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To cite this article: Vanessa Watkins, Cate Nagle, Bridie Kent, Maryann Street & Alison M. Hutchinson (2025) Labouring Together: Clinicians' experiences of working together to get the best outcomes in maternity care, *Journal of Interprofessional Care*, 39:4, 663-677, DOI: [10.1080/13561820.2025.2469308](https://doi.org/10.1080/13561820.2025.2469308)

To link to this article: <https://doi.org/10.1080/13561820.2025.2469308>



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Published online: 10 Mar 2025.



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Labouring Together: Clinicians' experiences of working together to get the best outcomes in maternity care

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ABSTRACT

Interprofessional collaboration (IPC) is crucial for the safe provision of maternity care. However, IPC is poorly understood in the maternity care context, and the role of the childbearing woman within this collaboration remains unclear. The Labouring Together study used a mixed method, multi-site case study design to explore IPC and decision-making with women from the perspectives of maternity health care professionals (HCP). Case studies included a range of maternity models of care in metropolitan and regional settings in Australia. Cross-sectional surveys were used to investigate organizational context and HCPs' attitudes toward collaboration. Experiences and perceptions of collaboration and decision-making were explored using in-depth semi-structured interviews. A conceptual framework "*Experience of collaboration: Working together to get the best outcomes*" was formed from the interview findings, with major themes of "*Organisation of care: working together for the organisation*" and "*Partnering in care: working together with women*." Individual-level behaviors were employed by HCP to transcend interprofessional tensions relating to IPC. Entrenched organizational and policy-level barriers to effective IPC were identified; and whilst participants agreed that women should have autonomy with decision-making, most identified barriers at multiple levels to achieving this ideal.

ARTICLE HISTORY

Received 13 April 2023
Revised 23 June 2024
Accepted 14 February 2025

KEYWORDS

interprofessional collaboration; maternity care; shared decision-making; mixed methods; Context assessment

Introduction

Effective interprofessional collaboration (IPC) is recommended to improve the co-ordination, quality, safety, experience, efficiency, and financial cost of healthcare (Agyekum et al., 2023; Pomare et al., 2020; Reeves et al., 2017). Indeed, central tenets of maternity care provision worldwide include collaborative practice between health care professionals (HCP) for the provision of safe and effective maternity care, with respect for self-determination, the facilitation of choice and informed decision-making as priorities for the planning and delivery of maternity care (ACOG, 2016; Agyekum et al., 2023; COAG, 2019; DOH & Do, 2019; NHMRC, 2010; NMBA, 2018a, 2018b; Victorian Government, State of Victoria, Department of Health and Human Services, 2019; RCOG 2016; WHO, 2022).

The terminology used in policy documents from multiple countries worldwide implies that maternity care should be "... implemented in a way that respects, promotes and facilitates women's choices and their autonomy in decision-making" (ACOG, 2016; COAG, 2019; DOH & Do, 2019; RCOG 2016; World Health Organization, 2015). However, the role of the childbearing woman¹ is not clarified in current definitions of interprofessional collaboration (IPC) in maternity care (Downe et al., 2010; Heatley & Kruske, 2011; Smith, 2015).

Frameworks for IPC focus on how health professionals communicate and interact with each other respectfully, to promote a positive maternity workforce culture based on interdisciplinary collaboration and communication (COAG,

2019; Heatley & Kruske, 2011). This approach focuses on the pre-conditions for collaboration but ignores important aspects of the process of collaboration (and the woman's decision-making role in the collaborative process) and the outcomes of the collaboration (often a decision about treatment or care).

Interprofessional tensions between midwives and doctors in the provision of maternity care have been documented around the world, particularly at the boundary points of uncomplicated to complex care (and vice versa) (Elliott-Mainwaring, 2020; Kirkup, 2015; Reiger, 2000). In Australia, critical discourse analysis of submissions from medical, midwifery, and consumer organizations to the Australian Maternity Services Review and Senate reviews held between 2008 and 2010 (Lane, 2010; McIntyre et al., 2012b) found that *collaboration* was used by obstetricians to describe midwifery subject to medical authority and midwifery cooperation under obstetric control (Lane, 2010; McIntyre et al., 2012b).

In contrast, in the discourses of midwives, *collaboration* was identified as relationships between professional equals to work toward a common goal, with the separation of normal birth as the domain of midwives, free from the jurisdiction of obstetricians in a maternity system perceived to "constrain midwives from working to full scope of practice" (McIntyre et al., 2012b). Consumer discourses were identified as more closely aligned to the midwifery discourse; "prioritising the right of mothers and families to choice of carer, setting, and to decision-making autonomy"^{21, p33}. Nonetheless, how to achieve

equitable decision-making autonomy crucial for effective IPC in clinical practice remains unclear.

Background

Theoretical literature and research evidence reveal diversity in the way researchers conceptualize collaboration in the health-care context (D'Amour et al., 2005; Downe et al., 2010; Henneman et al., 1995). Collaboration is proposed to be the process of effort by multiple stakeholders to address complex problems (Aldrich, 1976; Gray, 1985) by forming a collaboration of actors with a common interest to create understanding and problem-solving capacity that cuts across traditional professional boundaries (Gray, 1985; Wood & Gray, 1991).

Seminal work by social theorists Wood and Gray led to the development of a comprehensive theory of collaboration by mapping: a) the preconditions; b) the process; and c) the outcomes of collaboration (Wood & Gray, 1991). The following definition of collaboration emerged from this work:

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 (Wood & Gray, 2005), p146 .

The Labouring Together study explored the pre-conditions (culture and context), processes (systems for interaction and decision-making) and outcomes of collaboration in maternity care (perinatal experiences and outcomes) from the perspectives of both women and HCP. This paper focuses upon the perspectives and experiences of IPC and collaborative decision-making held by HCP. The research questions that underpinned this arm of the study were:

- (1) Who are the actors involved in IPC for decision-making in maternity care?
- (2) What level of decision-making autonomy do individual actors hold in the process of collaboration?
- (3) What perceptions are held by those involved in decision-making of the meaning of collaboration in maternity care?
- (4) What are the interests of the decision-makers who participate in the collaboration, and to what extent are the interests shared, differing, or opposing?
- (5) How are the essential elements hypothesized to influence the effectiveness of IPC reflected in perceptions

held by those involved in collaborative decision-making in maternity care?

- (6) What are HCP experiences of collaborative decision-making with the childbearing woman?

Methods

The Labouring Together study utilized a mixed method, multi-site case study approach (Watkins et al., 2017). The multiple sources of evidence offered by this approach encouraged convergent lines of enquiry and triangulation of data to strengthen the construct validity and reliability of the findings (Yin, 2009) and to enable in-depth exploration of IPC within a real-life context (Stake, 1995).

Setting

Four hospitals providing maternity services in Victoria, Australia were purposively selected as case studies to represent a range of models of maternity care available in both metropolitan and regional Victorian hospitals. These included midwifery group practice (MGP), midwifery or general practitioner (GP) shared care,² high risk pregnancy care, specialist maternity services and private obstetric care. A description of the attributes of the models of maternity care selected for the Labouring Together study (Watkins et al., 2022) is presented in Table 1.

Study participants and recruitment

A convenience sample of HCP providing maternity care was recruited from each case. The selection criteria applied were midwives registered by the Nursing and Midwifery Board of Australia (NMBA); obstetric specialty trainees or consultant obstetrician Fellows of the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG); or GPs with accredited to provide shared maternity care within one of the case study sites and Fellows of the Royal Australian College of General Practitioners (RACGP).

All eligible HCP were invited to participate in both the survey and/or an interview. Representatives from all professional groups were recruited until information power (Malterud et al., 2016) was reached. Potential participants were advised about the project during scheduled meetings

Table 1. Models of maternity care included in the labouring together study.

Model of care	Description
Midwifery Group Practice	Publicly funded continuity of low-risk maternity care is primarily provided by a named midwife or small team of midwives throughout pregnancy, birth and in the early weeks of caring for the new baby.
Midwifery Shared Care	Publicly funded low-risk maternity care is primarily provided by midwives, shared with obstetric doctors via the maternity hospital throughout pregnancy, birth and in the early weeks of caring for the new baby.
General Practitioner (GP) Shared Care	Publicly or privately funded low to moderate-risk antenatal care is primarily provided by a General Practitioner (GP), shared with an obstetrician and/or midwife/team of midwives via the maternity hospital throughout pregnancy and birth and in the early weeks of caring for the new baby.
Obstetric High-Risk Pregnancy Care	Publicly funded maternity care is provided to women with medically complex pregnancies by a team of obstetricians, physicians, midwives and other healthcare providers throughout pregnancy and birth and in the early weeks of caring for the new baby.
Specialist Maternity Services	Publicly funded low to high-risk maternity care is provided to vulnerable women and/or babies by a team of midwives, obstetricians and other healthcare providers throughout pregnancy and birth and in the early weeks of caring for the new baby.
Private Obstetric Care	Privately funded low to high-risk maternity care is provided by a named obstetrician during pregnancy and birth.

at their workplace, recruitment posters were displayed in the workplace and presentations were scheduled to inform HCP about the study during the data collection period.

Quantitative methods: cross-sectional surveys

Cross-sectional surveys were administered in paper-based or electronic format to participants to maximize the response rate and to minimize response bias (Burke & Hodgins, 2015; Clark et al., 2011). Studies indicate a benchmark of 35–45% for response rates in organizational research (Baruch & Holtom, 2008; Burke & Hodgins, 2015). We considered a minimum response rate within these parameters was acceptable. Participants were invited to enter demographic data pertaining to their professional group, role, and years of experience in maternity services. The surveys were formatted in the following sections:

- (a) **Context Assessment Index (CAI).** HCP perceptions of organizational factors that may influence their ability to integrate childbearing women as partners in the collaboration were explored using the Context Assessment Index (CAI) (McCormack et al., 2009). The theoretical framework underpinning development of the CAI is the Promoting Action on Research Implementation in Health Services (PARIHS) (Kitson et al., 2008). Three contextual elements comprise the CAI: *Culture*, defined as “the beliefs, values and assumptions held by those at an individual, team and organisational level;” *Leadership* defined as a culture “that recognises everybody as a leader of something,” and *Evaluation*, defined as “evidence gathered through a variety of sources to make decisions about individual and organisational effectiveness” (McCormack 2009, p. 4-5). The elements are assessed on a 4-point Likert-type scale from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*). For an organizational culture that has person-centered work practices and is receptive to change, all three elements must be assessed as strong (McCormack et al., 2009).
- (b) **Jefferson scale of attitudes toward physician-nurse collaboration instrument (Jefferson Scale).** HCP attitudes toward collaboration and individual HCP autonomy within the multi-professional team were measured using the Jefferson Scale (Hojat et al., 1999). This validated instrument measures attitudes toward shared education, caring as opposed to curing, nurses’ (midwives’) autonomy, and physicians’ (obstetricians’) authority autonomy (Hojat et al., 1999). The Jefferson Scale was particularly selected for the Labouring Together study to measure attitudes toward autonomy; an essential element for all individual actors in collaboration in the theory of collaboration proposed by Wood and Gray (1991), which was used to underpin the study. Items in the Jefferson Scale are answered on a 4-point Likert-type scale from 1 (*Strongly Disagree*) to 4 (*Strongly Agree*), and positive attitudes toward collaboration are reflected in higher scores (Hojat et al., 1999).

Qualitative methods: semi-structured interviews

HCP were interviewed, either face-to-face or over the telephone, to explore their perceptions of collaboration and decision-making in maternity care. An interview guide was used (Appendix 1) underpinned by the theory of collaboration (Wood & Gray, 1991) to explore HCP perceptions and experiences of collaboration, stakeholder interests for participation in the collaboration, and the decision-making role and autonomy of individual partners in the collaboration. Interviews were audio-recorded and professionally transcribed in full and verbatim.

Data analysis and synthesis

An alpha level of .05 was used for all statistical tests, and results were considered statistically significant at a p-value of ≤ 0.05 . Quantitative analyses were conducted using the IBM® SPSS® Statistics V22.0 analytical software (IBM SPSS Statistics for Windows, 2013). Statistical analyses were conducted using the Kolmogorov-Smirnov test of normality, and non-parametric Kruskal-Wallis one-way analysis of variance ANOVA to compare the independent variables of HCP group and case study.

Inductive qualitative analysis was guided by the Braun and Clarke thematic analysis framework (Braun & Clarke, 2006, 2022). Line-by-line coding was undertaken and explored by shared-meaning pattern matching to generate themes from the underlying concept of the HCP experiences of working in collaboration (Braun & Clarke, 2022). The raw data were condensed and coded into key words phrases to summarize their meaning to allow a) linkage between the data and the aims of the study (Thomas, 2006 and b) identify the interplay between the collection of data and reflection on data through both content and thematic analysis (Bowling, 2000).

The initial coding was conducted with three members of the research team (VW, AH, CN), using Case 1 as the index case to develop a coding framework. The coding framework was then tested using inductive replication logic with interview data from Case 2, followed by Case 3 and Case 4. Reflexivity was maintained by identification and reflection upon individual personal beliefs and perceptions of maternity care from *a priori* knowledge and experiences. These insights were identified and reflected upon during meetings to maintain objectivity throughout the study, including design, data collection and interpretation, and the determination of information power (Malterud et al., 2016) from the qualitative data collection.

Cross-case analysis was conducted on the HCP participant’s assessment of organizational context to provide person-centered evidence-based care and the attitudes toward collaboration held by HCP. Data from the HCP interviews were analyzed between and across cases and the perspectives and experiences of collaboration in maternity care were themed.

The analysis strategy allowed elaboration and expansion of findings from each case study using literal and theoretical replication logic. Replication logic enhanced the reliability and external validity of this multiple-site case study

Table 2. Contextual characteristics of cases.

Contextual characteristics	Case 1	Case 2	Case 3	Case 4
Range of births per annum	>2000–4000	>2000–4000	750–1500	100–600
Location				
Metropolitan Melbourne	•	•		
Regional Victoria			•	•
Hospital funding model				
Publicly funded	•	•	•	
Privately funded				•
Models of care available				
Midwifery Group Practice	•	•		
Midwifery Shared Care	•	•	•	
GP Shared Care	•	•	•	
Obstetric High-Risk	•	•	•	
Specialist Maternity Services	•	•	•	
Private Obstetric Care	•	•	•	•

research, as the same process was repeated in each case study in order to predict similar results in each case study site (literal replication); or to predict contrasting results for anticipatable reasons (theoretical replication) (Creswell, 2009; Yin, 2009). Integration of the datasets was achieved by reviewing the quantitative results in the context of the perspectives, experiences, enablers, and barriers that emerged from the qualitative data across cases to synthesize all results and findings (Creswell, 2009). Collaboration theory (Wood & Gray, 1991) was used for theoretical replication to analyze the contrasting results between the case study sites, and enabled rigor for analysis and cross-case synthesis of the quantitative results and qualitative findings (Yin, 2009).

Ethical considerations

Several measures were implemented to protect the identity of the research participants and organizations comprising the case studies, and to safeguard the integrity of the research. Ethics approval was granted by the Human Research Ethics Committees of individual health services and endorsed by the university prior to data collection.

Results

Contextual characteristics of cases

Comparisons of contextual characteristics for the four cases (Watkins et al., 2022) including birthing numbers,

metropolitan and regional location, publicly and privately funded models, and variation in models of maternity care are presented in Table 2.

Cross-sectional survey results

Professional group characteristics

The professional characteristics of participants for each case are presented in Table 3. The majority of HCP participants at each case were midwives, which resembled the staffing profile of each hospital. Cases 1 and 2 included midwives working in a continuity of midwifery care model, and accredited GP participants currently providing GP shared care. Cases 1 and 3 included participants that identified as obstetric specialty trainee doctors, whereas the obstetric practitioners who participated in the study from Cases 2 and 4 were exclusively consultant obstetricians, with no participation of obstetric trainees.

Reliability of instruments and subscales

The Cronbach's alpha values for each case were satisfactory for both the CAI (0.94–0.96) and the Jefferson scale (0.72–0.88).

Results from the Context Assessment Index (CAI)

Cross-case analysis of the CAI overall and subscales scores was conducted using Kruskal-Wallis ANOVA. The results showed no statistically significant differences between the four cases for the CAI elements of *Culture*, *Leadership* and overall *Context*. However, the scores for *Evaluation* for Cases 1 and 2

Table 3. Professional role characteristics of survey respondents by case ($n = 147$).

Professional role characteristic	Distribution per case (%)			
	Case 1	Case 2	Case 3	Case 4
Midwife	75	89	92	87
Consultant/Manager	5	8	3	6
MGP/Continuity Model	5	8	-	-
Midwife	63	70	80	81
Graduate Midwife	2	3	9	-
Medical Practitioner	25	11	9	12
GP Obstetrician	-	-	3	-
GP (accredited for shared care)	10	8	-	-
Consultant Obstetrician	5	3	-	12
Specialty Obstetric Trainee Year 5–6	2	-	3	-
Specialty Obstetric Trainee Year 3–4	5	-	3	-
Resident Medical (House) Officer	3	-	-	-

Table 4. Context assessment index elements by case (n = 142).

CAI elements	%				p-value
	Case 1	Case 2	Case 3	Case 4	
Culture	71.9	73.4	71.9	75.0	0.18
Leadership	71.4	75.0	71.4	71.4	0.07
Evaluation	71.2	73.0	67.6	69.4	0.02*
Overall context	71.3	73.5	69.7	72.5	0.06

Note. *statistically significant (p < .05). Analysis was conducted using Kruskal Wallis one-way analysis of variance.

Table 5. Total Jefferson Scale score by case (n = 142).

Case	n	Mean	SD	95% CI for Mean		Range	
				Upper	Lower	Minimum	Maximum
1	58	53.02	4.854	51.74	54.29	43	60
2	35	53.77	4.346	52.28	55.26	43	60
3	33	53.45	3.726	52.13	54.78	43	60
4	16	53.06	4.809	50.50	55.63	43	59
All	142	53.31	4.449	52.57	54.05	43	60

(metropolitan maternity services) were significantly (p = .02) higher than for Cases 3 and 4 (regional maternity services) (Table 4).

Results from the jefferson scale

Comparison of the total Jefferson scores between cases.

Descriptive statistics for the Jefferson Scale scores by case are reported in Table 5. Cross-case ANOVA was performed; no statistically significant differences in responses were found between the cases (N = 147, df = 3, F-value 0.234; p = .873).

Comparison of the total Jefferson score between professional groups.

Data from HCP participants for all four cases (n = 142) were pooled to evaluate potential differences in attitudes toward collaboration between midwives, obstetricians, and GPs (Table 6). The results showed that midwives had a higher median score for attitudes toward collaboration than doctors, and this difference between the HCP groups was significant (p < .001). Following post-hoc analysis using Bonferroni correction, midwives were found to have a statistically significantly more positive attitude toward collaboration than both GPs (p < .001; 95% CI 5.48–12.10) and obstetricians (p < .001; 95% CI 2.64–7.93).

Findings from the semi-structured interviews

Two major themes were identified from the inductive thematic analysis. HCP reports of their experiences of working within

the maternity service aligned with the theme *Organisation of care: Using the service*. HCP references to their experiences of working with other HCP and women to meet the unique needs of the woman and her family during pregnancy and transition to parenthood aligned with the theme *Partnering in care: Working together with women*. The subthemes and features were then compared and overlapping and/or similar categories were refined and synthesized to develop the final conceptual framework of *Experience of collaboration: Working together to get the best outcomes* (Figure 1).

Organisation of care: working for the organisation

This theme comprised three subthemes, *Communication: Sharing information with others*, *Scope of practice: Working to my full professional capacity*; and *Systems: Working within the rules and systems*.

Communication: sharing information with others. This sub-theme aligned with features such as a) organizational processes for transactional information transfer, for sharing of information to facilitate referral, or b) to promote mutual understanding between partners in the collaboration. The design, functionality, and accessibility of documentation systems and shared physical spaces were pinpointed as influential upon the quality of communication and the effectiveness of IPC. Both of these features were identified as pivotal to the efficiency of maternity care in avoiding omission or duplication of care.

Table 6. Attitudes toward collaboration by professional group (n = 142).

HCP group	Comparator	MD ^a	SE ^b	p-value	95% CI	
					Lower	Upper
Obstetrician (n = 13)	Midwife	-5.289	1.092	<0.001***	-7.93	-2.64
	GP	3.500	1.681	0.117	-0.57	7.57
Midwife (n = 121)	Obstetrician	5.289	1.092	<0.001***	2.64	7.93
	GP	8.789	1.366	<0.001***	5.48	12.10
GP (n = 8)	Obstetrician	-3.500	1.681	0.117	-7.57	0.57
	Midwife	-8.789	1.366	<0.001***	-12.10	-5.48

Note. *** statistically significant (p < .001). ^a MD= Mean Difference, ^bSE= Standard Error. Kruskal Wallis One-way ANOVA.

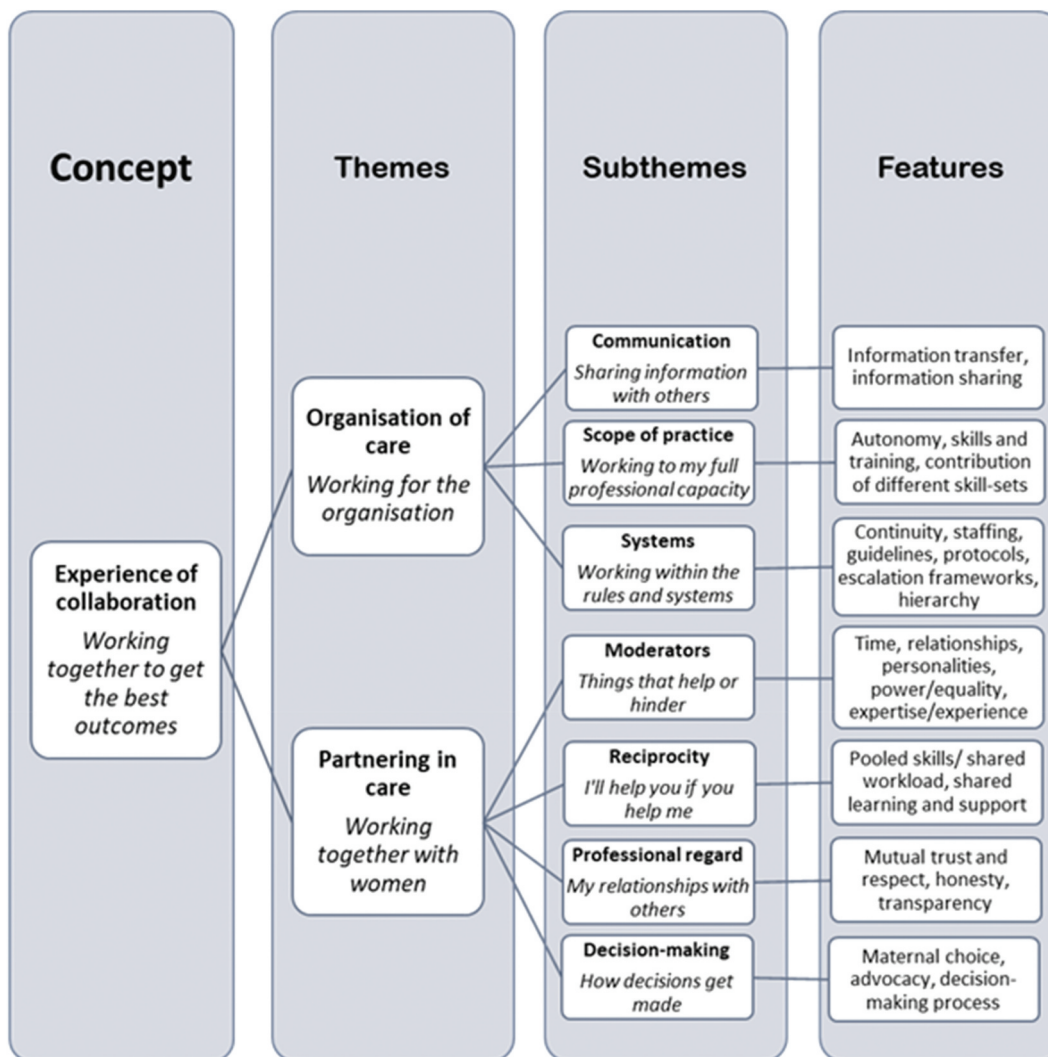


Figure 1. Experience of collaboration- *Working together to get the best outcomes.*

Some participants described electronic systems as helpful for sharing of information, however, challenges were associated with the use of incompatible documentation systems between private doctors' rooms and the hospital; outmoded systems of communication such as paper-based booking systems for scheduling of induction of labor; or reliance upon facsimile machines for transfer of information such as blood results. In the private obstetrician model of care at Case 4, midwives stated they did not have the opportunity to collaborate or communicate with women prior to labor and birth, as all antenatal care was conducted in private consulting suites, and records were not routinely accessible to the midwives in the hospital.

Scope of practice: working to my full professional capacity.

This subtheme included features such as professional autonomy, skills and training, and the contribution of different skill sets to the shared work within the collaborative alliance. All HCP recognized that different members of the collaborative alliance brought the benefit of different skillsets and points of view that were positive for the provision of the best possible maternity care. Several participants in Cases 1, 2 and 3

described a recent change in culture for IPC. They perceived obstetricians and midwives now encouraged each other to participate in the woman's care when care needs were beyond of their own scope of practice. This was perceived to occur when working with childbearing women across all levels of obstetric risk, and throughout the continuum of care.

Working to the full scope of professional practice was identified by several participants across Cases 1, 2 and 3 as essential to support the effective functioning of IPC, with clear professional boundaries, but with use of all professional skill-sets to the fullest capacity for the benefit of the woman. Conversely, blurred professional boundaries were identified across all cases as a barrier to collaboration and a source of potential conflict between HCP.

Several obstetricians across all cases perceived that collaboration with midwives working in full scope of midwifery practice was advantageous: for a more cost-effective workforce by shifting some of the workload from the obstetricians to midwives; for the support of women with complex social needs; for navigation of conflicting opinions about plans of care; and to provide the woman with more options from which to choose. Obstetricians working in the private obstetrician

model of care at Case 4 actively promoted the inclusion of midwifery practice (under their instruction) to support the woman's transition to parenthood as an asset to their business model within their private rooms.

Systems: working within the rules and systems. This sub-theme featured organizational and structural systems such as continuity of care or carer, staffing levels, protocols, guidelines, escalation systems and organizational hierarchy. Perceived benefits of relational continuity of care with both women and with teams and professional colleagues emerged as a common feature amongst all HCP groups. The development of relationships between HCP working in an interprofessional team was perceived as beneficial for IPC and fostering of trust. Similarly, the ability to develop personal knowledge and a trusted relationship with the woman was perceived as advantageous for engagement of women in their care and for SDM.

Several midwives from Cases 1, 2 and 3 perceived that the pathway of maternity care in use by their organization supported midwives to have autonomy within their scope of practice for uncomplicated pregnancy, underpinned by a clear escalation framework should complications arise. Synonymously, several obstetricians also expressed the view that obstetric confidence in midwives' decision-making was enhanced by use of a pathway of care.

Many midwifery participants from Cases 1, 2 and 3 indicated their acceptance of accountability for care decisions within the domains of midwifery scope of practice. Conversely, all midwifery participants from Case 4 expressed the opinion that midwives have a passive role within the collaborative alliance within the private hospital setting, as midwifery scope of practice was defined by the preferences of the private obstetrician and hospital guidelines, rather than professional standards for midwifery.

Midwives at all cases described medically dominated, hierarchical organizational structures as a barrier to collaboration. At Case 4, it was suggested that medical dominance was entrenched within the culture of the hospital, extending to elements of practice that were traditionally within midwifery scope of practice such as lactation and breast-feeding. In the public hospital setting of Cases 1, 2 and 3, several obstetricians shared their opinion that although midwives are accountable for their actions, the ultimate medico-legal responsibility for safe maternity care lies with the obstetrician.

Partnering in care: working together with women

This theme reflects HCP descriptions of their experiences of collaboration and decision-making when working together with other HCP and/or with women to deliver maternity care. Four subthemes comprised this theme, including *Moderators: Things that help or hinder*; *Reciprocity: I'll help you if you help me*; *Professional regard: My relationships with others*; and *Decision-making: How decisions get made*.

Moderators: things that help or hinder. This subtheme reflects HCP perceptions of factors that influenced the ability of individuals to function effectively within the collaboration. Features identified were relationships, expertise, personalities, power, equality, and equity. Behavioural

traits of territorialism, dominance, poor interpersonal skills, and defensiveness by HCP were framed as detrimental to collaboration, whereas the capacity to develop relationships between partners in the collaboration was reported by all participants as important for successful collaboration. Similarly, positive role modeling and altruistic behaviors of senior midwifery and obstetric staff were identified by many participants across cases as enablers of effective IPC.

Features such as a shared staff room were framed as enablers of interaction between HCP to develop professional rapport, and camaraderie among the team. Adequate time for communication between HCP, for example, during meetings or shared education, was perceived positively by most participants. Conversely, inadequate time for antenatal consultations with women was identified by several midwives from Cases 1, 2 and 3 as a barrier to information sharing required for SDM.

Reciprocity: I'll help you if you help me. This subtheme aligned with the exchange of ideas and pooling of skills and support with a broad range of HCP and non-clinical staff, to improve safety and achieve positive outcomes for women. Most HCP considered collaboration with other HCP groups personally advantageous: to obtain support and to learn; to promote safer outcomes; and to access resources. Conversely, many midwives and GPs across Cases 1, 2 and 3 indicated that the sharing of ideas, professional opinions or judgment was rarely sought by obstetricians due to perceived medical superiority. Particularly at Case 4, obstetricians were perceived to hold veto-power over domains of midwifery practice due to their financial arrangements with the private hospital.

Professional regard: my relationships with others. This subtheme aligned with features of mutual trust, mutual respect, honesty, and transparency. Mutual trust and respect emerged as important for successful collaboration between HCP from the perspectives of most participants, across cases. All obstetricians indicated that mutually respectful relationships with midwives were vital for the obstetricians to enable confidence in midwifery clinical practice and prompt escalation of care.

Midwives at Cases 1, 2 and 3 associated their role within the collaboration with empowerment of and advocacy for woman, by acting as an intermediary, negotiator, or translator between women and doctors in order to translate jargon and ensure understanding of all options from which woman could choose. However, systems of governance, where the dominant discourse of risk-prevention overrode the preferences of women, was identified as a major challenge to supporting woman's choices. Across cases, many midwives acknowledged an internal conflict between the professional midwifery role for guardianship of normal birth and advocating for the woman's choices, and the negotiation of care options with the obstetric team and hospital policy. Predictably, many midwives also indicated that advocating for women and challenging the status quo could prove personally disadvantageous for them, as they perceived a risk of being labeled as difficult to work with, and a threat of formal performance management.

Decision-making: how decisions get made. This subtheme was associated with maternal choice, advocacy, and the decision-making process. All HCP across cases described their respect for the woman's autonomy of choices in the decision-making process. However, there was no consensus on how decisions should be made within maternity care, or indeed, who had the final responsibility for collaborative decision-making.

An absence of continuity of care to support decision-making, poor obstetric leadership, rotating staff, and bureaucratic decision-making overriding women's choices were identified as barriers to IPC and SDM. Furthermore, many midwives across all cases perceived that withholding information about potential implications of obstetric interventions from women, led to coercion into choices that aligned with bureaucratic or obstetric-led decision-making.

Discussion

The integrated findings from all datasets are presented in Table 7. At the individual and professional (micro) levels, there was broad agreement from HCP that childbearing women should have an autonomous role within the collaboration for decision-making over their own care. Indeed, organizational context for the provision of person-centered care was rated similarly by HCP between cases in the results of the CAI, consistent with national standards for healthcare for partnering with consumers (ACSQHC, 2021). Minor contextual variation in *Evaluation*, could reflect less capacity for evaluation measures within the smaller health services of Cases 3 and 4.

At interview, participants indicated that an organizational context conducive to collaborative, woman-centered care was supported by leadership and positive role modeling, effective governance, interprofessional education and continuity of practice with both women and clinical teams. However, several barriers were identified that prevented women (and midwives working in partnership with women) from adopting an autonomous decision-making role within the collaboration, across cases. At the organizational (meso) level, a lack of continuity, a lack of respectful relationships, organizational hierarchy, complex care needs, unequal power of individuals within the collaboration, inadequate communication systems and inadequate time allocation were identified as barriers to IPC and decision-making with women as autonomous actors in the decision-making process.

When interviewed, HCP identified a mostly positive experience of interprofessional work, based upon mutual trust and respect. However, the historical legacy of interprofessional distrust and territorialism was evident, and there was evidence in the interview findings that HCP in this study were aware of, and, indeed, subject to these potential tensions. Previous researchers have reported that contrasting philosophies and beliefs of individual HCP were associated with tensions and incivility and challenged collaborative behaviors (Hirst, 2005; Reiger & Lane, 2009).

Yet, in the interviews participants also talked about the ways they tried to overcome historical power differentials to improve collaborative working, through positive role-modeling, professional courtesy and altruism, and the

conscious fostering of mutual trust and respect. The adoption of these behaviors to transcend interprofessional tensions are consistent with the recommendations of authors of several other studies in the broader healthcare context (Austad et al., 2017; Axelsson & Axelsson, 2009; Van Wagner, 2016). This strengthens confidence in both the validity and transferability of the findings of this study to other maternity settings globally.

Influential factors were identified at the macro-level, including inadequate funding to support the autonomy of midwives, inadequate legislation at the organizational and governance level to protect the rights of women to participate in decision-making; and inadequate commitment for evidence-based models of continuity of midwifery-led care in the publicly funded healthcare system. Most midwifery participants identified challenges to autonomous discretionary decision-making within their scope of practice such as unequal authority; bureaucratic or autocratic-style decision-making; the lack of organizational policy-level support for midwives to work to the full scope of midwifery practice; and hierarchical hospital systems and funding models. These findings are consistent with previous studies (Hansson et al., 2019; Lane, 2012; McIntyre et al., 2012a, 2012b; Murray-Davis et al., 2014; Reiger & Lane, 2009).

Other studies have revealed ambiguity in identifying who within the collaboration has veto-power over decision-making (Kruske et al., 2013) and how to transcend differences in opinion when they occur (Jenkinson et al., 2017, 2018). From a medico-legal perspective, a person with capacity for decision-making has the right to refuse treatment, even treatment needed to maintain life, and must not be subject to medical treatment without his or her full, free and informed consent (ALRC, 2014). Therefore, if a person with decision-making capacity decides to refuse recommended medical or surgical interventions, the decision should be respected. However, in maternity care, a woman's refusal of recommended treatment can be experienced as contentious, particularly in situations when the decision may lead to a perceived increased risk of harm to the fetus (Kruske et al., 2013). In practice, obstetricians and midwives have been reported to believe the ultimate legal accountability for outcomes is retained by the medical profession, despite the legal position that individual HCP can only be held responsible for outcomes caused by their own negligent actions (Kruske et al., 2013).

Midwives, overall, had a more positive attitude toward collaboration than obstetricians and GPs. These results highlight a challenge to the professional autonomy of midwives and correspond with the proposition that power and dependence may influence attitudes toward collaboration. Social scientists have proposed that those in a position of greater power are less likely to seek a collaborative relationship, and those who are less dependent upon the relationship have the most power, based upon the principle of least interest (Caldwell & Peplau, 1984; Eslinger et al., 1972; Hojat et al., 2003).

In healthcare, the context and culture of an organization is argued to be based upon the philosophy, beliefs, values and assumptions held, and "... needs to be understood if meaningful and lasting change is to be achieved ... changing the prevailing culture may enable that to happen" McCormack,

Table 7. Integrated results matrix for HCP perceptions and experiences of collaboration.

Quantitative results	Qualitative results	Example quotation
<p>Micro-level: Midwives were found to have a more positive attitude toward collaboration than either GPs ($p < .001$ 95% CI 5.48–12.10) or obstetric doctors ($p < .001$ 95% CI 2.64–7.93).</p>	<p>Individual-level barriers to successful IPC and collaborative decision-making with childbearing women were identified, including:</p> <ul style="list-style-type: none"> • Historical legacies of distrust and professional territorialism • Concern over medico-legal liability. 	<p><i>Some people don't like working in teams ... there are lots of cases of minor battles ... it is like resistance to change ... And sometimes it is just a case of well I have the best ideas and I don't need anyone to tell me what to do. (Case 2, Obstetrician 1)</i></p> <p><i>When there's a serious problem ... the end responsibility for dealing with that serious problem will be the obstetrician ... Does that mean they're in charge? Mm, sort of ... [because] the buck stops with him or her. (Case 1, Obstetrician 1)</i></p>
<p>Overall organizational context for the provision of person-centered care was rated similarly by HCP between cases (70.83–76.03%)</p>	<p>At the individual level, most HCP believed that the childbearing woman should be supported to be an active stakeholder of the collaboration.</p> <p>Most HCP identified a positive experience of working together, based upon mutual trust and respect.</p> <p>Organisational guidelines can be helpful for HCP to develop a shared understanding of individual roles and scope of practice for IPC.</p> <p>Positive role modeling by senior HCP was supportive of mutual trust and respect.</p> <p>Shared education can be helpful for HCP to develop a shared understanding of individual roles and scope of practice for IPC.</p> <p>Collaboration with other HCP can support individual learning needs.</p> <p>Continuity of practice with other HCP can foster:</p> <ul style="list-style-type: none"> • Mutual trust and respect • Peer support and camaraderie 	<p><i>The women are the experts in their own experience. They know what they want, and they know what their body can do. They know what their family respects and strives for. They should be the ones leading the care and being really involved in that care. (Case 4, Midwife 4)</i></p> <p><i>I don't think I can do my job without collaboration ... if I constantly felt that I was fighting all the time to get anywhere ... just "running uphill" all the time. I have a treadmill and I never put it on incline! (Case 2, Midwife 1)</i></p> <p><i>The Pathways guideline ... allowed us to first of all think about the process ... So that discussion was helpful ... in identifying how it all works and setting some agreed guidelines ... the conversation is important and continuing that conversation is important. (Case 1, Obstetrician 1)</i></p> <p><i>If there [are] really good relationships between the leadership group, that really helps ... if the leaders feel like they can communicate with each other and resolve things openly, then that makes it easier for everyone else. (Case 3, Obstetrician 2)</i></p> <p><i>We are all working together for healthy mother healthy bub. So, it might be that you learn something new. You learn a different way of doing things ... that has actually worked out better. (Case 3, Midwife 3)</i></p> <p><i>A GP ... may not [be] exposed to the contact of women as I am, which I see every day, every week, every month, every year. ... I guide them with what I know are appropriate things to do to achieve an outcome. (Case 1, Midwife 8)</i></p> <p><i>Trust with other members of the team is very important as well ... every time there's a new group of doctors coming through that to some extent those relationships need to be rebuilt again. But once they've sussed out where you're coming from and where they're coming from ... we have a very good working relationship with the obstetric team and they trust that we will come to them if there's a problem and they trust that things will not be withheld from them (Case 1, Midwife 5)</i></p> <p><i>You can't underestimate that [if] things go wrong ... they go catastrophically wrong, and it takes a toll on all of the staff. When you work collaboratively with people, that debriefing process is a lot easier ... talking to your colleagues makes a big difference in how you move forward and make changes to your practice or just move past those events. (Case 1, Obstetrician 2)</i></p>
<p>Meso level: Overall, barriers to organizational context for the provision of person-centered care were rated similarly across cases by HP (24.0–29.2%).</p>	<p>Organisational-level barriers to IPC and SDM were identified, including:</p> <ul style="list-style-type: none"> • Lack of continuity • Organisational hierarchy 	<p><i>Patients find their management plan gets changed from day to day, depending on who the consultant on is. (Case 2, Obstetrician 3)</i></p> <p><i>[Is there a hierarchy?] Definitely. ... I think you would rarely see a senior doctor ask a midwife for her opinion ... I think collaboration as we currently see it is seen as referral, and it is always referral up [to a doctor] ... Right? Very rarely down [to a midwife] (Case 1, Midwife 3)</i></p>

(Continued)

Table 7. (Continued).

Quantitative results	Qualitative results	Example quotation
	<ul style="list-style-type: none"> • Unequal power of stakeholders 	<p><i>[Midwives] work with the doctors, but the doctor has the final say. (Case 4, Midwife 3)</i></p> <p><i>A lot of women ... may be very confident outside in the world but as soon as they come into a health service, they may feel that they need to hand themselves over to us. (Case 2, Obstetrician 1)</i></p>
	<ul style="list-style-type: none"> • Complex care needs 	<p><i>Ideally [women] are part of the team and are part of the decision making. But in reality, that happens not all the time ... depending on lots of things – if they are more high risk they tend to have less collaboration in their own care I feel. (Case 3, Midwife 7)</i></p>
	<ul style="list-style-type: none"> • Lack of organizational support for midwifery practice 	<p><i>I've started saying ... you will be seeing doctors at each visit, but you could ask can I ... have those discussions with the midwife? ... We'll have insulin-requiring ladies in labour, and I'll say, so have you been ... expressing breast milk? They'll go, no ... I don't think it's fair on the women and it's not fair on the babies. (Case 1, Midwife 6)</i></p>
	<ul style="list-style-type: none"> • Inadequate systems to support three-way communication between stakeholders of the collaborative alliance 	<p><i>I do try and liaise with my shared care hospitals but ... at the moment I don't get a lot of information back ... Considering it's actually a shared care relationship it would be much nicer to actually have ... three-way dialogue. (Case 1, GP 1)</i></p>
	<ul style="list-style-type: none"> • Inadequate time allocation for sharing information with women to support SDM 	<p><i>In clinic you only get 20 minutes and it's so limited with what you can actually discuss with a woman. Along with doing ... all the basic care that you need to give ... you barely have time to talk about what happens in labour and birth. (Case 1, Midwife 7)</i></p>
	<ul style="list-style-type: none"> • Lack of respectful relationships 	<p><i>Women can't win ... If they don't question things ... you get frustrated because you think well ... you haven't been given as much information as you probably should have been. And yet, ... when women come into hospital and do exactly what we thought we wanted them to ... which is to be active and informed in decision making and question what we are doing to their bodies ... we get equally as frustrated and think, oh my goodness. This woman is a difficult patient. (Case 2, Midwife 4)</i></p>
Macro-level:	<ul style="list-style-type: none"> • Protocol-based decision-making 	<p><i>You've got all those policies and procedures in place ... and you think where's the autonomy? ... It's very fixed, cookbook delivery of medicine and maternity care in a way. So then where does the woman fit in with that? Well, she doesn't, does she? ... The women that do ... have particular requests ... They're seen as non-compliant, difficult. ... Particular services that are available in other hospitals [are] not available here, and that's purely a policy and system failure. (Case 3, Midwife 4)</i></p>
	<ul style="list-style-type: none"> • Financial vested interests 	<p><i>If you've got a collaborative model where the midwife's doing all the work ... If the obstetrician only came in for obstetrician-type stuff, [and] there were financial implications of that, then that might be a problem ... I suspect a turf warfare over who's going to look after what's essentially normal obstetrics, normal maternity cases (Case 1, Obstetrician 1)</i></p>
	<ul style="list-style-type: none"> • The dominant discourse of risk avoidance 	<p><i>This woman clearly knows what she wants. She is not just saying no for nothing. She doesn't need to be told again. She has said no ten times now to ten different people. Sending in more people is not going to change her mind. It is just upsetting her now, and she is actually feeling like her back is against the wall. Like these people aren't going to help me. I am scared. ... even signing an against medical advice form – knowing that you are signing that, that would be a difficult thing to do with a little baby still inside of you'. (Case 2, Midwife 4)</i></p>

et al., (2002, p. 97). Barriers to IPC and collaborative decision-making with women identified within the cases included organizational hierarchy, unequal authority, financial vested interests, a lack of support for midwifery autonomy, a lack

continuity of both carer and the interprofessional team, poor communication systems, and a lack of time for three-way discussions to support collaborative decision-making with women.

HCP attitudes toward power, authority, and the autonomy of midwives within the collaborative alliance were contentious in all case studies. Additionally, midwives disclosed their perceptions of a lack of organizational resources and processes to support the full scope of midwifery practice. Interestingly, results of a recent cross-sectional study of cancer care services in Finland indicated that work empowerment and interprofessional collaboration had a strong correlation (Karukivi et al., 2023). However, in the midwifery context, researchers predominantly reported work disempowerment, and Swedish researchers have proposed a theory of “Veiled Midwifery” (Hansson et al. 2019, p. 80) to explain the complex relationship between midwives with other professional groups. The researchers describe the perception of midwifery held other professions as a “solitary profession . . . marching to their own drum” (Hansson et al. 2019, p. 85). Demanding admittance to the midwife-mother relationship by scrutiny of midwifery work, and implementation of policies and protocols, were identified as “unveiling strategies” (Hansson et al. 2019, p. 84) used to control and subjugate midwifery practice. Further research is required in the Australian context to inform strategies to promote organizational transparency of midwifery practice without subjugation or unnecessary bureaucratic limitations upon practice.

In the Labouring Together study, the most fundamental barriers to IPC and autonomous decision-making by

women were identified at the policy and governance (macro) level, stemming from inadequate legislation to operationalize effective collaboration. Key healthcare policy issues for address include reliance on hierarchical systems of governance where financial vested interests and funding models that simultaneously privilege doctors whilst enforcing their professional liability and hindering midwives from participation in the full scope of midwifery practice, and the dominant discourse of risk-prevention that may override the preferences of women. Consequently, the role of the woman was mostly classified as a passive recipient of bureaucratic-style or obstetric decision-making, rather than with respect for the woman’s decision-making autonomy in all cases. This finding is consistent with women’s perceptions within the cases of the Labouring Together study (Watkins et al., 2022). Specifically, women perceived their decision-making role in maternity care was commonly confined to an informed consent process to pre-determined, bureaucratic, protocol-based decision-making, rather than active engagement in shared decision-making processes that were respectful and inclusive of their values and preferences (Watkins et al., 2022).

Factors supportive of collaboration and collaborative decision-making with women generated from the Labouring Together study are summarized in Figure 2.

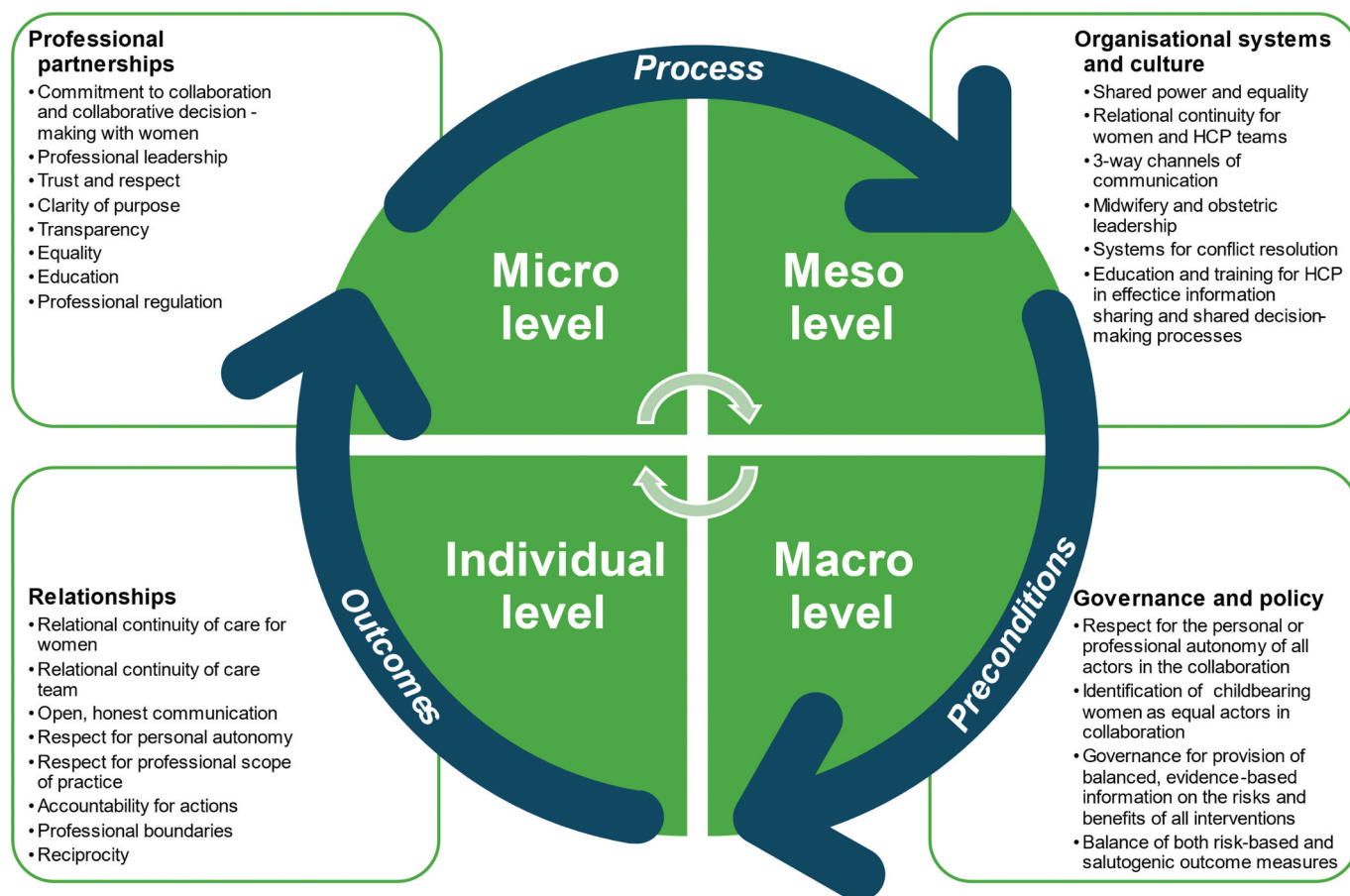


Figure 2. Factors supportive of effective IPC and collaborative decision-making in maternity care.

Strengths and limitations

One of the major strengths of the Labouring Together study was the study design which incorporated mixed methods across multiple cases. The mixed methods afforded identification and in-depth analysis of issues pertaining to IPC and SDM, and the literal replication of similar results across the cases provided support for the study findings.

Limitations of the study include potential recruitment bias and a relatively small sample size from each case. The limitation of small study size was balanced by the use of replication logic from the multi-site case study design. Every effort was made to recruit a diverse group of HCP from each case to participate in the study, yet it is possible that participants recruited to the study had extreme viewpoints or were discontented with the current context of maternity care provision.

Conclusion

An overlap in the essential elements associated with theoretical concepts of IPC and an autonomous decision-making role for childbearing women within IPC was implied by all groups of participants, contingent upon common interests and the maintenance of autonomy of all partners in the collaboration. However, in clinical practice, whilst most interpersonal and behavioral factors at the individual HCP level were found to be positive, equitable IPC and collaborative decision-making with women were not routinely evident in maternity care in Victoria, Australia.

Factors currently hindering the operationalization of IPC and SDM maternity care are: inadequate legislation and funding models to support stakeholder autonomy; inadequate organizational systems and funding models to support continuity of both carer and care team; inadequate systems to support effective three-way communication; the historical legacy of power imbalances; and the dominant discourses of risk avoidance and bureaucratic-style decision-making that can ultimately veto the woman's choice.

We believe that these findings are likely to be generalizable to other maternity care settings worldwide and recommend future healthcare systems and policy work to remove barriers that currently impede respect for the decision-making autonomy of individuals. To provide truly collaborative, woman-centered maternity care, further research and political endeavor are required to underpin a radical overhaul of the antiquated hierarchical systems and healthcare policies that perpetuate the subjugation of both women and midwives.

Notes

1. The term "childbearing woman/women" in this manuscript is inclusive of cisgender, transgender and non-binary pregnant people and parents.
2. An arrangement between a hospital (or other birth setting) and a local health care professional (commonly a GP or midwife), where pregnancy care is divided between the local provider and the hospital.

Acknowledgments

Vanessa Watkins was the recipient of the 2015 Australian Nursing and Midwifery Federation (Vic Branch) Research Grant.

Author Contributions

CRediT statement: **VW**: Conceptualization, Funding acquisition, Methodology, Investigation, Data curation, Project administration, Formal analysis, Visualization, Writing - Original draft, Writing - Review & Editing. **CN**: Supervision, Methodology, Formal analysis, Writing - Review and Editing. **BK**: Supervision, Methodology, Writing - Review and Editing. **MS**: Supervision, Formal analysis, Writing - Review and Editing. **AH**: Supervision, Methodology, Formal analysis, Writing - Review and Editing.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

The work was supported by the Australian Nursing and Midwifery Federation [Vic Branch] Research Grant.

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Ethical approval

Deakin University Human Ethics Research Committee (DUHREC 2014–238).

References

- ACOG. (2016). Executive summary: Collaboration in practice: Implementing team-based care: Report of the American College of Obstetricians and Gynecologists' task force on collaborative practice. *Obstetrics & Gynecology*, 127(3), 612–617. <https://doi.org/10.1097/AOG.0000000000001304>
- ACSQHC. (2021). National safety and quality health service standards (2nd ed.). In ACoSaQiH, (Ed.), *Care*. Australian Commission on Safety and Quality in Health Care. <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/national-safety-and-quality-health-service-standards-second-edition>
- Agyekum, E. O., Kalaris, K., Maliqi, B., Moran, A. C., Ayim, A., & Roder DeWan, S. (2023). Networks of care to strengthen primary healthcare in resource constrained settings. *BMJ*, 380, e071833. <https://doi.org/10.1136/bmj-2022-071833>
- Aldrich, H. (1976). Resource dependence and interorganizational relations: Local employment service offices and social services sector organizations. *Administration & Society*, 7(4), 419–454. <https://doi.org/10.1177/009539977600700402>
- ALRC. (2014). Equality, capacity and disability in commonwealth laws: Informed consent to medical treatment, rule 10.48. In Commission ALRA. (Ed.), *DP 81*. Commonwealth of Australia, Chapter 3 (pp. 55–73).
- Austad, K., Chary, A., Martinez, B., Juarez, M., Martin, Y. J., Ixen, E. C., & Rohloff, P. (2017). Obstetric care navigation: A new approach to promote respectful maternity care and overcome barriers to safe

- motherhood. *Reproductive Health*, 14(1), 1–8. <https://doi.org/10.1186/s12978-017-0410-6>
- Australian Government, Department of Health. (2019). Clinical Practice Guidelines: Pregnancy Care. Retrieved November 7, 2019, from www.health.gov.au/resources/pregnancy-care-guidelines
- Axelsson, S. B., & Axelsson, R. (2009). From territoriality to altruism in interprofessional collaboration and leadership. *Journal of Interprofessional Care*, 23(4), 320–330. <https://doi.org/10.1080/13561820902921811>
- Baruch, Y., & Holtom, B. C. (2008). Survey response rate levels and trends in organizational research. *Human Relations*, 61(8), 1139–1160. <https://doi.org/10.1177/0018726708094863>
- Bowling, A. (Ed.). (2000). Research methods in health. In *Investigating health and health services* (pp. 344–351). Open University Press.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Braun, V., & Clarke, V. (2022). *Thematic analysis. A practical Guide*. SAGE Publications Ltd.
- Burke, M., & Hodgins, M. (2015). Is ‘dear colleague’ enough? Improving response rates in surveys of healthcare professionals. *Nurse Researcher*, 23(1), 8–15. <https://doi.org/10.7748/nr.23.1.8.e1339>
- Caldwell, M. A., & Peplau, L. A. (1984). The balance of power in lesbian relationships. *Sex Roles*, 10(7–8), 587–599. <https://doi.org/10.1007/BF00287267>
- Clark, M., Rogers, M., Foster, A., Dvorchak, F., Saadeh, F., Weaver, J., & Mor, V. (2011). A randomized trial of the Impact of survey design characteristics on response rates among nursing home providers. *Evaluation & the Health Professions*, 34(4), 464–486. <https://doi.org/10.1177/0163278710397791>
- Council of Australian Governments (COAG). (2019). Woman-centred care. Strategic directions for Australian maternity services. Australian Government Department of Health. Retrieved November 1, 2019, from www.health.gov.au/sites/default/files/documents/2019/11/woman-centred-care-strategic-directions-for-Australian-maternity-services.pdf
- Creswell, J. W. (2009). *Research design: Qualitative, quantitative, and mixed method approaches* (Third ed.). Sage.
- D’Amour, D., Ferrada-Videla, M., Rodrigue, L. S. M., & Beaulieu, M. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical frameworks. *Journal of Interprofessional Care*, 19(sup1), 116–131. <https://doi.org/10.1080/13561820500082529>
- Downe, S., Finlayson, K., & Fleming, A. (2010). Creating a collaborative culture in maternity care. *Journal of Midwifery & Women’s Health*, 55(3), 250–254. <https://doi.org/10.1016/j.jmwh.2010.01.004>
- Elliott-Mainwaring, H. (2020). Who is ultimately responsible and accountable for patient safety in maternity services? *MIDIRS Midwifery Digest*, 30(2), 187–191.
- Eslinger, K. N., Clarke, A. C., & Dynes, R. R. (1972). The principle of least interest, dating behavior, and family integration settings. *Journal of Marriage and the Family*, 34(2), 269–272. <https://doi.org/10.2307/350797>
- Gray, B. (1985). Conditions facilitating interorganizational collaboration. *Human Relations*, 38(10), 911–936. <https://doi.org/10.1177/001872678503801001>
- Hansson, M., Lundgren, I., Hensing, G., & Carlsson, I.-M. (2019). Veiled midwifery in the baby factory — a grounded theory study. *Women & Birth*, 32(1), 80–86. <https://doi.org/10.1016/j.wombi.2018.04.012>
- Heatley, M., & Kruske, S. (2011). Defining collaboration in Australian maternity care. *Women and Birth: Journal of the Australian College of Midwives*, 24(2), 53–57. <https://doi.org/10.1016/j.wombi.2011.02.002>
- Henneman, E. A., Lee, J. L., & Cohen, J. I. (1995). Collaboration: A concept analysis. *Journal of Advanced Nursing*, 21(1), 103–109. <https://doi.org/10.1046/j.1365-2648.1995.21010103.x>
- Hirst, C. (2005). Re-birthing: Report of the review of maternity services in Queensland. Retrieved November 1, 2019, from www.health.qld.gov.au/_data/assets/pdf_file/0024/435660/maternityreview.pdf
- Hojat, M., Fields, S. K., Veloski, J. J., Griffiths, M., Cohen, M. J. M., & Plumb, J. D. (1999). Psychometric properties of an attitude scale measuring physician–nurse collaboration. *Evaluation & the Health Professions*, 22(2), 208–220. <https://doi.org/10.1177/01632789922034275>
- Hojat, M., Gonnella, J. S., Nasca, T. J., Fields, S. K., Cicchetti, A., Scalzo, A. L., Taroni, F., Amicosante, A. M. V., Macinati, M., Tangucci, M., Liva, C., Ricciardi, G., Eidelman, S., Admi, H., Geva, H., Mashlach, T., Alroy, G., Alcorta-Gonzalez, A., Ibarra, D., & Torres-Ruiz, A. (2003). Comparisons of American, Israeli, Italian and Mexican physicians and nurses on the total and factor scores of the Jefferson scale of attitudes toward physician–nurse collaborative relationships. *International Journal of Nursing Studies*, 40(4), 427–435. [https://doi.org/10.1016/S0020-7489\(02\)00108-6](https://doi.org/10.1016/S0020-7489(02)00108-6)
- IBM SPSS Statistics for Windows. (2013). *Version 22.0*. IBM Corp; Released.
- Jenkinson, B., Kruske, S., & Kildea, S. (2017). The experiences of women, midwives and obstetricians when women decline recommended maternity care: A feminist thematic analysis. *Midwifery*, 52, 1–10. <https://doi.org/10.1016/j.midw.2017.05.006>
- Jenkinson, B., Kruske, S., & Kildea, S. (2018). Refusal of recommended maternity care: Time to make a pact with women? *Women & Birth*, 31(6), 433–441. <https://doi.org/10.1016/j.wombi.2018.03.006>
- Karukivi, J., Leino-Kilpi, H., Kuokkanen, L., Kuusisto, H., Rautava, P., Seppänen, L., Sulosaari, V., & Stolt, M. (2023). Association between work empowerment and interprofessional collaboration among health care professionals working in cancer care settings. *Journal of Interprofessional Care*, 37(1), 21–28. <https://doi.org/10.1080/13561820.2021.1997949>
- Kirkup, B. (2015). The report of the Morecambe Bay Investigation.
- Kitson, A. L., Rycroft-Malone, J., Harvey, G., McCormack, B., Seers, K., & Titchen, A. (2008). Evaluating the successful implementation of evidence into practice using the PARIHS framework: Theoretical and practical challenges. *Implementation Science*, 3(1), 1. <https://doi.org/10.1186/1748-5908-3-1>
- Kruske, S., Young, K., Jenkinson, B., & Catchlove, A. (2013). Maternity care providers’ perceptions of women’s autonomy and the law. *BMC Pregnancy and Childbirth*, 13(1), 84–. <https://doi.org/10.1186/1471-2393-13-84>
- Lane, K. (2010). When is collaboration not collaboration? When it’s militarized. *Women & Birth*, 25(1), 29–38. <https://doi.org/10.1016/j.wombi.2011.03.003>
- Lane, K. (2012). When is collaboration not collaboration? When it’s militarized. *Women & Birth*, 25(1), 29–38. <https://doi.org/10.1016/j.wombi.2011.03.003>
- Malterud, K., Siersma, V., & Guassora, A. (2016). Sample size in qualitative interview studies. *The Qualitative Health Research*, 26(13), 1753–1760. <https://doi.org/10.1177/1049732315617444>
- McCormack, B. (2009). *Guide to using the context assessment index (CAI)*. Ulster University and University College Cork.
- McCormack, B., Kitson, A. L., Harvey, G., Rycroft-Malone, J., Titchen, A., & Seers, K. (2002). Getting evidence into practice: The meaning of ‘context’. *Journal of Advanced Nursing*, 38(1), 94–104. <https://doi.org/10.1046/j.1365-2648.2002.02150.x>
- McCormack, B., McCarthy, G., Wright, J., Slater, P., & Coffey, A. (2009). Development and testing of the context assessment index (CAI). *Worldviews on Evidence-Based Nursing*, 6(1), 27–35. <https://doi.org/10.1111/j.1741-6787.2008.00130.x>
- McIntyre, M., Francis, K., & Chapman, Y. (2012a). Primary maternity care reform: Whose influence is driving the change? *Midwifery*, 28(5), e705–e11. <https://doi.org/10.1016/j.midw.2011.08.004>
- McIntyre, M., Francis, K., & Chapman, Y. (2012b). The struggle for contested boundaries in the move to collaborative care teams in Australian maternity care. *Midwifery*, 28(3), 298–305. <https://doi.org/10.1016/j.midw.2011.04.004>
- Murray-Davis, B., Marshall, M., & Gordon, F. (2014). Becoming an interprofessional practitioner: Factors promoting the application of pre-qualification learning to professional practice in maternity care. *Journal of Interprofessional Care*, 28(1), 8–14. <https://doi.org/10.3109/13561820.2013.820690>
- NHMRC. (2010). *National guidance on collaborative maternity care*. NHMRC (National Health and Medical Research Council).

- NMBA. (2018a). *Nursing and midwifery board of australia (NMBA): Code of conduct for midwives*. Nursing and Midwifery Board of Australia.
- NMBA. (2018b). *Nursing and midwifery board of australia (NMBA): Professional Standards 2018*. Retrieved February 12, 2018, from <http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>
- Pomare, C., Long, J. C., Churruca, K., Ellis, L. A., & Braithwaite, J. (2020). Interprofessional collaboration in hospitals: A critical, broad-based review of the literature. *Journal of Interprofessional Care*, 34(4), 1–11. <https://doi.org/10.1080/13561820.2019.1702515>
- RCOG. (2016). *Providing quality care for women. A framework for maternity service Standards*. <https://www.rcog.org.uk/media/xt2fqcw0/maternitystandards.pdf>
- Reeves, S., Pelone, F., Harrison, R., Goldman, J., & Zwarenstein, M. (2017). Interprofessional collaboration to improve professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews*, 2018(8), 6. <https://doi.org/10.1002/14651858.CD000072.pub3>
- Reiger, K. (2000). The politics of midwifery in Australia: Tensions, debates and opportunities. *Annual Review of Health Social Sciences*, 10(1), 53–64. <https://doi.org/10.5172/hesr.2000.10.1.53>
- Reiger, K., & Lane, K. (2009). Working together: Collaboration between midwives and doctors in public hospitals. *Australian Health Review*, 33(2), 315–324. <https://doi.org/10.1071/AH090315>
- Smith, D. C. (2015). Midwife-physician collaboration: A conceptual framework for interprofessional collaborative practice. *Journal of Midwifery & Women's Health*, 60(2), 128–139. <https://doi.org/10.1111/jmwh.12204>
- Stake, R. E. (1995). *The art of case study research thousand*. Sage.
- Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, 27(2), 237–246. <https://doi.org/10.1177/1098214005283748>
- Van Wagner, V. (2016). Risk talk: Using evidence without increasing fear. *Midwifery*, 38, 21–28. <https://doi.org/10.1016/j.midw.2016.04.009>
- Victorian Government, State of Victoria, Department of Health and Human Services. (2019). *Capability frameworks for Victorian maternity and newborn services*. Retrieved December 1, 2024, from www.health.vic.gov.au/hospitals-and-health-services/patient-care/perinatal-reproductive/maternity-newborn-services/maternity-newborn-care
- Watkins, V., Nagle, C., Kent, B., & Hutchinson, A. M. (2017). Labouring together: Collaborative alliances in maternity care in Victoria, Australia—protocol of a mixed-methods study. *BMJ Open*, 7(3), e014262–e. <https://doi.org/10.1136/bmjopen-2016-014262>
- Watkins, V., Nagle, C., Kent, B., Street, M., & Hutchinson, A. M. (2022). Labouring together: Women's experiences of “getting the care that I want and need” in maternity care. *Midwifery*, 113, 103420. <https://doi.org/10.1016/j.midw.2022.103420>
- WHO. (2022). WHO recommendations on maternal and newborn care for a positive postnatal experience. Retrieved December 1, 2022, from <https://iris.who.int/handle/10665/352612>
- Wood, D., & Gray, B. (1991). Toward a comprehensive theory of collaboration. *The Journal of Applied Behavioral Science*, 27(2), 139–162. <https://doi.org/10.1177/0021886391272001>
- World Health Organization. (2015). *WHO recommendations on health promotion interventions for maternal and newborn health*. WHO Press.
- Yin, R. K. (2009). *Case study research designs and methods* (Fourth ed.). Sage Publications.

Appendix

Appendix 1: Semi-structured interview guide

Question	
1	In the course of a typical day, with which groups of HCP or women do you interact in the provision of maternity care?
2	What do you understand by the term “collaboration” in maternity care?
3	How do you participate in collaboration in maternity care in your current practice?
4	What conditions do you consider helpful for successful collaborative maternity practice?
5	What conditions do you consider are barriers to collaborative maternity practice?
6	What advantages are there for you (as an individual) to participate in collaborative maternity practice?
7	What disadvantages are there for you to participate in collaborative maternity practice?
	If disadvantages identified: In light of these disadvantages, what motivates you to continue to participate in the collaborative maternity team?
8	What are advantages or disadvantages of collaborative maternity practice overall?
