

**Final Report of the Interviews of Key Informants from the  
Partner Organizations of the MCP<sup>2</sup> project  
Technical Report Two**

**Mutual Respect is the Key:  
Knowledge, Attitudes and Beliefs about Collaborative Practice in Maternity Care  
in Canada**

**April 2006**

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Canadian Association of Midwives  
Canadian Nurses Association  
College of Family Physicians of Canada  
Society of Obstetricians and Gynaecologists of Canada  
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## **Mutual Respect is the Key**

The Multidisciplinary Collaborative Primary Maternity Care (MCP<sup>2</sup>) project is funded through the Health Canada Primary Health Care 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. The evaluation component of the project is using both quantitative and qualitative methods to understand and compare stakeholders' knowledge, attitudes and beliefs towards collaborative maternity care at the beginning and the end of the project. Stakeholders include practitioners (family physicians, midwives, nurses, nurse practitioners, and obstetricians in urban, rural and remote settings), professional association representatives, and government policy decision makers. This report outlines the findings from the qualitative interviews conducted with professional association representatives and government policy decision makers at the beginning of the project.

### **Protocol**

Ethical approval for this evaluation project was obtained from the University of Ottawa and Queen's University. The research team developed a semi-structured interview guide to probe study participants' knowledge, attitudes and beliefs about the MCP<sup>2</sup> project and collaborative maternity care for women and their families in Canada. A research assistant, trained to conduct telephone interviews, conducted all the interviews. This was a deliberate decision as the researchers (JMM and BLD) know many of the potential participants. The researchers wanted to ensure participants felt comfortable to be as forthright as they wished to be, including making statements that may be considered controversial. The research assistant assured the participants that their names would not be disclosed to the research team.

### **Methods**

Interviews were conducted between February and April 2005 with three to five individuals from each of the six organizations partnered for the MCP<sup>2</sup> project (Association of Women's Health, Obstetric, and Neonatal Nurses, Canada; [AWHONN]; Canadian Association of Midwives [CAM]; Society of Rural Physicians of Canada [SRPC]; Canadian Association of Family Physicians [CFPC]; Canadian Nurses Association [CNA]; Society of Obstetricians and Gynaecologists of Canada [SOGC]) and six provincial government decision makers representing four provinces (Nova Scotia, Ontario, Manitoba, British Columbia). The MCP<sup>2</sup> staff and representatives from each association invited eligible individuals and provided the research assistant with the name of those willing to participate. Eligibility was defined as those individuals who could provide a perspective on collaboration that was reflective of their membership in general.

The research assistant contacted the participants, arranged a convenient time for the telephone interview, and obtained written consent. Each participant was offered the choice of French or English for the consent forms and the interview. All participants chose to be interviewed in English. All of the interviews were audio-taped.

The interview guide was developed from the guiding principles of the knowledge, attitudes and beliefs of the project overall and towards collaborative maternity care practice. The guide consisted of twelve open-ended questions, which allowed participants the opportunity to add their views as they wished. Supplementary questions were added when necessary to clarify answers and request further information.

Twenty-eight individual interviews and one group interview (with three participants) were conducted. The interviews were transcribed verbatim with proper names removed to protect the identity of the participants. The researchers who analysed the data and are responsible for this report did not know the names of the participants, but did know the professional organization or provincial ministry that they represented. In some cases, after the interviews some participants self identified themselves to the researchers.

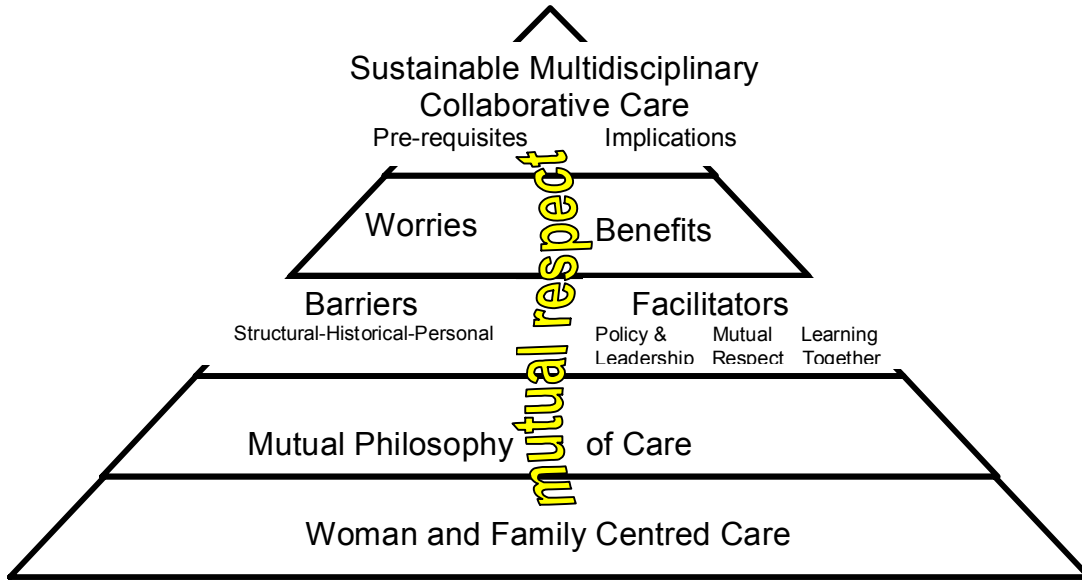
The audiotapes and the consent forms are stored in a secured cabinet in a locked office at the University of Ottawa. After a period of three years, they will be stored at the SOGC headquarters for two more years. Transcripts were loaded into the qualitative computer programme NVIVO version 2 for file management. The programme does not analyse the data, merely allows for storage and sorting which assists the researchers to order and find data for analysis.

Three researchers from the team were involved in the initial analysis of the data and the identification of emergent broad themes. The small number of participants precluded making comparisons across professional groups. Time was spent reading and re-reading the data to acquaint the researchers with responses before a coding scheme was developed. The researchers agreed on, and defined, the broad themes and sub-themes that emerged from the data. Subsequently, two of the researchers coded data separately and assessed congruence. There was general agreement of the coding. Where there were discrepancies the researchers discussed and made decisions about the coding. The process was iterative and themes were sometimes recoded as analysis continued. This was especially true in the categories of barriers and facilitators to collaboration, as many participants saw some barriers as facilitators for change.

## **Results**

Initial coding revealed 121 separate constructs that were then categorized under 14 broad themes. Several broad themes had more than 10 constructs (sub-themes). The broad theme with the most sub-themes was barriers to collaboration.

This report is divided into subsections that illustrate a synthesis of the broad themes and sub themes (Figure 1). The subsections are woman and family centred care, mutual philosophy of care, barriers to collaboration, facilitators to collaboration, worries and attitudes towards collaborative models, benefits of collaborative models of maternity care and components of collaborative models.



**Figure 1: Synthesis of the themes and sub-themes**

### **Woman and Family Centred Care**

Throughout the interviews participants reminded the interviewer of the importance of keeping collaborative models of care woman and family centred. Participants understood that the MCP<sup>2</sup> has a mandate to develop collaborative practice models to assist in delivery of care, but they all recognized the central component of being woman centred. Several quotes are reproduced below to illustrate how participants talked about family and woman centred care.

*You know she's more than a vessel carrying this baby and she's a person too.*

*...and that we keep, truly keep families central to the whole process, it will provide benefits.*

*It's a different way of thinking. Working in a trans-disciplinary setting in a situation where you have family and truly integrate the family model ...also if you look at the perspective from an ecological model.*

*I truly believe the collaborative model is probably better for women and families so I think ultimately yes, I think it would affect the care of this population.*

Several key constructs are linked to being woman centred including the idea of a practice being good for practitioners as well as women if it is supportive and finds common ground for clinicians to work together.

*Other facilitators are if we keep women and newborns at the centre of the unit of care then we favour this as our common ground and we're all interested in healthy women giving birth to healthy babies and how can we strengthen women to do that well, and how can we make sure that we have support roles and that the necessary supports are there to provide safe and effective care.*

*I think part of it is that ...we're definitely not altruistic as a species and I think people need to know that ...while it might be the best care for women and children and their families, the reality is its awfully good for the practitioners.*

Participants often spoke of the importance of relationships that they have with women as an essential component to woman centred care:

*Truly, I mean if you go back historically, even to the twenties and the thirties, it's not that long ago. It really was post World War II that we started messing with the process. And setting down rules and regulations about how you do this, the birthing of the baby and very focused on the outcome, the perfect baby outcome. And it's [going to] be hard to get back to our ground. That it is, it's going back to the groundedness that we have in the relationship that a health care provider has with the client who has chosen to have a baby.*

Participants who worked in collaborative models provided stories of where working together as a team had resulted in better outcomes for women and more cost effective care.

*...we had a woman here who was cocaine addict and her first baby I think was a stillborn, the second one was born at twenty six or something weeks gestation and was in the NICU for ten weeks prior to discharge, has multiple medical and behavioural and learning problems. So, she's still a cocaine addict but she got pregnant for the third time, and this time she was referred to us. And it was an incredibly labour intensive exhausting process especially for the nurse practitioner and the social worker to get her cocaine use down to a minimal amount to get her prenatal care, to get the nutrition up etc. but they were able to do that and the baby, her, the next baby was born into, the one that we looked after, was born at thirty five or thirty six weeks to a woman who had had, yes she had some cocaine but her cocaine habit was significantly reduced. The cost of ten weeks of neonatal ICU would've more than paid for the nurse practitioner salary and that's just an example of how it's more money upfront that it probably saved money in the system in the back, the back end.*

### **Mutual Philosophy of Care**

Participants spoke of the importance of a cohesive philosophy of care that team members and maternity organizations are able to articulate and practice.

A mutual philosophy enables the team to overcome external barriers to collaboration.

*...it doesn't matter whether it's a midwife, family physician, extended practitioner, team mixing up all of the above, what matters is the style of care, and creating the improved outcome and which is community based care, community based continuity of care that makes improved outcome. So I think the other thing is to be careful not to get stuck to seeing it as belonging to a certain practitioner but rather needing the style of care and saying that many different people can make up these teams.*

Participants often gave the example of collaborative teams sharing the philosophy that birth is a normal healthy event. Participants often expressed hope that increased collaboration would lead to a shift away from the perception of birth as an event that requires a lot of intervention.

*I think also that hopefully it will create a better balance between what I think at the moment is becoming a very technical driven birth experience for women and a more normal natural birth experience when it's appropriate.*

*...it's probably going to do what we ...have talked about for years and that is link women with the appropriate level of care provider given that birth is generally a low risk event.*

*If we can all work together just say well, this is what nursing brings to the table, this is what midwifery brings to the table, this is what family medicine brings to the table, this is what obstetrics brings to the table... it will be much, much richer than the one in use because right now I'm not sure that the medical model serves women best, I mean it's necessary, I think birthing has to be seen more as a celebration than as a surgical event waiting to happen.*

## **Barriers to Collaboration**

The broad theme with the most sub-themes was barriers to collaboration. Importantly, many solutions to overcome the barriers were described, suggesting that the barriers are issues that can be solved. The barriers can be broadly defined as those that are structural, historical, and personal. It is no surprise to those who work in health care that there are significant barriers to collaboration that are entrenched in the history of the development of the professionals who provide care. The structural barriers cited by participants included payment, regulation, liability, insurance and legislation. Historical barriers include entrenched models, mistrust of other health care professional groups, competitiveness, and education of health care professionals. Personal issues, attitudes and beliefs include cultural fears including loss of autonomy, birth as pathology, life style, and lack of understanding of others' scopes of practice.

### **Structural Barriers**

Many examples of structural barriers were identified from the data.

*Payment:* The differences between fee structures were consistently reported. In particular, the midwifery fee structure is resented by others as it is perceived as diminishing the value of their own professional practice in providing maternity care.

*Well ...I think payment is been a huge barrier in [name of province], in that the, the bundled payment for midwives in [name of province] is quite a bit higher than that that family practitioners get and so that caused a lot of resentment amongst some physicians.*

There is also the issue of sharing care and who gets paid. This means that women are unable to choose to have shared care between a physician and a midwife as only one is allowed to bill. Also physicians do not get paid if a nurse sees a women and her family for a visit.

*I do also think that finances are an issue, I know that women in our community have to choose whether they're followed by a doctor or midwife because the government won't pay for both. I know that if a midwife is covering for us and gets called in like for example for somebody in labour but a midwife is not recognized and therefore does not get paid.*

*In a model where you have nurses and physicians working together with straight forward funding so that ...we don't have...if I let you as a nurse see my patient I'm not gonna get funded for that visit. I think that's a big issue.*

Participants gave examples of how some of the funding barriers are being addressed and these are seen as helpful for collegial relationships between specialists and family physicians, and might also encourage collaboration between specialists and midwives.

*We're seeing some of this happening in the fee schedules where for instance my understanding is that there are fees now being developed where obstetricians and family doctors can look after a patient in labour together and not knowing who's actually gonna be delivering the patient but not having a financial loss if in fact the obstetrician versus the family doctor does the actual delivery which has always seem nonsensical to me for the small number of people involved. But same with women who seek midwifery care, if their potential risk factors change through the pregnancy there's no reason why they shouldn't be able to go see a family physician or obstetrician. And when those factors are stabilized they can return to the midwife without any worry about who bills what.*

There is also recognition that the funding barrier to collaboration can be overcome:

*So, fee schedule is an excuse, fee is an excuse, fee is not an end, it's a process, it's a way, it's an approach. So, no, fee to me definitely not, it's not a reason. You know, you can pay the different people in the team differently, and as long as it's done appropriately, as long as it's done properly, judicially.*

*And I think that there [is] payment improvement that could be made both to the mechanism and the evaluation of payments, not just to the providers but to the funding of the overall system that could be better configured to reinforce team practice. At the moment we have...different programs paying different providers, we have public health, we have hospitals, all of these are different payment streams and at the moment...the planning around how all these funding streams contribute to an overall system has never really been rationalized as fully as I would like to see it rationalized.*

**Regulation:** Participants spoke about regulation in terms of who is allowed to do what and how regulations contribute to a lack of teamwork. One participant illustrated this well using the example of regulations regarding charting:

*And then the nurses on their side are told the same thing, don't trust anybody else, you have to go and check to make sure the uterus is firm, and you also have to make sure, and the nurses know that you write the uterus is firm, and there's a place for the nurse's note and there's a place for the doctor's note. And if the doctor hasn't checked and hasn't written that the uterus is firm, even if it's written in the next page by the nurse, then the doctor is not doing a good job, and that's taught by the College of Medicine and by the School of Medicine.*

**Liability and insurance:** Many practitioners worry about being held liable for care that they were not directly involved in providing and that they may be sued as part of a team. Collaborative practice models need to be clear who is accountable for what component of the care.

*I think the other barrier ...is a medical legal barrier in other words if a case ends up as a team if there's a medical legal case, which insurance company has the biggest, bigger pocket is it the CMPA, or is it the midwives' insurance or is the hospital. I think a no fault insurance probably would help smooth out some of that; I think that is a potential barrier. As of for where the buck stops, where the responsibility stops is where the dollar stops with regards to medical legal liability.*

A recent document was seen as reducing the liability barriers as it outlines the liability of nurse practitioners and family physicians who work together

*And I also think that...another one of the barriers to collaborative models, of any type of practice not just maternity, is that whole liability confusion and there was just a*

*recent document put out March 2005 from CNPA and CNPF and I think that will help again what some of that liability confusion piece, but it always seems to be ...there's some concern about ...what we really need to do and how much they're responsible for if we do it so.*

Although professional liability was often viewed as a barrier, participants also expressed optimism that it can be overcome:

*I think ...many of the barriers may be perceptions of barriers or beliefs in barriers rather than the barriers themselves so, for example liabilities, liability is perceived as a large barrier by physicians primarily and yes you know, we understand that as a potential barrier but in practice we have worked it out, and it's not that it's never come up, it certainly has between the obstetricians and the midwives predominantly and to a less extent between the family physicians and the midwives but, where it has come up we've been able to resolve it fairly easily with...simply asking the question who's responsible for this, who's ...owning this decision, and once it's clear who owns it then the rest is easy and ensuring that we document where care is transferred and things like that. So I think that ...there's a perception that liability is a big issue and that's what creates the barrier.*

### **Historical Barriers**

Historical barriers include entrenched models, mistrust of other health care professional groups, competitiveness, and education of health care professionals. These barriers are recognized as unhelpful as they are entrenched in our health care system.

*Tradition, it's a big one, I think there're some very, very well entrenched legacy issues around perceptions of authority and scope of practice that we still have a lot of education to do to unwind.*

**Mistrust:** Historical mistrust of midwives is still seen by the participants as providing a significant barrier to collaboration.

*The physicians within [name of province] here, there's been a historic kind of clash between GPs and midwives here in [name of province]. Like I don't know if, you know, the GPs were adverse to that type of role when midwives were first introduced; I'm not sure...*

**Competitiveness:** The power imbalance that has existed in the past is perceived as not helping to change practice to encourage collaboration.

*Well, I think, unfortunately, it's the imbalance in power where... the ultimate decisions are made by the obstetrician and if, I think there could be a lot of inter-professional rivalry, and sort of turf protection, and perhaps a tendency, although I may not be totally fair about this, but I think there's a tendency on the part of obstetricians to control.*

There are also historical barriers between nurses and midwives that have caused resentment, lack of understanding, and competitiveness between the two disciplines. Some nurses do not understand the scope of practice of midwifery and this has made it difficult for midwives to develop collegial relationships.

*I don't know, I think there's, I worked on the case room for a long time and I think they [nurses] sort of see themselves as the... ones that are there, they think they do*

*everything midwives do, except deliver the baby. But it's so much more than that, and I've spent my professional career trying to explain that, what the difference is between midwifery and maternity nursing, and you know, it's certainly been a source of... "why do we need midwives when we're here?" that may be different ...in other provinces but certainly it's been my experience here, although there's always some nurses who'll say "oh I think we really need midwives", I think they're maybe beginning to think it more right now, that they, even some of the obstetricians are coming around because it just got so technical.*

**Health care education:** Educational programmes have historically been separate and this has led to lack of understanding of scope of practice of other providers. The way programmes are delivered to learners does not encourage development of collaboration. Participants articulated that if education was more integrated this would help to promote collaborative models.

*If we teach in medicine that midwifery is necessary, then the doctors are all [going to] see that for the rest of their lives. If they're taught from the very beginning that they're complementary, and they're made, and the modes are made to work together, and there are more benefits in working together than to compete, then they will have this reflex when they become professionals. And it's the same in the midwifery school, and the nursing school. But we still work in milieus where the nurses and the doctors for instance, do struggle for power in the same unit, you know, and never mind when we're talking about then at the higher levels inter-professional organizations and all that stuff.*

If education was more collaborative, participants believed this would help to remove the hierarchical structures that are barriers to collaboration.

*I think we have to do a lot of education, I think a lack of understanding of the different roles and I think we have to be willing to try different things. There's a lot of, I find in medicine in Canada or in health care in Canada, there's a lot of turf protection, and a lot of wanting to do things because that's probably how we've always done it whereas it's not necessarily the best way. So I think with a relaxing of roles and recognizing that people, other than physicians, can provide excellent care and that it is appropriate, that that would help, but that would really need to come because there's always been such, it's been so patriarchal and so protectionism between medicine and nursing, that ... to lots of education to break down that barrier and to recognize that it's not, you get this attitude of...doctor wanna be and it's like "no if I want to be a physician I would have gone to medical school", I chose not to do that, but to stay well within what I'm educated for, what is good patient care, what's based patient care, and I think we need to step back from traditional roles and look from the patient's perspective.*

## **Personal Barriers**

Barriers that are more personal may be the most difficult to overcome as they can't be legislated or enforced by outsiders, but may be reinforced by other colleagues. Participants described the lack of respect, trust and the sense of inequality among team members as important barriers that need to be overcome.

*I remember walking through emergency one day and a ...physician was asked a question by a nurse and he drew himself up to his height and he said: "You will do it because I'm the doctor and you are the nurse", and I thought oh, you're not gonna stay here very long. You know, I think... that we have to respect each other for what we are and what our training is.*

*It shouldn't be that way at all; we should all be equal and not have a hierarchy. And everybody's opinion respected and that sort of thing.*

*Well I think, I think [the lack of] teamwork is a barrier, and I think that team work comes from, from mutual respect...*

*So...to be truly collaborative I think you have to be pretty well seen to be equal but different.*

### **Facilitators to Collaboration**

Participants identified facilitators, those factors that would help to establish and maintain collaborative practice. Interestingly, many participants identified the MCP<sup>2</sup> project as a facilitator that would help to establish collaborative models across Canada.

*I mean this project is definitely a facilitator and the potential through the communication between the various associations.*

In total, there were 14 separate facilitators identified by the participants. The 14 facilitators are categorized into three broad themes: policy and leadership, mutual respect, and learning together.

#### **Policy and Leadership**

The provincial decision-maker participants identified that federal and provincial governmental and non-governmental organizations could facilitate collaboration.

*Each province arranges those health services in somewhat different ways but each province is equally reliant on some of the national level stakeholders to contribute to that system and so, there're things like Health Canada, there're things like the CMPA or the Canadian Society of Nurses Protective Society is another example, these are national stakeholders that do affect and in some cases drive the delivery of health services indirectly through the provinces, and I'm hoping very much that MCP<sup>2</sup> can engage those national level stakeholders because it's a national level organization and can translate or work with the provinces to translate some of those issues to, at the national level.*

Participants recognized the key support needed by officials in leadership positions as essential.

*But we need to identify some leadership in different areas, we need also to assure that we're going to have communication, because Canada is big and even each province is big. So, we need to find ways of closer communication, more readily available communications and groups that would work together, and that will have the knowledge and the consideration of the differences between the different areas, the different provinces, the different communities, and then, and then apply it, apply those principles and those visions into, come into a model, a common model that will be maybe malleable and flexible enough to be then applied in the best way in each area, or for each of the needs of the care.*

*I think that we have to force from the very, very high leadership, give the message and give the incentive both in educational structure and in professional application structure.*

Another participant linked the public support from organizations had to be placed in the education system as well.

*Organizations can lead their members into becoming more attracted to this, but I think that there's also a very, very important responsibility in the educational system in all the professions, educational system that have certainly an obligation or responsibility to develop the team approach, develop the consideration of the other members of the professions, of the other professions.*

## **Mutual Respect**

Participants' descriptions of collaborative environments were highlighted by the importance of respect and equality among team members:

*Everything that really helps is, I think all the members of the team and I guess it's the value of that particular practitioner, but all the members of the team are valued equally.*

Participants identified good relationships among team members as the cornerstone to developing and maintaining healthy collaborative models of care. The related concepts within this theme include: sharing success stories, trusting team members, taking the lead as appropriate only, and communication.

*And I think everybody is sitting down at the table as equals and I hope. I know some of the people on the committee and I'm sure they're quite outspoken, which I think is great because you have to be able to speak your mind and debate without anybody getting their knickers in a knot or whatever.*

*We need collaboration, between professionals, we need everybody and we need them to talk to each other and work together.*

*...while I don't consider (place name) a success, certainly the professional relationship between the physicians who were practising obstetrics and the midwife there, had been, had been supportive and positive and you know, and enabling, and so while they are struggling, that is certainly a very positive aspect of the... (place name) experience is that they have you know, mutual respect and a personal relationship between, between providers.*

## **Learning Together**

There are concepts that support collaborative models that are dependent on knowledge of the care that is necessary, the education of other team members, and best practice. These concepts are the primary responsibility of pre-licensure programmes and post licensure training as well as continuing education. Participants gave many examples of learning together as facilitating understanding of each other's education that then promotes working together in teams.

*I think, I think that training together, ALARM, also NRP will help and I think that more exposure, I think midwives for example coming into, into the ER assisting with, with c-sections. I think that that instead of midwifery hiding away in home care deliveries, coming into hospitals and delivering in hospitals.*

*And I think and I have to say, and maybe it's because I'm involved in undergraduate and post graduate education, but you [have to]start them young, you know, putting, I have medical, I've clerkship students, residents and fellows going through their*

*training being exposed to these models and seeing the different aspects of them, what they like and what they don't, what will work for them and what won't work for them, and making choices about how far in or out of the collaborative model, of this our collaborative model, they want to base their practice in.*

*... obviously if the government of [name of province] thought that it was a good idea because they've put the seeds there for that midwifery; however what I do know is that there's quite a bit of discussion between the school of nursing at [name of university] and the midwives program, that the instructors are actually shared between nursing and midwifery and that there is some wanting to move in terms of taking nursing first and then going into the midwifery in the third or fourth year.*

*Again, a revamping of education of health care providers, and in this case maternity care providers, that will allow interdisciplinary education and thereby that in itself would go a long way to eliminating some of the, the lack of understanding, and a comfort level with other practices, other provider' scope of practice.*

### **Worries and Attitudes towards Collaborative Models**

One of the main worries that participants identified was that those who may wish to work with colleagues may still want to provide all care for some or all of their clients. These worries apply to solo practitioners or groups of practitioners from the same discipline who does not want to 'share' responsibility with other disciplines. There may always be a component of solo practice within collaborative models. For example, midwives are the only health care providers who attend home births, and in any midwife collaboration with other maternity care providers the team would have to decide how to accommodate these wishes of the women that they care for.

*The fear may be to lose power and influence for certain practitioners like what does that mean? How does it affect my practice? And am I being told by others now what to do? You know like all kinds of fears that usually come with change.*

There is also the worry that midwives in Canada have fought hard to be recognized as a separate discipline that is independent of other health disciplines is in danger of losing their autonomy.

*Something [that]midwives have been fighting for being regulated, like being fully accepted but also like within their autonomy they now midwives of course don't want to lose that autonomy.*

Participants also worry that women may not want more than a small team in a collaborative model of care. The worry is that while it may be helpful to health care providers it may not be what women are wishing to experience in their care.

*And I think that it's wishful thinking on our part and so, I think what my experience is with people receiving maternity care is that continuity of caregiver is very important to them, and they really dislike what they see as factory style approach or large numbers of, large numbers of caregivers, they are willing to accept a small group of caregivers if those caregivers have similar philosophies and but, I think that there're limits on how many they're comfortable with*

One participant worries that providing care in a collaborative model may in fact fracture continuity so that only a small number of providers would attend the births and others would be

limited in the care that they provided. This may then lead to loss of confidence in skills, in particular with intrapartum care.

*So, I would not be pleased to work, by working in a setting like that where for example intrapartum care was reserved for only a small group of the caregivers and everyone else did antenatal and postnatal care. I think it's very important to preserve the skill set and preserve the confidence and competence that providers bring to intrapartum care so, I'd like to see that spread amongst everyone; and also that all of the care providers including the specialists have the opportunity to maintain their confidence and competence in some of the lower risk aspects of care if they're integral to the model. So labour support, antenatal care and even home, you know, non institutional care, so that to do things that's a part of the whole picture.*

### **Benefits of Collaborative Models of Maternity Care**

The MCP<sup>2</sup> project has been designed to develop collaborative models that will retain and maintain the health care workforce who provide maternity care. As a result a focus has been on the health human resources needed to sustain first class maternity care. Participants identified lifestyle and utilization of human resources as benefits of collaborative models. In addition, the benefits would be to women and potentially improve access to care.

*I think it's a model that has the potential to improve maternity care across Canada. I don't think it's any secret that maternity care is certainly of low risk and normal deliveries are becoming less and less normal I guess; so from a number of perspectives that is probably not a good direction for maternity care to take, and so collaborative care where some of those barriers, can be eliminated and where care is based on appropriate competency and, and scope skill mix would, would go a long way to, to normalizing birth again bringing it back to a community level as opposed to an institution level.*

*So, I think it's not only sustainable but it's a model that works for a lot of new physicians because it allows them to do maternity care in a way that is safe for women and ...that allows them to actually have a life and as well to be able to walk out of the office, part of it is beyond call, but the other part is to be able to walk out of the office at, on Tuesday night and know that if you take two days off, when you walk back on Friday morning you're not gonna find a disaster.*

*How multidisciplinary collaborative practice, how it affects care, like you know, you're looking at better access to a range of providers, you're looking hopefully at higher quality care.*

*Anyways, I think that in order to make it work that we need to reach some of the specialist physicians in sort of getting them to transition to, to look at this differently because there are a lot of places now where GPs are shy, shying away from obstetrics because of the other issues about life style and insurance and just not having enough man power. I think that potentially we can spread the poor resources, human resources better by having this kind of collaborative model.*

### **Components of Collaborative Models**

The participants were able to articulate many components of collaborative models that would be vital to ensure that the models of care were viable and sustainable. There was general agreement that not one model would be useful in all clinical settings. Models need to be locally determined and responsive to community needs.

*I guess the most important thing about collaborative models is that there's a plural at the end of the word model. And that there is gonna be a number of different models that can exist and it will work well and that in any one site you may have a number of people participating in different components of the model, in other words it's not a one size fits all and it probably won't even be a one size fit all, in certain locations you'll have people who would be able to buy in more or less comfortably to bits and pieces of it.*

We identified 16 sub concepts that were components of collaborative models as determined by the participants. These 16 sub concepts were clustered into pre-requisites and implications of collaborative models.

### **Pre-requisites**

The pre-requisites are those concepts and constructs that are needed prior to development of models and include motivation, participation of a number of disciplines, public awareness, and a holistic vision.

*I think the public is recognizing that they need accoucheurs, they need people who can deliver the babies and so that there's a public pressure on politicians and governments and regulatory bodies to be a little bit more innovative. And I think that's going to facilitate the model development in the collaborative care.*

*Probably the education of the women and families too... to know what to expect. I'm not sure that women necessarily understand the complimentary roles of nurses, midwives, physicians in the delivery of care.*

*The model of care is dependent on the, on the willing of each of the professions and each of the, of the specialists and experts in the different fields to work together.*

### **Implications**

The implications include having clear roles, working inter-professionally, using creative approaches, and providing continuity of care.

*Well, I like the idea of collaboration, ...I'm one of those, I really like collaboration but I think the role of each professional, within the collaborative model, is gotta be really clearly defined and understood by the others, because this is, I think, where you can get a lot of conflict. So, the physician for example, you know, sees her or himself, you know, as being the leader of the team, it's, it's the problem.*

*I think we need one organization where everybody's equal and it's called maybe the Canadian Association of Perinatal and Gynaecological Caregivers.*

*I mean I don't think the nature of the care should change but I think maybe who delivers it might. In other words our objective always is to deliver a certain standard of care for women and babies. And I don't think that, that's necessarily gonna change the ideas that maybe a more efficient use of resources or time and maybe a more improved continuity of care might be there for individuals.*

### **Mutual Respect is the Key**

There was overwhelming evidence from the interviews that the key to multidisciplinary collaboration is mutual respect within and between disciplines.

When present, mutual respect is a powerful factor that facilitates working together to overcome the barriers, using other facilitators, seeing the benefits and understanding the components of collaboration.

*...the reason why it works and it's because we've all chosen to respect each other's abilities and skills for what they are. And I think that's key and that we respect people's choices and that's not only between disciplines but within disciplines.*

*...when you have a collaborative model you've got a mutual respect amongst care providers on a certain professional level*

Conversely, lack of respect is a powerful barrier to collaboration. Participants spoke of the essential need for the development of mutual respect as an enabler to collaboration.

*I think some basics have to be in place before new models will really work. And some of those basics are equal representation or equal power basics between all of the disciplines - and I think that's a problem that we've had to date - a certain amount of respect needs to be developed between them; and again between nurses and midwives, midwives and family docs and obs and what not. So, I think possibly it could, but we have to get some things that come first.*

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## Summary

This group of individuals, speaking on behalf of their national organizations and provincial ministries, expressed cautious optimism regarding multidisciplinary collaborative maternity care in Canada. For the most part, they shared the belief that collaborative maternity care is the right thing to do. They spoke of how multidisciplinary collaborative care is part of the solution to the shortage of primary maternity care providers. Importantly, participants also described collaboration as the right thing for women and their families in terms of access to care and quality of care.

Participants shared the belief that collaborative maternity care should be woman and family centred, meaning that the women should play a central role in the care that they receive. Another commonly held belief was the need for multidisciplinary collaborative teams to verbalize and practice according to a mutually held philosophy of care. Most often, the example provided was that birth is a natural event that should not often require technical intervention. While moving away from 'birth as pathology' was described as a style or philosophy of care, it was also described as a potential benefit of multidisciplinary collaboration.

Most participants were knowledgeable of the MCP<sup>2</sup> project, and at least some of the components of collaborative care models, the barriers and facilitators of collaboration. While many barriers to collaborative care were described, participants expressed optimism that these barriers can be overcome. For example, participants believed that some of the structural and historical barriers to collaboration will be reduced with strong leadership at the federal, provincial and organizational levels and with increased multidisciplinary education.

Despite their belief that multidisciplinary collaborative care is the right thing to do, and their generally positive attitudes towards the current movement towards collaboration in Canada, participants expressed worries. In particular, they have concerns regarding continuity of care provider, fragmentation of care, the threat to professional autonomy and to the uniqueness of individual disciplines.

Based on the participants' descriptions of collaborative environments and partnerships, the essence of multidisciplinary collaborative care is the mutual respect within and between disciplines. When mutual respect is lacking, care will not be collaborative. When present, it is a powerful facilitator and when absent, a powerful barrier for collaboration. Teams that have mutual trust and respect for each other seem to be more capable of overcoming the structural and historical barriers to collaboration.

In summary, the optimism about multidisciplinary collaborative maternity care is fuelled by shared beliefs of woman centred care and the benefits of a shared philosophy of care. The findings from this study suggest that there is work to be done in terms of reducing the structural and historical barriers to collaborative care. However, the most significant and perhaps difficult barriers to collaboration centre on a change in culture from one of mistrust and lack of respect among the disciplines to one that reflects mutual trust and respect. Although there is optimism that this cultural change is beginning to happen, there is an essential need to enhance respect among disciplines before true collaboration is possible.