



Report on the Focus Groups from the MCP² Project

Technical Report Three

Types of Collaboration in Primary Maternity Health Care

Association of Women's Health, Obstetric, and Neonatal Nurses, Canada
Canadian Association of Midwives
Canadian Nurses Association
College of Family Physicians of Canada
Society of Obstetricians and Gynaecologists of Canada
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The analysis and conclusions presented in this report do not necessarily reflect the views of the members of the MCP² 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.

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Rules of Engagement: Four Levels of Collaboration in Primary Maternity Health Care

In November 2000, the *Future of Maternity Care Conference* was held in London Ontario that highlighted the critical state of maternity care in Canada. The conference delegates undertook to raise awareness of issues that needed immediate solutions and new approaches to deliver care. One of the initiatives was to investigate the role of multidisciplinary collaborative practice to encourage health care providers to continue to provide maternity services and to recruit and retain new health care providers. This initiative led to the professional organizations responsible for maternity services working together and submitting a proposal to the Federal Government Primary Health Care Transition Fund. The project the Multidisciplinary Collaborative Primary Maternity Care Project (MCP²) was funded for 33 months to reduce barriers and facilitate the implementation of national strategies to increase the availability and quality of maternity services across Canada. The MCP² is a unique process that has brought physicians, midwives, nurses and consumers together to evaluate the issues related to collaborative practice and is the first time all professional groups have had equal representation and have worked together to obtain consensus across the country and across the professions. As part of the process, focus groups were held at the national meetings of the partner organizations to obtain perceptions of the barriers and facilitators to collaborative practice. This technical report outlines the process of the focus group organization, data collection, and analysis.

Throughout the focus group discussions there was an overwhelming sense of the need for a strategy to protect maternity services and promote maternity as a healthy choice for care providers. There was also recognition that we all had lots of work to do, but it is possible with the right kind of collaboration. A phrase used by a midwife to describe the process was that we needed a vision, champions, and creative thinking but to move ahead we had to lead, as “*we can't push a rope*”.

The analysis of the data revealed four types of collaboration: the personal, the team, the institutional, and the professional. Each is important to understand so that collaborative primary maternity care can be implemented. Some barriers go across all levels but the idea of respecting each other and having clear ideas about the role of each other both within and between disciplines is important so that other barriers to collaboration can be overcome. The role of MCP² was acknowledged by participants as being an important first step to overcome the professional collaboration barriers.

Methods

The proposal to evaluate health care providers' knowledge, attitudes and beliefs was submitted for ethical review at the University of Ottawa and Queen's University and was awarded ethical certificates. Focus group questions were developed from the literature and from discussions with key maternity care providers and educators. The consent forms and questions were available in English and French, but all participants chose to sign English consent forms. At each focus group one of the moderators was available to ask and answer questions in French if participants wished but all chose to speak in English.

To evaluate knowledge attitudes and beliefs a number of different methods were undertaken to ensure we had a broad and deep understanding of the issues. At the start of the MCP² project interviews were conducted with key informants from the partner organizations and an online survey was conducted. This report provides the data from the third activity. As each professional organization was scheduled to meet in 2005 at annual conferences, the research team undertook to conduct focus groups. We wanted to include participants from across the country and we had participants from coast to coast to coast.

The focus groups were held in Vancouver, Halifax, Montreal, and Quebec City. Advertising for each group was coordinated with each conference organizer. In most instances the notice was posted on the web site prior to the conference. Information and consent forms were available at the SOGC booth at each conference venue. A time was selected when the maximum number of participants could elect to participate. We did not wish to conflict with other professional or research activities. Participation was voluntary. Both the nursing and midwifery groups had people on waiting lists as they were over subscribed.

Two pilot focus groups were held at the inaugural Collaborative Maternity Care conference held in February 2005 in Vancouver. This provided a unique opportunity to evaluate the appropriateness of the questions with groups of more than one profession. Following these two groups minor changes were made to the questions and the transcripts were kept for inclusion in the data set. The remaining focus groups were held at the annual conferences of the Society of Obstetricians and Gynaecologists of Canada; the Association of Women's Health, Obstetrics, and Neonatal Nurses, Canada; the Society of Rural Physicians of Canada, the Association of Midwives, and the College of Family Physicians of Canada. The conferences were spread over the year 2005 and so there were differences noted in the number of people who had heard about the MCP² project because of additional publicity including inserts in the professional journals. The primary author conducted all but one of the focus groups. The second author conducted three of the focus groups including the one that the primary author did not. The largest number of participants was in the midwifery group, the smallest in the obstetrician group. In the quotes used to illustrate the findings there are many by physicians; this is because physicians had three of their own focus groups and participated in one of the mixed groups, while nurses and midwives had one group each and participated in the mixed groups.

The focus group participants were asked to sign a consent form agreeing to the discussion being tape-recorded. Participants were asked not to talk about the discussion outside the session without express permission of participants so that the participants could feel safe to disclose difficult issues related to collaborative practice without being identified. The tapes were transcribed verbatim and checked by listening to the audiotapes to clarify statements. Many of the participants in the groups knew each other and proper names were removed to protect the anonymity of participants. The discussions were often lively and there were plenty of examples of the issues around maternity collaboration to illustrate key issues. The audiotapes will be kept in a locked drawer and will be destroyed at the end of the project. The transcripts will be kept for seven years and then be destroyed as required by the ethics boards of both universities.

The transcripts were entered into the NVIVO.2 program to assist in storing and sorting the data. The program allows the researchers to code the data and re sort at many stages. Prior to coding all the transcripts were read and re read to fully gain an understanding of the issues outlined. Many statements were co-coded as the participants were relating one sub code to another. As an illustration, participants linked overcoming barriers to collaboration to the crisis in health human resources and therefore this initiative and others to increase the visibility of maternity care as a positive career choice. The concepts and constructs identified by the participants varied by discipline, but there were core concepts that each group identified. It was from these core concepts that four levels of collaboration emerged and the level of collaboration section is subdivided to illustrate the issues related to these levels.

As with the first technical report in this series the authors have had to immerse themselves in this data set and try to block all other maternity projects that they are engaged in to be true to the data. This has been overwhelming at times because the primary and secondary author are engaged in a rural maternity women's study, a maternity educators study, interdisciplinary education initiatives, and provincial maternity planning in Ontario.

There were eight separate focus groups gathered at six meetings. The number of participants in each group varied. The total number of participants was 79. The midwives group was the largest, the obstetricians the smallest. There are many differences across the country in how and who provides maternity care. The majority of the participants talked about who would attend births. The nurses were the only group that addressed care in the post partum period, especially for those who needed medical care for post partum mood disorder. The worry for all groups was ensuring that there was access and care at the appropriate time in the antenatal period, who was responsible for care, and who would attend births. As there were limited numbers of focus groups, the report cannot be generalized to all maternity care providers across the country, although the intent of focus groups is not to generalize some may assume the findings are representative of all health care professionals who provide maternity care in Canada. As focus groups were held across the country there was a mixture of people from different provinces from coast to coast to coast.

Coding the Data

After the initial coding there were 78 concepts identified in the data. These 78 concepts were collapsed to 15 themes, and then into four broad areas: historical and cultural issues, financial resentment, rural and urban practice, and one broad area that seemed to envelope the majority of the data – that was the types of collaborative practice. The data is presented in these four sections.

Historical and Cultural Issues

All of the participants in the focus group reiterated that there were many historical and cultural issues that needed to be resolved before collaboration and collaborative teams could be fully integrated into maternity care. In particular, the experience of working with midwives had not always been easy. One obstetrician said:

It's historical. I think it's historical I think if you go back to the way midwifery and medicine doctors have butted heads in the past and that hostility has in fact carried over so one of the things that I find that happens is that if there's, if there comes a necessity consultation there's a huge discussion between midwife and patient before they finally decide that they want to consult the obstetrician.

Midwives also pointed out that it is hard to now work in collaborative models when they can remember that the official position from SOGC was not to approve of home births in the past

Yes, there's some kind of paradox. I remember in a journal of the SOGC less than 10 years ago they were against home births and against midwifery. They don't agree on that and it took really an article by JOGC to say okay well maybe midwives. And now you know we're talking about collaboration. We're talking about core competency with the full application of midwifery, competency and skills.

Another midwife pointed out that there was fear in provinces with no or limited midwifery to have a new model of care when the initial model of care was yet to be fully implemented.

I'm from British Columbia where a lot of the rural areas are not served at all. I think in Ontario they have some of the more rural areas served by midwives and right now in BC there's less than 100 practicing midwives in the whole province. So the idea of collaborative care, we aren't even ready to address that on a cultural level because it's midwives, I mean lots of kids on the street

say 'oh you're a midwife oh that's great what's a midwife?' You're not incorporated in a culture so that we can collaborate with physicians.

One nurse pointed out the difficulties in her community between midwives and physicians where there is historical distrust between the two professions.

I am a nurse in my community I see real strong historical distrust of midwives that are joining the community and to the point that we had a GP fire her patient there, their patient decided they would like to experience a midwifery, midwifery care and so they said "well you can't come back to me afterwards because this is not acceptable".

Another nurse identified that the culture of each profession is deeply embedded and has to be recognized and paid attention to especially if we are to embrace a change in the way we provide care:

I'd say [there is a] firmly rooted culture in every group. The historic cultures and the culturalization and you know the way they are even socialized into their career, chosen career path and how they practice and that all of us just sometimes that stepping outside the comfort zone is a little barrier.

Physicians often outlined that they felt that their contribution was not recognized and appreciated. Obstetricians do not appreciate the negotiation that can happen between families and midwives. One obstetrician said

This is our turning point we either change, or go to a c-section, or we continue you get an epidural which you've been resisting for days but you get an epidural and you see what happens. So I get dragged in and out of the room, she gets an epidural and lo and behold she's having a baby a few hours later and not a word of thanks.

The same obstetrician was bitter that the role of a consultant that means that they are often treated by midwives as the last resort, rather than being respected as being able to offer a crucial role in a birth requiring medical or surgical intervention.

I find that happens is that if there's, if there comes a necessity consultation there's a huge discussion between midwife and patient before they finally decide that they want to consult the obstetrician. The patient is giving her consent to the midwife to do this. After they have done that whatever you suggest the patient and the midwife have another discussion about your recommendations and whether they're actually appropriate or not.

One family physician noted that the discussion had revolved around the difficult relationships with obstetricians during the focus group but reminded participants in her group that family physicians have not always been easy to work with either.

Its interesting sitting around here how we're talking about the faults, particularly we seem to focus on the obstetricians and not about what the problem of family physicians as collaborators. But it is very easy to talk about how the others are poor collaborators. What are we doing to break barriers, what are we doing to be effective?

One obstetrician recognized that historically there had been difficulties but they were slowly being overcome as trust was built between midwifery and obstetrics.

Our midwives tend to be or have been very protective and now over the last four years there's a trust that is developing because you can see how they function, and barring some of the negative experiences that have happened over time you begin to say okay this is possible, this is feasible. Even with our anaesthetist there is now a more willingness to accept the midwives.

A nurse also pointed out that there are issues related to historical care patterns where women and their families expect specialized care that may not be conducive to adaptation to a new model and need to be recognized.

To go a little bit more on this idea convincing people yes that you don't necessarily have to have one thing, I find people say "oh I don't have a paediatrician for my baby. Okay you have a family doctor oh yes but no I want a paediatrician for my baby". It's going to make things better but I try to explain that you have a healthy baby, you have no complication, for your care and your baby's care you don't necessarily need somebody that can do tertiary care. I think perception of people, the population in general, is something that has to be overcome.

Another nurse agreed with the previous nurse and compared women and families in one community to another community and said

Some seem to be more ready to trust different care providers. The worst ones are my [place name] clients. "I need a paediatrician and if I don't have paediatrician it's the end of the world". No it's not, but I'm not sure if it's probably a regional thing. But in [place name] they love paediatricians.

This comment was countered by another nurse who believed there were women who were willing to change their expectations;

I do see consumers, I agree that there are some consumers that who definitely want paediatricians and lactation consultants and all of the specialized stuff, but I think, I also sense that there are some consumers out there that don't feel that is necessary. And would be more than willing and welcome to look at not needing that level of care.

The historical and cultural issues around maternity practice continue to influence the attitudes and beliefs participants had about each other which will continue to be a significant barrier to working in collaborative partnerships if they are not addressed. In addition women and their families will have to be willing participants of new collaborative models of care and recognize that specialized care is not always necessary.

Financial Resentment

Money differences between midwifery and medicine continue to be resented. While there are issues for all participants about appropriate remuneration physicians in particular talked about the different remuneration models that are in place for care.

Well the only thing I can state and I'm going to state this because I'm a Quebecer and I practiced here for a very long time and when I saw that a midwife in Quebec was going to be paid three times what I was paid I was a little bitter, hostile.

Definitely, but you reminded me that in Ontario anyway the, there's a lot of resentment amongst physicians towards midwives because there's the pay to move dollars for care they gave you even though the care they give is not much more as physicians would argue sometimes oh you don't

need that much. We get the same outcomes this way and that way. We have maybe not measuring all the possible outcomes, that is a barrier and that gets a lot of physicians' backs up.

One physician summarized the issues of resentment about funding as being the excuse people would use to prevent collaborative models from being adopted.

I think collaborative care is really about a willingness to recognize and respect where other people are and are not, and to give [time]. Without that the rest, without that you can rely on arguments like funding and you can rely of our arguments like liability and you can rely on arguments like turf. But as soon as that desire and that willingness is there, the rest of it [collaborative practice] can start.

One physician noted that there were differences in financial resentment between rural and urban places she had worked and it was less in rural settings where salaries were more the norm.

I definitely think that the future direction will be to become more formally collaborative, fortunately in smaller areas, the areas I have worked in, funding hasn't been so much of an issue as my experience in working in larger areas. Because people are on more of a salary, it is easy to share care which has been great.

It is not only in maternity care that financial remuneration issues are a barrier to care. One obstetrician described that nurses accuse physicians in operating rooms of performing surgery to make money and if nurses were on fee for service perhaps they would be more willing to stay after the end of the shift.

Nurses will tell me ...the only reason doctors what to operate on people is to make money which makes us feel somewhat mad cause I actually think from time to time we offer it to people because we think it will help them....and on the other hand the nurses seem awfully keen to go home at half an hour before quitting time so I mean one of our more contentious discussions began with the nurses saying if only doctors were on some sort of salary then they'd stop doing all this work and the doctors would say we can't get the turn over in the OR if we had nurses on fee for service maybe they'd actually be productive.

Another participant noted that valuing each person's expertise would overcome some of the historical financial resentment that impedes the ability of a team to work together.

People should get remunerated not by the five minutes they do something and have a dollar figure attached to that you are expected to work as a team and that is how you get paid. Regardless of whether you worked two hours today and five hours tomorrow and 24 hours the next day because it is just part of the job. Babies come whatever. Respectful. Equal work for equal pay, equal value especially to get away from the nitpicky and competitiveness.

There is no doubt that for all professionals to be able to work together in collaborative practice financial remuneration will need to be transparent and fair to each discipline recognizing their skills and scope of practice. However, one obstetrician pointed out that salary for physicians is not always the answer. Her example was of orthopaedics but could have implications for salaried employees in maternity care.

I'm told by friends of mine at [place name] that what used to be an emergency in orthopaedics was an emergency until 12 o'clock at night which time it ceased to be an emergency until tomorrow morning because I'm not going to get paid anymore to do this at midnight and I'm on an alternative funding plan and so to hell with it.

Fee for service puts up barriers to collaboration but salary for all may not encourage people to work hard.

In fee for service there's the incentive to do more than you should and to elbow people aside and see if you pay for doing piece work you want to more pieces. In salary work or however you describe it, the answer maybe I'm going to get the same pay whether I do a lot or a little so how little can I get away with?

A midwife identified the resentment because there was not the flexibility to change financial remuneration that would encourage collaboration and collaborative models at the moment.

I think one of the real barriers to the down up approach is the remuneration model that the caregivers all around cannot change and I think what needs to come from up is more flexibility and working out more types of models.

Financial reimbursement remains a single potent barrier to collaboration and will have to be given priority in any collaborative team approach that is developed.

Rural and Urban Practice

In all of the focus groups there were participants who addressed the rural issues as being critical now. However, one obstetrician pointed out that access is also difficult in urban settings and he believes there is too much emphasis on rural maternity care at the moment.

A couple of comments and I'll start with this rural area string of crisis. I get tired of hearing about rural areas. Most people in Canada don't live there. We're one of the most heavily urbanized countries in the world. In Regina we can't provide care for people in north central. This is 6 blocks north of the Regina General Hospital and there's minimal access to care there.

Rural maternity practice is in trouble. One, there are not enough practitioners of any discipline to be in a collaborative partnership. A family physician described her reaction to collaborative practice as:

I remember hearing about it but it went in one ear out the other cause really it's really irrelevant for us in North Western Ontario where you have nobody to collaborate with.

The reality in rural Canada is anyone to practice with in any type of partnership would be helpful.

I mean I would love to collaborate with a midwife or a nurse practitioner or somebody else but I don't have anybody else there to collaborate with. It's me and one other doc.

Another physician reiterated the difficulties in rural areas and pointed out that collaboration may be the only way to ensure quality care for women

There have been some models that have been supported whereby especially in rural areas where it's hard to have enough family physicians so that they can have decent docs on call. Then in fact it wouldn't matter who was there. It could one day, it could be a midwife and the following day it could be a physician and they're in fact interchangeable.

A family physician could understand that family physicians and midwives could work more closely together to provide low risk care for women experiencing straightforward labours.

I can envision for example, I'm the most urban of urban doctors,I can envision a rural set up where midwives and family doctors have a collaborative practice where they can take calls to each other and so then the family doctor ends up being second call for the midwife should there be something beyond their scope of practice.

Rural physicians have been trying to attract midwives to smaller communities but it is not easy for them

I think you'd be surprised of the volume most rural communities get. Like there's more then enough volume for midwives in most communities. Most midwives don't do a large volume of deliveries its quality not quantity. And we've talked to the midwives in (name) about coming to (name) maybe half time and stuff like that. It's just not, they already have a job, its not that we need somebody to move from one place to another we need more bodies period whether it's midwives, family doctors, it doesn't matter I think; we just need more bodies before we can collaborate.

The midwives also recognize the difficulty of setting up a practice in rural communities. They need infrastructure and a pattern of referrals that is sustainable and want to be able to offer established professional team approaches rather than only multi-professional teams. As one midwife stated:

I would rather see us put some of this energy that we're putting into this kind of thing into making resources available for midwives to do team midwifery in remote places or in rural British Columbia.

Another midwife from BC recognized that rural communities are not well served in that province and believed Ontario rural areas were better served but there was a long way to go before all communities could be served as people do not know what midwives do and therefore it would be difficult to part of the community.

I'm from BC where a lot of rural areas are not served at all....In BC there's less than 100 practicing midwives in the whole province. So the idea of collaborative care, we aren't even ready to address that on a cultural level because it's midwives....oh you're a midwife oh that's great what's a midwife?

Many of the participants who agreed to be in focus groups had rural experience. One obstetrician who spoke so eloquently about the urban situation in Regina was supported by his colleagues in the room in drawing attention to all areas of Canada, not simply rural and remote parts of the country.

The Levels of Collaboration

The fourth broad theme was the levels of collaboration and is subdivided into four sections. Quotes to support each are provided recognizing that there is some overlapping the issues.

The participants provided multiple examples of collaborative practice; those that worked and those that had not worked. If we are to develop collaborative practice, we must have clear unambiguous guidance that promotes sharing care and responsibility. One family physician said:

I mean the notion of interdisciplinary and some are learning from each other because most of what I hear about collaborative stuff is about power sharing. We got the power; you don't and many ways the power sharing that has happened has allowed nurses to have a different platform. And I'm all for that to be quite honest. The questions though that still have to be teased out is when you power share you better be explicit about how you're doing it. And you better have

proper protocols to use military terms, rules of engagement and ways of solving the issues that come up.

In all the focus groups there was a significant amount of humour that mediated the drama of some of the worrying stories about professional jealousy, and lack of collaborative practice. One family physician called caesarean sections ‘vaginal by pass surgery’. Another talked about being a ‘birth junkie’.

And yet at the same time when you find people no matter what their professional designation who are birth junkies who just love it who just get their “ya ya’s” out of it, you just bond and these are the people, you know, and it doesn’t matter what they’re professional designation is, you can do births together no problem.

The shortage of health care professionals was discussed at a very personal level in that participants were also actively trying to recruit each other to come and work in their environments. There had been some discussion about how collaboration does not work and another participant leaned down the table and said ‘why don’t you come to us, because what we do is the opposite’. There was much laughter around the tables at these times of recruitment.

Collaboration at the Personal Level

Participants talked about the personal relationships that establish the backbone to develop collaboration at the personal level. There are three components to the collaboration at the personal level: with the family, with their own profession, and with one other profession. One nurse described a collaborative practice that allowed public health nurses to provide care to women at the hospital where they gave birth as being collaborative and women focused

We have so far and it’s been tweaked and been given to public health but they do come into our hospitals to be checked 48 hours after discharge. Even if their baby is in special care or they come back to see the public health nurse....., they’re given the option of coming back [or having a] phone call.

Establishing a personal relationship with women is a core component of collaboration at the personal level and was described by a midwife as:

I am listening to what some people are saying and thinking I am hearing some concern about loosing the relationship between the women and yourself if you are in that primary care kind of setting with a particular women and her family and how opening up this can of worms like to a team can have positive and negative effects and what I am hearing it is an interesting thought because I think relationships are pretty important in this as well. So it’s how do you get that balance between having an ongoing relationship with a woman and her family um that continuity that I heard around the table and then also value the input of other professionals and what they can offer.

The relationship can be difficult to establish if it is not started early in the pregnancy. One family physician stated that this can be difficult *what’s best for her whom we have some relationships with her but particularly if you come on late in the game you don’t really know what her culture is in terms of her family, her expectations and all that kind of stuff.* A rural family physician believed:

I think collaborative care is really about a willingness to recognize and respect where other people are, and are not, and to give and without that the rest, without that you can rely on arguments like funding and you can rely on our arguments like liability and you can rely on

arguments like turf. But as soon as that desire and that willingness is there the rest of it can start.

Difficulties between physician groups were also discussed. One family physician admitted:

One is we've concentrated on the family doctor and the midwife that has been through sometimes been conflicting parts of the team but I think we should give some attention to the family doctor and the obstetrician because that is another difficult relationship at times. These difficulties have to be resolved so that inter professional team work can occur.

Another family physician felt that one of the issues was the obstetrician taking over care and the family physician was then not in a position to offer primary maternity health care.

Where as here the patients are swallowed up to the obstetrician; an obstetrician's got to be there to do the delivery or oversee the delivery. They don't want a family doctor having anything to do with it. This is 9 months of your patient's life and suddenly they're taking it away from you. So I think that's a problem.

Midwives also worried about the time it can take to develop relationships with other professionals and compared it to her experience working in another country.

A midwife is out there a professional and that's a major difference and just to give you an example from where I use to practice in the west of Scotland that the local GPs just accepted midwives. You didn't have to wait 2 years to build a relationship. It was from day 1 you could be relieving someone else but they've come and said can you look on Mrs. So and so and you go to them for something.

Collaboration at the Team Level

Collaboration at the team level was described in two ways, multidisciplinary teams and structured teams. There were differences between the two as multidisciplinary was seen as working together but not as integrated as structured teams. Nurses gave plenty of examples of multidisciplinary practice that they believed that they practiced in every day. One nurse described a maternity team practice where the nurses provided monitoring of pregnant women

And you speak to the doctor and they want to hear from you because they know that you are their ears and eyes in the community and that often they don't have to see this mother again. Just let them know what's going on. I remember one case I let him know what's going on, the mother was suppose to go back the day after and I said I don't think she does, I think I fixed this, you don't have to see her I'll call you back on Monday when I see her again.

Physicians pointed out those multidisciplinary teams can still work in silos and that is not necessarily collaborative.

But so you have all these people sort of walking through in parallel and that's multidisciplinary which is we each are here but we each come from our own training and our background and our silos and we work in a functional parallel systems or dysfunctional but largely functional because babies still get delivered and c-sections still get done.

Responsibility for care within a team was described as being problematic especially if team members did not understand each other's scope of practice. Being sued is an issue for all care providers in maternity and the obstetrician group discussed this at length. One described a scenario as

If the midwife leaves that patient in dystocia labour for three and a half days and brings the patient in desperate to the hospital and something goes wrong you're going to get sued. But I mean hell; they'll sue the cleaner in the hall. They'll sue everybody. The issue is you become responsible when the patient comes to you. If the midwife has screwed up the management, the midwife carries the can for that responsibility and should.

Working in teams does require cooperation between team members and those who refer. One obstetrician pointed out that some referrals have already had care while others haven't and this makes working in a team not that easy: *Someone's going to arrange an ultrasound on them so I think if you're going to have a model like that you have to know who was responsible for what.*

Sequential care teams were described by rural family physicians. In this situation another profession provides all care before referral for intrapartum care and then women are referred back to them. This happens in some rural communities where birth is not available locally. Or family physicians are the ones who have women referred from very remote communities to them for care.

Our collaboration is mostly, probably 75% of the women who birth in the hospital where I am come from other communities until they are 36 to 37 weeks all the prenatal care is provided by nurses in communities, we don't have midwives in our hospital but we do have midwives in the territory.

In another part of rural Canada there was a formal process of evaluation by the team to plan care for women. A midwife described it as a *religious time for all care providers* with a care plan that was agreed to and adhered to by all including the women and could only be changed in an emergency.

Multidisciplinary teams seem to be better understood than interdisciplinary teams as professional autonomy is still maintained while working together. A family physician said:

Multidisciplinary is good. I come, sit at the table. I can protect my turf, I know who's on my team and I know who's not. I can identify them because we've got either a professional designation or a responsibility. I think those are some of the things we need, if we're talking about knowledge, attitudes and beliefs about working with others, those are something's we need to look at

Team collaboration was more easily recognized and understood by those talking about primary maternity care rather than high-risk care. Several participants could envisage teams working in rural and small town places where they may not work in larger settings with mixed risk care. One nurse stated:

I think collaboration works best at the family doctor, nurse practitioner, midwife, nurse level and leaving the obstetrician specialist to do what obstetrician specialists do and that is look after high risk, look after whatever issues surgeries all that sort of thing. But I think in the sort of smaller group with a family doc, nurse practitioner, nurse, midwife really that is collaborative care. I see a specialist as being outside that.

One obstetrician stated that. *"there is a place for everybody on the team and it works very smoothly and the patient gets very good care. Another obstetrician who had worked in a collaborative team believed that it is in fact possible to provide very good care; you have a whole variety of providers and working in teams and presumably where the contribution of each of the people is valued by all of the people.*

Participant's vision of teams varied. One obstetrician described a busy practice where some days all they did all day was prenatal clinics. Whether nurse practitioners would want to work in someone else's clinic rather than in independent practice would be questioned but the participant described the NP as part of a team. The obstetrician said:

Having a nurse practitioner as part of the team would be welcome as I feel like I'd have a life and a lifestyle of some sort to go back to at the end of the day instead of feeling so exhausted at the end of everyday that the weekend is recuperation time and sleeping time. So a nurse practitioner to me would be a very good part of my practice.

One midwife envisioned a team where there would be referral back and forth and reciprocity.

One of the key components for me would be some kind of reciprocity. I mean it needs nurturing and all of that but I have yet to see a woman for example who would have been followed by one of the doctors and who would express fears or whatever and hat the doctor would say why don't you go see a midwife a couple of times.

Collaboration at the Institutional Level

Most of the discussion revolved around examples of the collaboration that exists and are exemplars in the view of the participants. The participants differentiated between hospitals and the larger community but the issues were the same and needed to be adaptable to local needs. A nurse said:

And their goal was to create a collaborative approach to care and collaborative in I think every sense of the original definition collaborative amongst professionals and the client or consumer as well as collaborative across systems because they also work very closely with the resources that are available in the community.

One of the obstetricians who had worked in a rural community as a consultant described his role as monitoring and responding as required but that he was at arms length from the every day care. *I know I get called a lot at night just to[go] in and look at the tracing ...and it's just to reassure everybody... and it works very, very smoothly.* This contrasted greatly with a family physician that described obstetricians *who are interested in doing more and it's actually a competitive environment where people are arguing over patients.* A midwife described the situation as even worse when financial compensation is involved:

In a hospital where the obstetrician is there on salary and they're not going to lose if they call you in the way they lose if they're billing for that birth. So a woman is pushing and the [patient] she's the obstetrician's client and he's down at lunch and I'm next door and I walk in and I'm with her – he comes flying up from lunch because it's his money.

The administrators and the administration of units in hospitals were recognized as either being a barrier to better collaboration. One nurse was particularly frustrated when she tried to have an issue sorted out that was systems level and the administrator did not recognize this and tried to blame it on an individual

When you go forward with specific examples at an interdisciplinary group and say we have got a problem there and it's the system that we are working with if we fix the system the senior administration response is "I will talk to that person" so instead of looking at it at a system level which is what we had all been inculcated to do... from his perspective it is your fault so therefore I will speak to you rather than working with the system.

A family physician described that he knew how to work collaboratively as he did in his practice but not in maternity. In fact he said *I would say where I work, and do the bulk of my time is collaborative. In terms of maternity care it is not.*

The nursing group discussed birthing centres as a viable option. All professional groups discussed home births. One obstetrician believed that the system as established in Ontario was not giving women the choice of home birth as much as it should because of the fee structure which meant some women requested midwifery care but had every intention of having interventions requiring obstetric care in labour. She saw this as double dipping in the system and therefore denying care to women who did want to give birth at home:

I feel that patients who truly want to have a home delivery, who truly want to have a natural childbirth may be denied access to a midwife because someone is double dipping. So it really angers me that some patients I guess feel they're getting the best of both worlds.

Another family physician who worked in a remote community where there were not midwives working was supportive of home births but only as a second attendant and was worried that if she attended she might get into trouble with the rest of the medical professional.

If I was working in bigger areas as a physician I think home births are great I am very comfortable supporting them even attending them. What would give me second thoughts is that, attending them with a midwife, I am not trained to do them myself but as an attendant I would be open to that, I don't know if I am open enough to loose my licence though.

The midwives worry about a collaborative model at the institutional level, with family physicians, that would preclude them attending home birth's as this is core to their practice.

They're not about to go out and deliver them at home. So that whole part of it is gone but women are forward because it's so much better than what's out there compared to going to a typical medical model of care for many women, it looks pretty darn good.

One midwife pointed out that the real worry to her midwifery group was not whether they could continue to provide home births but continuity of care. This was more troubling to them if they worked in a collaborative model of care.

I'm really concerned about is that in our working group, it was very striking to me was usually the contentious issue of he midwifery model of care is home birth that wasn't the contentious issue. The contentious issue was continuity of care.

Collaboration at the Professional Level

Several times in the focus groups, participants alluded to the role of MCP2 and the work that needs to be done in the future. As one midwife stated:

It's already been said in another angle but I think that knowing that a group like this one is could be a bank of ideas as well as a bank of resources, a place to discuss some remuneration issues which is very important I understand that and other issues.

One of the participants succinctly put the issues involved in changing practice to collaborative models that is sobering for all the professions. One nurse described the process as: *One is 'well we'll figure out a way to make this fit what I do or you know I'm going to continue doing the same thing but if everybody*

else changes we're going to have this collaborative model'. For collaborative models to work there will need to be change of all practices from all professions.

This carries over to the perceptions that the obstetricians have about what midwives think about physicians:

In general I don't have an issue with that at all but there's very much this attitude of we are not the medical model. We rid ourselves from this. And you are the medical model and the minute that you have that attitude, oppositional, you're butting heads.

A rural physician was quite hopeful about the development of collaborative models:

If everyone got along I think it would be, I think there's the potential for it to be very positive collaborative environment but there are a lot of personalities that make it difficult.

There are some participants who are hopeful that collaborative models may help to retain family practice and even persuade some who have given up practice to retain. However, a rural physician participant cautioned that we had to get models right otherwise we may have the opposite effect.

If collaborative care is done well it will actually bring family doctors back into the fold but I think the way we're going now collaborative quote unquote collaborative care is going to push the last few docs doing it out and that's my concern. And I think it runs that risk.

Both midwives and family physicians worried about the blurring of the professions into one 'a maternity care provider'. While some family physicians talk about extended scope of practice so that they can provide surgery backup and pain control they also recognize that this may blur their role as a primary maternity health care provider. A rural family physician said:

You see that's the problem I think true trans-disciplinary model is not about distinct role definitions limited to the specific caregivers. Like I think, I actually did train to do c-sections, trained to do epidural but I don't like doing them so I don't do them. But I love c-sections. So I'm willing but I don't want to just to be the c-section guy. I like what low risk volumes contribute to my identity as a family doctor and my practice as a family physician. So although I can, I could just be the c-section dude wake me up when she needs to be cut. I don't want to think just tell me she needs to be cut I will come in and do it. I could do that. I love doing c-sections totally get a charge out of it but the fact is as a family doctor I also enjoy the low risk deliveries and I don't want to choose. And the fact that I happen to have an area of overlap with a midwife doesn't mean that I think the midwife should take that entire area of overlap. It's an area of overlap we both get to do it.

One nurse from a rural community was very worried about the relationship between midwives and family physicians and wondered how collaborative models can work when as a nurse in the community she said:

I see real strong historical distrust of midwives that are joining the community um and to the point we have had a GP fire her patient there, there patient decided they would like to experience a midwifery, midwifery care and so they said "well you can't come back to me afterwards because that is not acceptable"

A rural family physician was worried about the relationships between family physicians and obstetricians as they believed that this relationship has been strained in the past.

One is we've concentrated on the family doctor and the midwife that has been through sometimes been conflicting parts of the team but I think we should give some attention to the family doctor and the obstetrician because it is another difficult relationship at times.

Nurses did not come out as collaborative necessarily and as one family physician stated:

We don't want to be undermined in front of our patients and that's been an issue with some obstetric nurses in teaching hospitals who have deliberately torpedoed family doctors in front of their patients.

In fact all three disciplines were accused of protecting their territory to the detriment of families and families' wishes. A family physician said:

And for some family doctors it's keeping midwives out. For some nurses it's keeping midwives out of course some nurses are keeping family doctors out of there. What is it about child birth that there is this need to exclude certain people from this event?

Another family physician noted the midwives

Have been virtually dismissed from our teaching hospital to the point that they are looking at getting privileges at a community hospital.

One family physician believed some of the issues that have contributed to the crisis is that family physicians have been pushed out by obstetricians who are now complaining that they have to do all primary maternity health care as well as the high risk care. In the opinion of one family physician it the obstetricians are at least partly to blame for this problem.

That'll be interesting to let happen is family doctors got sort of thrown out of childhood care in some centres which is what they wanted to achieve because birth is far too dangerous and family doctors are incompetent by definition and you know women and babies are going to die just by their presence. And then all of a sudden here we are, consultants that are wandering around, they're kind of lonely like I've got nobody to push around like where are the family doctors like why aren't they involved here. They push everyone out of here and now you're lonely and you're doing all this primary care and you want us to come in and run the triage centre because everybody with the urinary tract infection or vaginitis or whatever have shown up.

This comment was balanced by another family physician who noted:

you know what I've noticed in my hospital is family doctors become increasingly competent in the eyes of specialists when there's more work to be done.

The role of the professions to lead the process was strongly endorsed by participants – leadership being important as *we can't push a rope* according to a midwifery participant. MCP2 was recognized as being important as a first step but we had more to do as professional organizations.

Discussion

The opportunity to discuss collaborative models with health care professionals from across the country in the past year allowed the MCP² evaluation team to hear directly from clinical maternity care providers' view the proposed collaborative models of practice may work. There is a profound worry about the state of maternity practice especially as there are not enough care providers across the country. Almost eighty people participated in the focus groups in Vancouver, Halifax, Montreal and Quebec City. We conducted two mixed professional groups in the first focus groups and then we deliberately chose to interview professional groups separately as we were anxious that each group would feel comfortable to describe their anxieties about practice and share with the research team their particular issues. In fact, we did not find profound differences between the first two mixed groups as the subsequent solo professional groups. This was important to the research team as we have heard informally many of the issues raised in the focus groups.

Attitudes are deeply embedded and are unlikely to change over 18 months and the issues raised will continue to impede the ability to provide care. Midwives feel vulnerable especially about protecting the model of care fought so hard to develop. This is especially true in provinces that have yet to receive official recognition, let alone public funding. Obstetricians are sensitive about their role in teams where they feel that midwives and families exclude them from discussions about intervention options. Nurses believe that they collaborate already but there were several participants who pointed out that nurses are equally disrespectful and undermining of others, particularly family physicians. Obviously, there is a lot of discussion that has to take place to understand what makes each group feel left out, there is plenty of work for everyone, and respect for each team member is important.

Family physicians are resentful of the amount of money for each course of care that midwives receive and that is an issue that will have to be dealt with early in the process of setting up collaborative models of care. Liability issues were raised but not dwelt upon by the participants. In fact the nurses did not discuss liability at all as a barrier to collaborative practice.

All groups highlighted rural and remote maternity practice, as being particularly vulnerable and in crisis now. Closure of maternity units in rural BC was discussed at length and participants from other provinces wanted to explore how collaborative practice might mediate the effect on women's choices in the future. However, other rural practitioners pointed out that there were significant barriers to collaboration when you had no one else to collaborate with other than your own discipline.

Collaboration starts with personal trust and respect for the individuals that you work with and that this foundation is required before teams can be formed. The personal trust also extends to the women and their families relationship with health care providers, although the participants talked mainly about personal trust with colleagues and other health care providers. Teams then require institutional policies and understanding of administrators to ensure that they are able to function, both within hospitals and then in the wider community. The work of the professional organizations will need to parallel the local groups to ensure barriers are removed that prevent collaborative practice. Dialogue about professional collaboration, such as through MCP², have helped develop the list of issues that need attention. These issues include remuneration for collaboration, scope of practice, and liability.

Overall, while there was concern, we think participants are interested in developing collaborative models that will be locally and contextually organized. The crisis in maternity is seen as an opportunity to engage in thinking and delivering care differently. The focus groups did provide opportunities for people to engage in discourse and exchange ideas and plans for the future. In health care today, with the looming and present practitioner shortages, it was interesting to observe active recruitment during the focus groups.

Participants are weary about change for change sake. The cautious optimism comes with the idea that we must plan very carefully, teams have to be selected, and the barriers of liability and remuneration have to be worked out prior to offering something new and different. With adequate preparation and rules of engagement collaborative models to deliver maternity care may work in some communities but is not a panacea for all situations and all communities rural and urban and remote in Canada.

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FOCUS GROUP QUESTIONS

1. Can you tell me what you heard about the Multidisciplinary Collaborative Primary Maternity Care Project funded by Health Canada?
2. What does the term "Collaborative Maternity Care" mean to you?
3. Can you describe the key components of collaborative team practice?
4. Do you work in a collaborative team practice now?
5. If yes, can you describe how the team works?
6. Do you believe your discipline is willing to work in collaborative maternity care teams?
7. Have you heard of other collaborative models of care?
8. If yes, can you tell me about them?
9. If yes, would they work in your environment? If not, why not?
10. What do you think are the barriers to collaborative models of care for maternity?
11. What do you think are the facilitators to collaborative models of care for maternity?
12. Do you have anything else to add about collaborative maternity care models?