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Inter-professional collaboration in delivery suite: A qualitative study

Carolyn Hastie *, Kathleen Fahy [1]

School of Nursing and Midwifery, The University of Newcastle, RW 2-49 Richardson Wing, Callaghan 2308, NSW, Australia

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Abstract
Background: Communication problems between clinicians are the most common cause of preventable adverse events in hospitals. In spite of these known risks the 'turf wars' between midwives and doctors continue unabated.
Question: What factors affect inter-professional interactions in birthing units?
Participants: 9 doctors and 10 midwives from 10 Australian maternity units.
Methods: Interpretive Interactionism was the research design. Probing in-depth interviews were conducted to elicit stories of inter-professional interactions and their perceived effects on birthing outcomes. Analysis resulted in two theoretical models of inter-professional interaction: one positive and the other negative.
Findings: Midwives and doctors agree that positive interactions are collaborative, include the woman and her partner and are associated with the best possible outcomes and experiences possible. In contrast, they agree that negative interactions involve power struggles between the professionals and these are associated with adverse outcomes. All participants are able to demonstrate emotional and social competence when interacting and applied those skills sometimes. Factors related to the organisational culture within the 'birth territory' of a particular maternity unit seem to be predictive of the type of interactions that are likely to occur there.
Conclusion: Interventions to enhance inter-professional collaboration should be directed first at changing organisational structures and policies to promote easy opportunities for natural dialogue between doctors and midwives.

Introduction

Poor communication is the most common cause of preventable adverse events in hospitals.[1–7] Major enquiries into maternity services continue to find that ineffective, absent or rude communications are usually associated with poor outcomes for women and babies.[8,9] Despite these understandings, absent or negative interactions between clinicians

* Corresponding author. Tel.: +61 418428430.
E-mail addresses: carolyn.hastie@newcastle.edu.au, heartlgc@bigpond.net.au (C. Hastie), Kathleen.Fahy@newcastle.edu.au (K. Fahy).
[1] Tel.: +61 49215966.

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continue. There is an urgent need to investigate the causes and possible cures of ineffective communications and to foster collaboration between doctors, nurses and midwives.[10]

This paper reports on part of a study which sought the answers of participants to the question: ''What factors affect inter-professional interactions in birthing units and how do these interactions impact on birthing outcomes?'' Two models of interaction which depict how doctors and midwives interact in the delivery suite environment are presented. Factors that are involved in, or affect inter-professional collaboration are described. The ultimate aim of the study is to make research-based recommendations for promoting inter-professional collaboration at the local level.

The key terms from the research are: inter-professional, collaboration and interaction'. For the purpose of this study we define 'Inter-professional' as being professional activities involving health professionals from different but complementary groups; in this case doctors and midwives. Coming from different professional groups also means that there are differences in some or all of the following attributes: education, qualifications, expertise, experiences, values, beliefs, socialisation and access to organisational and legal power. The standard definition of 'collaboration' meaning 'working together cooperatively' is too vague in our view[11] [11 p. 366]. The problem with this definition is that it ignores issues of power and purpose. Therefore, our definition expressly defines the quality and purpose of the relationship. We define collaboration to mean ''working harmoniously together with a shared aim''. 'Interaction' means ''reciprocal action or influence of persons or things on each other''[11] [11 p. 1091].

Two theories that have guided this study, 'Birth Territory and Midwifery Guardianship'[12] and 'Social and Emotional Intelligence and Competence'[13–15] are first outlined (see Table 1 for definitions of the main concepts from these theories used in this study). Then, the traditional way in which doctors and nurses/midwives have been ascribed particular social roles is briefly described and the findings of related research are summarized. Research involving both nurses and midwives in their interactions with doctors has been included because in Australia at least, the recognition of the discrete nature of midwifery as a profession, separate from nursing, is only recent. The interpretive interactionist research design, including steps in data collection and analysis is then outlined, followed by the findings. Two contrasting models of negative and positive inter-professional interactions are presented to illustrate the nature and impact of each type of interaction. The conclusion contains recommendations for policy and practice change.

Theoretical framework for the study

According to Fahy et al.[12] the theory of Birth Territory and Midwifery Guardianship has been informed, in part, from the theories of Michel Foucault about the way in which power operates in organisations.[16] Specifically, the theory of Birth Territory claims that contemporary maternity services are structured and function in ways that make childbearing women and midwives docile and submissive to medical authority. This submissiveness is theorised to weaken both childbearing women and midwives.[17] 'Birth Territory' is a theory that gives an explanation of how the environment relates to the way the childbearing woman feels during pregnancy labour and birth. How the woman feels is argued to be directly related to how her mind and body functions which is another way of saying; how the woman feels is causally related to the health and wellbeing of both woman and the baby. 'Midwifery guardianship' means that the midwife protects the birth territory which is conceptualised as encompassing all that is external to the woman during pregnancy, labour and birth.[18] The first aim of the midwifery guardian is to be very conscious of her own power and to do no harm, physically, psychologically or spiritually to the woman or her family. Midwifery guardians know that they cannot give the woman power, but they also know that midwives can take the woman's power away from her. When the woman is disempowered she is weakened as a woman, as a birthing woman and mother (see forced birth in Table 1). This theory recognises that the power to birth is an energy which is intrinsic to the woman. That energy needs to be promoted, protected and facilitated by skilled and sensitive midwifery guardians. When midwives practice as guardians, they support and guide women to experience themselves as strong and competent. The theory of birth territory and midwifery guardianship also provides guidance at the political level by suggesting ways in which birthing services can be organised and facilitated according to the theory so to promote 'genius birth'. If this theory is followed, the authors argue, then optimal birthing outcomes can occur for all women which will promote the health and wellness of women and babies.[12,19] Emotional intelligence and competence[13,15] refers to the way we manage ourselves while social intelligence and competence[13,14] refers to the way we manage relationships. Both social and emotional intelligence and competence are considered essential elements of effective communication and good relationships in the workplace.[13–15,20] The competencies provided by Goleman,[14,15] Bar-On and Parker[13] were used to guide analysis of the doctors' and midwives' stories.

Background

Traditional doctor–nurse/midwife roles create stereotypes which limit individuals in the performance of their clinical work. A role, based on anthropological and sociological theory, is defined as 'a set of behavioural expectations that an individual is given by the society which directs and limits how they should enact a particular role: in this case 'doctor', 'nurse' or 'midwife'.[21] These stereotypical roles were well described as far back as 1968 as the doctor–nurse game, where the nurse is required to make decisions and contribute ideas while appearing passive so that the ideas appear to have originated in the doctor.[22–24] Twenty years later Pervin-Dixon[25] studied inter-professional interactions when nurses and nurse–midwives had conflict with doctors and revealed that the game is alive and well. A subsequent study of inter-professional relationships by Snelgrove and Hughes[26] showed that both occupational groups saw a clear dichotomy in their respective work roles along traditional doctor/nurse lines. Even as recently as 2005, nurses reported 'fighting back' or 'moving on' to cope with feeling 'betrayed' and 'disillusioned' when they experienced the doctor–nurse game as strongly as ever in what they described as an increasingly 'conflict laden workplace'.[27]