Collaborative Care in Obstetrics

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During his year as Society of Obstetricians and Gynaecologists of Canada president, Dr. Dario Garcia chose the theme of respectful care in obstetrics and gynaecology, which encompassed both patients and care providers. The theme that I chose for my year as president was collaborative care in obstetrics. I believe effective collaboration in maternity care is an extension of respectful care by applying its foundational principles of respect and civility to our interactions with other members of the health care team. This can only be accomplished when interprofessional collaboration is well supported. There are many challenges and barriers to achieving high-quality interprofessional practice but also many ways to move toward that goal.

A Canadian Medical Protective Association panel report published in the March 2019 issue of *Journal of Obstetrics and Gynaecology Canada*[1] identified the 5 areas of highest risk in delivery of antepartum care. With no surprises, these included induction and augmentation of labour, assisted vaginal delivery, shoulder dystocia, decision to delivery time for cesarean delivery, and collaborative care. Intrapartum fetal surveillance was noted to be an important component of patient safety affecting all of the previously mentioned categories.

Collaborative care simulations can make a huge difference in managing these events. For example, simulation-based education in obstetrics can be an important part of improving clinical outcomes. Bogne Kamden et al.[2] published a review of the literature on simulation training in obstetrics, showing that simulation team training, which included crisis response management, is associated with better clinical outcomes. We need to support this type of training in our institutions and allow all team members to participate.

In a scoping review of interprofessional collaboration in hospital-based care with a focus on Africa, Yamuragiye et al.[3] identified interactional, systemic, and organizational factors as challenges to collaborative practice. Hierarchical natures of health care professions and clinical decision-making were identified as influential. Understanding these factors can lead to a stronger collaborative practice.

In Canada, employment and funding models can act as significant barriers. Many provincial fee schedules for physicians do not promote collaborative practice! This issue also exists for midwives, with a patchwork of funding models across the country, including private practice, private fee-for-service, and course-of-care and salaried funding.[4] We must advocate for changes to models that disincentivize collaborative care.

The literature supports interdisciplinary opportunities for education to enable clinicians to participate in team-based care effectively. Learning with, and about, one another will improve teamwork in intrapartum care. When we are educated in separate streams, we miss the opportunity to move into a collaborative clinical practice.

In Canada now, we are in the position of having 6 baccalaureate-level university-based programs for midwifery training. These programs offer opportunities for interprofessional education, as midwives learn alongside other health care practitioners. We have had a successful model of integrating midwifery care into our teaching clinics at our tertiary care centre so that the full spectrum of learners is seeing what a midwife can do in the course of care. We need to create as many of these opportunities as

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we can. As expected, identifying funding for this was a challenge and continues to be.

A 2018 survey of family practice residents in British Columbia found that strong knowledge of midwifery practice, including education, prescribing practices, and equipment brought to home births, was associated with more positive attitudes towards midwifery. Residents who had experience with midwifery care also viewed the profession more positively.[5] The development of interprofessional teaching curricula will be essential to realizing high-quality collaborative care, connecting all learners involved in the delivery of maternity care.

As midwifery programs expand training to include management of epidurals and oxytocin, the gap between our areas of practice will shrink. For example, a program at McMaster University currently trains registered midwives in these skills, in the hope that low-risk, postdates induction of labour will, one day, fall within their scope of practice.

An ethnography-informed study, conducted by Brydges et al.[6] at the University of Toronto, reviewed critical incidents and mapped all day/night work done by midwives, obstetricians, and nurses. The researchers identified 3 intrapartum work processes that were causing issues in collaborative care, including transfer of care, electronic fetal monitoring interpretation, and issues related to medico-legal liability and remuneration. This article illustrates the strength of a qualitative research approach in identifying barriers to interprofessional care.

Interprofessional collaborative opportunities arise when we learn with, about, and from one another. Barriers include compensation schemes for health professionals involved in care and support from administration at both the university and hospital levels. Time and resources are also barriers, as midwives, nurses, and physicians are currently experiencing high levels of burnout. When there are not enough practitioners in an area, for example, it is difficult to achieve a strong collaborative care model. Despite the many challenges, collaborative care in obstetrics is a goal worth striving for!

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