

# Creating a Collaborative Culture in Maternity Care

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Effective collaboration between professional groups is increasingly seen as an essential element in good quality and safe health care. This is especially important in the context of maternity care, where most women have straightforward labour and birth experiences, but some require rapid transfer between care providers and settings. This article presents current accounts of collaboration—or lack of it—in maternity care in the United Kingdom, United States, and Australia. It then examines tools designed to measure collaboration and teamwork within general health care contexts. Finally, a set of characteristics are proposed for effective collaboration in maternity care, as a basis for further empirical work in this area. *J Midwifery Womens Health* 2010;55:250–254 © 2010 by the American College of Nurse-Midwives.

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## INTRODUCTION

The issue of collaboration is high on the health care agenda in many countries. In maternity care, collaboration is seen as particularly important for pregnant women who cross boundaries, from low- to high-risk status (or vice versa) or from one geographic place of birth to another. It is at these boundary points that differing philosophies of care may lead to miscommunication, tension, or even antagonism. Resolving these issues might not only benefit women at higher risk of adverse outcome, but also facilitate the normalisation of childbirth for the majority of women. If women and their partners are to feel confident about the birth choices they make, then a collaborative climate is needed, in which the views of all those involved in maternity care are acknowledged and respected. To date, there has been very little discussion about the nature of collaboration or of the efficacy of various collaborative models.

## COLLABORATION IN A MATERNITY CONTEXT

### The Current Situation

Rates of routine intervention for healthy women and babies in normal childbirth have reached epidemic proportions in some settings in both resource-rich and resource-poor countries. This is not a benign occurrence. Recent studies have indicated that above a certain level, high rates of intervention may be harmful for both women and babies.<sup>1–4</sup> In this context, the term “medicalisation of childbirth” is taken for granted as a description of modern maternity care that does not need to be challenged or problematised. This phrase is not neutral. Anecdotally, its use tends to be associated with the assumption that the overtreatment of some women in pregnancy and childbirth is a consequence of unnecessarily extreme risk aversion, with a consequent polarisation of professional positions

into those who resist this move (usually midwives) and those who embrace it (usually obstetricians).

Studies conducted with childbearing women in different birth settings suggest that some women are drawn into this polarity of views and beliefs. For example, in her ethnographic study of a midwife-led birth centre in the United Kingdom, Annandale<sup>5</sup> found that women who chose to receive care in the birth centre became highly allegiant to the philosophy and beliefs of the birth centre midwives—sometimes in opposition to the views and attitudes of friends and family. On the other side of the equation, Machin and Scamell<sup>6</sup> observed what they termed the “irresistible biomedical metaphor” at work. In their study, women who attended National Childbirth Trust classes and had the intention of giving birth normally changed their allegiance and accepted the use of intervention once they entered a hospital setting for birth.

To date, few studies have sought to illuminate the subject of interprofessional relations within a maternity setting, but those that have tend to support the view that there are fundamental clinical and professional differences between midwives and physicians with regard to maternity care. A qualitative evaluation of the relationship between physicians and nurse-midwives at a large maternity hospital in the United States revealed clinical, professional, and personal differences between the two disciplines in relation to specific procedures, particularly around the use of oxytocin to induce and augment labour and the use of routine fetal monitoring.<sup>7</sup> However, although there were profound attitudinal differences around tools and techniques in labour, the core motivation for both groups was actually the same. As the authors concluded: “Nurses and physicians shared the common goal of a healthy mother and baby but did not always agree on methods to achieve that goal...”<sup>7</sup>

This situation of professional groups bypassing each other—rather than working with each other—is mirrored by an article reporting on the views of junior physicians working in maternity care in northeast England.<sup>8</sup> The physicians were sent a survey asking them about collaboration issues with midwives. The majority of the 68 physicians who responded were positive about these relationships. However, nearly a quarter of respondents (22%) reported

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midwives to be disrespectful and argumentative, and more than half (53%) felt that there were communication issues between junior physicians and midwives that needed to be addressed. There was no parallel survey of midwives, so these perspectives are only from the physician viewpoint. An earlier study from Australia suggests that part of the issue might be dissonance between what midwife mentors think junior physicians should learn and the activities the physicians themselves believe they should be involved in.<sup>9</sup>

This kind of finding at the level of junior physicians suggests that opposition between midwives and medical staff might be established at an early stage. Initial antagonism between the two groups is then likely to continue when junior staff become more senior, setting up a self-perpetuating pattern between midwives and physicians that is echoed at all levels of the organisation. In complexity theory, this phenomenon is known as a “fractal.”<sup>10</sup> Fractals are features that have been observed at a range of biologic and systems levels. They are “self-similar” in that observation of the organism or system reveals the same features at the micro, meso, and macro levels. Because physicians move regularly, antagonisms set up by difficult relationships with midwives when they were junior staff may also become viral, resulting in a general (and self-perpetuating) expectation among midwives and medical staff that collaboration is likely to be difficult. The findings of a recent Australian study suggest that the problem is widespread and persistent.<sup>11</sup>

These data have obvious safety implications for pregnant and labouring women. In the United Kingdom, the triennially published Confidential Enquiry into Maternal and Child Health (CEMACH) found that a “lack of communication and teamwork both within obstetric and midwifery teams and in multi-disciplinary team working” contributed to the deaths of a number of women.<sup>12</sup>

The problem has been recognised, and moves are being made at a high level in the United Kingdom to address it effectively. Multiprofessional education is often seen as a solution to the issue. For example, in 2007, the two leading maternity care professional regulatory bodies in the United Kingdom, The Royal College of Midwives and The Royal College of Obstetricians and Gynaecologists, published a joint document calling for, “multi-professional development and training...by all who are involved in the care of women in labour and her baby.”<sup>13</sup> However, to date there is no significant evidence that multiprofessional training of itself makes a difference

to mutual understanding, trust, and respect. This may be because the nature of collaboration is not yet well understood.

## The Nature of Collaboration

Etymologically, the word collaboration can be traced back to the Latin verb *collaborare*, which is a combination of “with” (*co*) and “work” (*-labore*).<sup>14</sup> This suggests that collaboration is a dynamic and active process between people that is generally directed towards doing and achieving something. In the midwifery literature, Homer, Brodie, and Leap<sup>15</sup> add contextual nuance by defining collaboration as “the exercising of effort by midwives and doctors towards each other for the purposes of shared functions, namely the provision of safe, rewarding and effective care to women and their families” (our emphasis). This interpretation also suggests that collaboration is a shared, dynamic function requiring the will to make meaningful contact rather than something that “just happens” when professionals get together in a clinical environment or for education and training purposes.

Despite this apparent clarity in definition, in practice the term collaboration is used synonymously with related terms like cooperation and teamwork.<sup>16,17</sup> It is also used as a universal expression of relatedness across, between, and within professional disciplines.<sup>18</sup> Therefore it is not always clear if collaboration refers to a group of people from one discipline where the composition is fairly fixed; a group from one discipline where membership changes frequently; a fixed group with cross-disciplinary membership; or a wide-ranging group of staff who may work in a defined area or with a particular group of service users or customers who do not regularly meet together. In a review of a specific set of nine research articles exploring theories of collaboration, Wood and Gray<sup>19</sup> make the claim that any effective definition of collaboration must address the following question: “Who is doing what, with what means, toward what ends?” Based on the data in the included articles, they conclude that:

“Collaboration occurs when a group of autonomous stakeholders of a problem domain engage in an interactive process, using shared rules, norms, and structures, to act or decide on issues related to that domain.”<sup>19</sup>

Wood and Gray<sup>19</sup> explicitly note that stakeholders must have some degree of autonomy, or the result is a merger and not collaboration.

In the United Kingdom, the National Health Service (NHS) Leadership Qualities Framework<sup>20</sup> proposes a hierarchy or maturity matrix of collaboration (Box 1), which is specifically focused on interdisciplinary cross-boundary activities.

More specific quantitative instruments have been developed and tested within a health care context, particularly in

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## Box 1

### NATIONAL HEALTH SERVICE LEADERSHIP QUALITIES FRAMEWORK: COLLABORATIVE WORKING<sup>20</sup>

#### 0 Goes it alone

- Fails to involve others in bringing about integrated health care
- Does not share information with other stakeholders.

#### 1 Appreciates others' views

- Expresses positive expectations of internal and external stakeholders
- Acknowledges and respects others' diverse perspectives

#### 2 Works for shared understanding

- Shares information with partners when appropriate
- Summarises progress, taking account of differing viewpoints, so as to clarify understanding and to establish common ground
- Surfaces conflict and supports resolution of this conflict

#### 3 Forges partnerships for the long term

- Maintains positive expectations of other stakeholders, even when provoked, and strives to create the conditions for successful partnership working in the long term
- Is informed on the current priorities of partners and responds appropriately to changes in their status or circumstances
- Ensures that the strategy for health improvement is developed in a cohesive and "joined up" manner

the intensive care unit environment. In a review of instruments designed to measure nurse–physician collaboration, Dougherty and Larson<sup>21</sup> identified five pertinent questionnaires. All of them used Likert-type scales to measure perceptions of collaboration, and most were developed and/or validated in the intensive care unit. The oldest of these instruments, The Collaborative Practice Scale, adopts a relatively simple 10-question strategy using two separate measurements: an assertiveness scale for nurses and a collaborative scale for physicians.<sup>22</sup> This is an interesting reversal of the classic health care hierarchy in which nurses are held to have little power and physicians are deemed to be dictatorial. The tool is explicitly designed to challenge this hierarchy. This may limit its applicability, because it does not acknowledge that health systems are more nuanced than the classic stereotypes suggest. Contemporary derivatives of this original format incorporate more comprehensive and finely tuned interpretations of collaboration. The Jefferson Scale of Attitudes toward Physician-Nurse Collaboration, for example, monitors nurse and physician attitudes towards authority, autonomy, responsibility, shared decision making, role expectations, and collaborative education.<sup>23</sup>

Despite our concern not to confuse collaboration with teamwork, we have found that some studies designed to describe attributes of teams do also offer valuable insights into the components of collaborative working. In some cases, the number of team members and/or their personal characteristics are related to an idealised theoretical model. Belbin's "team role descriptors"<sup>24</sup> or derivatives of Jung's personality types<sup>25</sup> are often used in this manner.

From a slightly different perspective, research into teamwork also highlights the significance of organisational structure as a contributory factor in team effective-

ness.<sup>26</sup> By encouraging team autonomy and providing resources for training, senior management can foster a climate in which the potential for effectiveness is enhanced.<sup>27</sup> Both of these factors are also likely to be pertinent in a collaborative interdisciplinary context where group members tend to fulfil the same or very similar roles. However, it is limited in a context where collaboration is needed between reasonably autonomous professionals from disparate disciplines,<sup>28</sup> as is the case in many maternity care contexts.

Of particular relevance from the teamwork literature are studies that highlight process as a key component. By assessing the levels and quality of communication, decision making, and participation in group exchanges, researchers and organisational theorists aim to judge the operating effectiveness of teams.<sup>18</sup> Similar process-oriented characteristics also feature strongly in the relatively few studies that explore collaboration from a conceptual or theoretical perspective.<sup>28,29</sup> In their literature review of studies examining the conceptual basis of interdisciplinary collaboration, D'Amour et al.<sup>28</sup> highlight sharing, partnership, interdependency, and power as key constructs. A similar review by Bronstein<sup>29</sup> identifies a number of factors that constitute collaboration and several factors that influence collaboration in practice. She describes interdependence, shared ownership of goals, and flexibility as constitutional factors, and a history of effective collaboration and personal attributes as influencing factors. On the basis of this analysis she went on to design, test, and validate a 42-item Likert-style questionnaire called the Index of Interdisciplinary Collaboration.<sup>30</sup>

The authors of a recent review on Health Care Team Effectiveness note that organisational and contextual nuances may play a significant role in the success or failure

## Box 2 POSSIBLE CHARACTERISTICS OF EFFECTIVE COLLABORATION

### Contextual components

- Clear and respected boundaries
- Effective systems for conflict resolution
- Opportunities for participation and for building cohesion
- Acceptance of open and honest communication
- Mutual trust
- Acknowledgement of interdependence
- Acceptance of shared responsibilities

### Influencing factors

- Supportive organizational structure
- Availability of resources (including time)
- A history of collaboration
- Positive individual attitude

of an intervention aimed at increasing team effectiveness.<sup>18</sup> They outline a health care model, the Integrated Team Effectiveness Model, that incorporates organisational context, task design, team processes, and team psychosocial traits. The authors recommend that researchers develop models of effectiveness tailored to the types of teams being studied, the relevant patient populations and care delivery settings, and the particular work processes that are operational in that setting. In a collaborative sense, this has some resonance with Wood and Gray's question, "Who is doing what, with what means, toward what ends?"<sup>19</sup>

In the absence of a definitive appraisal of the philosophical, cognitive, and theoretical characteristics of collaboration, it is difficult to draw any hard conclusions about its nature. However, based on the studies, reviews, and concept analyses highlighted above, the characteristics in Box 2 seem to be important.

## DISCUSSION

There does seem to be a reasonable degree of agreement on the general definition of collaboration. However, there has been less focus on the active components of that definition or on how to measure if it is happening in practice. The evidence from the review of the literature in this article indicates that effective collaboration emerges from a dynamic interaction between organisational and personal characteristics. Initiatives that actively and consciously foster trusting and mutually respectful relationships might create positive feedback loops into the system that alter the fractal structure of existing organisations. This may create a "tipping point"<sup>10</sup> that moves an organisation from one of negative feedback and self-perpetuating distrust between professional groups to one where positive feedback and mutual appreciation is the norm. Given the movement

of health care staff, and, particularly, of junior physicians, this creates the opportunity for the creation of positive viral spread that could enhance collaboration in wider contexts. Making space to build mutually respectful and trusting relationships within and between professional groups might be fundamental to the generation of authentic collaboration. In order to test this assumption, the authors are currently conducting an empirical study in northwest England that is funded by the United Kingdom NHS NorthWest. This combines the characteristics given in Box 2 above with an adapted version of the Index of Interdisciplinary Collaboration.<sup>30</sup>

## CONCLUSION

At the beginning of this article, we made the claim that authentic collaboration based on mutual trust and appreciation underpins success in both increasing maternal and fetal safety and normalising childbirth. Our examination of a range of articles exploring practical and philosophical approaches to teamwork and collaboration in health care in general has resulted in a synthesis of possible characteristics for effective collaboration in maternity care in particular. Current<sup>31</sup> and future studies will continue to explore these issues, and to further develop tools and techniques to build collaborative working in maternity care in a range of organisational and clinical settings.

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