



**Final Report of the Second Interviews of Key Informants from the
Partner Organizations of the MCP² Project
Technical Report Four**

**Groundbreaking Work: Post Project Interviews of Key Stakeholders in the Partner
Professional Organizations**

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GROUNDBREAKING WORK: POST PROJECT INTERVIEWS OF KEY STAKEHOLDERS IN THE PARTNER PROFESSIONAL ORGANIZATIONS

The Multidisciplinary Collaborative Primary Maternity Care (MCP²) project is a two year initiative 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 has three components. First, the report outlines the findings from the qualitative interviews conducted with representatives from each of the six national partner association partners at the end of the project. Second, the report outlines core themes from the two sets of interviews and the focus groups. Third, there are recommendations that came from the analysis and from participants about next steps.

Part One: Post Project Interviews

The purpose of these interviews was to ascertain if there had been changes in attitudes and beliefs towards collaborative maternity care, to ask participants to reflect on the effect of the project on themselves and their organization, and to ascertain their perspectives on some contentious issues raised in the first survey: hierarchy, supervision, and accountability.

The sub-title Groundbreaking Work reflects the main theme that emerged from the data and summarizes the consensus that the MCP² project has been successful in laying the groundwork towards developing, implementing, and evaluating newer models of multidisciplinary collaborative maternity care practice. In addition, we have laid the groundwork in understanding different professional and discipline perspectives that will enable us all to work together more easily in the future.

Methods

An interview guide was developed following discussion of the results of the initial survey and feedback from members of the executive, national committee, and staff of the MCP² project. Specifically the concepts of hierarchy, accountability and supervision were identified as needing in depth analysis to understand why there was such variability among survey respondents' ratings with regards to how essential these concepts are for collaborative models. In particular no hierarchy, no supervision and joint accountability were identified negatively by about 25% of all participants in the initial survey. The guide was submitted to the research ethics board, in English and French for approval at the University of Ottawa. Once ethical approval was received, project staff helped the research associate identify and approach participants for interviews. In total 23 telephone interviews were conducted with professionals from each of the partner organizations in March and April 2006. As participants are mostly in clinical practice, interviews had to fit in with their busy schedules and so two months were needed to complete all interviews. In addition, as with any research project it is important to read and discuss early interviews to modify and learn as we went along. This is especially important if, as we were trying to do, to sort out difficult concepts and gain a deeper understanding. That is, analysis of the data was conducted during the process so that if a question was not appropriate or not well understood, we could adjust the interview guide.

The participant's names were not identified to the primary researchers (JM, WP, BD, and IG). This was done to protect their anonymity in the process. The participants signed a consent form and sent by fax back to the research associate. The telephone interview was audio-taped, transcribed verbatim, and read by the research team. Each team member (JM, WP, and NL) independently read the transcripts, and then

the research team identified core concepts and a coding template was developed. The researchers then coded transcripts together to check that each was identifying and coding the same piece of text to the same node. All 23 transcripts were then coded and entered into NVIVO 2.0 for sorting and storage. The NVIVO 2.0 program allowed the researchers to check for similarities across professional groups on common themes and to organize the reporting. The program does not analyze data, it simply assists researchers to ensure that they are able to manage large volumes of data in an organized approach.

The data was organized into common themes and will be presented with quotes to illustrate the main concepts and constructs that emerged from the data. Participants were asked explicit questions that addressed the value of the project and the opinions of the participants on the requirement to maintain the National Maternity Committee. This part of the report is organized with these three concepts, hierarchy, supervision, and accountability, first and then the answers to the pragmatic questions about effect of the project and the long term sustainability of the National Maternity Committee.

Hierarchy

In general participants did not believe that there should be a formal hierarchy in a collaborative model. Many providers expressed the notion that each collaborative provider should be considered as an equal partner in decision-making and therefore the term hierarchy was not appropriate.

I don't like the idea of a hierarchy at all.... Everybody has equal importance in the whole decision making and that you sit down, even on a unit if you've got a problem going on, you sit down on the unit and you brainstorm whoever's involved in that case, how you're going to manage it but you do it collaboratively.

Another participant said:

Well collaborative maternity care should not have any hierarchical structure if it's collaborative. It doesn't, the two of them don't go together in my opinion.

Although participants were not comfortable with the notion of a hierarchy within collaborative teams, most participants felt that there would always be a need for a defined process for decision-making that is understood by all members of the team and is based on open communication.

I think what ...is important is that there is a clearer process for every member to know how decisions are made and either by consensus if it's by voting or if it's by give and take. I think members need to know when they disagree whether there's any process in resolving those differences. So I guess my answer is that I don't know if it needs to be hierarchical. I think it needs, there needs to be a clear structure or process where by all members of the multidisciplinary team know how decisions are formulated.

Another participant continued with the theme about when hierarchy was not appropriate:

when you say hierarchical...I'm not sure what that word will mean for me. It has to be clear on who's responsible of what. I don't know how much of a hierarchy that will create ...I mean I don't see that we would gain from one profession being systematically above the other. That's not how I see it. How I see it maybe then the word hierarchy is not the right one and maybe it didn't sound the same in the ears of whoever answered those questions before. For me, at the moment where we're not quite in a collaborative but we view the transfer and consultation and back and forth type of thing, we have to know at any given point in time who is responsible for the follow-up of one specific woman or baby. And that may change in an hour. She could be sent back to her treating midwife or whatever you call her but at any point we have to be clear on who's responsible for what's going on there. And when the woman or the baby is transferred back, it has to be transferred with all the appropriate information so that the best care could be

pursued, I mean kept going on with the woman. So it's not about hierarchy as well as understanding who's doing what in time because it might change throughout the whole process.

Again, this participant believes hierarchy is not part of collaborative care

I think that you need to recognize the uniqueness and the specialities that are part of collaborative care but it's not about hierarchy. It's about providing safe care. And recognizing the different caregivers' will to do different things but I don't think it's about a hierarchy. It's about a relationship in respect to the woman who is at the centre of the care.

A defined process for decision making would help teams to identify who the most appropriate provider, and therefore the most responsible person within a team is at a given time. It was noted by this participant that the decision regarding which provider is most responsible is dynamic and will change over time.

I don't know that you need a hierarchical structure. But you need a clear structure....it's very hard for an individual to relate to a whole team and that there clearly needs to be a designated way into the team and also a clear understanding for the person who is being served by the team who is their ongoing most responsible person within that team. That could and potentially will change over the course of a pregnancy for instant. But how that changes, the person approaching that team for care needs to be a part of the discussion about the change and the most responsible caregiver. But also needs to be very clear on when that change is happening and how.

When asked about hierarchy within collaborative teams, a few participants described the importance of the woman being the centre of the care. Knowledge of each woman's needs will help to define the most responsible provider.

...if you're [going to] collaborate on care you have to have the same objectives. So physicians and midwives, if that's the collaboration that's involved, have to have the same idea of what the woman should have or needs or wants. And once that is established it doesn't matter who delivers it as long as the care that the woman gets is delivered. So it's the hierarchy, I mean I don't think necessarily ...hierarchy is the right term. I think it's an understanding of what each caregiver can provide and then an understanding that we all expect that the woman gets the care she needs and then the care moves between professions based on what cares, the care they can provide.

Another participant emphasized the role of the woman in contributing to the decision about which provider will be the most responsible:

I think that ultimately women identify or women chose or select their primary care provider and integrating woman's choice into autonomy for decision making becomes an important aspect of who should have the most important voice or the loudest voice or the decision making voice. And I think that needs to be considered. So in terms of answering the question I think that the woman's choice in terms of who she trusts based on all the information and her knowledge of the different individuals I think that has to be a part of the decision making process as to who.

There were different opinions about how teams could function that would transform maternity care with hierarchy still intact, and decision making still predominately one persons responsibility.

Well I would like to see possibly a staff consultant OBGYN in charge of the collaborative care unit. And under his or her jurisdiction would be nurse practitioners and midwives working closely together and to provide maternity care.

Another Participant said

Well I think there has to be some clear form of hierarchy otherwise there will be too many bosses running the show. Now that doesn't mean to say there can't be input from various levels but I think you have to have one person in charge and you know hearing the input from various areas and making the decisions.

Supervision

There were predominantly two ways supervision was interpreted. First, supervision is necessary until individual practitioners are competent within their scope of practice. For example there is a perceived need to supervise students or new practitioners:

...teaching is a life long commitment and ...for instance when you train surgeons you have to supervise the training. The same with you got to train people to do obstetrical care under you know maybe not always ideal circumstances, supervision is important as well. I think it's part of the teaching, integral part of the teaching.

Once providers were deemed competent by their respective colleges and feel competent, direct supervision of practice within their scope of practice from within the collaborative team was not seen as necessary. The respective Colleges would have the responsibility for this ongoing supervision. In this sense, each professional in the group would function within their scope and not need supervision by another profession.

Again I would say each professional is responsible for their own actions and their own knowledge and their own care and if you're working with a committee or some body that includes everybody it comes to the committee and it's discussed there and a decision is made there and a consensus is usually achieved

...if the competencies are outlined and people are deemed to have those competencies then ...they should be supervised within their discipline not by another discipline.

I think if caregivers are competent I don't think they should be supervised. I mean I think that's what the question is. I mean I don't think, I don't need my care supervised by an obstetrician if I'm competent and I know my limits and what I, you know what I'm able to do.

I don't think the physician needs to be supervising midwives or anybody else if they're within their scope of practice and their level of competence. And I certainly don't think that anybody would be supervising a physician doing something that they were competent, and trained to do.

if I think of a small team with family doctors and midwives working together then what's so different then a team of midwives working together and what's the importance of supervision in there? There's none. I mean we're not supervising each other. We're working as a team so the word supervision is not adequate. It's just not...so there is a very regular, very like weekly reviews of decisions being made of ways of doing things and a lot of communication both within the whole team as a group and personally and it's working very, it's flowing from day to day. But the word supervision is not there. I mean where there is supervision is that there is a legal committee of midwives that ...would be presented any complaint about either malpractice or any deficiencies in care or any questions or any so that is there it's in the hierarchy actually and it's but within the team there's not such a thing as supervision. So I don't see that family doctors should supervise midwives and vice versa but definitely there is a need for continuing well functioning communication and discussion over issues that over which we don't agree. So that a common ground could be decided upon and everybody could feel comfortable to keep practicing you know with such decisions if we can imagine any point for on which people would have a different view on how to do things.

Secondly, the degree of supervision within the collaborative practice group will change depending on the clinical circumstances. For example, in a stable situation, consultation would be possible rather than supervision. Consultation was described as regular communication and discussion among collaborative team members and was seen as essential to effective collaborative care:

I would hope that you know that the importance of supervision in a collaborative setting would be more one of communication so that there's to and fro with the information and communication and then there would probably be less requirement for supervision.

However, some participants expressed that in an emergency situation the physician may have to step in.

So on a decision related to whether or not we, whether or not me as a physician is going to do a caesarean section I think that I've got to be the person who makes that decision. I don't think that a midwife or nurse or administrator can make that decision for me.

Participants also differentiated between clinical and administrative supervision, with administrative supervision viewed as an important component of any organization. Although the survey did not ask about administrative supervision, only within team supervision, it is an important concept that must be well defined so that team members what type of supervision is being examined.

I think in a supervisory role whether, I mean most teams report to some sort of structure or person to account for their, you know productivity and patient care outcomes and that sort of thing. I don't know that it needs to have whether it is a physician or a nurse but I think there needs to be some lines of clearly reporting structures so that that kind of internal monitoring is not omitted or neglected. So I think from a day to day supervisory I don't know that that's...I'm not sure when so I think what we need to have is a process and structure for the team to monitor it's outcomes and be accountable for its quality of care the team delivers to the patient population.

The participants highlighted the importance of really understanding the language used. This became obvious to the researchers as we analyzed the data. As different professions have different understandings of words it is important that everyone knows what we are talking about especially when there are several definitions. As one participant said:

...you need to watch the language. And I think the language gets in the way. So if you change things like 'clearer hierarchical structure' and 'supervision' to things like 'consulting', a 'consulting structure' and a 'preceptor-ship' then that softens things and it puts everybody on an equal playing field professionally with respect to the fact that some people have more knowledge in some areas...

And another participant said:

...is there someone within the team who is an overall supervisor? Is this another code word for team leader in a circumstance where we're trying not to assume hierarchical relationships and are looking for other words? If that's the case then my thinking around this would be that yes there needs to be, there needs to be some team leader in the sense of each individual who's being cared for but that isn't necessarily [the same] person ...for the duration of the care.

Accountability

The researchers asked specifically about accountability and did not ask about joint accountability. In teams, joint accountability would probably be a better concept to discuss with team members and how they would work out principles to guide their practice. Most of the participants saw each person in a collaborative practice as accountable within their scope of practice.

I mean nurses are accountable for nursing practice and they should not have to answer to medical practitioners for nursing practice ... the same for midwifery, I don't think physicians should be directing ...or evaluating midwifery practice. That should be evaluated and directed by midwives. And I think the same is true for obstetricians, for family doctors, for anaesthesiologists, for paediatricians, for neonatologists. So I think those accountabilities need to be discipline specific.

This participant continued, explaining the importance of clear communication among team members about who is most responsible and when the decision to delegate responsibility is made:

I think on the other hand one needs to be clear as to who is the most responsible clinician who is providing the overall care for the client, the woman. So that needs to be clear so that when something falls outside of the scope of that practitioner, that client gets transferred to a practitioner where that clients' problems could be met within the scope of that other practitioner and every team member needs to be aware of who that practitioner is.

With respect to accountability and litigation, participants felt it would be necessary for each professional to have liability insurance in a collaborative practice.

Well every professional that would be involved has their own body of knowledge, their own legal requirements, their own ethical statements and so on that they must abide by. And if they don't then it's the profession that will take them to task.

Everybody is ultimately, every person is ultimately accountable. Every professional is to their own practice but not to anybody else's.

I think that each profession is just by virtue of being a professional is accountable and responsible for the care that they provide and that their association is the ultimate regulating body through their membership. That's probably about all that I can say to make it really clear. I would expect that the midwives and nurses and other and family physicians who are part of that team to have appropriate coverage for the mishaps that might occur under their watch and within their responsibility.

However, many participants expressed the belief that liability would become less of a concern in true collaborative care teams because of the mutual respect and communication that is inherent in a collaborative model:

I think [liability would be] less of an issue. I think if again from a point of view of nursing if you go to a physician to ask a question or to challenge that physician and they go right down your throat you're not going to do that again. It's just it's very difficult to do. Where as you if you've got mutual respect there then there's discussion and I think the patient benefits in the long run. I think it's critical for patient safety.

I think it would just depend on how well people work together and how if they...if the health care providers were working together were kind of working from the same kind of page or the same belief about how to care for a client, I think it would be less of a concern as oppose to if there were some disagreements in how to work with people. Because different care, health care providers can come from very different kind of belief systems and how to treat people, how to work with people. So I think that thing about liability would be more of an issue if people were coming from very different places.

No I don't think it becomes more of an issue at all so long as like I say so long as there are checks and balances in the system to make sure that the practitioners that you have from every

discipline are competent, engage and continuing ongoing education. Those sorts of activities I think then your liability is no greater.

I mean if that's the case I would expect me, I wouldn't expect my malpractice or medical legal insurance to go up because I was part of a collaborative team.

Another participant said:

...I think that collaborative care doesn't put more liability...I think collaborative care in fact probably improves the liability issue because you have an opportunity for two individuals to participate or three individuals or how many individuals it is; I don't think liability is a big deal.

Some participants raised the idea that there is a need for change regarding liability insurance, specifically a need for insuring collaborative teams instead of or in addition to individuals:

We need to ensure that we're all adequately covered for our individual liabilities while we work in a team. And maybe at some point then it's going to need to be looking[ed] at: Is there some way of insuring a team?

When asked how the collaborative team would respond in a situation with a poor outcome, many mentioned the need to meet in a non-judgemental environment to review the situation and look for ways to prevent a reoccurrence. Many mentioned the MORE^{OB} program as an example of this.

Well I think it's a group task, a group responsibility to look at that, to understand the system issues and ways that would identify if the poor outcome had any preventable component.... My sense is that most of any preventable adverse outcomes are due to system issues and that we need to focus on the system rather than on the kind of shame and blame of the practitioner which has been all too common in health care in general and in maternity care in particular.

And through programs like MORE^{OB} for instance which are addressing nurses, midwives, obstetricians and family physicians we can then limit the risk to the patient of any mis-functions or mishaps. And I think that the liability is better shared and is much less.

One participant talked about joint liability for the whole team

Well insuring, of indemnifying the whole team as opposed to the individuals on the team. Like the more you have to single out the individuals the harder it is to be a team. And if liability continues to be an individual issue it's going to be one of those things that, not necessarily but potentially becomes a barrier to building the team.

The Value of the MCP2 Project: Discussion and Awareness

Participants agreed that the MCP2 project has not yet made a difference in terms of increasing collaborative primary maternity care practice in Canada. However, most described an understanding that this type of change will take time and that the value of the MCP2 project has been in increasing discussion about collaborative maternity care.

It does take time to build collaborative relationships and I think that in two years of a project that's not enough time.

I don't think it's made a direct difference yet for the practice area which I was in. Which was a very remote isolated community but I certainly think just speaking for myself that it's made me more aware that there is ongoing discussion and that there are steps being taken to move towards that direction and that there are things happening perhaps maybe quicker in other regions.

It's had no impact where I practice because nothings changed. I think across Canada though everything else change happens slowly. And I think we have to talk about things for a long time before things, people think it's possible. And then maybe some of the situations in terms of institutions and payment schedules and anxiety in the part of both practitioners lessen and then the people can start doing things.

I don't think it has yet but I'm hoping that it will in the near future. These things take time to go through the channels and we're waiting for some very positive things to come out of this. But it hasn't made a difference so far.

I wouldn't say that at the level where I am currently I have seen any evidence of that. There's more talk about it but I haven't seen any evidence of change.

...there's certainly more discussion, so locally you know I'm hearing collaborative projects in other sites which may have even been discussed before the MCP² Project started. So I'm not sure that there is a direct link to that but I think there are certainly more awareness of the need to be collaborative in providing maternity services not least of which you know arise from a shortage of providers in this particular speciality.

Some participants believed that there was more awareness of the MCP² project among their members since the beginning of the project.

all the written material has been widely circulated so it's been more visible certainly in work settings and in newsletters and on websites and places like that.

I mean I know that more of our members know about this initiative.

I have the opportunity to talk with a number of physicians around the country. And we're all aware of the MCP² and looking to hopefully have some positive outcomes from this project.

Several participants said that change had to occur, even though people don't like change, because there were simply not enough providers to sustain a maternity system.

I think everybody; nobody likes change that's the trouble. And I think some of us around feel that there has to be change in this situation because there just aren't enough physicians or midwives to do the deliveries that are necessary right now with a lot of people giving up from retiring and for a number of reasons they're not wanting to continue to doing OB. So there has to be change but just how we're going to facilitate that change I think is the question.

At the very least for intrapartum care it's going to be necessary for us to have multidisciplinary teams to provide that I'd say now and in the next generation of care providers because there aren't...I'm afraid there aren't going to be enough family physicians, obstetricians, gynaecologists and midwives to provide that care unless we're all working together.

Got to happen. We're all in this together and there aren't enough of us in it. And there's going to be fewer in the future. I mean I've sort of emphasized intrapartum because antepartum and pre-pregnancy care and postpartum care and all these things are important but the one that's really tough to provide, the one where it's hard to get providers to stay in the practice in intrapartum care. That's what people are dropping out of. It's hard to be up all night.

One participant sounded quite worried

Canada isn't producing enough midwives to answer the problem. And it maybe that Canada can't produce enough midwives because there are not enough people who want to be midwives. And we don't have the four or five midwifery schools that are producing approximately 60 to 80

midwives per year. It would take 20 years for us to get anywhere near the number of midwives that we need.

Requirement for a National Committee

The participants were asked specifically if they thought there was a need for a national maternity committee to continue the work of MCP². There were a few who were not sure but the majority were absolutely convinced it was essential and would help move the discussion forward and was positive for maternity care across the country.

I do think there should be a national committee really...Became things are changing. Because we need to reflect on how things are changing, how it's affecting the way that perinatal care is given in this country. We can see from one province to the other that the emergence of private services, we have to look at what that means in maternity care. We have to look at things that have been done or are at the point of being done in some provinces. See what's to be learned in there. I don't see why we should reinvent the wheel one by one in every province and territories in Canada

Because I think if change is going to occur the momentum must be carried on and continued.

Absolutely. I think it's really crucial to maternity care in Canada. A lot of family docs aren't doing maternity care which is unfortunate in lots of ways. And we're having trouble getting obstetricians and nurses and you start wondering who's going to deliver these babies? And I think it's absolutely crucial.

I think you absolutely need a group of people respected and known about across the country to lead this forward. I think people, change always in my opinion takes time and we need to see the people who you respect promoting something for some individuals to get on the band wagon. So yeah I do think it's important and to move the agenda forward, to build models, to promote the outcomes of those models especially if they're successful, hopefully they're successful, and to keep advertising and to build confidence in that model by experience.

I think it would be very valuable to have this national committee continue to meet if there are clear objectives and directions to pursue. If we can measure the results of future meetings and understand exactly what the intentions are then it would be most worthwhile to have this committee continue meeting.

Yes I think they should because I think this is something that's emerging and it's a way we need to go in this country. And it's not I think as we get it up and going we're going to refine it. And I think to have those people who have been most familiar with it would be helpful and because it's going to be ongoing. I don't see this as a static one time thing.

Discussion

Overall, the participants were very positive about the project and believed that over the time of the project there has been in depth discussion and discourse about major issues related to collaboration. The work has been ground breaking and should be celebrated as such. We asked difficult questions about difficult concepts and, as the participants were honest, it may appear negative. This is not the intention but simply to provide exemplars of the issues that require more discussion and understanding. The participants were able to discuss the issues of hierarchy, supervision, and accountability and provide context for the researchers. While we presented them separately they are connected. Although some participants suggested that these terms are not appropriate in the context of collaborative care, they are concepts that are included in our professional regulations. Difficulties arise as the different professionals view them differently.

Hierarchy is “a means of layering the staff of an organization into categories of work responsibilities and accountability that has been in existence for at least three millennia” (Owens, 1999). Teams require joint accountability as well as individual accountability if they are to function effectively. While there has been constant examination of team functioning in businesses to elucidate the elements of teams that help successful team functioning and an understanding of hierarchy within an organization there is less in health care and very little in maternity care.

While most participants agreed that the term *hierarchy* was not appropriate for collaborative care, many expressed the belief that a clear process for deciding which provider is the most responsible is essential. This process would include ongoing discussions, a good understanding of each other’s scope of practice and would be informed by individual women’s choices. This study highlighted the differences between disciplines. A key component of medical practice outlined in the CanMEDS document (RCPC, 2005) recognizes that physicians have within their role as a manager the element of ‘supervising others’. Therefore the concept of supervising others is embedded in practice. However, both nurses and midwives have the concept of accountability for their own practice in their ethical guidelines or core competencies, and so understandably believe that they don’t need other disciplines to supervise them.

The expectation of many in collaborative teams is that there would be flattened hierarchy in that decisions would be made jointly with equal input from team members. The literature on hierarchical structure in teams is limited but confirms our findings. A Canadian study summarized the outcomes of an analysis of the team functioning of a geriatric team was ‘we decide, you carry it out’. Although the team was supposed to be multi-professional with a flattened hierarchy, the day to day running was seen by the researchers as highly dominated by an established hierarchy, in particular in nursing work (Cott, 1997). Krause (1977) has argued that bureaucratic hierarchy of hospitals has assisted to maintain a strict hierarchy that makes control of occupations easier.

Business researchers have maintained that it is important for teams to understand where their team fits into the hierarchy of the business as well as how they will be accountable within the team for joint decision making. Perhaps maternity teams will also have to consider where they appear on an organizational chart in an organization so that they too can understand the constraints on their team functioning.

Supervision is embedded in education programmes in health care. At first learners are closely supervised often hour by hour to ensure that they perform as they should, acquire the knowledge and skills to progress, and end their academic program well prepared for clinical practice. Supervision post qualification becomes less overt but there is still recognition that at times health care professionals require some supervision from colleagues and sometimes other professional groups. The reality of clinical practice is that as long as a person is practicing according to their own scope of practice then they should not need to be supervised by another professional discipline. However, because of the structure of institutions in health care, physicians have often taken a leadership role which gave them the power and authority to supervise others clinical practice. This could extend to restricting scopes of practice of others

through protocols and using precedence to maintain a status quo. A prime example is changes in policies and procedures often are channelled through a Medical Advisory Committee that has the power to stop or change protocols. Supervision within teams is difficult to determine, because if there is a flat hierarchy and joint decision making, individuals practicing within their own scope of practice, there should be no need for supervision within a team unless there are new skills which will be part of joint clinical practice.

Each health care professional is *accountable* for their own practice. Within a team there may be an additional expectation that there is team accountability as well. If team members make a commitment to the clients of the team that one of them will always be available for care during labour and birth, the team has committed but individuals also have to commit to ensure there are no gaps in care. Team accountability is linked to understanding each team members scope of practice, particularly if there is overlap to ensure the most appropriate carer is available at the time that a woman goes into labour.

Overall, the participants provided a positive endorsement for MCP2 and believed that the National Committee should continue. Rather than dwelling on barriers, participants recognized them and looked forward to continuing the dialogue as a group of maternity care providers – with the goal of providing excellent maternity care for women and their babies.

Part Two: Understanding the Results of the Interviews and Focus Groups

Trying to understand how people view a national initiative to explore multidisciplinary primary maternity care is a challenge as the views are not universally shared, people do not agree on key contentious issues, and there are differences in how each professional group would design a collaborative model. However, one of the most exciting findings is the enormous willingness to work together to create a better sustainable system. In the first report we found mutual respect was a core component, this was also embedded in the focus groups when people recognized that people can't be forced into teams or groups without the personal knowing that develops with mutual respect for individuals and groups. Much of the literature supports this concept. When teams of health care professionals talk about their innovative practice there is belief that it works because they know each other very well, respect their professional scope of practice, and understand where there is overlap and sharing of care provision.

Overall midwives and nurses were much more enthusiastic in determining new models that would allow both to practice to full scope of practice and become part of a team with true shared decision making. Other studies have highlighted that physicians would like to continue to offer care with a hard call system of care that means that they provide pre and post natal care but do not necessarily attend the birth. Midwives, according to their predominate model of care, provide pre-, labour and birth, and post partum care and value the continuity of care and presence during the labour and birth of the women that they have cared for in pregnancy. Midwives and nurses were anxious to participate in the focus groups at their national committees, whereas physicians were more reluctant. National committee members were asked to help in recruiting participants to the focus groups and this was unequal across the professional organizations.

In the interviews, we tried to ascertain a deeper understanding of the issues that seemed difficult to interpret in the survey as well as understanding how health care professionals foresaw their roles in the future in maternity care. We tried to tease out why hierarchy, supervision, and accountability are so contentious to maternity care providers. There are several reasons why these concepts are difficult for people to understand. Principally, maternity care providers have been educated to accept that the liability issues around pregnancy and birth are so problematic that it is always better to err on the cautious side and not to challenge the assertion that birth is inherently dangerous and we need to 'manage' birth. Midwives however see the process of pregnancy and birth from a different view and would rather monitor and check for deviations from the normal while not managing birth.

The people who volunteered to be interviewed and participate in focus groups were enthusiastic about maternity care. There was a palpable passion for caring for women and their families, and indeed some

identified that it was a privilege to be present at the birth of a new baby. Those that volunteered were predominately nurses or midwives. Family physicians were the next largest group and those included rural and urban family physicians. The smallest group were obstetricians and they predominately practised in unusual circumstances that included small rural communities and those that were fully integrated with midwifery practice and those obstetricians who were funded in alternative funding schemes. The obstetrician group were not representative of obstetricians in Canada, whereas the other groups were more representative of the profession across the country.

Overall the researchers detected positive changes in attitudes around liability and collaborative care over time. Rather than identifying liability as a barrier to collaboration, as they had at the beginning of the project, several participants interviewed at the end of the project said liability would be less of a concern with collaborative teams because of better communication within the team. Teams need to understand how the team will function and that includes discussions of structure that may be uncomfortable for professionals who have worked in hierarchical structure and are used to being in charge.

In addition participants recognized that women are central to teams and have a responsibility to ensure that they are true members of the team.

Part Three: Recommendations

1. More theoretical work that articulates the new paradigm of collaborative practice needs to be completed before collaborative practice is recognized as a legitimate way to practice maternity care. As such, while there is enthusiasm for collaborative practice, there are individuals who will want to know what the new paradigm of collaborative practice means to their practice before they can be expected to adapt their maternity care practice.
2. Continue to engage all professional groups on an equal level, recognizing shared and unique aspects of scope of practice, and value each group's contribution to high quality maternity care.
3. There needs to be multiple collaborative models that adhere to a common set of principles, including understanding each others scope of practice, having team rules, and respecting each other.
4. Potential teams need to be established and education about how to organize team work must be completed together. That is, teams need to have time to develop and must not be forced into teams that they are not comfortable working in.

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Post Interview Questions for January 2006 data collection

1. Are you (your organization) aware of more discussion about collaborative maternity care among your members over the last year?
2. Has the MCP² project made a difference in terms of facilitating collaborative primary maternity care? If so, how?
3. Are you aware of any new collaborative maternity care models/practices that are being planned in Canada?
4. How should collaborative maternity care be taught in our educational programs?
5. According to our initial survey results from 800 family doctors, nurses, midwives, and obstetricians, there was disagreement about how supervision and clear hierarchical structure should be demonstrated in a collaborative practice.
 - How would you describe the importance of "a clear hierarchical structure" in decision making in collaborative maternity care?
 - How would you describe the importance of "supervision" in collaborative maternity care?
6. In our survey, primary maternity care providers had different views as to whether it was important for one health care provider in a collaborative team to have the ultimate accountability. Please describe how you see accountability working well.
7. Mutual respect between disciplines is a foundation for collaborative practice. Within your discipline how can mutual respect of other professions be promoted?
8. From the perspective of your professional association, do you think that liability becomes more of an issue when care is collaborative?
9. One objective of the MCP² project was to establish a National Primary Maternity Care Committee. This committee has been meeting regularly throughout the project. Do you think this has been worthwhile? Do you think a way should be found to have this national committee continue meeting? Why or why not?
10. What needs to happen to keep the concept of collaborative maternity care in Canada moving forward?
11. Do you have any other comments about collaborative models of care for maternity?