Nurses' Perceptions of Interprofessional Teamwork in Labour and Delivery

by

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Abstract

Within healthcare today, teams and teamwork have been rapidly implemented with the belief that they are capable of improving outcomes for patients, staff and the organization. However, there are also differing understandings of what teamwork means amongst healthcare providers because of differences in professional culture that influence effectiveness. In labour and delivery, it is critical that nurses and physicians work well together as part of an effective team in order to provide safe and ethical family centered maternity care. This study was a focused ethnography that examined the perceptions of nurses working in labor and delivery to understand, from their perspective, the characteristics of interprofessional teamwork, especially with physicians, and the features that facilitate or impede its effective functioning. Interviews were conducted with 10 labor and delivery nurses and time was spent observing their work and interprofessional interactions. These nurses identified relationships as a key factor in effective teamwork. Nurses also acknowledged working in a normative hierarchy, with physicians ultimately responsible for patient care decision making. These nurses navigated the traditional power structure in familiar ways by acknowledging their own autonomy when the physician was absent, by using tactical communication and by their control over certain unit resources, including new resident learning and socialization. Nurses described a very small cluster of physicians that inappropriately assert power over them, residents and their patients through the use of disrespectful behaviors. As a result, these nurses described the myriad of ways that they work to smooth and preserve the functioning of the working relationship, mainly by circumventing disrespectful behaviors and venting. Nurses revealed the major facilitators of their working relationships with physicians as

time, trust and respect, credibility and social connection. The attainment of practice knowledge, as rooted in the medical aspects of care, emerged as being a major facilitator of trust and respect in this workplace. Positive relationships with physicians influenced intent to stay, workplace morale, the perception of healthy communication and good patient outcomes. Negative or unestablished relationships were perceived as having the opposite effect. This research has implications for management efforts to support and develop teamwork. The findings may also provide nurse educators with insights to better prepare nurses for interprofessional working environments.

Preface

This thesis represents an original work by Megan Dorothy Gleddie completed as part of a research project that received ethical approval from the University of Alberta Health Research Ethics Board, Nurses Perceptions of Interprofessional Teamwork in Labour and Delivery: An Exploratory Study, Pro00050420, December 4, 2014.

Study design, data collection, analysis and thesis composition was led by Megan Gleddie and supervised by Dr. Sarah Stahlke and Dr. Pauline Paul. The manuscript that appears in Chapter 3 will be submitted to *Qualitative Health Research* to be considered for publication as co-authored by Megan Gleddie, Dr. Sarah Stahlke and Dr. Pauline Paul. I was responsible for the data collection, analysis as well as the manuscript composition. Dr. Sarah Stahlke provided assistance with concept formation and was involved in manuscript edits. Dr. Pauline Paul also provided guidance with concept formation and manuscript edits.

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Table of Contents

Chapter One

Introduction to the Thesis

This study investigates nurses' perspectives of interprofessional teamwork when working with physicians in labour and delivery. It is timely given the rapid adoption and promotion of teamwork in healthcare settings that is believed to be the answer to improving patient care outcomes, staff morale and organizational efficiency. This is despite documented differences in healthcare provider attitudes about teamwork and known differences in professional culture as emanating from their origins, which raises issues related to power, status, knowledge and gender. This study adds a perspective to the teamwork literature that has been relatively unacknowledged until now. Further, individual provider perspectives have also been less visible. These nurses represent one professional group in healthcare whose perspective must be acknowledged in order for true interprofessional teamwork to be realized.

Organization of Chapter and Thesis

This thesis follows a paper-based format. Contained within is one publishable paper that reports on the major findings of this research (Chapter Three). The introductory chapter explains the background, significance, method and research question. The second chapter contains a literature review that was conducted prior to commencing research in the field. The gaps identified in the literature helped shape how this research project was designed. The concluding chapter outlines the substantive and methodological contributions of this research study and contains recommendations for further research. In addition, this study's limitations are discussed followed by what are believed to be the major implications for nurses, administrators and educators. The plans

for knowledge translation are presented along with future questions. A number of appendices follow the concluding chapter, adding further detail to the documents described in the method section.

Background

Obstetrical nurses are believed to be working as part of an interprofessional team in the provision of family-centered care. However, in healthcare, the nature of teams and teamwork remains an elusive concept (Bleakley, 2013). Within the patient safety literature, healthcare team processes have been elevated to embody "an interprofessional collaborative, with the first term alluding to an integration of two or more professional cultures operating transdisciplinary and the second encompassing concepts of sharing, partnership, interdependency, power and process" (Canadian Patient Safety Institute [CPSI], 2011, p. 3). Professional cultures such as nursing, midwifery and medicine all have distinct knowledge, beliefs, attitudes and values that can interact as a barrier to interprofessional teamwork (Hall, 2005). Issues of class, gender, knowledge and power have been identified to affect nursing's influence within the healthcare system (Ceci, 2004a; Ceci, 2004b; Stein-Parbury & Liashenko, 2007). It stands to reason that these same issues influence the nurse's ability to participate fully as a member of the interprofessional team (Storch & Kenny, 2007).

To date, much of the research conducted has focused on the 'team' as the level of analysis with little attention paid to understanding the individual perspectives of those working within them. Moreover, only a very small body of research has applied a critical lens to understanding nurses' work experiences (Wall, 2010). Thus, this study will examine the perceptions of nurses working within the interprofessional team in labour

and delivery using a critical lens in hopes of understanding, more fully from a nursing perspective, what is happening within it.

Within labour and delivery, nurses share a close, intimate relationship with the patient and family in their birthing experience. They can be the first to identify issues, evaluate and negotiate care, and summon additional members of the healthcare team as needed (Lyndon, 2006). Thus, they are an integral part of the team in the provision of safe, ethical and supportive care in a hospital labour and birth unit (Lyndon & Powell Kennedy, 2010; Simmonds, Peter, Hodnett & McGillis Hall, 2013).

Teams and teamwork in healthcare have been broadly implemented and are believed to promote good outcomes for patients and the organization alike. Effective teamwork is thought to be a better way to care for complex patient needs and to improve patient outcomes overall (Reeves, Lewin, Espin & Zwarenstein, 2010). For the organization, teams and teamwork promise to maximize efficiency and effectiveness, despite a healthcare environment with limited ability to infuse any added resources (Reeves et al., 2010; Suter et al., 2012). Ineffective teams, on the other hand, can compromise patient safety and quality of patient care (Barrett, Curran, Glynn & Godwin, 2007; Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2004).

Effective interprofessional teamwork is also viewed as being beneficial for nurses, specifically, with respect to promoting their health and improving job satisfaction and retention (Camerino et al., 2008; Canadian Health Services Research Foundation [CHSRF], 2006; Canadian Institute for Health Information [CIHI], 2005; Jolivet et al., 2010; Sherehiy, Karwowski & Marek, 2004). The connection between nurses'

perceptions of interprofessional teamwork and patient quality of care has been established (Kenaszchuk, Wilkins, Reeves, Zwarenstein & Russell, 2010).

Many solutions have been implemented in healthcare to mitigate deficiencies in teamwork including interprofessional education (IPE) and systematic processes, such as standardized checklists and communication tools, to improve patient and organizational outcomes (CPSI, 2011). While they are important and worthwhile attempts, they do little to address the root cause of ineffective team functioning as it relates to formally identified and ongoing issues of hierarchy, fear and intimidation within obstetrics (JCAHO, 2004). Some studies demonstrate the moral distress and feelings of stigma and blame nurses continue to experience working in this context specifically (Simmonds et al., 2013; Waters, Hall, Brown, Expezel & Palmer, 2012). In addition, relational problems between physicians and nurses puts patients in potentially unsafe and unethical situations, which may result in harm (Jacobson, Zlatnik, Powell Kennedy & Lyndon, 2013).

Nurses' effective participation in the interprofessional team in labour and delivery is a valuable resource that impacts patient safety, nursing quality of care and the health of the work environment for nurses (Kenaszchuk, et al., 2010). The findings from this study could be used to generate understanding of what must be acknowledged about working professional groups before effective teamwork can be expected and experienced amongst all healthcare providers. In this study, the unique experiences of nurses were uncovered. The organization will benefit by having a fuller understanding of how to address ongoing patient safety and workplace health issues. Nurses will benefit from understanding their own level of participation in the interprofessional team and what they might do to negotiate change (Wall, 2010).

Research Question

The primary research question guiding this study was formulated to understand nurses' experiences or perspectives when working with physicians as part of an interprofessional team in labour and delivery. More questions were formulated to understand what nurses think, believe, value and to understand how they behave when working as part of a team in labour and delivery. The research questions are:

- What are nurses' perspectives of teamwork when working with physicians in labour and delivery
- What is the nature of nurses' relationships with physicians?
- What kinds of knowledge are utilized within the team?
- What makes it difficult or easy to work as part of a team?
- What is the role of nurses on the team?
- What are the experiences that have prepared them to work as part of a team with physicians?
- What constitutes good teamwork?
- When poor teamwork occurs, what is happening within the team?

Definition of Terms

An interprofessional team is defined for this study as: Two or more healthcare professionals with various levels of hierarchy, experience and expertise who work together on the labour and delivery unit to care for women during labour, birth and the immediate post-partum period (Burford, 2012; Janss, Rispens, Segers & Jehn, 2012).

Method

A qualitative study was conducted using focused ethnography to guide a critical exploration of nurses' perceptions of interprofessional teamwork with physicians in labour and delivery. What follows is a brief description of focused ethnography and its main tenets followed by a synopsis of the research plan as it unfolded in the setting including obtaining ethics and operational approval and recruitment of the study participants. In addition, a description of the sample is provided along a synopsis of the methods used to collect, store and analyze the data. A discussion of how rigour was maintained is included alongside the data analysis.

Ethnography and Focused Ethnography

Focused ethnography is part of the larger tradition of social ethnography. Like its larger counterpart, it suitably, "generates or builds theory of cultures or explanations of how people think, believe or behave", which are "situated in local time and space" (LeCompte & Schensul, 2010, p. 12). Further, focused ethnography is described as being problem oriented or 'applied' in nature. That is, it focuses on one aspect or theme within a community as opposed to describing the whole community, for which traditional ethnography is most known (De Munck, 2009). This one aspect or theme of interest to the researcher is a socially embedded phenomenon, observed in the actions, interactions and communications of the participants as a collective (Knoblauch, 2005). It stands to reason that, like traditional ethnography, focused ethnography is capable of illuminating that which is culturally or collectively believed within the group and whether these beliefs or understandings are acted upon or rejected in real life (LeCompte & Schensul, 2010). Ethnography is also recognized for being particularly useful for the study of work,

specifically as it is "positioned to detect how power is exercised, control asserted and maintained, conflict and resistance expressed and social inequalities manipulated and recreated", which was a major focus of this study (Smith, 2007, p. 224). In focused ethnography, the researcher's sole purpose is to authentically represent the cultural perspective on the phenomena of interest, also known as the emic perspective, which is unique to ethnographic research (Roper & Shapira, 2000; Fetterman 2010; LeCompte & Schensul, 2010). By studying a specific theme in the context where it emanates over time, the researcher is able to gain an informed and in-depth perspective (Higginbottom, Pillay & Boadu, 2013). In focused ethnography, the researcher's background knowledge and experiences are welcomed as part of 'knowing something' about the context wherein the research is taking place and the specific social phenomena under investigation (Knoblauch, 2005). As such, the researcher can come to a quicker understanding of who the "key informants" are within the group. Thus, the time for data collection and engagement in focused ethnography is significantly shorter than for traditional ethnography (Higgenbottom et al., 2013).

Methodologically, focused ethnography helped achieve the research purpose of gaining an in-depth understanding of what nurses' think, believe, how they contribute and what they value in regards to interprofessional teamwork in labour and delivery. It was determined to be well suited to explore how issues of professional culture, power, knowledge and gender intersect and are embedded within their interactions and communications with other team members, namely physicians.

Ethics, Operational and Site Approval

Ethical approval for this study was obtained from the Health Research Ethics Board (HREB) at the University of Alberta on December 4, 2014. Operational approval was requested through the Northern Alberta Clinical Trials and Research Centre (NACTRAC) and granted by the appropriate authorities within Alberta Health Services. Approval for the site was granted by the Executive Director of the facility involved. This individual requested an informal meeting occur to introduce the study and obtain approval from the individual managers allowing access to the Birthing Unit, which was granted. The Birthing Unit was accessed to recruit study participants on February 5, 2015.

Recruitment

Recruitment took place on the Birthing Unit via information sessions, poster advertisement and an information letter. Three information sessions were conducted during shift changes just before formal report was given. Information letters (Appendix B) were left on the unit in the break room. A poster (Appendix A) was given to the unit manager to display in the nurses' lounge for those who were not present during these shift change sessions. In addition, my information letter (Appendix B) was circulated by the nurse manager through the work email to let the nurses know about my presence on the unit. My aim during the information sessions and within my information letter was simple. I articulated the purpose of the study as well as my background and interest in conducting it. I also communicated what would happen with the findings afterwards. Potential participants were made aware that participation in the study was voluntary and in no way tied to their employment. In all instances, nurses were provided with my contact information to privately indicate their wish to be part of the study. Registered

nurses with at least three months' experience on the unit were invited to be a part of the study, recognizing that time would be needed after starting on a new unit to become aware of the culture. Nurse participants were also encouraged, at the end of their interviews, to share information about how to become part of the study with another colleague if they believed they had relevant experiences to share (snowball sampling).

Formal consent for nurse participants was obtained prior to interviewing. A number of things were done as part of this process including asking them to read through an attached letter (Appendix B) which outlined the background, study purpose, their participation including a description of the observation portion of the study, benefits, risks and how their privacy would be maintained. After reading the letter, participants answered a series of questions to ensure they understood their consent to participate voluntarily in the research and address any questions they had (Appendix B). Participants were also aware that the data from the study would be kept in a de-identified form in the University of Alberta repository indefinitely and that it could be used again at a future date. A copy of the letter and signed consent form was left with the participant and a copy of each was taken by the researcher to store securely in a locked drawer in my supervisor's office as per HREB protocol.

Although there was no active recruitment of physicians for this study, it was acknowledged that they may inadvertently be included as part of the observations when interacting with nurses on the unit. It was determined through ethics application that formal individual consent was not required. Instead, an information letter (Appendix C) was given to the unit manager for circulation to all physicians, residents and obstetricians to make them aware of the study. The letter specifically outlined what observations I

would be making in regards to nurse-physician interactions. Instructions were also given in the letter that if they did not want to be observed they could let me know and that any observations made would be stricken from the data. I received no objections to during my observational sessions. I also made a point of introducing myself to as many physicians as possible when on the unit to remind them of the study. No physicians were interviewed for the study.

Data Collection

Data were gathered from three sources in this study, including semi-structured interviews, participant observation and review of pertinent administrative documents. All interviews were conducted in a private setting of the participants choosing, using a semi-structured interview guide (Appendix D). Each interview lasted approximately 60 minutes and all were audio recorded with permission. Four, four-hour participant observations sessions were conducted at the unit desk and captured participants' interactions over various shifts. The role of the researcher during these sessions was purely observational (O'Reilly, 2012). Field notes were generated within 24 hours of conducting each session with special attention to documenting the space, actors, activity, objects, acts, events, time, goal and feelings (Spradley, 1980). Administrative documents, memos and posters deemed relevant to the research question were reviewed during the observational times. Field notes were also generated using a framework to ensure collection of data relevant to the research question (source Solina). Nurse participants were asked about policies, protocols, memos, posters or other administrative resources they utilized or were familiar with in this regard. Bulletin boards were also scanned for

pertinent documents. Data collection and analysis was conducted iteratively with the assistance of memos and field notes generated.

Data collection and recruitment ceased when saturation was achieved, which was the point where no new themes were emerging from the data (Roper & Shapira, 2000). Recruitment and data collection were limited in the setting due to the burden that the researcher's presence placed on an already busy and very private unit. All interviews were conducted between February 1 and March 30, 2015. Observations were also completed over a two-week period during this time.

Detailed field notes were also generated at the conclusion of most interviews to record non-verbal responses to questions or impressions of the researcher during the interview process. Memos were also generated periodically to record inferences and overall impressions about the major themes being discovered. A personal journal was kept to record my emotions and feelings during the data collection and analysis process.

Data Analysis and Rigour

All documents, transcripts and field notes, were analyzed using standard ethnographic techniques involving coding, sorting and abstraction to the level of connecting the ideas with current theory (Roper & Shapira, 2000).

Morse, Barrett, Mayan, Olson and Spiers (2002) speak to the importance of ensuring rigor as a mindset to be evident in the very design of the research proposed. Moreover, the design should articulate how the credibility, confirmability, dependability and transferability of the research endeavor will be guaranteed, making its articulation at the conclusion of the research endeavor a matter of follow through (Lincoln & Guba, 1985). A number of techniques were employed to help ensure each of the criteria

indicated. Triangulation and peer debriefing help to enhance the credibility or 'truthfulness' of the findings (Lincoln & Guba, 1985). The strength in having three data sources to understand nurses' experiences of interprofessional teamwork is that credibility is enhanced. Also, peer debriefing by my experienced supervisors during our semi-regular meetings helped to ensure that the iterative process of data collection, analysis and confirmation of findings with my participants was being executed in a fashion that was consistent with the methodological tenets of focused ethnography.

Confirmability of the research is important to ensure that the findings are indeed representative of the participant's experiences and not simply researcher bias (Lincoln & Guba, 1985). Reflexivity on the part of the researcher throughout the research process is important (O'Reilly, 2012). I kept a personal journal to reflect on personal biases, beliefs, preconceived ideas or feelings I had during this endeavor. I am an experienced labour and delivery nurse and my professional experience was helpful to discern relevant elements of the context and to interpret the data collected in this setting. However, I was also aware that my familiarity with labour and delivery nursing could make it possible for me to overlook important aspects of these nurses experiences. I took care to guard against this (Roper and Shapira, 2000). At many points during data collection and analysis, I actively reflected on these biases in addition to purposely asking questions of the data in order to ensure my findings were truly representative of what these nurses were saying. In addition, I was able to keep an audit trail which consisted of decisions and conclusions I was making about the data in the form of memos, drafts documenting the development of ideas of the findings and feedback received from my supervisors, which demonstrate what Knoblauch (2005) recognizes as "data sessions." Here my interpretation of the

findings was opened up to my supervisors who gave feedback in relation to ensure my coding, categorizing and patterning were similar to the way that they would approach that data, enhancing the confirmability of the findings. Dependability was also ensured via this process as well.

Lastly, transferability of the findings was attended to by ensuring the appropriate scope and depth of nurses' experiences of interprofessional teamwork was discovered (Lincoln & Guba, 1985). The iterative and cyclic protocol for data collection and data analysis through the use of memos and field notes helped to ensure the findings were going deep enough and not too thin (Morse, 1994). I had some assistance with this as well by my supervisors who were able to confirm that I was going far enough in my analysis and able to suitably ground my findings in current theory (Morse, 1994).

Data Management and Security

Privacy and anonymity of all the participants was given top priority. To maintain security, all audio files and field notes generated were uploaded immediately into the University of Alberta data repository. All audio files were transcribed verbatim therein and all identifying information, including names, places and institutional names were removed from the data. Pseudonyms, known only to the researcher, were assigned to the participants to protect their identities.

All contact information was stored securely a separate locked drawer of my supervisors office. At the conclusion of the active phase of study was disposed as per HREB protocol. De-identified data from this study will be kept indefinitely in the University of Alberta health research data repository (HRDR).

Sample and Site

Ten registered nurses agreed to be interviewed regarding their views on interprofessional teamwork with physicians in labour and delivery, which was congruent with the number of 10-15 projected at the beginning of the study (Polit, Beck & Hungler, 2001).

All participants were female with the majority representing a younger cohort. Three participants were between the ages of 20 to 25 years; three between the ages of 26 to 30 years; two between the ages of 31-35 and two greater than 36 years of age. Most of the participants indicated a Bachelor's degree as their highest level of education (n=9). Two nurses indicated that they were diploma prepared to practice. One participant indicated that she was working on completing a graduate degree. About half of the nurses interviewed indicated that they had completed other education prior to entering their nursing program. Similarly, about half indicated that they started their careers in other contexts prior to settling in labour and delivery. Experience levels matched what would be expected from interviewing a predominantly younger group of nurses. Five participants had less than five years of experience as a Registered Nurse. Three participants had between six to 10 years and two had greater than 10 years of experience.

The unit is a very busy labour and delivery located in the heart of a large metropolitan area within Western Canada. The unit accepts cases of the highest acuity from its surrounding areas with well over 5,000 deliveries per year. Many specialists for both for the mother and the neonate are accessible within this context. Nurses describe themselves as potentially working with a wide range of healthcare professionals depending on the needs of the mother or the fetus/neonate. Specifically, they describe

different physician groups who might be involved in their cases including family doctors, obstetricians, anesthesiologists, obstetrical medicine specialists, perinatologists or neonatologists. There are also many groups of residents including obstetrical residents, off-service, anesthesiology and medical students. When describing "the team" in labour and delivery, the nurses interviewed all listed their nursing colleagues, the charge nurse, residents, physicians and obstetricians to be the most obvious. Most expanded their accounts to include the larger "team" to include other healthcare professionals observed on their unit including, the unit clerks and housekeeping staff, neonatal nurses, management, respiratory therapists and other healthcare professions. Midwives and doulas came to the unit periodically to deliver their clients as well.

Nurses on the unit work a combination of eight-hour day, evening or night shifts. Most of the rotations of the interviewees were described as a day-night or a day-evening schedule. As such, nurses described consistency and familiarity in working with many of the same nurses.

There are three parts that make up labour and delivery for the nurses on this unit including the assessment room, case room and the operating room. Nurses find out where they are assigned to work at the beginning of their shift. Only some of the nurses interviewed were operating room trained. Likewise, only a few of those interviewed were currently eligible to be assigned to the charge nurse role. In the assessment room, nurses work closely with residents to assess and triage outpatients. Inductions are also started on this side. When a woman is determined to be in active labour or in situations in which her delivery needs to be expedited due to complications, she is admitted to case room. Within

case room, there are 14 labour and delivery rooms. After delivery, patients are transferred, once stable, to a separate postpartum unit.

At the time of conducting this study, many of the nurses interviewed remarked about the number of obstetrical emergencies that had occurred on the unit within the few months prior to conducting the interviews. Nurses describe the outcome of these cases to be stressful for them personally and for the unit. Many of the nurses interviewed, including a veteran nurse, described the enduring emotional impact of these kind of cases.

In this context, nurses work closely with residents and medical students to care for patients in case room. Residents can be divided into two groups, obstetrical residents and off service residents. Obstetrical residents are given an official title based on their year of residency. Hence, an R1 is in the first year and R5 would be in their fifth year of the program. In the data, nurses primarily talked about obstetrical residents and their year of residency and off-service residents.

On any given shift there is both a high risk and a low risk obstetrical resident assigned to the unit in addition to any other medical residents, students and off service residents. In the assessment room and on admission, the case room nurse completes a patient history prior to either the high or low risk resident coming and completing their own history. This resident then approaches the obstetrician to arrange or confirm the ordered plan of care. Similarly, when a concern arises about patient or fetal well-being, the case room nurse summons the resident or students and other residents through the charge nurse to come to the unit and assess the patient. In the case of a family doctor, nurses have a more direct role in speaking with and negotiating the plan of care with the physicians themselves.

Five administrative documents were reviewed, including three posters, one policy and one binder containing individual physician preference sheets. Although these documents were not directly relevant to understanding nurses' perspectives of interprofessional teamwork with physicians, they did provide a deeper understanding of the organizational environment that these nurses worked in.

Chapter Two

Literature Review

A formal literature review was conducted prior to embarking on this study. The search strategy was devised in coordination with a University of Alberta Health Sciences librarian that included the databases CINAHL, MEDLINE and SCOPUS. The main search terms included team or team*, interprofessional, interdisciplinary, multidisciplinary, transdisciplinary, cross disciplinary, nurse-physician relations, nurse-physician relationship, communication, interprofessional relations, patient safety, hierarchy or power, labour and delivery, or obstetrics or maternity or perinatal. These terms were searched individually and in various combinations. Due to the broad understanding of teams within and across contexts in healthcare, the titles of articles were reviewed individually and limited to the acute care context. Only research articles written in the English language were included for review. What follows then is a synopsis of where research involving nurses and teamwork has taken place, the design of the research that has been conducted, the participants and the quality. In addition, what is broadly understood in the literature about nurses and teamwork, nurse-physician relationships and teamwork, nurse physician communication, nurses' role on the team, professional culture, knowledge, power and gender and teamwork is presented. A number of gaps were identified that not only confirmed the need for my research but also helped provide direction for its design.

Contexts of Previous Research

Research capturing nurses' perceptions of interprofessional teamwork has primarily been conducted in acute contexts outside of labour and delivery. With the

exception of two studies (Lyndon, 2006; Sexton et al., 2006), the remainder have been conducted in intensive care (Jensen, Ammentorp, Erlandsen & Ording, 2011; Paradis et al., 2013; Piquette, Reeves & Leblanc, 2009), the medical-surgical ward (Nelson, King & Brodine, 2008; Reeves & Lewin, 2004; O'Leary et al., 2010), emergency department (Simmons & Sherwood, 2010), neonatal intensive care unit (Simmons & Sherwood, 2010; Thomas, Sherwood, Mulhollem, Sexton & Helmreich, 2004), critical care (Thomas, Sexton & Helmreich, 2003), the operating room (Carney, West, Neily, Mills & Bagian, 2010; Fleming, Smith, Slaunwhite & Sullivan, 2006; Makary et al., 2006; Sherry, 2008; Wauben et al., 2011) and within in generalized acute settings (Atwal & Caldwell, 2006; Chang, Ma, Chiu, Lin & Lee, 2009; Hojat et al, 2003; Hughes & Fitzpatrick, 2010; Garber, Madigan, Click & Fitzpatrick, 2009).

Although the majority of research has been conducted in the United States (n=12), a smaller number of the studies have been conducted in Taiwan (Chang et al., 2009), the United Kingdom, Holland and Canada (Atwal & Caldwell, 2006; Jensen et al., 2011; Reeves & Lewin, 2004; Wauben et al., 2011). One study explored the perceptions of teamwork among nurses and physicians cross culturally comparing numerous contexts internationally (Hojat et al., 2003). To date, only two studies revealing perceptions of nurses involved in interprofessional teamwork have been conducted in the Canadian context (Fleming et al., 2006; Piquette et al., 2009).

Participants, Unit of Analysis and Methods

The participants of most of the studies included primarily nurses and physicians. Appropriate to the context studied, there are different types of nurse providers (i.e. theatre nurses) and physician providers included in the samples. Often no distinction was made

within the studies as to whether the participants were registered nurses or if licensed practical nurses were included as well. Other participants included anesthetists, certified nurse anesthetists, surgical technicians, fellows, respiratory therapists, social workers and therapy workers, residents and unit clerks. Among nurse and physician participants across studies, there is a marked difference in the populations with regards to gender. Nurse samples are proportionately dominated by females and physician samples predominately male, including the obstetrical study reviewed (Sexton et al, 2006). However, in other contexts, male nurses make up an increased percentage of the sample in comparison to nurse samples in labour and delivery (Carney et al., 2010; Hughes & Fitzpatrick, 2010).

In reference to the methods used, the majority of studies utilized descriptive cross sectional survey designs. These studies yielded differences between the professions' ratings of teamwork climate or attitudes toward teamwork and collaboration using validated survey instruments (Carney et al., 2010; Chang et al., 2009; Fleming et al., 2006; Garber et al., 2009; Hojat et al., 2003; Hughes & Fitzpatrick, 2010; Jensen et al., 2011; Makary et al., 2006; Nelson et al., 2008; O'Leary et al., 2010; Sexton et al., 2006; Thomas et al., 2003; Wauben et al., 2011). Most of these studies were limited in their ability to produce generalizable findings due to small sample size or lower response rates. However, it is worth taking note of results that were similarly demonstrated in so many different contexts.

There were two scoping studies included in this review. The first examined gaps in the literature around the role of assertion, teamwork and the application of aviation theory and mechanistic processes in labour and delivery (Lyndon, 2006). There were 13

studies included in total, five of which were studies on teamwork, communication and safety attitudes in aviation; 2 studies comparing factors in aviation and healthcare and six studies about nurses' assertiveness and decision making. Overall, the quality of this study is believed to be reasonable given the clear research question, and the presentation of a systematic and repeatable method of determining articles for inclusion and analysis. It is unclear, however, whether additional people were involved during the inclusion/exclusion process.

The second scoping review sought to consolidate the ethnographic research conducted in adult intensive care units (Paradis et al., 2013). Using the conceptual framework of interprofessional teamwork first proposed by Reeves et al. (2010), 16 studies were reviewed to understand the current influence of relational, processual, organizational and contextual factors. They noted how processual (space and time) and relational factors have been well explored while organizational and contextual factors have been less emphasized (Paradis et al., 2013). From a quality perspective, this study demonstrates a clear and comprehensive research question, a pre-defined protocol with demonstration of a systematic and repeatable process for including and excluding available research.

Lastly, there were six qualitative studies examining healthcare professionals' perceptions about teamwork. Due to their methodological design, three of the studies integrated interviews and participant observations (Atwal & Caldwell, 2006; Reeves & Lewin, 2004; Sherry, 2008). Many of the studies incorporated interviews with multiple members of the healthcare team (Piquette, Reeves & Leblanc, 2009; Reeves & Lewin, 2004; Sherry, 2008; Thomas et al., 2004) and only two of the studies offered the

exclusive perceptions of the nurse about interprofessional teamwork (Atwal & Caldwell, 2006; Simmons & Sherwood, 2010). Specifically, Atwal and Caldwell (2006) interviewed and observed orthopedic, medicine and elder care nurses in one British hospital about their perceptions of interprofessional teamwork. Simmons and Sherwood (2010) explored emergency and neonatal intensive care nurses perspectives about working together interprofessionally in their respective contexts. This study was a secondary analysis of the findings from a larger qualitative study involving the other members of the interprofessional team.

Overall, just two of the studies were able to demonstrate sound qualitative design and execution (Piquette et al., 2009; Reeves & Lewin, 2004). The others were not explicit whether or not saturation had occurred or if data collection and analysis occurred iteratively (Atwal & Caldwell, 2006; Simmons & Sherwood, 2010; Sherry, 2008).

Nurses and Teamwork

There are differing understandings of what teamwork means amongst healthcare providers (Thomas et al., 2004). Although individual personality traits can be influential, a number of studies establish significant differences amongst different care provider types regarding perceptions about teamwork and collaboration (Garber et al., 2009; Hughes & Fitzpatrick, 2010; Reeves & Lewin, 2004). Where most healthcare providers believe collaboration to be an interprofessional endeavor, physicians, in contrast, describe professional exclusivity (Reeves & Lewin, 2004). Professional differences in attitudes toward teamwork are also noted. Specifically, amongst nurses and physicians exclusively, nurses were more inclined toward the idea of working interprofessionally as part of team as compared to physicians (Garber et al., 2009; Hughes & Fitzpatrick, 2010). Hojat et al.

(2003) found that this gap between physicians and nurses to be more profound in countries in which a more collaborative working relationship was expected, such as in the United States.

In general, multiple studies demonstrate a significant discrepancy in current perceptions of levels of teamwork and collaboration (Carney et al., 2010; Jensen et al., 2011; Makary et al., 2006; O'Leary et al., 2010; Thomas et al., 2003; Wauben et al., 2011). Specifically, while physicians rate levels of teamwork with nurses to be good, nurses rate their interactions with physicians to be significantly less satisfying across multiple contexts. This finding is consistent within the context of labour and delivery where physicians and nurse managers were much more satisfied with current interprofessional teamwork than the nurses surveyed (Sexton et al., 2006). Discrepant attitudes about teamwork were not just a function of caregiver role but differences were noted between the hospital delivery wards surveyed suggesting that unit culture was also a significant factor (Sexton et al., 2006).

Two studies gave voice to nurses' descriptions and expectations of teamwork (Piquette et al., 2009; Simmons & Sherwood, 2010). Sharing a common goal with other healthcare providers and establishing a mutual respect for others' expertise and contributions was common to both studies and important to nurses working interprofessionally. In addition, good communication, developing and maintaining positive relationships and a flattened hierarchy between providers was viewed as being necessary for good teamwork to occur (Simmons & Sherwood, 2010). However, the problematic nature of the nurse-physician relationship, impaired communication and the dynamics of power are all recognized as barriers to interprofessional teamwork and are

well documented in this body of literature (Atwal & Caldwell, 2006; Carney et al., 2010; Lyndon, 2006; O'Leary et al., 2010; Sherry, 2008; Thomas et al., 2003; Thomas et al., 2004; Wauben et al., 2011).

Nurse-Physician Relationship and Teamwork

The exact nature of the nurse-physician relationship remains the object of many years of speculation and debate. Stein's (1967) pivotal work first described the doctor nurse relationship as a game with the object of ensuring the preservation of a social order.and avoiding conflict. Recommendations from nurses over patient care were expected for physicians to make decisions but they were to be presented subtly so as not to usurp physician authority. Both parties were rewarded if the game was executed well (i.e. presenting themselves as a well-functioning team). Doctors had a reliable informant while nursing experienced approval and legitimacy. Citing the numerous social changes since the 1960s, Stein, Watts and Howell (1990) revisited the original game theory and concluded that nurses were no longer interested in playing. It has been asserted that, by nursing's will to change the relationship, the two professions are now more apt to relating interdependently and collaboratively (Stein, Watts & Howell, 1990). However, many question whether nursing has actually been able to achieve the interdependency desired (Tosh, 2007). Still, others believe that the game is still being played but on a more subversive and subtle plane than was originally described which, perhaps is exposing denial about the underlying issues that continue to thwart nurses and physicians working relationships (Holyoake, 2010; Manias & Street, 2001; Tosh, 2007). In contrast, rather than understanding the relationship as a game and applying simplistic understandings of medical dominance, Svensson (1996) first proposed that nurse- physician interactions

could be better understood as a negotiated order. Negotiated order theory, as first conceptualized by Strauss (1978) posits that what is accomplished within an organization is primarily the result of negotiation among actors. Likewise on wards, nurse-physician interactions can also be understood as negotiations set in the context of a larger organizational social structure (Svensson, 1996). Svensson concluded based on interview data that the nature of nurse-physician relationship had changed; nurses now reported their communication with physicians as "straightforward and open" (Svensson, p. 383). In contrast, Allen (1997) found interprofessional tension and discord widespread amongst individual doctors and nurses, yet this tension did not reveal itself observationally in the day-to-day workings on the unit she studied. Instead, nurses utilized work-arounds and "boundary blurring" that was clearly non-negotiated. Nurses attended directly to workflow issues, sometimes stepping outside of their professional boundaries, in order to minimize the effect that differences in how work was organized between the two professions influenced patients and their care. However, Campbell (2000) presents a compelling argument that nurses' workarounds demonstrate how their work within the healthcare system is still fundamentally gendered but not acknowledged to be so.

Certainly, in some contexts, nurses do report working very closely and collaboratively with physicians; however, in other studies, nurses' desire to work collaboratively and collegially is not fully acknowledged nor is their desire reciprocated (Garber et al., 2009; Hojat et al., 2003; Hughes & Fitzpatrick, 2010; Johnson & King, 2012; Piquette et al., 2009). Some studies have examined whether the specialized or generalized nature of the setting influences the interactions between nurse and physician. However, study findings are mixed and may indicate that the increased levels of

interaction in specialized settings are associated with less satisfying relationships (Johnson & King, 2012; Schmalenberg & Kramer, 2009). In a study culminating the experiences of over 20,000 nurses, nurse-physician relationships were found to be of higher quality in hospitals with magnet status (Schmalenberg & Kramer, 2009).

There are several reasons documented in the literature as to why nurses and physicians may struggle in their professional relationship. The organization of work between the two professions, respect and hierarchy may each have a role. First, both physical and organizational barriers exist in relation to how work is organized for nurses and physicians, which may impact their ability to interact and form good working relationships (Paradis et al., 2013; Reeves & Lewin, 2004). Specifically, nurses and doctors are physically separated with nurses on wards and physicians likely visiting with patients either before or after office hours. Spatially, nurses care for patients on one ward whereas physicians see patients on many wards. As such, it is observed that physicians may more readily identify with the medical team and nurses the nursing team due to the way work is socially organized for either profession (Weller, Barrow & Gasquoine, 2011). In addition, the timing of organizational routines, such as shift change, appear to be out of sync with when physician rounds occur, leaving nurses feeling excluded (Paradis et al., 2013). The task-based nature of nurses' work seems to limit opportunities for interprofessional interaction and, as such, the professions give the appearance of working parallel to one another (Reeves & Lewin, 2004; Sherry, 2008).

Second, some studies suggest that a lack of professional trust and respect may contribute to poor nurse physician relations (Tang, Chan, Zhou, & Liaw, 2013). A study by Fleming et al. (2006) documents nurses' perceptions of a lack of respect in

comparison to the surgeons surveyed. Weinberg, Cooney, Miner and Rivlin (2009) describe residents' attitudes in believing the promotion of the quality of the nurse physician relationship to be trivial since they believed the nurse's role was simply to follow orders.

Lastly, antiquated understandings that the relationship between physician and nurse should remain hierarchical are problematic and very concerning. Nurses, in many contexts describe their expectation of an egalitarian and collaborative working relationship (Piquette et al., 2009; Tang et al., 2013) and attempts at relating to nurses in a hierarchical fashion are overtly rejected, yet in many contexts descriptions of this kind of relationship remain. Many nurses still report being treated like handmaidens (Johnson & King, 2012; Sherry, 2008). The issues with this particular kind of relationship are well documented to threaten patient safety and compromise quality of care (Kenaszchuk et al., 2010). Furthermore, these types of relationships thwart efforts to develop the interprofessional team, negating efforts to improve patient safety (Lyndon, 2006; Paradis et al., 2013). Within the context of labour and delivery, the need to improve the relationship between doctors and nurses has been documented (Lyndon, 2006; Sexton et al., 2006). If ignored and unfavorable relationships remain, communication between the professions may also be negatively affected (Goldsztejn, 2009; Grobman et al., 2011). As such, it is necessary to explore the nature of nurse and physician communication more fully.

Nurse-Physician Communication

The way work is structured physically and socially between nurses and physicians appears to inhibit communication. Socially, nurses and physicians appear to

communicate in patterns similar to how they socialize, as parallel performers rather than partners (Reeves & Lewin, 2004; Sherry, 2008). In many studies, nurses were physically excluded from rounds or processes in which critical information was being shared (Atwal & Caldwell, 2006; Thomas et al., 2004; Lyndon, 2008) and attempts to change these practices on the part of nurses were met with resistance from administration (Lyndon, 2008). Nurses, in many studies, report being left out of the loop (Grobman et al., 2011; O'Leary et al., 2010). In one study of acute care team members, direct communication with a physician constituted only 1.5% of the nurses' twelve-hour shift (Tschannen et al., 2013). Grobman et al. (2011) described that it was often the nurse directly involved in patient care who was most often skipped over in the team coordination process and that communication gaps were compounded due to healthcare professionals documenting in separate places in the chart and on the units. Finally, many physicians do not physically remain on site and, as such, both professions report difficulties in contacting each other when needed (O'Leary et al., 2010). Ironically, in one study, the difficulties associated with communication and coordination of care seemed to disappear, according to the participants, during an acute emergent event (Grobman et al., 2011).

Nurses and physicians, in many instances, describe their communication as positively influencing their ability to work together and keep patients safe (Fleming et al., 2006; Simpson, James & Knox, 2006). However, there are many examples in which communication is problematic, compromising their ability to work effectively as a team (Simpson et al., 2006; Tang et al., 2013).

Nurses appear to be less satisfied with the communication on units than do physicians in many contexts. Specifically, nurses feel left out of the loop with respect to

the exchange of information, the creation of a shared understanding, and the coordination the team (Wauben et al., 2011). In addition, nurses perceive themselves to be less able to share their concerns, express disagreement or influence decision-making (Carney et al., 2010; Thomas et al., 2003; Lyndon et al., 2012). Nurses' perception of disempowerment appears to contribute to an increased sense of dissatisfaction and distrust that disagreements are resolved ethically (Thomas et al., 2003). Within the context of labour and delivery, nurses confirm these findings in their perceived inability to speak up and influence plans of care they believe to be unsafe or as contradicting best practice (Lyndon, 2008; Simpson et al., 2006; Simpson & Lyndon, 2009; Lyndon et al., 2012). Furthermore, described as part of the everyday nature of nurse physician interactions, nurses depict being ignored, demoralized and the recipients of overt rudeness when communicating their concerns to physicians (Lyndon, 2008). Communication is also negatively influenced by administration who are described as unsupportive and reluctant to address the hierarchy, fear and intimidation experienced by some nurses in obstetrics (Simpson & Lyndon, 2009).

Within this body of literature, disruptive behavior affects communication and can impair teamwork (Piquette et al., 2009). Although physicians are most often found to be the perpetrators of disruptive behavior, nurses can also be perpetrators of it (Veltman, 2007). In labour and delivery, new nurses appear to be targeted by physicians due to their inexperience and a mistrust of their ability to keep the course of labor on track (Simpson et al., 2006). Sherry (2008) demonstrates that disruptive behaviour is not always an overt verbal attack but can be rooted in behaviours that convey blatant disregard and/or disrespect. Even more concerning is the failure on the part of nurses, who observe these

behaviors, to intervene when they witness them (Sherry, 2008). This may be explained by a pervasive theme in the literature regarding nurses' avoidance of open conflict when in front of the patient (Piquette et al., 2009; Lyndon, 2008; Simpson & Lyndon, 2009). From an interprofessional team perspective, disrespectful behaviour not only impairs communication now but also creates an environment in which speaking up behaviors may be impaired in the future (Grobman et al., 2011).

It is apparent from the literature that nurses employ specific behaviours in an effort to overcome disruptive interactions or physical exclusion in order to influence communicative and decision-making processes with physicians. Specifically, nurses describe using avoidance, passive aggressive or "work around" approaches in order to minimize confrontations with physicians (Simpson & Lyndon, 2009). Work arounds include using suggestion, employing "sweet talk" and initiating independent action (Lyndon, 2008). In labor and delivery, nurses describe intentionally modifying communication tactics to either prompt physician intervention or to keep them away from the patient (Simpson et al., 2006). The use of silence is also documented in the literature. This is recognized as both a normal occurrence in certain situations and contexts; however, it can also be the result of dysfunction and used purposefully to gain or deny power (Gardezi et al., 2009; Sherry, 2008; Simpson & Lyndon, 2009). Silence or lack of communication after traumatic events or medical crises between members of the team is recognized to have a potentially negative emotional impact on nurses (Goldbort, Knepp, Mueller & Pyron, 2011; Piquette et al., 2009).

In many of the studies, nurses and physicians reported divergent understandings with regard to participation in communication and decision-making processes. Physicians

and other members of the interprofessional team report being open and even expecting full nurse participation (Lyndon, 2008; Nelson, King & Brodine, 2008). Lyndon et al. (2012) found that nurses who were more vocal and confident in their abilities to speak up reported better quality relationships and less disruptive behaviour from physicians. The importance of the nurses' ability to be assertive in order to be an effective team member cannot be understated yet, studies examining actual nurse assertiveness show inconsistencies in their behavior (Atwal & Caldwell, 2006; Lyndon, 2006). It has been suggested that nurses, in fact, lack skills and the confidence required for assertiveness, particularly in communicating their unique perspective for patient care with physicians (Nelson, King & Brodine, 2008). However, it is also recognized that the needs of the physician and technical information dominate the limited communication that occurs between the two professions (Tschannen et al., 2013; Vogwill & Reeves, 2008). Furthermore, this limitation with respect to information needs of the physician appears to be an expectation of the larger interprofessional team (Propp et al., 2010). Diplomacy on the part of the nurse is also expected and reprimand, according to the nurses, is experienced as a consequence if the physician perceives disrespect in how communication about the plan of care occurs (Goldsztejn, 2009; Propp et al., 2010; Simpson & Lyndon, 2009). Lastly, nurses appear to risk having their communication disregarded if too much emotion is conveyed in its delivery (Garon, 2012; Ceci, 2004a).

It is clear that power differences, whether real or perceived, are an important aspect of nurse and physician communication (Nelson et al., 2008). It is evident that hierarchy affects how all professions ask questions and who they will ask them of (Thomas et al., 2004). It can also affect information sharing between professions (Nelson

et al., 2008; Thomas et al., 2004). Challenging ideas and practices appear to be strongly influenced by who is being confronted. One study demonstrated that the larger the perceived power differential, the less likely that individual would be challenged, despite a high risk of harm to the patient (Lyndon et al., 2012). When exploring nurses' perceptions about their ability to speak up in professional practice, nurses described both personal and organizational influences (Garon, 2012). Although personal influences, including a strong sense of doing the right thing, were evident, it may be nurses' perceptions of their own powerlessness that is negatively influencing their ability to speak up and share information (Garon, 2012; Lyndon et al., 2012; Nelson et al., 2008).

Nursing Role

Descriptions of nurses' roles within the interprofessional team are available from a variety of perspectives and contexts. According to physicians within the intensive care unit, nurses have a vital role on the team, primarily as observers, evaluators and reporters of the patient condition (Piquette et al., 2009). They are also recognized as the conduits of information amongst other team members and to those outside the immediate team (Propp et al., 2010). Of course, nurses are acknowledged for their patient advocacy role and for the emotional connection they are able to form with patients and their families (Piquette et al., 2009). According to Propp et al.'s (2010) study, which interviewed an interprofessional team about optimal nurse-team interactions, the nurses' role should be grounded in enabling others, namely the physician, to make sound decisions. The team recognizes that assertiveness on the part of the nurse is needed in order to engage in a collaborative process, however diplomacy and tact are also paramount so as not to usurp physician authority (Propp et al., 2010). With respect to team dynamics, nurses seem to

shoulder the responsibility for ensuring the teams' cohesiveness (Propp et al., 2010). Activities such as mentoring new team members, even junior physicians, managing conflict and absorbing the stress on the unit, preserving and building morale and coordinating patient care activities within the team are noted. Lastly, others on the team recognize the role that nurses have in educating their colleagues; however, in one study, this clearly did not extend to having a role in teaching specialists, physicians or residents (Speck, Jones, Barg & McCunn, 2012).

In some studies, nurses describe their own role within the interprofessional team. Nurses from the emergency department and the neonatal intensive care unit recognize their role in coordinating the efforts of others during an acute emergent event (Simmons & Sherwood, 2010). Similarly, trauma room nurses describe their responsibility for taking care of patients and families, for ensuring timely and orderly throughput, and for restoring physical order to the department in the aftermath left by other professions (Speck et al., 2012). Similarly, nurses in obstetrics acknowledge their role mitigating patient harm. Specifically, nurses describe themselves as being vigilant about "preparing the environment, anticipating potential problems and trapping errors" (Lyndon, 2010, p.1).

There are some descriptions of misunderstandings about each other's roles or nurses not being regarded as team members at all (Tang et al., 2013). Specifically, both medical residents and junior doctors did not acknowledge nurses as having a role on the trauma team in one study (Speck et al., 2012). In addition, Sherry (2008) documents how the role of the nurse within the operating room is sometimes reduced to that of being the surgeons' helper.

Professional Culture

Hall (2005) defines professional culture as the social and cultural history of a profession that contributes to what the profession thinks and values and how it behaves. Deeply embedded issues of gender and status have shaped the evolutionary histories of both nursing and medicine (Hall, 2005). It is believed that professionalization and the educational process, unique to each profession, engrain differences which may fuel the ongoing tensions observed between nurses and physicians today, although presumably not formally acknowledged by either (Hall, 2005). In general, physicians are groomed during their medical training and upon entering the profession to assume authority and make decisions about patient care, including what contributions they will accept from others (Nugus, Greenfield, Travaglia, Westbrook & Braithwaite, 2010). Outcomes of interest, from the medical perspective, include saving, curing and prolonging life. The objective facts of the situation are preferred as opposed to the patient's story (Hall, 2005; Stein-Parbury & Liaschenko, 2007). This is in contrast to nurses, who are socialized to value the patient's story and are concerned with issues of human suffering, healing and quality of life. This dichotomy of worldview exists as a source of ongoing frustration with regard to patient care and beyond. Studies show that nurses and physicians often prioritize tasks very differently, which causes tension (Tang et al., 2013). Miller et al. (2008) describe nurses' "esprit de corps" as interfering with interprofessionalism due to nurses' "in group" protectionist behaviours observed during their study. Esprit de corps is defined as the "feelings of group solidarity emanating from the position nurses have as subordinates within healthcare team" (Miller et al., 2008, p. 336).

In labour and delivery, nurses and physicians do share a common goal of optimal outcomes for both mother and baby and assert a collective commitment to patient safety and quality of care (Goldsztejn, 2009; Simpson et al., 2006). They both articulate a desire to work in coordination with each other and in a compassionate manner towards patients (Simpson et al., 2006). However, differences are revealed when interviewing nurses and physicians about how valued outcomes are achieved. In particular, physicians define a "good nurse" to be one that is attentive to their needs, keeping labour on track by aggressively administering artificial means when ordered, and keeping them informed. Furthermore, a good nurse is able to get them to the delivery "on time", which, most suitably, is also at a convenient time (Simpson et al., 2006). This is in contrast to nurses who believe a "good doctor" to be someone who asks questions, listens to their concerns, trusts them, and, most importantly, does not rush the process of labour (Simpson et al., 2006).

Knowledge and Teams

There are many examples that document the different kinds of knowledge utilized by members of the healthcare team. Stein-Parbury and Liashencko (2007) acknowledge case knowledge and patient knowledge to be relevant between the professions within the context of the intensive care unit. Within the operating room, HØyland, Aase and Hollund (2011) found that the team utilized both explicit and tacit knowledge. Case knowledge or explicit knowledge is observed as the kind of understanding that comes from a textbook, where what is known can be documented with lab values, empirical observation or by technical measurement (Stein-Parbury & Liaschenko, 2007; HØyland et al., 2011). This is in contrast to patient knowledge that emanates from an

understanding of a patient's response to the illness, condition or treatment. The nurse is acknowledged as being privy to this type of knowledge as a result of the proximity to and time spent with the patient (Stein-Parbury & Liaschenko, 2007). In numerous studies, physicians appear to value and act primarily based on case knowledge although they are reported to consult nurses for their perspective regarding the patient condition (Stein-Parbury & Liaschenko, 2007; Nugus et al., 2010; Piquette et al., 2009). Nurses also utilize case knowledge but seem to draw more heavily upon patient knowledge when soliciting the action physicians and other team members (Stein-Parbury & Liaschenko, 2007; Miller et al., 2008). Carper (1978) theorized at least four ways of knowing, including empirical, aesthetic, ethical, and personal, which various authors have expanded upon since her foundational article. These other ways of knowing do not appear to be acknowledged within the research on interprofessional teamwork between physicians and nurses. Interestingly, in clinical scenarios where case knowledge fails to explain what is occurring with the patient, a breakdown of interprofessional collaboration is observed between the two professions (Stein-Parbury & Liaschenko, 2007).

Amongst professions, patient knowledge, as presented by the nurse, is well received within certain spaces within healthcare setting and not in others. Miller et al., (2008) describe the conversations that occur between professions in the hallways or corridors as being welcome spaces for this type of knowledge. However, nursing knowledge is not well received and even censored in some spaces such as interprofessional case meetings (Miller et al., 2008).

Some professions lay claim to owning certain types of knowledge that can either privilege or alienate team members (Lingard, Espin, Evans & Hawryluck, 2004).

Medicine's claim to case knowledge and, likewise, nursing's relegation solely to the realm of patient knowledge is an example observed within the literature (Lingard et al., 2004).

Within the team, physicians appear to have ultimate authority in determining not only what kind of knowledge is pertinent to the patient condition but also what kind will be acted upon (Nugus et al., 2010; Stein-Parbury & Liaschenko, 2007). This authority appears to be organizationally, professionally and culturally accepted (Ceci, 2004a; Nugus et al., 2010). Ceci's (2004b) review of the inquiry into the deaths of 12 children in 10 months at a prominent Canadian hospital uncovers how knowledge may be influenced by power and status. That is, it is not enough to "know" but one must be recognized as credible, which may put nursing at a disadvantage (Ceci, 2004b).

In labour and delivery, despite having clearly identified guidelines and protocols from which to practice, nurses and physicians continue to experience a significant amount of conflict specific to the interpretation of fetal heart rate tracings and identifying and acting upon uterine hyper stimulation (Simpson et al., 2006). Nurses report feeling at a loss with regard to the knowledge base used to make patient care decisions, sensing at times that it is not the same as the physician's (Lyndon, 2008; Simpson & Lyndon, 2009; Simpson et al., 2006). Lyndon et al.'s (2012) research reveals that physicians and nurses appear to interpret information about patient care, rating the information's relevance to potential harm quite differently. Lyndon's (2006) review of teamwork in obstetrics draws specific attention to the fact that "nurses' knowledge" within this context is chronically underutilized by physicians.

Power and Teamwork

Although power within the team is not evenly distributed, it does not imply that others, specifically nurses, are powerless (Ceci, 2004b; Lingard et al., 2004). Across both acute and transitional contexts, physicians are recognized to dominate decision-making, input into care delivery and the evaluation of care delivery (Nugus et al., 2010). All involved in the interprofessional team in Nugus et al.'s (2010) study recognize that an imbalance of power exists. This finding is also confirmed in other studies conducted in acute care settings, including labour and delivery (Lyndon, 2008; Piquette et al., 2009).

The authority afforded physicians in their work within the team is either welcomed, or creates tension and conflict. In the ICU, nurses can be relieved when physicians assume authority for the team during acute emergent events (Piquette et al., 2009). In a study of operating room personnel, nurses believed more strongly than the surgeons surveyed that junior members of the team are ill equipped to assume leadership roles (Fleming et al., 2006). In contrast, a number of studies document the tension and the frustration experienced as a result of this acknowledged power imbalance (Hughes & Fitzpatrick, 2010; Lingard et al., 2004; Lyndon, 2008). In particular, dissent occurs when residents erroneously assume their authority over senior, more experienced nurses (Simmons & Sherwood, 2010).

Despite medicine's authority in healthcare, nurses and other healthcare team members are not powerless, appearing to exert power when necessary in order to influence decision-making (Ceci, 2004b; Lingard et al., 2004). Nurses have been known to employ workarounds in order ensure their concerns are taken seriously (Simpson et al., 2006). In addition, Lingard et al. (2004) describe the intentional sharing or withdrawal of

information by nurses and the authority to act as gatekeepers of the unit, restricting new admissions if perceiving a lack of respect or a failure to recognize nurses for their work or knowledge (Lingard et al., 2004). Physicians and residents in this study recognized the implications that a failure to "pay attention to the rules of the game" meant for present and future interactions and their sphere of influence on the unit (Lingard et al., 2004; Miller et al., 2008). Exertions of power within teams can benefit patients; however, they can also unnecessarily trap patients in power plays between professions where patient safety may be compromised (Ceci, 2004b; Jacobson et al., 2013).

Gender and Teamwork

Gender and status continue to colour the professional evolution of both medicine and nursing (Bell, Michalec & Arenson, 2014; Hall, 2005). An increase in the status of women has significantly advanced the profession of nursing from a time when it was regarded as an occupation for women, whereas medicine was seen as a profession for upper class men (Porter, 1992). Despite these advances, nursing still remains a female dominated occupation. The same rings true for medicine, which continues to be dominated by men (Canadian Medical Association [CMA], 2016).

Nurses, today, are recognized to be more assertive than their predecessors (Porter, 1992; Allen, 1997), yet gender differences are still widely observed and assumed, which influences behaviour in the healthcare setting. Specifically, Rudan (2003) notes differences in leadership style, socialization and communication of male and female leaders within a healthcare management team. Males are observed to be direct and dominating in their approach, competitive and very structured while maintaining hierarchical roles. Women, on the other hand, are more relational in their approach, open

to share power and seek input from others. The study also recognized differences in patterns of communication and in the way men and women interact socially with one another (Rudan, 2003). Male and female doctors are also reported to behave differently by the nurses assisting them for routine procedures (Porter, 1992). Female doctors were described as asking politely when needing something and cleaning up after themselves post procedure. In contrast, male physicians used one-word commands when requiring assistance and left their disarray for the nurses to attend to afterwards (Porter, 1992).

Gender may also be evident in regards to expectations about teamwork (Thomas et al., 2004). Wilhelmsson, Ponzer, Dahlgren, Timpka and Faresjö (2011) found female students regardless of profession more willing and open to engage in interprofessional education than male students. In addition, nursing students were found to be more open to interprofessional education than their colleagues from medicine. These attitudes do not appear to change over time with increased time spent together or with increased years of study (Wilhelmsson et al., 2011). Of course caution is required to avoid making generalizations about women or men's behavior to be a byproduct of innate differences related to sex alone. Socialization most likely plays a prominent role.

Historically, certain gender characteristics have also been assumed to be inherent to nursing and nurses' work. Caring and the emotional work that nurses do as part of their therapeutic relationship with the patient is the most prominent example (Miller et al., 2008; Stein-Parbury & Liashecko, 2007). According to Miller et al., (2008), nurses' emotional work garners both positive and negative attention, to the point of rejection, from the other members of the interprofessional team. Within the hallways of the unit, nurses' insight about the response of the patient to illness and treatment is accepted.

However, within the interprofessional case meetings, nurses' emotion work is not welcomed. Specifically, the contribution of nurses in this space is rejected as being redundant and insensitive to the efficient tone of the meeting (Miller et al., 2008; Sorenson & Iedema, 2009). Displays of emotion are also mentioned in other studies as reasons why nurses may be disregarded (Ceci, 2004a; Garon, 2012).

Gaps Identified

To date, there is a paucity of research conducted in the context of labour and delivery within Canada relating specifically to the experiences of nurses as part of the interprofessional team. In addition, much of the qualitative work investigating teamwork has integrated nurses' perspectives alongside other professions thus offering the reader only excerpts of what may be the unique perceptions and experiences of nurses. This literature review revealed that the expectations, attitudes, beliefs and values of nurses may differ from physicians with respect to teamwork and collaboration. To date, this difference has only been established by studies utilizing descriptive survey designs. Thus seeking a rich description of nurses' unique perspective is warranted.

The exact nature of today's nurse-physician relationship is elusive. Although in many contexts, this relationship is described as being collegial and satisfying, in labour and delivery it is recognized as potentially problematic and requiring attention. Similarly, nurse-physician communication appears strained from the perspective of nurses across contexts. The dissatisfaction on the part of nurses may be implicated in their lack of assertiveness. However, it may also explain covert behaviors nurses employ as work arounds to circumvent physicians altogether. Thus, issues of power appear to intersect interprofessional teamwork and it is unclear whether nurses perceive themselves as

powerless, as some studies have suggested, or whether they believe themselves to have the power to influence decision-making within the team.

Much of what is known about the nurses' role on the team has been conducted in other contexts such as emergency, surgery and the intensive care unit. In labour and delivery, what has been articulated about the perceived role is related directly to patient safety. To date, there are no studies that fully explore how nurses perceive or describe their role as part of the team in labour and delivery.

It appears that nurses and physicians in labour and delivery articulate the same goal, which is a healthy outcome for mother and baby, but they appear to express contrasting views on what actions and behaviors are appropriate in order to achieve the goal. In Canada, nurses continue to be predominantly female and physicians predominately male. In many studies, gender and socialization appears to influence how professions relate and communicate with each other. Thus it is likely teamwork perspectives of nurses could also be different from physicians, as emanating from differences in professional culture and gender. These differences have not been fully explored within the context labour and delivery and thus a gap is apparent.

The concept of knowledge and nurse physician relations has been explored and breakdowns in interprofessional communication and teamwork were evident, particularly in situations where case knowledge failed to explain changes in the patient condition. In labour and delivery, specifically, there have been ongoing documented conflicts between nurses and physicians over the collective interpretation of fetal heart rate tracings and determining action on uterine hyperstimulation cases. Nurses in numerous studies conveyed frustration in trying to understand the basis of some clinical decision-making as

it was different from what they expected would happen. In this context then, questions remain as to the types of knowledge that labour and delivery nurses contribute to the interprofessional discussions over patient care and what influence they have in decision-making.

Some quality issues were uncovered for both the quantitative and the qualitative studies included in this review. Thus an opportunity existed to improve upon the issues that surfaced for qualitative research specifically by ensuring sound design and execution with special attention paid to saturation and iterative data collection and analysis.

Chapter Three

Nurses' Perceptions of Interprofessional Teamwork in Labour and Delivery[1]

Teams have been broadly implemented in healthcare today and are believed to provide benefits for patients, healthcare workers, and the organization alike. Medicine and nursing are inextricably linked within the healthcare system yet acknowledged to be divergent in many ways, with respect to their beliefs, values, and attitudes. What is unclear then is how these two healthcare professional groups come together to work equitably as part of a team, when taking into account the socio-historical forces that shaped them. In obstetrics, nurses work very closely with physicians in the provision of family-centered maternity care. Thus the aim of this study was to examine critically the perceptions of obstetrical nurses working with physicians within an interprofessional team with a view to understanding more fully, from their perspective, what is happening within it.

Background/Literature

Teams and teamwork are believed to offer benefits for patients and the organization. Effective teams are believed to improve care and achieve better outcomes overall (Reeves, Lewin, Espin & Zwarenstein, 2010). Teams are also thought to maximize efficiency for organizations already limited in their ability to infuse added resources (Reeves et al, 2010; Suter et al., 2012). Effective teamwork is also believed to benefit nurses and patients. Links have been established between teamwork and job satisfaction and retention (Camerino et al., 2008; Canadian Health Services Research Foundation [CHSRF], 2006; Canadian Institute for Health Information [CIHI], 2005;

[1] This chapter will be submitted for publication.

Jolivet et al., 2010). The connection between nurses' perceptions of interprofessional teamwork and quality of care has been established (Kenaszchuk, Wilkins, Reeves, Zwarenstein & Russell, 2010). Ineffective teams, on the other hand, can compromise patient safety and quality of care and may serve to reinforce occupational division and hierarchy (Barrett, Curran, Glynn & Godwin, 2007; Finn, Learmonth & Reedy, 2010; Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2004).

According to nurses, good teamwork with physicians is promoted by sharing a common goal, establishing mutual trust and respect, good communication, developing and maintaining positive relationships and working within a flattened hierarchy (Piquette, Reeves & Leblanc, 2009; Simmons & Sherwood, 2010). Barriers include impaired communication, professional disrespect, and power imbalances (Atwal & Caldwell, 2006; Carney, West, Neily, Mills & Bagian, 2010; Lyndon, 2006; Lyndon, 2008; O'Leary et al., 2010; Tang, Chan, Zhou & Liaw, 2013; Wauben et al., 2011). A theoretical framework of interprofessional teamwork confirms many of these same relational factors to be relevant but has included processual, organizational and contextual factors as potentially helping or hindering interprofessional teamwork amongst healthcare providers (Reeves et al., 2010).

Nurses are recognized for certain roles within the team that includes a key role as observers and evaluators of the patient condition but also as patient advocates, cultivators of key relationships with patients and families, mentors of new team members, managers of conflict, diffusers of stress on the unit, preservers and builders of morale, and coordinators of patient care activities (Piquette et al., 2009; Propp et al., 2010). Nurses recognize their own role in coordinating the care of others and ensuring efficient

throughput on the unit (Speck, Jones, Barg and McCunn, 2012; Simmons & Sherwood, 2010).

Within the team, the nurse-physician relationship remains the object of many years of theorizing, debate, and research. Stein's (1967) original work first described the doctor nurse relationship as a game. The object of the game was to avoid conflict at all costs, preserving this social order. Nurses were expected to function as reliable consultants, making recommendations in such a way so as not to usurp physician authority. Citing social changes since the 1960s, Stein, Watts and Howell (1990) concluded that nurses were no longer playing the game; however, many question whether the game has been abandoned or whether aspects still linger (Holyoake, 2010; Lingard, Espin, Evans & Hawryluck, 2004; Manias & Street, 2001; Tosh, 2007). Rather than understanding the relationship as competitive game, Svensson (1996) first proposed that interactions between nurses and physicians may be better understood as a negotiated order. Following on the work of Strauss (1978), nurses and physicians on a ward actively negotiate aspects their working relationship in the context of the norms of the larger organizational structure. Svensson's work concluded that nurse -physician relations had undergone a metamorphosis and that nurses now communicate openly with physicians. Others since have noted what aspects of nurses' work with physicians remains non-negotiated (Allen, 1997).

Many studies have documented the ongoing disconnection between nurses and physicians over what constitutes effective teamwork (Thomas, Sexton & Helmreich, 2003; Hughes & Fitzpatrick, 2010; Garber, Madigan, Click & Fitzpatrick, 2009). Further, professions such as medicine, nursing, and midwifery are all acknowledged to have

distinct professional cultures that likely shape their ability to work together (Hall, 2005; Price, Doucet & McGillis Hall, 2014). Amongst patient safety experts, teams are thought to embody "an interprofessional collaborative", both "transdisciplinary" in nature and "encompassing concepts of sharing, partnership, interdependency, power and process" (Canadian Patient Safety Institute [CPSI], 2011, p.3). However, in many healthcare contexts, power is not shared nor is it evenly distributed (Nugus, Greenfield, Travaglia, Westbrook, & Braithwaite, 2010). Nurses, however, have been seen to exert influence over certain unit resources and by employing work arounds (Hewitt, Sims & Harris, 2015; Simpson, James & Knox, 2006; Lingard et al., 2004). Within healthcare, physicians have traditionally determined the kind of knowledge pertinent to the patient condition and what will be acted upon (Nugus et al., 2010; Stein-Parbury & Liaschenko, 2007) This authority appears to be organizationally, professionally, and culturally sanctioned (Ceci, 2004a; Nugus et al., 2010). Ceci's (2004b) review of the inquiry into the deaths of 12 children in 10 months at a prominent Canadian hospital uncovered how the credibility of knowledge was influenced by gender, power, and status. The dismissal of nursing knowledge in this example resulted in significant patient safety issues. In a labour and delivery example, nurses and physicians have had difficulty agreeing on the interpretation of fetal heart rate tracings and action related to uterine hyper stimulation (Simpson et al., 2006). In short, there remains much to be learned about how nurses and physicians negotiate their roles and relationships as part of the team in labour and delivery.

Method

Focused ethnography guided this critical examination of nurses' work with physicians in labour and delivery. The goal was to obtain a cultural perspective (Roper & Shapira, 2000; Fetterman 2010; LeCompte & Schensul, 2010) while being sensitive to any of the social nuances, inequities, or other issues related to power, knowledge, and gender that may be present (Smith, 2007; Wall, 2015). Unlike traditional ethnography, focused ethnography converges in on a topic of interest, in this case teamwork between nurses and physicians (De Munck, 2009). In this method, the researcher's previous experience as a labour and delivery nurse is acknowledged as potentiating an expedited understanding (Knoblauch, 2005; Higginbottom, Pillay & Boadu, 2013). Because teamwork experiences can vary depending on the unit, a single unit was chosen to recruit nurse participants (Sexton et al., 2006). Both ethics and operational approval were obtained prior to initiating contact with the site or any of the participants.

Study participants were recruited from a very busy labour and delivery unit located in the heart of a large metropolitan area in Western Canada. Registered nurses with at least three months' experience on the unit were invited to participate.

Data were gathered from three sources including semi-structured interviews, participant observation, and document review over a four week period during February and March, 2015. All interviews, which were recorded and transcribed, lasted approximately 60 minutes and were conducted in a private location using a semi-structured interview guide. Four participant observation sessions were conducted at the unit desk over various shifts. Field notes were generated within 24 hours of conducting each session. Administrative documents and memos were also reviewed. Data collection

and analysis were conducted iteratively. Data collection ceased when saturation was achieved. Data were analyzed thematically (Roper and Shapira, 2000). Analytic rigour was ensured through regular meetings with the co-authors to discuss the themes emerging during data collection and analysis (Knoblauch, 2005). An audit trail recorded the evolution of this project and the associated methodological and analytical decision-making.

Ten registered nurses agreed to be interviewed regarding their views on interprofessional teamwork with physicians in labour and delivery. All participants were female with the majority representing a younger cohort. Three participants were between the ages of 20 to 25 years; 3 between the ages of 26 to 30 years; 2 between the ages of 31-35 and two older than 36 years of age. Most participants had a Bachelor's degree and two were diploma-prepared. About half of the nurses started their careers in other areas prior to settling in labour and delivery. Experience levels matched what would be expected from interviewing a predominantly younger group of nurses. Five had less than five years of experience as a registered nurse; three with 6-10 years, and two with greater than 10 years of experience.

The unit accepts high acuity cases and anticipates well over 5,000 deliveries per year. Many specialists for both the mother and the neonate are available at this hospital. Nurses described themselves as potentially working with a wide range of physician groups including family doctors, obstetricians, anesthesiologists, obstetrical medicine specialists, perinatologists, or neonatologists. There were also residents representing obstetrics, anesthesiology, and other services, as well as medical students. Nurses worked a combination of eight-hour day, evening, or night shifts. Nurses were assigned daily to

work in one of three sub-areas of the labour and delivery department: the assessment room, the case room or the operating room. In the assessment room, nurses worked closely with residents to assess and triage outpatients.

Findings

Relationships emerged as one of the core themes describing healthy and satisfying teamwork for participants when working with physicians. The majority of the nurses interviewed described the teamwork in case room as positive. They believed it to be better than other nursing contexts because of the relationships they developed with physicians. Major subthemes uncovered describe the characteristics of their relationships, the facilitators or barriers for forming them, and the impact or consequences of their interactions.

Characteristics of Relationships

The characteristics of their relationships are understood in terms of the push and pull of power; the need to manage issues related to teamwork and hierarchy and decision-making.

The push and pull of power. Power dynamics were evident in nurses' relationships with physicians; power flowed in complex and multidirectional ways. Nurses were found to be subject to but also exerting their own power in their relationships when working as part of a team. Nurses gave rich descriptions of the autonomy they experienced, when working toward the upper levels of their scope. They also described how they influenced physicians' attitudes and how physician requests were viewed, depending on the nature of their relationships. Finally they identified a small group of physicians who exercised power over them.

Nurses saw themselves as powerful in terms of the independence they experienced; as Tracey and others recognized, “there’s quite a bit of autonomy for nurses.” The sense that they were working at the upper levels and even to the very outer edges of their scope was expressed by the majority of these nurses. In this context, physicians, including residents, were not able to stay on the unit around the clock. Thus, there was an expectation, as Theresa noted, for the nurses to “troubleshoot first.” There were many things these nurses would consider initiating if an emergent situation warranted it; some things they felt were beyond their scope. Nurses also acknowledged the influence they had in counseling patients regarding pain management options and the use of syntocinon (drug used to increase the strength of uterine contractions) when ordered. Nurses reported using a variety of resources to support their decision-making including referring to existing physician orders and their unit guidelines and policies, using their experience to know the “general rules” of what would happen to the patient, and taking into account individual physician preferences. As a result, nurses reported a high amount of satisfaction with this part of their working relationship with physicians. As Sally stated, “ there are so many things I can do.” Lindsay asserted, “we can decide.” Theresa recognized instances when nurses “can go ahead and just do.” Rachel concurred, noting that “they just say yes, so it’s kind of like ordering it yourself” in regard to some of the requests she’s made of physicians.

While communication with most physicians was described as the need to be clear, concise and direct, at times, nurses also explained using communication in a strategic manner to direct or influence physicians in order to get what was needed for patients. Specifically, they talked about tailoring their communication to “direct” certain

personalities on the unit, based on what they knew about a particular physician. Sally conceded that she used an approach to get them to "respond in the way you want them to." Lindsay agreed and noted that with certain individuals she gave "certain facts that kind of steers them in a certain direction." A few nurses indicated that passive techniques ease tension with certain individuals. Nanette acknowledged how it is important to consider "how to best phrase your suggestion "so that you "won't push their buttons." Lindsay agreed, "you are trying to get them to hear what you have to say without saying this is what I think and I am the nurse and you have to listen to me." Two of the nurses talked about being aware of and using alternate channels, such as the charge nurse or the resident, when communicating with some physicians.

Nurses exerted power over new and off service residents, possibly as an attempt to influence developing physician attitudes. Some nurses pointed out that labour and delivery was a difficult place for new and off service residents because they needed to "prove themselves" as trustworthy, competent, accessible, and respectful. Colleen pointed out that, "you can kind of keep them in line," managing the relationship for the future. Cindy acknowledged, "the poor resident; we are always tough on them." A few of the nurses recognized their influence over residents' future attitudes and behaviours. Lindsay summed up the relationship, saying, "they learn that we are of value and we value them and we cannot disrespect each other."

Lastly, nurses explained how they influenced patient throughput. Rachel asserted, "the unit couldn't run without us" in reference to the work they accomplished in the physicians' absence. They also explained that the quality of nurse-physician relationships were evaluated prior to determining if special requests would be granted, such as

amniotomies (rupture of membranes) suited to the physician schedule or priority admissions as determined by the physicians themselves, which added to the workload. As Francine acknowledged, “you are more willing to do things for people when you have a relationship with them.” Conversely, Nanette described how poor relationships can mean that “I am not particularly inclined to go the extra distance to make it happen or make it happen faster.”

Despite most of the nurses recognizing their relationships with physicians as positive and enhancing the teamwork on the unit, the majority recognized “a very small cluster” of physicians who seemed to assert power inappropriately over the nurses, residents, and even patients using certain difficult behaviours. Three nurses clearly described one physician’s impertinent behaviour of making nurses “run at beck and call” while retrieving a whole host of items that would never be used. New people, in particular, were targeted. Francine explained, “they’ll purposefully try to be extra difficult and demanding just to see how you react to it.” Nurses were distressed when they saw residents being treated poorly. Colleen recalls how she has observed them being told they were “incompetent in front of the patient.” Nurses also described how physicians, who exhibit difficult behaviors or attitudes, influenced patient care. Some nurses expressed frustration at the practice of rushing a delivery for physician convenience. Tracey acknowledged that this practice is how some doctors “might get a reputation for not having the patient’s best interest in mind.” Francine agreed that it is “a situation that’s quite common.” Finally, some of the nurses cited certain physicians for being unreliable members of the team owing to a pattern of missing deliveries.

The need to manage issues in teamwork. Despite experiencing some very challenging behaviours, nurses were reluctant to describe their working relationships as poor. Rather, many of the nurses described a myriad of ways in which they actively managed issues related to teamwork in an effort to smooth and promote the functioning of their work with physicians. Although some nurses explained they would directly confront the perpetrator of negative behavior, more of them described circumventing and venting as strategies for relationship management. Many also highlighted knowing and attending to physician preferences.

Dealing directly with negative behavior or "standing up" was identified by a few of the nurses as a means to improve their working relationships. Nanette learned, "once you've asserted that you have a backbone, now this person will listen to you." Only one nurse talked about actively bringing concerns to management. In contrast to direct confrontation, more nurses described the many ways in which they circumvented confrontation in order to preserve the functionality of their working relationships. Some nurses described buffering others from difficult behaviour, particularly new people. Theresa explained how experienced nurses accompanied her in her deliveries to offset "intimidating" physicians. Cindy offered that, "we share information, you know, like she likes this and this" so "hopefully we'll ease the stress level in the room a little bit." A few nurses indicated they would avoid certain individuals altogether or ignore the impact negative behavior had on them personally. Rachel used "different channels" such as the charge nurse or resident instead of approaching a difficult physician, opting to "wait" and "call someone else" if able. Lisa conceded, "I put in my 8 hours and I go home and I try not to think about what's happened on my shift." Some nurses justified and tolerated

demeaning behaviours. Theresa wondered if her experiences were related to her being new and "they don't know what it's like with you." Sally and others acknowledged poor behaviour to be the byproduct of the "mood" of a particular physician. Cindy added, "that's just the way they are," or as Rachel asserted, it's tolerated because "they make up for it by being skilled." Colleen acknowledged that the behaviour is longstanding, so "it's just accepted."

Venting emerged as the main way nurses dealt with negative behaviours, mitigating their effect on themselves and the team. Cindy described, "we vent a lot to each other, sometimes to other doctors, but we vent a lot." Some, like Lindsay, described venting as a means to commiserate and know "it's not just me." While many found it to be a supportive practice, other nurses admitted that venting became "negative" and transitioned into "gossiping and complaining" that could linger for a number of weeks.

In addition to sidestepping and venting, several of the nurses acknowledged the importance of attending to individual preferences in order to ensure smooth functioning of the team. Francine explained that some obstetricians "just want to be called to deliver and other people want to make sure that they're there a good portion before a patient delivers." There appeared to be an expectation, even organizationally, for nurses to attend to these individual preferences to promote the smooth functioning of the team. A number of black binders were observed around the unit, highlighting individual physician preferences including glove size, points of expected communication and specific preferences for managing patient care.

Hierarchy and decision-making. The nurses described and were observed to engage in collegial relationships with the obstetrical residents, particularly those who

started at the same time or after them. They reported positive, reciprocal relationships in which they were respected and valued. As Tracey explained, “I find with the residents, it’s a discussion.” Lisa echoed, “they ask us a lot so what would you do? Or what do you think she needs? It’s a two way thing.” A few of nurses indicated problems approaching residents who started before them, quoting a lack of relationship, which exaggerated differences in status. In general, although nurses experienced collegiality with new obstetrical residents, their working relationships with residents gradually shifted to take on more traditional, status-oriented characteristics; these characteristics were more established in relationships with residents who had been there longer.

Further most nurses acknowledged that the physician was the ultimate decision maker on the team. Most nurses described the nursing role as being rooted in information-sharing and alerting physicians to action. Lisa acknowledged she was expected to “observe what’s going,” “know when I need help” and then “get the resident here.” According to Theresa, nurses conveyed “the information that they [physicians] might need to make their end decision.” For many, it involved “knowing where the patient’s at” and “reporting those findings” to the physician. Observations of their interactions were consistent with how the nurses described them including cervical exams, temperature, blood pressures, fetal heart rate abnormalities, times of rupture and the interventions they’d completed in an effort to correct emerging issues. Sally agreed that her objective assessment was required so that physicians “can act however they want to act” and “write orders or decide what needs to happen next to the patient.”

Interestingly, these nurses also described knowing much more about “patient wishes”, “patient experience” and patient response to labour owing to the time they spend

at the bedside. Nurses like Rachel and Sally described detecting "subtle changes" in patient status or "gut" knowledge of when there was a problem. However, it was unclear how these nurses integrated this unique knowledge of the patient or whether it was relevant within their working relationship. None of these examples were directly observed during any nurse-physician exchanges. Some nurses maintained they have shared patient wishes with physicians in the past. Of their exchanges, Francine stated she will "go and mention it." Cindy indicated, she will "pass" patient wishes on. Rachel asserted that she will "present and protect them"; but, Lindsay, indicated that "it depends" on the physician, the situation and "what's at stake" when determining if she would lobby for an alternate course of action.

Of decision making, Rachel acknowledged, "even though we are a little bit more collegial than a ward, I would say there is still that power dynamic there in that they [physicians] run the show." Tracey agreed, "the final decisions aren't with the nurse, it's with the doctor." Theresa acknowledged, "I can only question it so much but there's nothing else I can do." Francine added, "a lot of instances when you're not the top of the chain" and "you have no control." Overall, traditional professional hierarchies greatly impacted the character of relationships between physicians and nurses in this care area.

Facilitators of Interprofessional Working

Nurses identified key factors that facilitated their efforts to establish effective working relationships with physicians in labour and delivery. These factors included time, trust and respect, credibility, and social connection.

Time. Time was a key component of nurses' working relationships with physicians. These included the time of day or the particular shift in question and the

amount of time spent on the unit together. For many of the nurses, the night shift emerged as a place where teamwork was perceived to be more abundant. Participants reported a greater frequency of interactions with physicians that helped them establish relationships, as opposed to the day shift where there were many more physicians to interact with and know.

Time spent on the unit together also resonated with these nurses as one of the main reasons they were able to establish such good working relationships with physicians. Obstetrical residency seemed to be an important time in which nurses established relationships that carried forward in their professional careers. Rachel acknowledged, "we have pretty good relationship with most of our residents, especially the [second year residents]. They're always here so we get to know them really well." Lindsay added, "they kind of grow up with us." Some pointed out the presence of many longstanding relationships on the unit that benefited working relationships. Sally observed, "lots of the physicians that we work with, the attendings, they did their residency through us."

Nurses shared their impression that physicians, in general, physically spend more time on their unit compared to the other units they've worked on. As a result they felt they had a greater opportunity to get to know them. Theresa shared, "you see the physicians more, I guess, than you would on postpartum or even antepartum". Rachel added that it is not uncommon for residents and younger unit staffs to "just hang out at the desk." In sum, time was a vital aspect of relationships that helped to create positive teamwork between nurses and physicians.

Trust and respect. Establishing trust and respect was an essential aspect of these nurses' generally high functioning working relationships with physicians. Specifically, it impacted their sense that they would be heard and listened to if concerned.

Becoming "known" as a trustworthy nurse to physicians in this context was regarded as key. According to many of the nurses, being regarded by physicians as trustworthy, was a byproduct of the attainment of practice knowledge, time and experience. As such, these nurses stressed the importance of developing practice knowledge to the level of proficiency for both nurse and physician in order to be regarded as convincing members of the team. Specifically, nurses talked about when they started on the unit and the process of establishing practice knowledge in order to have successful relationships with physicians. Most of the participants spoke of their feelings of inadequacy with regard to knowledge and confidence in their assessments. With time and experience, most believed that they possessed the good "clinical judgment" needed to work effectively with physicians in this context. Further some felt strongly that time in their role was needed to be confident enough to approach physicians. Colleen asserted, "you need to be confident in saying this is the way it is, so that just comes with time." Sally asserted her belief, "they don't want to talk to someone who is unsure."

Time was implicated in order to be acknowledged as a trusted practitioner and an established team member. Nurses talked about when they first started on the unit and the level of interaction they had with physicians. Sally related her experience as, "I don't even remember talking to the physicians for the first year I worked here." Theresa concurred with this experience, speaking only to some of the residents and interacting with physicians, "occasionally." Francine recognized, "most doctors didn't bother to

learn my name until I worked here for two years." Cindy agreed, "it has taken a long time, lots of babies" to develop trusting relationships with physicians. Some nurses pointed out how difficult it could be for new people. Francine recalled as a new nurse, "people don't trust you at all when you first start. And people will redo your exams, will recheck everything just to make sure what you are saying is true." Off service residents were a group not trusted by many of the nurses. Cindy and others thought it was because they're not established. This experience is contrasted for those with seniority and an established relationship. Lisa noted of physicians and residents, "they respect me, because I have years of experience." Sally agreed that her longstanding relationship with a particular physician makes her confident in saying, "I know the physician" and "he trusts me." Theresa, a newer nurse, admitted that she "is not there yet" with most of them, but with some of the residents, with whom she has a relationship, "they know me enough to take my word for it." Sally agreed of the relationship, "when they get to know you better and get to know how you work" then, as Colleen also reasoned, "you are trusted." Francine concluded, "once they know you are a good worker then they'll trust you." Some nurses, like Cindy, strongly believed, "we have to prove ourselves to them."

Interestingly, in this context, the weight given clinical competence as it related to professional trust and respect was evident. Some nurses pointed out how physicians are respected and excused for social missteps due to their professional competence. In the same sentence Cindy described one obstetrician as "intimidating" but "she knows her stuff." Rachel agreed, despite experiencing some overtly difficult behavior, "you kind of respect how they do their job even though they may be barking at you, ridiculously."

Some nurses saw physicians as "putting a lot of trust in the nursing staff" to keep patients safe. Most importantly though, a relationship involving trust and respect meant they would be listened to and their concerns heard if they were worried. Sally listed the doctors she believed "trust" her and would "take it seriously", if she was concerned. Rachel indicated this to be true for younger physicians and herself based on this kind of relationship she has developed with them.

Credibility. An extension to becoming known as proficient and trusted, nurses also regarded credibility as a vital facilitator of the working relationship between nurse and physician. Nurses interviewed talked about the importance of credibility in order to get through to the physician, especially when action was required. The charge nurse emerged as an important ally. Nurses acknowledged that more established nurses possessed the credibility needed. Rachel observed," I feel like sometimes because I am junior, more senior physicians won't listen to me." In the meantime, established and trusted individuals like the charge nurse and residents were identified as important people to help new nurses relay concerns to the physicians, lending credibility. Theresa, a novice nurse, determined if she needed to establish credibility through the charge nurse first because "they don't really don't know me and my assessment status." Likewise, Rachel, who is young but not new, also described taking the same things into account. She explained, "I think the older ones, if you came to them personally, you would kind of have to almost go through charge to get through to them."

The importance of social connection. Nurses highlighted the many social relationships that exist between nurses and physicians on this unit. In turn, they

underscored social connections as a facilitator and strengthener of their working relationships with physicians.

Nurses valued the friendly relationships that they fostered with the majority of physicians in this setting. Most of the nurses were observed to engage socially at the desk with residents, family physicians and some of the obstetricians. They mostly talked about their families, their vacations and common activities. Rachel added, “it’s nice to see and be friends with people like that.” As previously mentioned, most all the nurses described developing very close, friendly relationships during obstetrical residency, particularly with those that started at the same time or after them. Some nurses reported social interactions with some physicians to extend outside of the work setting as well. Of them, Francine observed, “there’s some good friendships there.”

As a result of their friendly relationships with physicians, particularly residents, the majority of the nurses viewed these individuals as being accessible and approachable. Colleen, like most of the other nurses, related she feels “super comfortable” to approach residents. Lindsay agreed, “I feel I am able to speak up a lot more, just a lot more comfortable.” Francine added, “when you have a better relationship with people that you are working with, then you are able to go and voice your opinions better” in contrast with those who “don’t get along with anyone” thus “you’re just not able to have good relations with them.” Tracey related that at the beginning of a shift she considers those individuals she would feel comfortable approaching if she had to.

Impact and Consequences

Positive relationships influenced aspects such as nurse satisfaction with teamwork, workplace retention, and healthy communication patterns, and gave nurses a sense that

they were able to enact their role and care for patients safely. Nurses regarded positive working relationships with physicians as contributing significantly to job satisfaction on the unit and, possibly, influencing their intent to stay. Rachel described that positive friendly relationships made coming to work "fun" as she enjoyed having "friends at work." Lindsay recognized how the supportive environment that was created "makes people care about it other." These nurses were most drawn to relationships with physicians where they were able to achieve a high level of trust and respect and experience autonomy within the team. There was also good indication that these types of working relationships contributed to their retention. Nanette aptly described the general perspective of these nurses:

> And one of the things that sort of keeps me here is that I don't know where, when and how long it would take me ever again to achieve the level of trust and respect and autonomy that I am provided here to work here within that team. I don't know when I would again get the opportunity to call up the head of obstetrics about the patient, who he doesn't know is here today, and say pretty sure, you know, that the graph is bad and the cervix is not changing and I think she needs a [cesarean] section and have the physician say to me,'Get the resident to see her but book and prep the OR,' right?

In contrast, some nurses shared how negative or unestablished relationships could result in dissatisfaction. Some nurses related that mistrust exists for those who are unable to establish themselves as dependable members of the team. According to Sally, some physicians have asked nurses to check up on other nurses. Francine explained it is because "they want to be very careful about who takes care of them" implying some people are not trusted. Rachel agreed that there are negative nurse-physician relationships to the extent that certain physicians will say, "I don't want that nurse touching my patient." Some nurses noted that new nurses may be particularly vulnerable. Francine revealed that "some people can be unnecessarily mean to new people". Cindy agreed the

unit culture was “very hard on new people” and added, “if they last past first year, then they’ll be here for a while.” It is evident from these nurses’ descriptions that the quality of team relationships can have a tremendous impact on a nurse’s work experience and job longevity.

As relationships influenced job satisfaction, intent to stay, and morale, communication patterns were also affected. Established, positive relationships were seen to enhance communication. Most described their relationships with physicians in terms of the comfort level they felt in approaching and communicating with them. Specifically, nurses described clearly how positive relationships with physicians makes communication easier and enhanced their perception that they were able to approach and would be heard and be responded to.

On the other hand, nurses provided a few key examples of threats to open communication. Colleen stressed that she will not “ask questions” of one specific obstetrician for fear of being disrespected. Lindsay agreed, “it makes you not want to talk to them” in regards to some negative relationships with difficult physicians. Nanette acknowledged a specific “incident” with a physician, which she felt altered communication between them. She explains, “we don’t talk anymore…he doesn’t discuss with me anymore.”

The quality of relationships and communication influenced patient outcomes. Positive, friendly relationships were viewed as important in achieving positive outcomes. As Tracey recognized, “it enhances it for the most part,” allowing the nurses to communicate with physicians or summon them. However, nurses also provided a few severe examples, highlighting how negative or non-existent relationships could result in

poor outcomes. In the first example, a falling out with the physician earlier in the evening affected communication and delayed action for another patient. The nurse involved confided, "it's a night that still bothers me. It's a night I still worry about the day I get called or receive the email and get told that it's going to litigation." Another example, a perceived failure to rescue, occurred because of a lack of familiarity between nurse and resident. This nurse recalled her repeated, unheard attempts to communicate her concern about a situation. She admitted, "I got to the point where I was like, 'You need to go to the staff [physician] now,' but it was too late." Indeed, the quality of team relationships had a real and direct impact on nurses' work experiences and patient outcomes.

Discussion

The findings from this research highlight the centrality of the quality of the nurse-physician relationship, based on the experiences of nurses working as part of a team in labour and delivery. Although a number of other studies have identified the quality of relationships between nurse and physician as an important aspect of working well within a team (Al Sayeh, Szafran, Robertson, Bell & Williams, 2014; Piquette et al., 2009; Simmons & Sherwood, 2010) and important to how they work together to provide safe patient care (Lyndon, 2008; Sleutel, Shultz & Wyble, 2007), the emphasis given this theme has not been as apparent in the literature as was found here.

Similar to what others have found, these nurses identified that they work within a normative hierarchical structure where physicians are ultimately responsible for patient care decision-making (Baxter & Brumfitt, 2008; Nugus et al, 2010). Similarly, practice knowledge, centered around medical aspects of care, appeared to be most relevant for these nurses when working as part of a team with physicians. The significance of practice

knowledge in the formation of good working relationships with physicians has been documented before (Lyndon, 2008). Further, the weight given to clinical or technical information in their interactions, despite knowing much more about the patient experience is also recognized (Stein-Parbury & Liaschenko, 2007). Yet, it was not clear how nurses incorporated their unique knowledge as it was not directly observed in any of the nurse-physician interactions in this study, which may be problematic. Some authors argue that labour and birth should be a patient-centered experience that encourages the integration of the knowledge of all providers and the patient, encouraging full disclosure communication (Lyndon, Zlatnik & Wachter, 2011).

Despite working in a traditional hierarchical structure, nurses were not found to be powerless. Rather, they exerted their own power through an increased sense of autonomy, their tactical use of communication, and their perceived control over unit resources, such as new resident experience and accommodations, as has been described before (Allen, 1997; Edmonds & Jones, 2013; Lingard et al., 2004; Lyndon, 2008; Manias and Street, 2001; Simpson et al., 2006). Communication continues to be used as a work around in order to get what is needed for patients (Edmonds & Jones, 2013; Lyndon, 2008; Simpson et al., 2006). However, its presence could pose a threat to the open, honest and equitable dialogue needed for good interprofessional teamwork and effective agency (Lyndon, 2008; Sims, Hewitt & Harris, 2015).

In terms of new resident-nurse relationships other studies also document mounting tensions when respect is not afforded to nurses (Simmons & Sherwood, 2010; Lingard et al., 2004). In this study, however, nurses also spoke very strongly about the social repercussions of this perceived lack of respect towards them suggesting the

presence of a potential authority gradient. Several studies examining residents' formative years in practice document the presence of a temporary inversion of status where residents defer to experienced nurses' knowledge and status (Allen, 1997; Burford et al., 2013). Certainly, this may also explain the differences in the interactions observed between nurses and new residents on this unit as being more collegial in nature as opposed to those with more established residents or other physician types. Thus, these findings may make important links to the literature about nurses' role in the informal learning and socialization of new physicians (Burford et al., 2013; Weller, Barrow & Gasquoine, 2011).

Taken together, the findings from this study indicate that the nature of the nurse-physician relationship is complex, nuanced and, at times, subtly retaliatory. On one hand, nurses' increased sense autonomy when left alone on the unit mirrors Allen's (1997) description of boundary blurring that is consistent with a negotiated (or non-negotiated) order perspective. Similarly, nurses' reported influence over new resident socialization and learning is also suggestive that the relationship has moved away from hierarchical understandings consistent with negotiated order theory (Allen, 1997). Yet, nurses continued reliance on strategic communication that requires passivity suggests that the doctor-nurse game is potentially alive and well (Allen, 1997; Stein, 1967). In addition, the fact that they evaluated their individual relationships with physicians and residents in terms of respect relayed when making decisions about admissions and new resident learning also bears some resemblance to the "game" or other versions of it (Lingard et al., 2004; Tosh, 2007).

Disrespectful behavior was one of the most consistent aspects of these nurses' accounts. The fact that it was at the hands of a small but well-known cluster of physicians speaks to the hold these individuals and their behaviour has over the nurses. New people seemed to experience it more readily (Leape et al., 2012; Simpson et al., 2006). These nurses also described disrespectful behavior toward residents and patients, which is also recognized, but less prominently so, in the literature (Leape et al., 2012). Certainly the presence of disrespectful behavior, no matter its source or prevalence, is problematic and must be addressed whether directed toward nurses, residents, or patients (Leape et al., 2012).

Nurses in this study were found to expend a significant amount of energy managing issues and smoothing conflict in order to ensure the continued functioning of their working relationships. A number of other studies have also found nurses to utilize avoidance strategies (Lyndon, 2008; Valentine, 2001). Some have documented the problems with this strategy citing increased levels of stress and ineffective agency (Lyndon, 2008; Tabak & Orit, 2007). Thus the strategies that these nurses described, as mainly smoothing and avoidance strategies, require attention. Specifically it will be important to understand the barriers to more equality-based ways of dealing with negative behaviour. Both nurses and physicians need strategies to deal with conflict in constructive ways, which promotes the open and honest dialogue between professions (Lyndon et al., 2011). Venting, which emerged as the main coping mechanism for nurses, is also recognized in the literature. Miller et al. (2008) described how nurses in their study bonded together forming strong intragroup support systems. In contrast, nurses in

this study described sharing their difficulties with some physicians, suggesting the presence of an intergroup support network.

Nurses identified four key factors that facilitated their working relationships with physicians including time, trust and respect, credibility and social connection, which was consistent with aspects corresponding to the relational and processual factors described by Reeves et al. (2010). Time spent together with physicians, and particularly residents, as manifested in several ways, was a unique and important facilitator of teamwork for these nurses in this context. Many other studies acknowledge that differences in work organization between the two professions challenges interprofessional teamwork (Allen, 1997; Paradis et al., 2013; Reeves et al., 2009). As demonstrated in this context, establishing good interprofessional relationships takes time and opportunity, which is often a missing or taken for granted aspect of today's busy, chaotic and fragmented healthcare environment (Simmons & Sherwood, 2010; Weller et al., 2011).

The establishment of trust and respect continues to be an essential facilitator of these nurses' working relationships with physicians (Sims et al., 2015; Pullon, 2008; Schmalenberg et al., 2005; Simmons & Sherwood, 2010). In fact, many studies describe nurses' drive to develop practice knowledge and gain experience, deriving confidence and eventually acquiring the professional competence to secure the trust and respect needed to work effectively with physicians (Pullon, 2008; Fackler, Chambers & Bourbonniere, 2015; Lyndon, 2008). The finding that suggests the weight given to professional clinical competence in this setting outweighing any kind of social inpropriety on the part of physician, even to the point of overt rudeness, is particularly interesting. Schmalenberg et al. (2005) found professional respect from nurses was

afforded for demonstrated expertise, which may also point to the continuing hegemony of medical intervention within the healthcare system. Other studies acknowledge, as did these nurses, an expectation that physicians will come when they are called, not doubt them, and truly listen when there is a concern (Schmalenberg et al., 2005). The nurses in this study said they could communicate concerns and solicit action more readily when moderated by those more established than them. This finding is validated by other studies of physicians who actively sought out a particular nurse when considering action (Schmalenberg et al., 2005; Weller et al., 2011). The findings in this study contradict others that report that trust is automatically conveyed towards all staff. Rather it appears to be individually negotiated through a trust relationship between nurse and physician (Schmalenberg et al., 2005). These findings also suggests that communication, which was also vital part of interprofessional teamwork between nurse and physician, remains a complex social process, involving more than the conveyance of information in a direct and systematic fashion (Lyndon et al., 2011).

Only one study has recognized something similar to social connection as facilitating teamwork (Al Sayah et al., 2014). Schmalenberg et al. (2005) observed that communication within collaborative nurse-physician relationships can extend beyond patient care into the social realm. Studies examining interprofessional teamwork in other contexts have shown a lack of socialization between physicians and other healthcare professionals (Reeves et al., 2009; Miller et al., 2008). In contrast, these nurses underscored the many positive social relationships they shared with physicians, particularly residents, which supported their comfort in approaching them when concerned.

For these nurses, positive and established relationships enhanced their sense of worth, which affected their morale and intent to stay, and positively impacted communication and patient care. Other studies have linked the quality of nurses' relationships in the workplace with professional satisfaction (Pullon, 2008; Sabatino et al., 2014; Sims et al., 2015); communication and agency (Lyndon, 2008) and the sense they are providing optimal patient care (Kenaszchuk et al., 2010). On the other hand, poor relationships are acknowledged to achieve the opposite (Goldsztejn, 2009; Grobman et al, 2011; Lyndon, 2008; Rosenstein, 2002; Rosenstein & O'Daniel, 2006; Sims et al., 2015). What has not been well understood is the influence unestablished relationships have as described by these nurses. Thus, ensuring a positive working environment that fosters the successful integration of all members and supports the development of positive working relationships is key to job satisfaction and quality of care.

Implications

These findings have implications for nurses, administrators, and educators alike. A critical lens has helped to uncover taken for granted aspects of nurses' relationships with physicians and highlighted the importance of relationships to effective and healthy interprofessional teamwork. Nurses can identify their influence within the team but they must also be aware of the ways that some of their communication patterns continue to hinder the attainment of open, honest communication and collaboration, which is what they likely desire most. Nurses must also be willing to re-consider their use of indirect and passive communication strategies, tap into their power and knowledge, and take steps toward assertive and constructive conflict management, for their own health and for the safety of their patients (Polifroni, 2010). That said, managers and administrators have a

significant role to play in creating the kinds of work environments where more equality-based interactions and teamwork can occur. Disrespectful behavior towards nurses, residents, and patients cannot be tolerated, even if only at the hands of a few (Leape et al., 2012). All have an active role in confronting it and managing conflict in respectful and constructive ways. This also highlights the importance of ensuring that new people have adequate supports, including recognizing the influence of time and exposure in this context, needed to integrate successfully into the team. Organizationally, open communication must be facilitated to allow all viewpoints to be considered. Finally, the findings can assist educators in preparing new practitioners for the realities of interprofessional teamwork. Specific attention needs to be given to healthy conflict management and addressing disrespectful behaviors. The nurses in this study appeared to omit aspects of their own knowledge during collaborative efforts. Specifically, it was unclear how, when or if they integrated what they knew as a result of the time they spent with the patient. This presents an opportunity for educators to help re-frame nurses' understanding of clinical power as being uniquely positioned to understand and articulate the complexity of the patient and their experience during nurse-physician interactions (Polifroni, 2010).

Beyond surface solutions, systematic change is needed. Social historical analysis reveals deeper issues related to gender and knowledge in healthcare that must be addressed in order for interprofessional teamwork to be realized (Bell, Michalec & Arenson, 2014; Price et al., 2014; Reeves, MacMillan and Van Soeren, 2010). Despite the entry of more women into medicine and more men into nursing, gendered and patriarchal notions toward the work of other "helping" professions remain, which comes

through in how healthcare professionals interact and relate with each other today. Thus, governments, healthcare organizations, and professional associations must look critically at how the work of nurses and others remains gendered within the healthcare system and the team by addressing systemic inequities such as the gendered and status laden language, work routines, and documentation that still conveys subservience (e.g "doctors orders") and discourages involvement in the everyday, institutional, and system decision-making processes (Bell et al., 2014). In addition, the social history of both professions and of obstetrics itself needs to be acknowledged in healthcare curricula (Price et al., 2014). It must be actively worked through within formal educational programs and carried through during the early socialization period when it seems ideas about working together continue to be formed and acted upon.

Future critical research is recommended. First, this research endeavor involved only nurses. Future efforts could include the other important groups identified during this study, including residents, physicians, obstetricians, and charge nurses. These perspectives are needed in order to fully understand nurse-physician teamwork in this context.

Limitations

This study has some limitations. First, the study was conducted on one unit and so the findings are, therefore, not immediately generalizable, although the aim of qualitative research is rich illumination of a phenomenon, which can then be transferred to a range of contexts. Further the majority of participants were from a younger cohort thus it is recognized that important voices may be underrepresented, including charge nurses and more established nurses on the unit. It is important to note that at the time of observations

on the unit, many nurses also remarked how quiet the unit was, which meant that fewer observations of nurse-physician interactions were made than would otherwise be expected. Lastly, all observations were made at the desk. Other research supports this positioning as suitable for observing nurse-physician interactions, recognizing it to be a back stage interaction as opposed to being something that would occur in front of the patient (Scott & Pollock, 2008, Svensson, 1996).

Conclusion

This research was undertaken to understand nurses' perceptions of interprofessional teamwork in labour and delivery. What was discovered is that these nurses' underscored the quality of their relationships with physicians for effective teamwork. A closer look at the characteristics of their relationships as described by nurses revealed taken for granted aspects related to power, conflict, hierarchy, and knowledge. Nurses feel they do well to navigate this complex social and deeply hierarchical environment; however, on-going problems within their relationships as it relates to honest, open communication, disrespectful behaviour and healthy conflict resolution were exposed. Nurses also described facilitators of achieving relationships with physicians that were responsive, which is essential in labour and delivery. Nurses believe quality relationships based on trust and respect are paramount in affecting intent to stay, communication patterns that benefit the patient and positive patient outcomes. There are important insights that can be gleaned from this critical work, for the organization, educators and most importantly, nurses themselves. Effective teamwork cannot easily be implemented without regard for underlying issues. Healthcare leaders must be aware of the critical role they have creating the healthcare culture needed to

support the attainment of the open, honest, and equitable working relationships required amongst physicians and nurses in order to promote safe patient care.

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Chapter Four

Discussion and Conclusions

Significance of the Study

This study has contributed substantively to what is known about interprofessional teamwork and methodologically. This research has produced a rich description of what labour and delivery nurses think and believe, how they behave, what they value and how they contribute within this interprofessional team, when working with physicians. Although nurses' descriptions of teamwork exists in the literature (Simmons & Sherwood, 2010), their exclusive views have been less prevalent than a collective perspective. As a result, these nurses focused on their relationships with physicians, specifically, the quality of which was found to be imperative for effective interprofessional teamwork in this setting. This major theme has been discussed in Chapter three, which will be submitted for publication. Other studies have also made mention of quality relationships being important for teamwork with physicians (Al Sayah, Szafran, Robertson, Bell & Williams, 2014; Piquette et al., 2009; Simmons & Sherwood, 2010) yet the results of this study go further to highlight the centrality of this theme. Much more, as well, has been learned about the dynamics of the relationship that nurses and physicians share when working together in labour and delivery as it pertains to power, conflict resolution, hierarchy and knowledge. These nurses, as in other studies, acknowledge working in a traditional hierarchical structure in which the physician is ultimately responsible for the decision making related to patient outcome (Baxter & Brumfitt, 2008; Nugus et al., 2010). They recognized their own role in sharing clinical information that would assist the physician in decision making and alerting them to action. Their role as communicators of the

patient condition in order to primarily assist physician decision-making has been recognized (Piquette et al., 2009; Propp et al., 2010). Like other studies, nurses in this study were not found to be powerless but exerting influence within the relationship in familiar ways (Lyndon, 2008; Simpson et al., 2006; Paynton, 2009). On one hand, a few of the nurses accounts, namely an increased sense of autonomy when left alone on the unit and the influence they had over new resident learning and socialization, correlated well with negotiated order literature that concluded nursings' improved status and rejecting hierarchical understandings of the relationship (Allen, 1997; Svensson, 1996). On the other hand, their relationships were found to be nuanced, as certain aspects still strongly resembled the doctor-nurse game or some variation of it, specifically when they used passive communication strategically when requesting something from the physician and when they evaluated their relationships with physicians and subsequent actions in terms of respect relayed (Stein, 1967; Lingard et al., 2004).

The presence of disrespectful behavior, at the hands of a few but well known individuals, continues to have a significant influence within the workplace on nurses, residents and even patients. Disrespectful and even disruptive behaviors have been acknowledged within the literature in this context (Lyndon, 2008; Veltman, 2007; Leape et al., 2012). Nurses confirmed a well-known tendency of choosing to acquiesce or circumvent disrespectful behavior (Lyndon, 2008; Simpson & Lyndon, 2009) in an effort to smooth and preserve the working relationship. More research is needed to understand the factors that influence nurses' response to disrespectful behaviors and conflict within the team.

Nurses highlighted the strong collegial relationships they shared with new obstetrical residents in this study. Other studies have recognized the role that nurses may have on the team to share their knowledge and mentor new residents (Propp et al., 2010; Lingard et al., 2004). The extent to which these nurses perceived themselves to have control over new resident experience if professional respect was not perceived has also been documented (Lingard et al., 2004). Taken together, the findings from this study may make important links to the literature on nurses' specific role in the socialization of new physicians that is suggestive of certain power dynamics that may be unique to this relationship for a brief period of time (Burford et al., 2013; Lingard et al., 2004; Weller et al., 2011).

The emphasis that these nurses ascribed to the attainment of practice knowledge centered around medical aspects of care in order to have good working relationships with physicians has been recognized previously (Lyndon, 2008). Further, the weight given to clinical or technical information in their interactions, despite knowing much more about the patient experience has also been documented (Stein-Parbury & Liaschenko, 2007). For some of these nurses, professional competence on the part of the physician outweighed any kind of social incompetence, even to the point of overt rudeness towards them further pointing to the hegemony that medical knowledge has within this team. This finding is connected to nurses' responses to disrespectful behavior and more research is recommended to confirm attitudes linking knowledge and professional respect with other groups of nurses.

Nurses identified four main facilitators of their working relationships with physicians in labour and delivery. These facilitators as well as the characteristics of the

relationship have been identified as relational and processual factors within Reeves et al.(2010) framework of interprofessional teamwork. Aspects related to the concept of time and the trust/respect continuum have been recognized previously by nurses as being important (Schmalenberg et al., 2005; Simmons & Sherwood, 2010). Credibility, as described by these nurses to be the byproduct of the trust and respect coupled with the experience needed to garner an individual response from a particular physician, has not been as widely acknowledged in the literature (Schmalenberg et al., 2005). In addition, the numerous friendly well established relationships that these nurses described, particularly with residents starting with or after them, as influencing approachability has also not been widely identified. Thus, more research is needed to confirm these findings with other nurses and explore the similarities and differences in how physicians might reflect differently about these same concepts.

Finally, these findings add to what is already known in literature with respect to outcomes. Positive, established relationships appear to influence intent to stay, communication and the sense that they were working well with physicians to promote healthy outcomes for their patients and families (Kenaszchuk et al., 2010; Lyndon, 2008; Pullon, 2008; Sabatino et al., 2014; Sims et al., 2015). On the other hand, these nurses confirmed links between poor relationships and outcomes, which was supported in the literature (Goldsztejn, 2009; Grobman et al, 2011; Lyndon, 2008; Rosenstein, 2002; Rosenstein & O'Daniel, 2006; Sims et al., 2015). The influence that these nurses felt un-established relationships had on communication and patient outcomes has not been previously considered and more research is recommended.

There were a few aspects of these nurses' experiences that did not correspond with the literature. First, these nurses did not refer to specific areas of disagreement such as fetal heart rate surveillance or uterine hyperstimulation as being sources of conflict with physicians or residents on their unit, which has been previously identified (Simpson et al., 2006). Further, another study identified nurses expecting a flattened hierarchy for teamwork to occur (Simmons & Sherwood, 2010). In this study, nurses desired positive relationships with physicians characterized by trust and respect and were found to navigate the normative hierarchy that they worked in. There may be a few reasons for this finding. First, nurses in this study described sharing very close collegial relationships with obstetrical residents that they identified as being key in their experience of interprofessional teamwork on the unit. Second, the nurses in this study described only a very small group of individuals as perpetrating disrespectful behaviours in comparison to the majority of positive relationships they shared with physicians on the unit.

Taken together this study contributes to what is starting to be acknowledged in the literature about professional culture and its influence on interprofessional teamwork and interprofessional learning (Bell et al., 2014; Hall, 2005; Price, Doucet & McGillis Hall, 2014; Reeves, Macmillan & van Soeren, 2008). The social historical forces that originally established nurses' work as supplementary and subordinate to medicine still seem to be evident in the understandings of their work with physicians today, specifically related to knowledge within the team (Bell et al., 2014). Nurses are not handmaidens; yet at the same time, they are not functioning as equal partners either as evidenced in this study (Tosh, 2007). Communication remains tactical, emphasis is placed on the attainment of practice knowledge that is medically focused and discrepancies exist in

what nurses report knowing about patients and sharing in their interprofessional interactions with physicians.

Future research is recommended as only one professions' experience was explored. Views that should be explored include charge nurses, senior nurses, residents, family physicians, obstetricians and management. Further what these groups say can be put alongside what these nurses have said in order to understand more fully what is happening. Methodologies utilized should continue to be sensitive to the critical aspects that are expected to be found within each of these accounts. Specifically, dynamics that are unique to each professions' culture such as gender, status, knowledge and professionalization (Hall, 2005; Wall, 2010). Midwives, interestingly, were acknowledged as coming to the unit but not included in a description of the larger team. Given the social histories of midwifery, nursing and medicine with regards to labour and birth in this country, a critical analysis of the teamwork as experienced amongst these professionals is recommended. The views from the larger team identified by many of the participants include unit clerks, service workers, respiratory therapists and neonatal staff among others would be valued. Patients, as women, have a unique perspective as a member of the team that also needs to be explored.

This study also contributes methodologically. Specifically, the application of a critical lens was imperative in uncovering an alternative perspective of what nurses think and believe and why they behave the way they do in interprofessional teams, which was found to be significantly underrepresented in the literature. Furthermore, focused ethnographies have been less prevalent and, as shown here, are effective in producing a rigorous ethnographic account, despite their variations from traditional ethnography. Rich

cultural descriptions were produced in this study, while my background in obstetrics allowed me to spend less time in the field and to decipher quickly what these nurses were saying about their work with physicians.

Beyond the main findings reported in the paper, other themes were apparent in the data. First, in interviewing these nurses, many had their own question they wanted answered about the nurse-nurse teamwork on the unit. A large amount of data was collected as nurses shared richly about a range of experiences that need to be explored in the future. Notably, nurses in this study also spoke about the organizational and contextual factors that help or limit teamwork in this context. Given that a known gap exists in the literature on this aspect of teamwork, this may be a worthwhile line of research for the future (Paradis et al., 2013; Reeves et al., 2010). Also, nurses spoke about the process of becoming integrated members of the team. Thus the data could be reanalyzed using grounded theory approach to understand and map this trajectory. Finally, nurses talked about the special relationship they shared with new residents. New questions could be formulated about the nurses' attitudes in the socialization process of new residents in labour and delivery.

Limitations

This study had some limitations. First, it is recognized that this research is time bound. That is, it is reasonable to suspect that the findings may not be reproducible as nurse perspectives change over time; however, one of the strengths of focused ethnography is that it is an applied methodology, producing findings that are useful and can be acted upon, which is the case here. Second, it was recognized that some nursing voices were underrepresented, including senior nurses and charge nurses. Efforts to

encourage more participation from these groups were not successful and it is not known why. Thus this study's sample represents a predominantly younger cohort with moderate levels of experience, which may in fact actually be quite characteristic of most labour and delivery units today. Readers of the research will need to take this into account when considering transferability to other contexts. Thirdly, there were limits encountered at the Birthing Unit with regard to the amount access granted. This was not explicit but sensed due to the added pressure the researcher's presence was adding to an already busy restricted access unit. Hence, all recruitment and data collection took place within a month's time. Although there were limitations, this study successfully produced a suitably thick description of labour and delivery nurses' experiences of interprofessional teamwork that is transferable to other contexts, which is ultimately the strength of qualitative research.

Implications

The study's findings are expected to benefit not only nurses but other members of the healthcare team and the organization as well. Nurses everywhere have the opportunity to reflect on their own role within the interprofessional team and compare their experiences with the ones discovered here. However, there are a few things that nurses and physicians would benefit from reflecting on specifically.

1. Strategic communication, while fundamentally used to get what is needed for the patient, may undermine the actual attainment of honest, open communication and teamwork between healthcare professions, which is a concern;
2. Nurses' proximity to the patient allows them to know unique and important things about the patient, the patient's experience and their response to labour and birth.

This knowledge should be recognized as truth and shared as part of all interprofessional interactions (Polifroni, 2010; Lyndon, Zlatnik & Wachter, 2011)

3. Nurses and physicians must question the environment that exists for new people, ensuring that respectful behavior is available for everyone and that disrespect is not tolerated, even if only at the hands of a few;
4. Nurses must re-evaluate the ways in which they currently manage difficult people, disrespectful behavior and ultimately conflict.

Of course, the issues identified here are recognized as systemic and the organization must see the need for reflection and active participation in the efforts to remedy them. A few key recommendations include:

1. Organizationally, nurses must be supported to share what they know in interprofessional interactions as being essential to the provision of safe maternity care. A culture change is needed to ensure equity so that different kinds of knowledge are encouraged and accepted when coming together over patient care.
2. Social historical issues related to gender and knowledge must be acknowledged to be a part of the very fabric of the system that healthcare occupies (Bell et al., 2014; Wall, 2010). Policies, practices, work routines, communication and language and involvement in larger organizational committees needs to be examined with this lens.
3. Administrators must acknowledge the benefits of ensuring and maintaining positive nurse-physician relationships on the unit and the potential impact that negative or un-established relationships can have on retention, morale, safe communication and patient outcomes.

4. Administrators must swiftly and effectively address all disrespectful behavior on the unit, even if only at the hands of a small number of people. The findings of this study suggest that current solutions, which advertise for nurses or others to report disrespectful behaviors, may not work and new strategies must be designed understanding the underlying forces related to power, knowledge and gender that influence.
5. The organization must also ensure that new people are supported to achieve successful integration as part of the team. Efforts must also be made to encourage staff to engage in conflict, embracing divergence of opinion, but managing it in healthy ways.

Finally, nursing educators have a role in preparing nurses for the interprofessional working environment with an emphasis on being aware of nursing and medicines' social history, the influence of which seems to be evident in the ways they relate and work with each other today.

Knowledge Translation Strategies

Study findings will be shared in multiple venues. I will share the findings with research participants, through posters and presentations. Wider dissemination efforts will include formal publication of the paper found herein in a scholarly peer reviewed journal. *Qualitative Health Research* has been identified as a suitable venue. Conference presentations will also be pursued. Specifically, I will submit an abstract to the annual professional conference for the Canadian Association of Perinatal and Womens' Health Nurses [CAPWHN] for 2017 and/or the Margaret Scott Wright Research Day.

Future Questions

Beyond the data in this study, a number of key questions surface. Much of the teamwork literature has identified mutual trust and respect as imperative to interprofessional teamwork (Pullon, 2008; Schmalenberg et al., 2005; Simmons & Sherwood, 2010) but what is actually meant when exploring these concepts within a profession? Will significant differences in professional culture emerge with regard to these concepts? How do these concepts align with what is being communicated within the organization or even societally? For example, how does a concept such as workplace respect compare amongst professional groups, organizationally and societally?

In regards to what nurses shared about the way they summon physicians to come, an important question emerges around nurse physician communication and patient safety. Specifically, how do physicians make sense of their communication with nurses and requests to come see the patient?

Conclusion

Much was learned through conducting this study about the research process itself and about nurses and their work with physicians as part of a team in labour and delivery. A critical lens has helped to uncover taken for granted aspects of their working relationship related to power, hierarchy, knowledge and gender and illuminated other aspects which these nurses felt were key in influencing important organizational and patient care outcomes. Although there are acknowledged limitations, the findings of this research have the potential to directly benefit the healthcare professionals working within the context where the data was collected and, more importantly, may help shift the focus toward the larger questions that need to be asked about the influence of social history and

specifically gender within healthcare, signaling the need, of course, for more research. Much was also learned from the nurses involved that extended beyond the scope of this study and new questions emerged that deserve investigation. In short, a great deal was learned with much more needing to be discovered.

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Appendix A
Recruitment Poster

Nurses! Participate in a study by sharing your thoughts about working as a team member in labour and delivery

To participate in this study you must be:

- A Registered Nurse on Unit 4E Labour & Delivery
- Worked on this unit for at least 3 months

What's involved?

A **30-60 minute interview** in a place and at a time of your choosing. I would like to ask you questions about your experience of working as a part of a "team" with other healthcare professionals in labour and delivery.

Observation sessions: I would like to observe your work with others on the team. I plan on coming to the unit over a two week time period for 4 hour sessions where I will be at the unit desk to witness teamwork as it is playing out in real life. I will not be asking to observe you when you enter patient rooms or in waiting areas to protect patient privacy.

This project has been reviewed and approved by the University of Alberta Research Ethics Board at Ph # 780 492 2615

If you would be interested, please contact the researcher, Megan Gleddie, for more details on this study at Gleddie@ualberta.ca or Ph # 587 990 3446

Appendix B
Information Letter and Consent
Nurses Perceptions of Teamwork in Labour and Delivery
Information Letter & Consent for Nurses

Research Investigator:
Megan Gleddie
Level 3, Edmonton Clinic Health Academy
11405 87 Avenue

University of Alberta
Edmonton, AB, T6G 1C9
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Supervisor:
Dr. Sarah Wall
Faculty of Nursing, Level 3, Edmonton Clinic Health Academy
11405 87 Avenue
University of Alberta
Edmonton, AB, T6G 1C9
SWall@ualberta.ca
780 492 3801

Background:

You are being asked to be a part of this study because you are a Registered Nurse on this labour and delivery unit who has been working for at least 3 months. The results of this study will be used in support of my masters thesis.

Purpose of this Info Sheet:

To let you know, if you choose to take part, what this study is about, how the information you give me will be used and what your rights are.

Study Purpose:

I want to understand, from a nurses' point of view, what teamwork is and what it is like to work with other healthcare professionals, particularly physicians, within a team.

What do I hope to learn?

I want to learn more about how nurses view their work within a team with other healthcare professionals in labour and delivery. Specifically, I want to understand, from the nurses' perspective, what is happening within it.

What role you have in the research?

Interviews:

- I will be asking Registered Nurses to volunteer their time to be interviewed

- I will be asking you about what it is like, as a nurse, to work as part of a team with other health care providers in labour and delivery
- The interview will be in person at a time and in a location that allows you to talk openly, but privately, about your experiences
- The interview will take no more than 60 minutes of your time

Observations:

- I will also be asking Registered Nurses to allow me to watch them talk with other healthcare providers at the unit desk and in the hallways
- The purpose of the observations is to understand more about teamwork as it plays out in real life.
- I may ask you some questions during my time on the unit in order to learn more about your work with others
- I will not be asking to enter patient rooms or asking to watch conversations in the waiting areas to protect patient privacy
- I will come to the unit over a two week time frame for four hour sessions, including a session or two over a shift change.

Who is eligible to participate?

Registered Nurses who have been on the unit for at least 3 months.

Do you have to take part in the study?

- No, your involvement is completely voluntary and you can change your mind and leave the study at any time.
- As well, you can refuse to answer any of the questions I might ask you during the interview or observations for any reason.

Benefits:

Participation in this study presents an opportunity for you to reflect on your involvement and your role as a member of the team in labour and delivery.

This study will provide information about how nurses work as part of a team in the labor and delivery. This information will be useful to understand how to further improve efforts to keep patients safe and how to improve teamwork on the unit itself.

Risks:

None

Information about your privacy:

- Any information I gather will be kept private
- No names will be linked with any information that I collect for the study
- No names will be used in any research reports or papers
- I will refer to your unit in any reports or papers as a Western Canadian Birthing Unit in order to protect your privacy
- All information that I collect will be kept in a locked cabinet or on a secure hard drive at the University of Alberta. Only my supervisor and I will have access to this information.
- Data from this study may be kept indefinitely in a secure University of Alberta repository where it may be accessed and re-used at a future date. This data would be held in form where the original participants would be unrecognizable.
- Results of the study will be presented back to the unit at the conclusion of the study. Registered Nurses taking part in the study will be asked how they wish to receive this information whether it be a short report, an informal presentation or a poster for the unit.

Further Information:

If you have any further questions regarding this study, please do not hesitate to contact

Megan Gleddie, Masters Student, gleddie@ualberta.ca
Or
Dr. Sarah Wall, Supervisor, University of Alberta Faculty of Nursing, swall@ualberta.ca

The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615

CONSENT

Dr. Sarah Wall , Supervisor, Principal Investigator, 780 492 3801
Megan Gleddie, Masters Student, 587 990 3446

Please answer the following questions with either a Yes OR No (X)

	Yes	No
Are you aware that you have been asked to be a part of a research study?		
Have you read and received a copy of the attached information sheet?		
Do you understand the benefits and the risks of taking part in this research study?		
Have you had an opportunity to ask questions and discuss this study?		
Do you understand that you are free to leave the study at any time and for any reason?		
Has the issue of confidentiality been explained to you?		
Do you understand who will have access to the information you provide and what will be done with the findings at the conclusion of the study?		

Signed _____
Date:_____

Print Name:_____

This study was explained to me by _____(print name)

Signature: _____

Date: _____

** This signed consent form is kept by the researcher in a safe location as described in the attached letter. A copy of the information letter and this signed consent form will also be given to you for your records at the time of signing.

Appendix C
Notice to Unit Physicians and Staff

To all Obstetricians, Family Physicians, Residents, Midwives & Unit Staff,

My name is Megan Gleddie and I am a Masters of Nursing student from the University of Alberta. I will be conducting a study exploring the perspective of nurses about interprofessional teamwork in labour and delivery. The results of this study will be in support of my Master's thesis. I will be on the unit intermittently beginning March 7th for 2 weeks. You will see me conducting observation sessions, witnessing nurse's interactions with other healthcare professionals at the unit desk and in the hallways. I will not be seeking admittance to patient rooms or observing interactions in waiting areas to protect patient privacy. These observations are part of a three part data collection plan which includes interviews and a review of administrative documentation (policies and formal communication) which pertain to interprofessional teamwork on the unit.

Why is this important?
Nurses in labour and delivery are believed to be working as part of a team with physicians, residents, midwives and other unit staff to provide safe, ethical care to women and their families. When teamwork goes well, all benefit; but, when teamwork is strained or breaks down, patients and healthcare providers can suffer. Most studies on teamwork have focused on the 'team' with little attention paid to the perspectives of the professionals that make them up. Nurses constitute ONE professional group whose perspective informs a larger picture of what is happening within a healthcare team.

What do I hope to learn?
I am interested in finding out about what nurses think, say and what they do when working as part of the team in labour and delivery. Specifically, I hope to understand, from their perspective, what teamwork is and how they interact with others when working as part of one.

How are you involved?
While, I am not observing your behaviors directly, you will be inadvertently involved in my study as a result of interacting with nurses who agree to be a part of it. Of course, you may opt out altogether by letting me know if there is a specific interaction that you wish me to exclude from my data.

Further Information:

If you have any further questions regarding this study, please do not hesitate to contact

Megan Gleddie, Masters Student, gleddie@ualberta.ca

Or

Dr. Sarah Wall, Supervisor, University of Alberta Faculty of Nursing, swall@ualberta.ca

The plan for this study has been reviewed for its adherence to ethical guidelines by a Research Ethics Board at the University of Alberta. For questions regarding participant rights and ethical conduct of research, contact the Research Ethics Office at (780) 492-2615

Thank you.

Appendix D
Interview Guide

Demographic/Background information:

Age

Highest level of education (diploma, bachelor degree, masters, PhD in nursing or other)

Have you taken part in any teamwork training on the unit? How long ago?

Interview Questions:

Start off by telling me about yourself, how long have you been a Registered Nurse?

How long have you been working in obstetrics? And on this unit?

Can you tell me about your work on the unit? And what other professions you work with?

On this unit, who do you recognize as part of the team in labour and delivery?

What is your role, as a nurse, as a member of the team in labour and delivery?

What is it like to be a nurse, working as a member of an interprofessional team, in labour and delivery?

From your perspective, what constitutes good teamwork? What makes it good?

Can you think of a time when teamwork has gone poorly? What do you think caused it to go poorly? Why did this happen?

Tell me about the relationships that nurses and physicians have on this unit?

How can relationships affect teamwork from your experience?

Do you think that other professions share your views on what you think good teamwork is?

How do you, as a nurse, contribute to the decisions that are being made within the team? (Probe how they specifically contribute to patient care decision-making)

How is what you do as a nurse valued by other members of the team?

From your perspective, what kinds of things cause conflict within the team?

As a nurse, what kind of influence (or what kind of control) do you think you have within the team? (Probe for kinds of things or situations that nurses feel they have control over when working in a team)

How did the time you spent in nursing school prepare you to work with other healthcare professionals (Probe specifically about working with physicians, obstetricians and residents)?

Is there anything that makes it difficult to be a nurse on the team?

From your observations, would you say that nurses value the same things as other professionals on the team in L&D?

What kinds of knowledge do you bring as a nurse when working as part of the team?

Do you feel that you are able to speak up as a member of the team? (Probe about what influences ability to speak up)

What is communication between team members like? How do you as a nurse have to communicate to be heard? What do you have to do to be heard? (Example of when communication went poorly, why did this happen?