logistic regression was conducted. Results indicated that gender, practice group, years providing maternity care and region were independent predictors. Therefore, future communication efforts need to be targeted to groups with fewer respondents such as males, family physicians, those in practice less than 9 years, and those residing in Quebec.

Conclusions

A survey about knowledge, attitudes and beliefs towards collaborative maternity care was conducted in English and French with responses from all across Canada and from all professional groups surveyed (family physicians, midwives, nurses, and obstetricians). This survey establishes baseline rates and a platform for understanding sensitive attitudes about multi-disciplinary collaborative care. There are important multiple determinants of attitudes towards collaborative practice of interest to practitioners, professional associations, policy makers and the public.

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