

Chapter 6

HOW THE PAST INFLUENCES THE COLLABORATION BETWEEN OBSTETRICIANS AND MIDWIVES IN THE NETHERLANDS.

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Abstract

Collaborations between groups of professionals often have a long history, which can still influence contemporary practice. If problems in the collaboration occur, the search for effective interventions for these problems may be informed by analysing current practice as well as the historical development of the collaboration.

In this study, we used a questionnaire among midwives and a historical analysis to explore the collaboration between obstetricians and midwives in the Netherlands as a case. We used template analysis to analyse the questionnaires. The initial template was based on a model for interprofessional collaboration.

The midwives experienced a power imbalance and a lack of trust and mutual acquaintanceship in their collaboration with obstetricians. They also reported a need for interprofessional governance and formalization. Most of these reported problems in the collaboration have their origin in the historical development of both professions and in the development of the collaboration between both professional groups.

Combining a historical perspective on interprofessional collaboration with an exploration of contemporary practice is fruitful for understanding problems in collaboration between professional groups, and provides guidance for improving collaboration.

Introduction

Collaborations between groups of professionals often have a long history, which can still influence contemporary practice. If problems in the collaboration occur, the search for effective interventions for these problems may be informed by reflecting on the historical development as well as on contemporary practice of the collaboration. Yet, the historical perspective is often neglected (Kuper et al., 2013).

According to D'Amour, establishing effective collaboration entails the interplay of several elements within both the relational and organizational domain of the collaboration between the involved professionals. In her model for interprofessional collaboration, D'Amour distinguished the elements 'governance', 'formalization', 'shared goals and vision' and 'internalization' to be key for effective collaboration (D'Amour et al., 2008).

In a previous study, we explored the historical development of the collaboration between obstetricians and midwives in Dutch maternity care (van der Lee et al., 2013a). This historical perspective revealed that the development was rather unfavourable for the establishment of effective interprofessional collaboration. Problems were found within both the organizational and relational domain of collaboration. For example, we found that the interaction between the professions could be characterized as being competitive rather than collaborative (van der Lee et al., 2013a). Both professions united in separate professional societies, developed and used unidisciplinary protocols and strived to preserve autonomy in professional practice (Janssens, 1997; NVOG, 2013; KNOV, 2009; Houtzager, 1993). And although both professions shared the same patient population and pursued the same goal, i.e. good maternity care (De Vries, 2004), there was no evidence of 'interprofessional governance' and 'shared goals and vision'.

Also, on the level of 'formalization' and 'internalization', the other two key elements of D'Amour's model, the historical development appears to have negatively affected the interprofessional collaboration between obstetricians and midwives. The formalization of the collaboration predominantly entailed the introduction of regulations restricting midwifery practice to the physiological processes of pregnancy and delivery, without any usage of instruments or medication (Schoon, 1995). Consequently, the obstetricians acquired a dominating position over the midwives, which led to numerous discussions about the position and authority of the midwife in maternity care (Klomp, 1996; Kroes-Suverein, 1998).

Although the historical development of interprofessional collaboration in Dutch maternity care has been especially difficult for the midwives, nowadays the nature of the collaboration has changed and the position of midwives in Dutch maternity care has improved considerably. In today's maternity care practice, the midwives run an autonomous practice in the community, they hold a gatekeeper function for the care of the obstetrician in the hospital, and care responsibilities appear to be clearly divided between the professions. In a way, the midwives appear to have freed themselves from historical domination by the obstetricians.

Yet, although this might imply that obstetricians and midwives have overcome their historical problems in collaboration, the outcome of their combined effort in maternity care remains weak. A recent study by the Dutch Steering group on pregnancy and birth found a relatively high perinatal morbidity rate in the Netherlands compared to other European countries (Europeristat project, 2008). The causes for these findings are sought in the organization and coordination of Dutch obstetrical care as well as in a sub-optimal

collaboration between obstetricians and midwives (Adviesgroep Zwangerschap en geboorte, 2009). However, it remains unclear what exactly causes the collaboration to be sub-optimal and whether the historical development is of any influence in this matter. An exploration of the collaboration as experienced by those involved could provide a better understanding of the different aspects of the collaboration which in turn would help the different stakeholders to identify interprofessional threats and opportunities. Subsequently, it allows us to more specifically and efficiently implement interventions aimed at improving the interprofessional collaboration and the corresponding provision of health care.

In this study, we aimed to gain a better understanding of the collaboration problems that contribute to the diminished quality of Dutch maternity care from the perspectives of the professionals involved. We explored the perceptions of midwives on their contemporary collaboration with obstetricians, using a questionnaire with open ended questions. For the analysis of the data, we used the interprofessional collaboration model of D'Amour.

Our research question is:

- How do midwives perceive their collaboration with obstetricians now that their formal position has substantially improved?

Methods

Setting

In the Netherlands, maternity care is mainly provided by two professions, the midwives and the obstetricians. Community midwives provide prenatal and maternity care in the community. They are concerned with the physiology of pregnancy and the care surrounding physiological labour. Also, community midwives are authorized to guide home births. In acute maternity situations or if pathology during pregnancy is suspected, they refer patients to the obstetrician in the hospital. Almost all obstetricians work in a hospital and are concerned with the pathology of obstetrics. Most of them are also concerned with gynaecological care. Therefore in this article, an obstetrician is a professional in gynaecology as well as in obstetrics.

Data

To gain insight into the perspectives of the midwives on their collaboration with obstetricians, we undertook a focused second analysis of the data of 57 midwives who had been included in a previous study. These data originated from a study performed between November 2009 and February 2010 and explored the perspectives of societal stakeholders on the performance of Dutch obstetricians using a questionnaire (van der Lee et al., 2013b). In this previous study, the questionnaire was sent to patients, community midwives, general practitioners, specialized obstetrics nurses and board members of Dutch hospitals, asking them to give feedback on the performance of obstetricians by answering the following two open-ended questions:

- Describe three aspects of the performance of obstetricians that you consider to be positive (*strengths*).
- Describe three aspects of the performance of obstetricians that you consider to require improvement (*weaknesses*).

The purpose of the original study was to gather information on the performance of obstetricians in order to inform the redesign of the current Dutch postgraduate training programme for the specialty Obstetrics and Gynaecology. The analysis of the data provided by the midwives in particular revealed that the majority of the midwives' feedback reflected on the collaborative performance of the obstetricians. Therefore, the present study provides a focused analysis of the midwives' data collected in the previous study. We looked for information on the collaborative performance of obstetricians, defining collaborative performance simply and broadly as any interaction between obstetricians and midwives. The purpose of this focused analysis was to consider if existing theoretical frameworks on interprofessional collaboration would help to complement or extend our current interpretation of the data and might thus lead to a better understanding of the aspects of the collaboration that cause difficulties for the midwives.

Analysis

We used template analysis to analyse the data (Cassell, 2004). This systematic form of thematic analysis allows themes to emerge in a hierarchically structured way from the data as well as from a theoretical framework.

The first step in template analysis involves establishing a theoretical coding template by defining *a priori* themes that are expected to emerge during data analysis. For the theoretical coding template of the present study, we defined four overarching *a priori*

themes and ten *a priori* subthemes based on the four elements and the ten features of D'Amour's model on interprofessional collaboration. In her model, D'Amour distinguishes 2 domains of collaboration, the relational domain and the organizational domain. The relational domain includes the elements *shared goals and vision* and *internalization*, and the features *goals, client-centred orientation versus other allegiances, mutual acquaintanceship* and *trust*. The organizational domain of collaboration comprises the elements *governance* and *formalization*, and the features *centrality, leadership, support for innovation, connectivity, use of formalization tools* and *structured information exchange* (D'Amour et al., 2008).

The second step in the analysis consisted of initial coding of a subsample of the interview transcripts based on the *a priori* themes and subthemes, which was conducted by the first author. In the next step, the first and third author discussed this initial coding. Their viewpoints generally coincided, and the discussions mainly focused on how to categorize codes which seemed to fit multiple themes and subthemes. After the two authors reached consensus on the initial coding, an initial coding template was developed, in which 5 subthemes of the theoretical coding template were discarded and two subthemes were added to the template. After this, the initial coding template was applied to the entire dataset by the first author. The authors regularly met to discuss issues that arose during the coding, such as resolving overlaps between several themes and subthemes and finding names and definitions for newly found (sub)themes. In this process, a final coding template was developed, which was iteratively applied to the entire dataset.

The next step in the analysis consisted of interpreting the coding results of the dataset. The interpretation focused on identifying and understanding the components and dynamics of collaborative performance according to the final coding template. At the same time, a search for disconfirming evidence was conducted. A final interpretation was carried out, which resulted in the findings that are discussed in the next section, supported by illustrative quotes from the respondents.

Due to the self-selecting nature of the recruitment of respondents and the pursuit of data saturation in the original study, a response rate could not be calculated in the current study. However, the analysis of the present study also showed data saturation, which means that the inclusion of further data would probably not have resulted in the identification of new themes.

Results

Our analysis revealed several influencing aspects at the relational level and at the organizational level of the midwives' collaboration with obstetricians.

RELATIONAL ASPECTS OF THE COLLABORATION

At the relational level of the collaboration, we found several aspects to influence the midwives' collaboration with obstetricians. First of all, according to the midwives, obstetricians tend to express a willingness to collaborate with the midwives. Midwives noticed being taken more seriously when consulting and communicating with obstetricians. Also, they reported a tendency among obstetricians to be more open to the midwife's opinion when care decisions were to be made by the obstetricians.

Despite this willingness to collaborate, the midwives experienced a power imbalance in which the obstetricians rank themselves above the midwives. Midwives reported that they often did not feel acknowledged by obstetricians as being well-trained professionals and that they did not feel being taken seriously in the care they provide. In the collaborative performance of obstetricians, this power imbalance was expressed by treating midwives as inferior partners, taking a somewhat condescending and haughty attitude and frequently questioning the midwife's action, as indicated by this response.

'In my surroundings, I sometimes notice that obstetricians consider themselves 'above' me. That is a matter of discussion, I did not attend a medical education, but a higher vocational education. However, we do have to work together.' (p41)

Besides the perceived power imbalance, the midwives also reported a lack of trust in the midwife's practice and actions, which was demonstrated most clearly when a patient was transferred to the hospital. The midwives experienced that the obstetricians, instead of trusting the midwife's insights and actions, tended to evaluate the patient all over again and to repeat the actions already taken by the midwife at the patient's home. According to the midwives, this led to unnecessary delay in patient care:

'They often do not understand the reason why a patient was referred or they do not suppose that immediate action is required if they are called. They do not readily assume that we have already tried everything in the preliminary stages.' (p14)

Fortunately, however, the midwives reported that a time-consuming repetition of preliminary activities usually did not occur in case of consultations or transfers involving life-threatening situations.

Moreover, according to the midwives, obstetricians have a lack of knowledge regarding the activities and responsibilities of a midwife and regarding the limited range of care offered by a community midwifery practice. This lack of knowledge was reported to lead to a lack of understanding and sometimes even to disrespect and to a condescending attitude towards the midwife's decisions, actions and provision of care.

The midwives also reported that obstetricians had a lack of knowledge about the physiology of pregnancy and labour, which sometimes resulted in unnecessary and premature medical interventions.

'In my opinion, an obstetrician should have more regard for the physiology during parturition, which could limit unnecessary interventions (e.g. vacuum extraction).' (p40)

ORGANIZATIONAL ASPECTS OF THE COLLABORATION

At the organizational level, we also found several aspects which influence the midwives' collaboration with obstetricians. The midwives reported that the structure of information exchange from midwives to obstetricians was functioning properly. Also, when needed, obstetricians were easily approachable to discuss a patient with the midwife if she suspected a problem.

'When we ask an obstetrician for advice or support (a consultation), we (and the pregnant woman we transfer) are often helped well. The request is taken seriously and dealt with appropriately.' (p54)

The information exchange from obstetricians to midwives, however, was reported to require perfection. Information about a consultation or a delivery of patients whose care had been transferred from the midwife to the obstetrician, was reported to be shared much too late with the responsible midwife or not at all. Lacking this information about the delivery and possible complications was perceived as inconvenient and potentially harmful, as the midwife is responsible for the follow-up of the patient's postpartum care at home.

Moreover, midwives expressed a need for more interprofessional guidelines and protocols on the formalization of the collaboration and maternity care policy. Such formalization was thought to help clarify professional boundaries between both professions and to standardize provided care. However, they actually expressed a need for an attitudinal change on the part of the obstetricians, as the midwives reported that obstetricians tended to neglect or ignore the interprofessional guidelines and protocols that already exist.

'Obstetricians tend to adhere very strictly to protocols and guidelines of their own society (the NVOG), but they are not open to other insights or points of discussion. "There is no NVOG protocol for that yet", in such situations it is difficult to reach collaborative agreements.' (p24)

Also, the midwives reported that within the group of obstetricians, individual obstetricians tended to follow the treatment options they personally related to most. As a result, the treatment policy often changed during the day or night when the responsible obstetrician's shift was taken over by a colleague. This attitude was perceived to have a negative influence on the collaboration with midwives and sometimes even on patient care.

Finally, the midwives reported a need for connecting and discussing with the obstetricians. In interprofessional meetings, the midwives reported to want to discuss the provided care following a particular consultation, delivery or incident with all parties involved.

'Discussion or evaluation of parturition takes place in the hospital, in secondary care, but to improve communication, the primary care midwife should also be included in case of parturitions involving a transfer between primary and secondary care.' (p19)

The midwives also expressed a need for opportunities for reciprocal sharing of possible changes and difficulties in practice, to develop consensual guidelines and to improve the collaboration and quality of care.

'Regular meetings of obstetricians and primary care, in order to clearly inform primary care about a hospital's new policy on induction, counselling in case of breech position or post-term pregnancy.' (p17)

For some of the midwives, this need for connectivity was already fulfilled. They reported a well-functioning system of sharing experiences, meetings and discussions on provided care, quality of care and guideline development, in which there was an open atmosphere of communication and exchange of feedback. Due to the meetings and the open atmosphere, the midwives experienced a swift resolution of miscommunication and

conflicts. Consequently, the meetings actually helped improve the collaboration and care provided, since discussions on provided care resulted in the evaluation, reconsideration and revision of guidelines or practices.

'Our multi-disciplinary meetings are almost always attended by several obstetricians. They feel very involved with our work and appreciate hearing our opinions on certain matters (and we appreciate their opinions, of course).' (p43)
'Irritations and miscommunications are quickly resolved thanks to consultation and direct interaction.' (p22)

Discussion

In this study, we analysed the midwives' perspectives on their collaboration with obstetricians, using a model for interprofessional collaboration. Our results show interprofessional difficulties both within the relational and organisational domains of collaboration, which to some extent can be explained by the historical development of the collaboration.

Within the relational domain of interprofessional collaboration, our results show that contemporary practice is still influenced by the historical development of the relationship. Midwives report a power imbalance in which they are inferior to the obstetricians. This perception is probably caused by a history of belittling regulations and adjusting professional boundaries on the part of doctors (Klomp, 1996). And the perception seems to continue because of these historic roots, despite the midwives' well-defined and crucial role in Dutch obstetrics and despite the fact that midwives experience that obstetricians are willing to cooperate.

The perceived power imbalance could harm interprofessional collaboration and may be related to the experienced lack of trust and mutual acquaintanceship. Power inequalities are known to influence the entire process of interprofessional collaboration and can even set up a barrier for effective collaboration in teams (King et al., 2008; D'Amour et al., 2005). The negative effect of the perceived power imbalance could be amplified by the obstetricians' reported lack of knowledge about the midwives' responsibilities and activities. A study within the practices of General Practitioners (GPs) showed that the extent of GPs' collaboration with and patient referral to allied health professionals was negatively influenced by the GPs' limited understanding of the roles and capabilities of those allied professionals (Chan et al., 2010). Furthermore, an unclear or incomplete understanding of one's own role and other professionals' roles in the collaboration is known to have a negative effect on a person's attitude of towards collaboration and to inhibit collaboration skills (Parsell & Bligh, 1999; Fewster-Thuente & Velsor-Friedrich, 2008). Instead, mutual recognition of each profession's strengths and weaknesses leads to a greater willingness to interact (Carpenter, 2013) and thereby positively influences the effectiveness of the collaboration (King et al., 2008).

Also, within the organizational domain of the Dutch maternity care collaboration, historical developments might underlie contemporary difficulties. The midwife perspectives show a partially unmet need for connecting with one another, consensual guideline development and improvement of collaboration and quality of care. The fact that obstetricians and midwives are historically organised in two different professional societies with their own visions, protocols and political lobbies is easily understood from a

historical perspective, but it is also potentially detrimental for optimal interprofessional governance. It might seem obvious for both professions that they might best serve the patient by sharing goals and visions, sharing patient forms and sharing the same professional community. However, due to the deeply rooted shortcomings in both organizational and relational aspects of the collaboration, the contemporary collaborative problems are probably impervious to minor interventions and require disruptive changes (Christensen et al., 2000; Schuitmaker, 2012). Examples of such disruptive changes are a government-driven fusion of the professional societies, an insurance-driven financial structure demanding obstetricians and midwives to collaborate in a professional as well as a financial partnership, and a patient-driven demand for common protocols and procedures for midwives and obstetricians, sustaining their function as a team. This requires the midwives and obstetricians to leave their autonomous positions and to continue working as a true team. Yet, giving up one's autonomy might be perceived as a loss of status and for doctors this loss of status is known to inhibit their participation in a collaboration (Whitehead, 2007).

This study has important limitations. Foremost, the data were collected with a view to inform the competency-based training of Dutch ObGyn residents. The original questionnaire was not developed with the explicit goal of evaluating the midwives' collaboration with obstetricians, but rather to evaluate the overall performance of obstetricians. The aspects of the performance concerning collaboration or interacting with other professions were selected from the original data. As the goal of the original questionnaire differs from the aim of the current study, important issues in the collaboration between midwives and obstetricians might have remained unmentioned. However, the data of 57 midwives evaluating the performance of obstetricians were dominated by remarks about the collaborative performance of obstetricians. As this indicates an urgent need for change of practice we think that the most critical issues in the collaboration did feature in the present evaluation.

We chose to explore only the midwives' perspectives on the interprofessional collaboration in Dutch maternity care, because from a historical point of view this is the profession that has been the repressed party in the collaboration.

To find clues for improving the interprofessional collaboration, the perspective of obstetricians on contemporary practice is indispensable. Therefore, an obvious next step would be to also explore the obstetricians' perspectives on the collaboration, followed by a discussion aimed at finding solutions for each of the problems that emerged.

This study shows it is important to explore how contemporary interprofessional practice is perceived by those involved and how the experienced collaborative difficulties are historically rooted. It provides a better understanding of the content, impact and origin of the collaborative difficulties. Moreover, it helps us to identify interventions that actually have the potential to solve interprofessional problems.

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