MODELS OF MATERNITY CARE IN RURAL ENVIRONMENTS

Barriers and Attributes of Interprofessional Collaboration with Midwives

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Centre for Rural Health Research
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About the Centre for Rural Health Research

Centre for Rural Health Research

Goals & Objectives

1. Introduce findings from the CIHR-funded study, “Interprofessional Collaborative Maternity Care Project”

2. Highlight barriers and facilitators to interprofessional collaboration among primary maternity care providers in rural British Columbia

3. Present recommendations for bridging the research-to-action cycle, emerging from knowledge exchange with key stakeholders

Background: Interprofessional Collaboration

- What is interprofessional collaboration?
- Health policy
  - BC Maternity Care Enhancement Project (2004)
  - Multidisciplinary Collaborative Primary Maternity Care Project (MCP^2) (2006)
  - SOGC National Birthing Initiative (2008)
- Teams in British Columbia
  - South Community Birth Program (South Vancouver, 2004)
  - Jim Pattison Outpatient Care and Surgery Centre (Surrey, 2012)
  - Fraser Valley Maternity Group** (Abbotsford and Mission)

**No provincial sponsorship

About the Research

- This study explores the barriers to and facilitators of interprofessional models of maternity care between physicians, nurses, and midwives in rural British Columbia, Canada, and the changes that need to occur to facilitate such models.

- Methods
  - Qualitative, exploratory approach
  - Interviews and focus groups with key stakeholders in 4 rural BC communities

Research Communities

Community	Midwifery Care	Surgical Back-up	Collaboration
A		Mixed model	
B	✓	Mixed model	Parallel practice
C		GP Surgery only	
D	✓	GP Surgery only	Shared care

- What did we ask?
- What did we learn?

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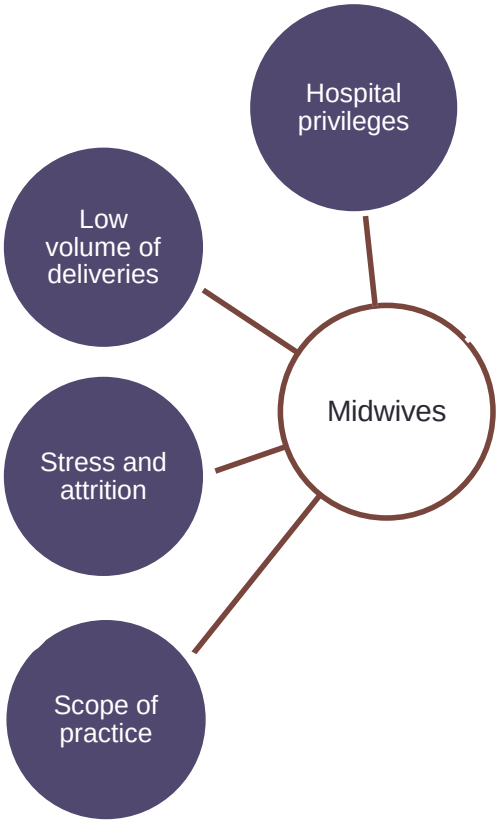
Key Findings: Themes



Knowledge Exchange

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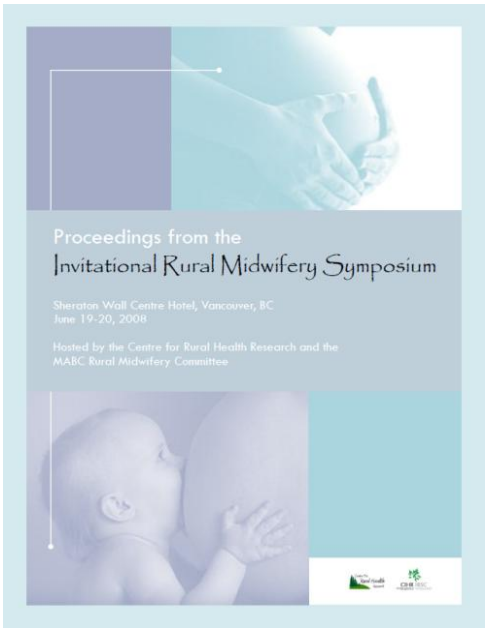
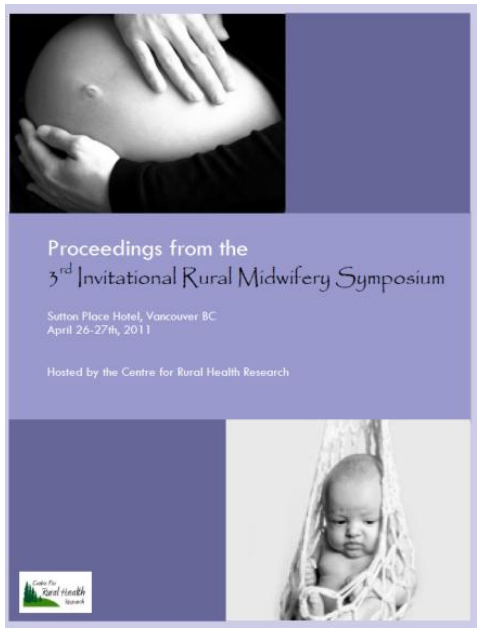
Knowledge Exchange





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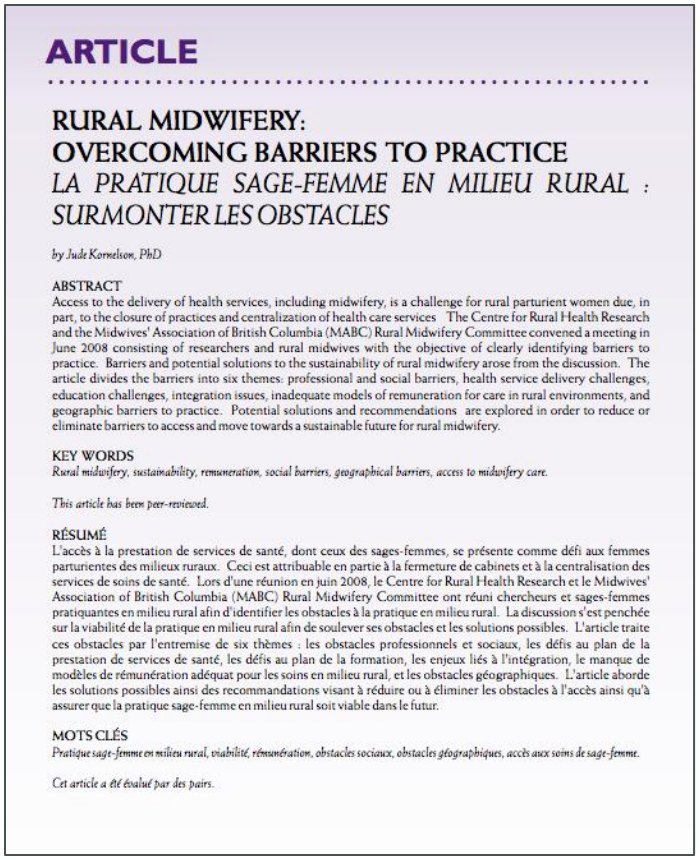


ARTICLE

RURAL MIDWIFERY: OVERCOMING BARRIERS TO PRACTICE

LA PRATIQUE SAGE-FEMME EN MILIEU RURAL : SURMONTER LES OBSTACLES

by Jude Kornelsen, PhD

ABSTRACT

Access to the delivery of health services, including midwifery, is a challenge for rural parturient women due, in part, to the closure of practices and centralization of health care services The Centre for Rural Health Research and the Midwives' Association of British Columbia (MABC) Rural Midwifery Committee convened a meeting in June 2008 consisting of researchers and rural midwives with the objective of clearly identifying barriers to practice. Barriers and potential solutions to the sustainability of rural midwifery arose from the discussion. The article divides the barriers into six themes: professional and social barriers, health service delivery challenges, education challenges, integration issues, inadequate models of remuneration for care in rural environments, and geographic barriers to practice. Potential solutions and recommendations are explored in order to reduce or eliminate barriers to access and move towards a sustainable future for rural midwifery.

KEY WORDS

Rural midwifery, sustainability, remuneration, social barriers, geographical barriers, access to midwifery care.

This article has been peer-reviewed.

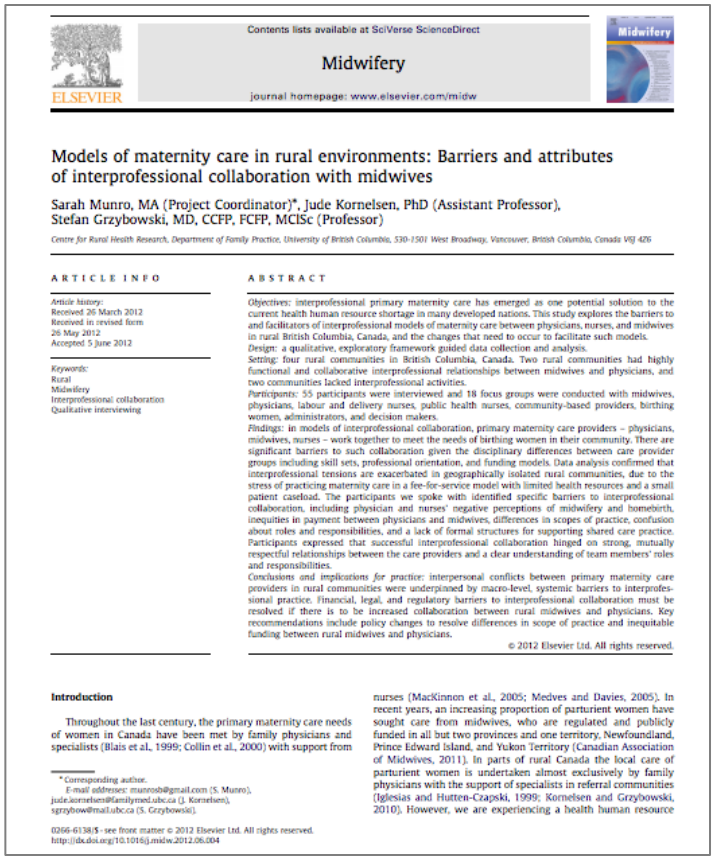
RÉSUMÉ

L'accès à la prestation de services de santé, dont ceux des sages-femmes, se présente comme défi aux femmes parturientes des milieux ruraux. Ceci est attribuable en partie à la fermeture de cabinets et à la centralisation des services de soins de santé. Lors d'une réunion en juin 2008, le Centre for Rural Health Research et le Midwives' Association of British Columbia (MABC) Rural Midwifery Committee ont réuni chercheurs et sages-femmes pratiquantes en milieu rural afin d'identifier les obstacles à la pratique en milieu rural. La discussion s'est penchée sur la viabilité de la pratique en milieu rural afin de soulever ses obstacles et les solutions possibles. L'article traite ces obstacles par l'entremise de six thèmes : les obstacles professionnels et sociaux, les défis au plan de la prestation de services de santé, les défis au plan de la formation, les enjeux liés à l'intégration, le manque de modèles de rémunération adéquat pour les soins en milieu rural, et les obstacles géographiques. L'article aborde les solutions possibles ainsi des recommandations visant à réduire ou à éliminer les obstacles à l'accès ainsi qu'à assurer que la pratique sage-femme en milieu rural soit viable dans le futur.

MOTS CLÉS

Pratique sage-femme en milieu rural, viabilité, rémunération, obstacles sociaux, obstacles géographiques, accès aux soins de sage-femme.

Cet article a été évalué par des pairs.



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Models of maternity care in rural environments: Barriers and attributes of interprofessional collaboration with midwives

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ABSTRACT

Objectives: interprofessional primary maternity care has emerged as one potential solution to the current health human resource shortage in many developed nations. This study explores the barriers to and facilitators of interprofessional models of maternity care between physicians, nurses, and midwives in rural British Columbia, Canada, and the changes that need to occur to facilitate such models.
Design: a qualitative, exploratory framework guided data collection and analysis.
Setting: four rural communities in British Columbia, Canada. Two rural communities had highly functional and collaborative interprofessional relationships between midwives and physicians, and two communities lacked interprofessional activities.
Participants: 55 participants were interviewed and 18 focus groups were conducted with midwives, physicians, labour and delivery nurses, public health nurses, community-based providers, birthing women, administrators, and decision makers.
Findings: in models of interprofessional collaboration, primary maternity care providers – physicians, midwives, nurses – work together to meet the needs of birthing women in their community. There are significant barriers to such collaboration given the disciplinary differences between care provider groups including skill sets, professional orientation, and funding models. Data analysis confirmed that interprofessional tensions are exacerbated in geographically isolated rural communities, due to the stress of practicing maternity care in a fee-for-service model with limited health resources and a small patient caseload. The participants we spoke with identified specific barriers to interprofessional collaboration, including physician and nurses' negative perceptions of midwifery and homebirth, inequities in payment between physicians and midwives, differences in scopes of practice, confusion about roles and responsibilities, and a lack of formal structures for supporting shared care practice. Participants expressed that successful interprofessional collaboration hinged on strong, mutually respectful relationships between the care providers and a clear understanding of team members' roles and responsibilities.
Conclusions and implications for practice: interpersonal conflicts between primary maternity care providers in rural communities were underpinned by macro-level, systemic barriers to interprofessional practice. Financial, legal, and regulatory barriers to interprofessional collaboration must be resolved if there is to be increased collaboration between rural midwives and physicians. Key recommendations include policy changes to resolve differences in scope of practice and inequitable funding between rural midwives and physicians.

Introduction

Throughout the last century, the primary maternity care needs of women in Canada have been met by family physicians and specialists (Blais et al., 1999; Collin et al., 2000) with support from nurses (MacKinnon et al., 2005; Medves and Davies, 2005). In recent years, an increasing proportion of parturient women have sought care from midwives, who are regulated and publicly funded in all but two provinces and one territory, Newfoundland, Prince Edward Island, and Yukon Territory (Canadian Association of Midwives, 2011). In parts of rural Canada the local care of parturient women is undertaken almost exclusively by family physicians with the support of specialists in referral communities (Iglesias and Hutten-Czapski, 1999; Kornelsen and Grzybowski, 2010). However, we are experiencing a health human resource

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Recommendations

- “One size does not fit all”
- Systemic changes
  - Funding
  - Hospital privileging
  - Differences in models of care
- Learning from successful models

Questions?

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