ATHABASCA UNIVERSITY

SELECTED ASPECTS OF THE EXPERIENCE OF BEING AN ONTARIO REGISTERED MIDWIFE PRACTICE PARTNER

By

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A thesis submitted to the faculty of graduate studies in partial fulfillment of the requirements for the degree of Master of Health Studies

Centre for Nursing and Health Studies

Athabasca, Alberta

[August, 2010]

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ATHABASCA UNIVERSITY

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ABSTRACT

In 1994, Ontario midwives became regulated independent providers of midwifery provincially and organized themselves into practices. At each practice two or more midwives act as partners responsible for overseeing a practice as an independent business. The purpose of this descriptive exploratory study was to describe selected aspects of the experiences of being an Ontario midwifery partner, including the benefits and drawbacks and how decisions are made and conflicts are resolved. Convenience sampling was used to recruit nine participants who met inclusion criteria. Semi-structured interviews were conducted via telephone. Findings revealed partnership benefits and drawbacks, decision-making and conflict resolution strategies and indicated that midwives' experiences of partnership emerged from having been an associate midwife or past partner. Limitations include a small sample size, a novice researcher and telephone interviewing. Recommendations for further studies emphasized how to best prepare midwives for partnership and the impact of partner workload imbalance on intra-partnership relationships.

ACKNOWLEDGEMENTS

First I wish to thank Dr. Beth Perry who acted as my supervisor throughout this journey. The realization of this thesis as a completed goal is in part because of Beth's unyielding support and commitment to me. I am extremely grateful for her gentle guidance, wisdom, and generosity to this project. Thanks for helping me to 'hang in there' and find the finish line.

I also want to thank the members of my committee Dr. Kimberley LaMarche, Dr. Virginia Vandall-Walker, and Dr. Mary Sharpe for their time and commitment. All of you are recognized leaders and well respected in your chosen field. Your critical feedback enhanced my academic knowledge and helped me to develop a stronger thesis.

My gratitude goes to the nine participants in this study for their openness and willingness to share their experiences with me.

The financial support from the Athabasca University's Graduate School Disciplinary Research Fund and the Athabasca University's Access to Research Tools Award offset some of the financial burden of this thesis and was much appreciated.

A big thanks to my family and friends for their ongoing support and belief in me throughout this journey of learning.

Finally, I want to thank my colleagues who have been friends and excellent role models both as midwives and as fellow partners. Your example has greatly influenced my work both as a midwife and in the development of this thesis.

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Abbreviations

Association of Ontario Midwives	AOM
Billable Course of Care	BCC
College of Midwives of Ontario	CMO
Canada Pension Plan	CPP
Caseload Variable	CV
Employment Insurance	EI
Independent Contractor	IC
Midwifery Education Program	MEP
New Registrant	NR
Ontario Midwifery Program	OMP
Operating Fee	OF
Partnership Agreement	PA
Registered Midwife	RM
Short Message System	SMS
Transfer Payment Agency	TPA

CHAPTER ONE

INTRODUCTION

Overview

Since 1994, in the province of Ontario, midwifery has been regulated under The Midwifery Act which identified Registered Midwives (RMs) as maternity primary care providers. In addition to their responsibilities for clinical care, RMs who are identified as partners in a midwifery practice are also responsible for operating their practice as a small business (Association of Ontario Midwives, 2003). The key to success in these business ventures rests on the success of the partnerships and whether partner synergy has been achieved. The intent of this study was to better understand the nature of these business partnerships.

To reach partnership synergy, the ideal for any partnership, individual members must collaborate effectively so that their combined abilities help them to achieve results that surpass the sum of their individual efforts (Brown, White & Leibbrandt, 2006; Henneman, Lee & Cohen, 1995; Huxham & Vangen, 2006; Mattessich, 2005; Wistow & Hardy, 1991). This success is due to multiple factors including core values such as members' commitment to participate in their partnership and their personal investment in, and accountability to, the partnership (Campbell, Dieneman, Kub, Wurmser & Loy, 1999; Hattori & Lapidus, 2004; Way, Jones, & Busing, 2001; Russell & Flynn, 2000). In addition, partnership goals need to be mutually beneficial and relevant. Shared leadership in which all members are treated respectfully and as peers enhances the possibility of partnership synergy (Brown et al., Chrislip, 2002; Hattori & Lapidus, 2004; Henneman et al.; Roussos & Fawcett, 2000). Group dynamics need to be managed through assertive dialogue and a commitment to naming and resolving conflicts (Brown et al.; Chrislip,

2002; Hattori & Lapidus, 2004; Henneman et al.; Roussos & Fawcett, 2000). Communication must be well established with responsibilities clearly defined (Brown et al.; Roussos & Fawcett; Wistow & Hardy). Finally, attention needs to be paid to the organic nature of partnerships with continuously evolving roles, criteria and membership (Wistow & Hardy).

Creating and maintaining successful partnerships is so important for Ontario registered midwives (RMs) who are the practice partners and are ultimately responsible for running their practice. The midwifery practice partners work together in a practice group with associate RMs, new graduates (also known as New Registrants (NRs)) or locum RMs providing maternity care to low-risk women. As partners, they, in addition to their clinical responsibilities, carry the liability for operating and maintaining their practice as a small business. As with any partnership, midwifery partners must find ways to manage all aspects of partnership including accountability, fulfillment of roles and responsibilities, decision-making, conflict resolution, and the overall functional running of the practice. With no studies available thus far examining Ontario RMs as partners, there is much to be understood about the experience of being a partner and how they manage partnership dynamics.

The purpose of this introductory chapter is to provide readers with background information on how Ontario midwifery practices are funded as partner-run small businesses, the nature of midwifery partnerships and RMs' legally recognized status in Ontario as Independent Contractors (ICs) and how this impacts partners. As well, the concerns regarding potential liability risk for partners appearing as employers to long standing associates in their practice groups are examined. The researcher`s own experience of being a RM and a practice partner is also discussed followed by a discussion of the study`s significance. The purpose of the study and the research question are then described. An overview of the study is presented including its

design, methodology, participants, sampling approach, data collection instrument, and data analysis process. The chapter concludes with a list of terms central to the study defined and a summary with an overview of the thesis. For the purpose of this thesis, RMs are referred to as only of the feminine gender since this reflects the current membership.

Background

Funding for midwifery practices as partner-run small businesses

Midwifery in the province of Ontario was regulated in 1994 under The Midwifery Act (AOM, 2003). This gave RMs status and recognition as primary care maternity providers. In addition to their responsibilities for clinical care, RMs who are the named partners are also responsible for operating their practice as a small business (AOM). Since 1994 funding for midwifery services in Ontario has been from The Ontario Midwifery Program (OMP), a program within the Community Health Division of the Ministry of Health and Long-Term Care. Funds flow through a contracted Transfer Payment Agency (TPA) to a practice group (AOM). A TPA (for example, a local hospital or community health center) is responsible for contracting with a midwifery practice group for payment of funded services (AOM). These services are primarily for direct clinical care as well as for some discreet non-clinical care. There is an annual budget approval process during which these funds are allocated. Payment is determined by a Billable Course of Care (BCC). A BCC is payment for prenatal, intrapartum and postpartum clinical care for a woman and her baby (AOM). Compensation for each BCC is typically paid to a RM and varies in amount according to her experience level. Another source of revenue for a midwifery practice groups is Caseload Variables (CVs) which are paid out for mostly non-clinical work such as community outreach, hospital and committee work, new practice group start-up costs as

well as supervision and mentoring of NRs for a minimum of 48 hours of work per CV (AOM). Attached to each BCC including CVs is an Operating Fee (OF) which, as a source of revenue, is paid in recognition of the supporting costs to a practice for that unit of work such as rent, administrative support etc... Typically in a larger practice with more RMs, there will be more clients that will generate more BCCs and sometimes more CVs and therefore more OF revenue. While the funds from BCCs are paid directly to the RM in recognition of her clinical care, CV and OF funds are at the discretion and direction of the partners at each practice to pay for the global costs of running their business including offsetting a deficit or generating a surplus (AOM). In many cases, partners would also have access to a line of credit as a business as another source of revenue in the event of a deficit or the partners would provide personal funds to act as cash collateral as needed (AOM).

Structure of midwifery partnerships

At each practice there is either a RM who is the only partner (a sole proprietor) or a group of at least two (or more) RMs forming a partnership (AOM, 2003). Only a RM can be a partner at a practice (AOM, 2003). The number and selection of partners is at the discretion of practice partners although generally the founding RMs who open the practice upon funding approval are the first named partners. Each partnership may have a signed contract or a Partnership Agreement (PA) that lays out the agreed upon aspects of their partnership including roles and responsibilities, conflict resolution processes, how profit and loss will be managed, as well as how the partnership will be dissolved (AOM). Most practice groups use a PA template provided by the AOM but make alterations and changes under the guidance of a practice group hired lawyer and as mutually agreed upon by the existing partners (AOM). (Occasionally some partners may have only a verbal agreement in which case the Ontario Partnership Act as a

provincial legal contract generalized for any partnership involved in carrying on a business would prevail) (AOM). All of the other RMs that work at the practice including possibly a NR, an associate RM or a locum RM would generally have their own signed agreements with the practice group (AOM). While partners carry a financial and legal liability for the practice as a business, NRs, associate RMs or locum RMs are typically solely responsible for the provision of clinical care although they may be expected to perform other non-clinical duties at their clinic (AOM). A chart depicting an overview of Ontario midwifery structures is included below as an overview (see Figure 1).

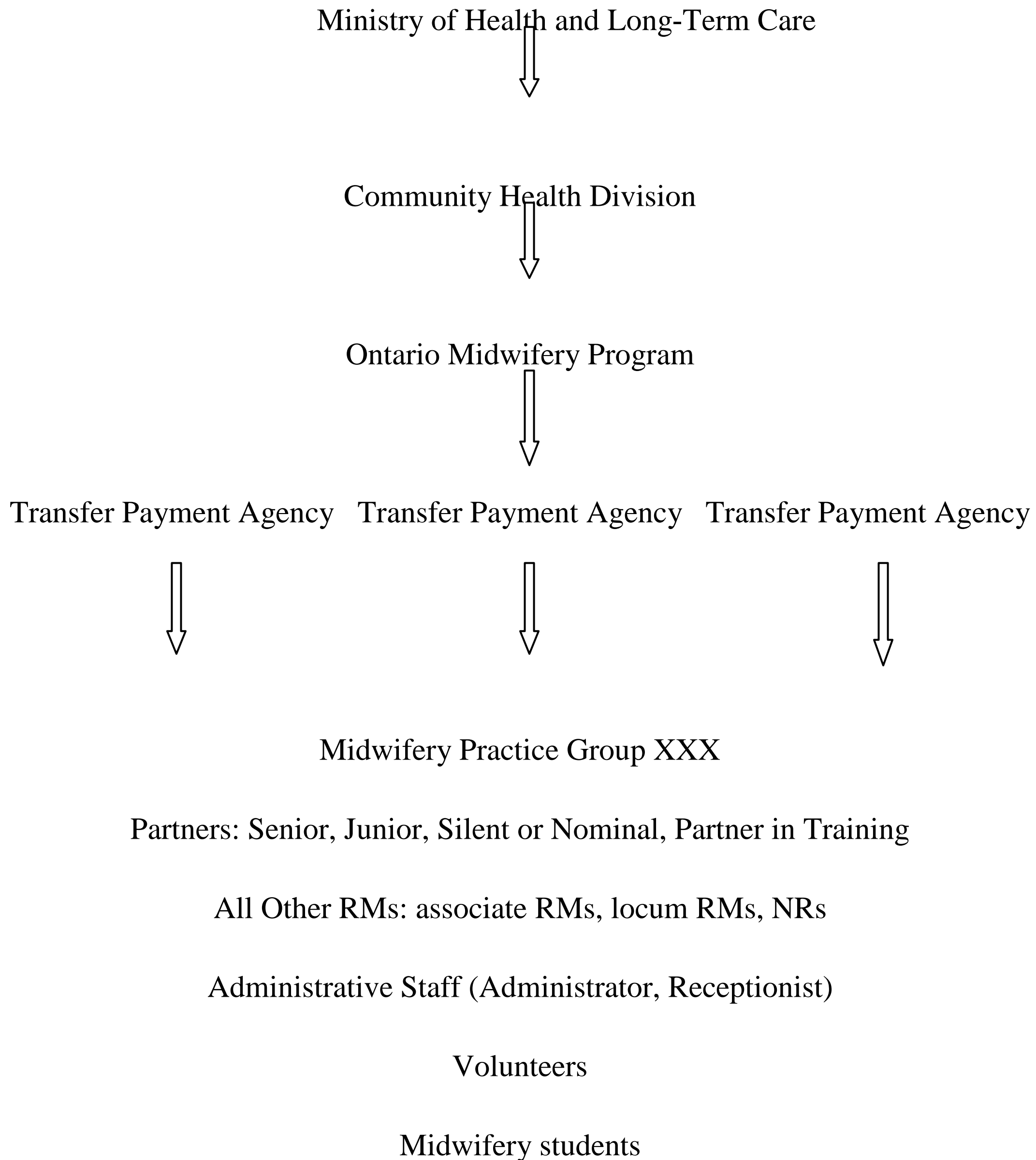

Figure 1. Ontario Midwifery Structure

In Figure 1 the chart demonstrates the flow of funding to the individual practice groups made up of RMs including partners and all of the other RMs. In Ontario, there are currently 79 practice groups. All administrative staff are employees with source deductions paid. Student midwives do clinical placements at a practice as part of their educational training. Volunteers help administrative staff and are not involved in any direct aspect of client care (AOM, 2008).

Practice group partners, in addition to running their practice as a business, also determine practice and partnership structure including the terms and criteria for joining or dissolving the partnership (AOM, 2003). In some practices, the original founding partners continue presently to make up the partnership while in other practices new partners have been added. In cases where a RM does not become a named partner, she remains an associate RM for as long as she is working at the practice. In some cases associate RMs have become long-standing remaining at a practice for many years. Other associate RMs have moved on to other practice groups continuing as associate RMs or as locum RMs or have chosen to open a new practice group as a founding partner (assuming approved OMP funding) or have opted out of midwifery.

RMs status as self-employed ICs

RMs whether they are partners, NRs, associates or locums are all self-employed ICs according to Employment Standards (AOM, 2008). This means they are exempt from paying source deductions such as Canada Pension Plan (CPP) or Employment Insurance (EI) and are eligible for making income tax deductions as self-employed contractors (AOM). In contrast, all administrative staff employed at a midwifery practice group would pay these source deductions as employees of the practice with the partners recognized as their employers (AOM). A staff person such as an administrator cannot be a partner as they are employees (AOM).

Concerns regarding potential liability risk for partners with long-term associate RMs

In May, 2008 the AOM at its Annual General Meeting and Conference held a workshop entitled `Effective Practice Management' which addressed partnership and RMs as ICs. This presentation was repeated as a webinar in October, 2008 in order to reach as many RMs as possible. The presentation was also made accessible to members only on the AOM website

(www.aom.on.ca) (AOM). One of the speakers was Jean Teillet, LLB who explained the potential legal implications of having long-standing associate RMs at a practice and the possible risk for partners as practice owners (AOM). Ms. Teillet explained that at any place of employment a worker is either classified as a) an IC or a partner or b) an employee and that the two categories are never mutual. This worker classification means that an employee can never be a partner and that a partner can never be deemed an employee (AOM). Ms. Teillet then explained that partners not wanting to appear as employer of RMs could consider entering associate RMs into a PA in an agreed-upon capacity such as a junior or silent or nominal partner with clearly assigned and documented roles and responsibilities (AOM). This action would in effect protect partners who ultimately hold the liability for the practice group against looking like employers who have failed to pay source deductions (for example, CPP, EI) and who are contravening all RMs' classification with Revenue Canada as self-employed ICs (AOM).

The researcher's personal experience as a partner

As the researcher, I have been a practising RM in the province of Ontario since June, 2002 at the same practice since my final year of training in the city of London. I was named a partner in my 5th year of practice and joined a partnership with 3 other more senior RMs including the then president of the AOM. This partnership initially was non-tiered with equal division of liability including all profit shares and losses. At my time of entry into the partnership, the practice had an established track to partnership for potential partners which included the criteria of having worked as a RM for a minimum of five years at the practice group with a demonstrated commitment to the practice, excellence in clinical care and an ability to also manage non-clinical responsibilities in a leadership role. Despite meeting all these criteria, when

I was asked to join the partnership I felt honoured to take on this additional level of responsibility. I was proud to be recognized by my more senior and respected peers.

When the AOM hosted the 2008 ‘Effective Practice Management’ webinar, our practice was quick to take steps to protect against the liability that could be associated with having long standing associate RMs. As partners we utilized our most senior RM’s expertise as then AOM president as well as a private lawyer to best incorporate the proposed changes. Our track to partnership criteria changed. For example, a maximum of two years beyond the NR year in practice (if applicable) was imposed and our partnership became tiered with senior and junior partners. Our revised PA laid out the roles and responsibilities for both the senior and junior partners as well as defined the split of profit shares and losses. As with other practice groups provincially, partnership at the practice became then an expectation after one to two years unless an associate RM was asked to leave or was leaving on her own accord.

As a RM and a partner, I have always been a supporter of partnership in part to reduce appearing as an employer but also because I believe strongly that it can (assuming a good ‘fit’) enhance a RM’s commitment to her practice group, to her colleagues, and to her community. As well, I feel partnership can increase a RM’s sense of investment and ownership in her practice and build her leadership potential. With the right team of RMs, the practice group as a business is made stronger with RMs working together collaboratively through consensus. This strengthening as a team can also domino to positively impact clinical care and clients.

I view becoming a midwifery partner as an achievement on many levels. It reflects a change in status legally within a practice group in terms of financial liability and additional roles and responsibilities. It brings an increase in knowledge and awareness of practice operations. It is

also an important rite of passage for a RM that reflects recognition by her peers, a maturing in her role and an opportunity for increased leadership. In recognition of this, I feel becoming a partner is of cultural significance and an important milestone for RMs personally in terms of their career as well as for practice development.

The focus of my thesis was therefore borne out of my own values and beliefs regarding partnership but also the topic seemed timely and relevant to Ontario RMs in light of the AOM's 'Effective Practice Management` presentation. I was aware that midwifery practice groups including my own were having many partner meetings and discussions with lawyers to determine how to protect ourselves as partners against potential liability risk and the implications for both current and future partners. As well, upon starting the literature review for this project, I was unable to source any research on the subject of RMs as business owners much less Ontario RMs as partners making it seem a needed area of study. As an initial research focus, I felt examining aspects of the experience of being a partner for an Ontario RM would make a good starting point to lay a qualitative foundation. An increased understanding of aspects of being a midwifery partner I felt would be of value for all those involved in partnership and for future partners. Similarly, I felt a descriptive qualitative study was appropriate as little is known about this complex human experience (Richards & Morse, 2007).

Finally as the researcher I was aware of how my views and perspectives could be influential as the instrument of data gathering and analysis (Richards & Morse, 2007). As making data in qualitative research is a collaborative and interactive process negotiated by the researcher and her participants, I was mindful of how my own experience of partnership - both past and current - could shape this study (Richards & Morse). Although a potential source of

partiality, I feel the awareness of my experience as a partner was overall beneficial to me as the researcher to create richer data and deeper understanding.

Significance of the Study

This recommended change in status for RMs from associate to partner would mean entering into a new level of responsibility and relationship with colleagues. These associate RMs would join partners in a joint effort as business owners. This change has been adopted by many midwifery practice groups provincially in Ontario. As RMs work closely together sharing clinical on-call responsibility, it is crucial that they also learn how to become effective partners in matters such as caseload planning, budgeting, and overall leadership of the practice group. There is much at stake. Just as a well run practice can enhance the relationships between RMs as partners and as clinicians, mismanagement is ultimately capable of eroding a practice at its core leaving RMs (and potentially their clients) at risk. In light of this heightened awareness of the potential risks for partners maintaining long-term associate RMs and appearing as employers, understanding the experience of partnership for Ontario RMs including the perceived benefits and drawbacks, the process for decision-making, strategies used for conflict resolution, as well as how RMs learn to become a partner is felt both a timely and relevant area to investigate.

Beyond being germane to Ontario RMs, the study is felt to be relevant and timely particularly to three of the primary stakeholders that shape midwifery in Ontario – the AOM, the College of Midwives of Ontario (CMO) as the regulatory body of midwifery in Ontario and the Midwifery Education Program (MEP) which educates and prepares future RMs through a Bachelors of Health Sciences (Midwifery) degree. The AOM's interest could mostly be in light of their 2008 `Effective Practice Management` presentation and how midwifery practice groups

have decided to structure their partnerships. As the AOM is also invested in its membership in terms of supporting practice group development, a study that aims to understand the dynamics of partnerships and the needs of the partnerships could be seen as beneficial. The CMO is mandated to protect the public, to respond to complaints regarding RMs as regulated practitioners, and to develop and maintain standards of professional ethics (CMO, 2008). In situations of extreme practice group instability due to unresolved conflicts, client care potentially can be compromised. As internal practice group instability may be influenced by aspects of partnership such as decision-making and conflict resolution, the CMO may be interested in this study from a public safety perspective. Additionally, the CMO's processes have at times been burdened with investigating complaints stemming from these types of practice disputes including partnership breakdowns. In an effort to mitigate these disputes and build a stronger foundation of business education and contractual relationships for midwives including partners, the study provides insights into the types of knowledge RMs as small business owners would find beneficial (R. Kilpatrick, CMO Deputy Registrar, personal communication, September 17, 2010). Finally, the MEP as the educational component preparing students could be interested in determining whether details pertaining to partnership are included in the curriculum and if so, at which level. For currently practising RMs working in practice groups that are currently deciding for themselves whether to make any changes to their existing partnership and practice group structures, the study provides much-needed insight into the realities of being a partner including its benefits and drawbacks and overall responsibilities.

Overview of the study

Purpose of the study

The purpose of this descriptive exploratory study towards a Masters of Health Studies at Athabasca University is to describe aspects of the experience of being a partner in an Ontario midwifery practice. The aims of the study are as follows:

1. to describe the inner workings of midwifery partnerships in particular decision-making and conflict resolution processes;
2. to detail how RMs learn the role and develop the skills of being a partner and
3. to illustrate the benefits and drawbacks of being a partner.

Research Question

The research question is to describe aspects of the experience of being a partner in an Ontario midwifery practice group. Specific questions include: How are conflict resolved and decisions made within a partnership? What are the perceived benefits and drawbacks of midwifery partnership? How do RMs as new partners learn their role? What are the assigned roles and responsibilities of partners? Overall how satisfied are participants with being partners and what, if anything, would they change about partnership?

Study Design and Methods

A qualitative descriptive approach was chosen for this research because the goal of the study is to detail aspects of partnership from the participant’s perspective in her own language and in all of its complexities (Marshall, 1996). By utilizing a qualitative framework, the PI acknowledged that there are multiple possible realities constructed by different individuals

related to the partnership experience (Trochim & Donnelly, 2007). As a descriptive study, it was exploratory in nature with an attention to detail (Trochim & Donnelly).

Data collection involved a series of open-ended interview questions reflecting the aspects of midwifery partnership which are the focus of this study. Questions were added to the interview schedule pertaining to Ontario RMs to better ascertain demographics and determine specific roles and responsibilities of respondents.

Study participants and sampling

The study's inclusion criteria included Ontario RMs who had been practice partners for at least two years and who work in a practice with at least one other partner. Participants had the ability to articulate and reflect on being a partner and by consenting to be in the study would have (hopefully) the time and willingness to participate in the given time frame. This group would be homogenous in terms of selection criteria. The PI also reasoned that for participants to be able to comment on aspects of partnership they would need to have been a partner for at least two years, if not longer, at one practice. As the PI is interested in the dynamics and relationships within a partnership, solo partners were excluded as it was felt they would have a different and unique experience running a practice independently.

A convenience sample of nine Ontario midwifery partners who met the inclusion criteria were recruited for this study. Although the total number of respondents needed to reach data saturation is not defined, it was anticipated that the final sample would be between five and 10 individuals. An attempt was made to include a balance of rural and urban RM partners as well as both newer partners – still with at least two years experience - and those more experienced.

Data Collection Instrument

Data collection involved a semi-structured interview. The interview schedule included a series of open-ended questions reflecting the aspects of partnership that are the focus of this study namely decision-making and conflict resolution processes, learning the role of being a partner, and the benefits and drawbacks of midwifery partnership (see Appendix A). Questions were added to the interview pertaining to Ontario RMs to better ascertain demographics and determine specific roles and responsibilities.

Interview Data Analysis Approach

Once the interviews had been transcribed and verified by the participants as accurate, the interview data was coded for themes. Two participants were asked to verify themes from their interview as a means of strengthening the rigour of the study. The analysis unfolded inductively with the interview data organized into categories according to the interview guide questions.

Definition of Terms

Several terms that are specific to this study are defined to help achieve clarity.

Registered Midwife (RM) – A regulated health care professional who provides primary care to low-risk, healthy women throughout pregnancy, labour and birth, and postpartum for up to six weeks. There are currently approximately 500 RMs in the province of Ontario (AOM, 2003).

Partner - A RM who is a member of a practice who has signed a Practice Group Partnership Agreement (AOM, 2003).

Partnership – A legally recognized relationship wherein the owners or partners share the responsibilities, profit and liabilities for running the practice (AOM, 2003).

Associate Midwife – A RM who is not a NR nor a locum nor a partner. A RM becomes an associate once she has completed her NR year. She remains an associate RM until she is either named a partner or leaves the practice. She typically has signed an Associate RM Agreement which as a contract lays out the terms of agreement working at a practice group. As a non-partner, an associate RM carries no liability for the practice as a business however may be expected to complete non-clinical responsibilities within the practice (AOM, 2003).

Independent Contractor (IC) – A classification for all RMs in the province of Ontario as recognized by Revenue Canada that reflects their status as self-employed and therefore not as employees of a practice group (AOM, 2008).

New Registrant (NR) – A newly graduated RM typically in her first year of practice who receives mentoring and clinical support from a more senior RM. She is contracted by a practice group as a mentored RM and signs a Mentored RM Agreement (AOM, 2003).

Association of Ontario Midwives (AOM) – A professional body that represents in the province of Ontario RMs and the practice of midwifery. The AOM is active in aspects such as public education, representation of RMs to the Ministry of Health and in advocating for the interests of Ontario RMs (AOM, 2003).

College of Midwives (CMO) - The provincial regulatory body that determines the qualifications and status of RMs in Ontario and sets the standard and scope of practice for RMs. Its role is to protect the public by ensuring standards of care are being met and by providing available disciplinary action when deemed necessary (CMO, 2009).

Midwifery Education Program (MEP) – There are three universities in the province of Ontario that prepare future midwives towards a Bachelor of Health Sciences (Midwifery) including

Ryerson University, McMaster University and Laurentian University. Students learn through a mixture of clinical placements and courses that emphasize health, social and biological sciences (MEP, 2010).

Transfer Payment Agency (TPA) – An organization such as a hospital or community health center which has been approved by the Ontario Midwifery Program to transfer funds to a practice group through a signed agreement for budget approved billable courses of care and caseload variables (AOM, 2003).

Billable Course of Care (BCC) - A completed unit of work that includes a course of midwifery care for a minimum of 12 weeks upon discharge or more typically a full course of prenatal, intrapartum, and postpartum care up to six weeks past delivery. BCCs are paid typically to the RM who has primarily provided the client care upon the client`s discharge. A maximum number of BCCs allowed is determined through the practice group`s TPA. A full-time RM would generally complete 40 BCCs per year with approximately four women due each month (and eight weeks annually of vacation time) (AOM, 2003).

Caseload Variable (CV) - Another type of BCC that is paid for those completed recognized and budget approved activities that are generally not a clinical course of care. These activities include outreach to specific client populations such as teen or isolated women, mentoring for a NR as well as travel for practices whose catchment area is very large or remote (AOM, 2003).

Locum Midwife – A locum RM acts as a temporary member of a practice group contracted to provide midwifery services for a defined period of time. Often locum RMs are covering a leave. A locum RM has the same clinical responsibilities as any other RM. She does not however have

any responsibility for operating the practice as a business and therefore is not a partner of the practice group.

Incorporation – A legal entity in which a company is owned by shareholders. The shareholders are protected by limited liability in Canada (AOM, 2003).

Practice Group – An organization formed by midwifery partners to provide midwifery services. A practice group is made up of partners as well as NRs, associate RMs and locum RMs (AOM, 2003).

Chapter Summary

This introductory chapter has set out some of the key components of any effective partnership that potentiate partnership synergy. For Ontario RMs working in practice groups with named partners who carry ultimate responsibility for the practice as a business, developing an understanding of aspects of their experience is felt by the researcher to be both timely and relevant in light of the changes some practice groups are currently making to their partnerships. The researcher also asserts that the three primary stakeholders surrounding Ontario midwifery – namely the AOM, CMO and the MEP – as well as Ontario RMs themselves would find this research pertinent and applicable to their professional working relationships. The study which uses a qualitative approach to develop rich description examines many aspects of partnerships including roles and responsibilities, benefits and drawbacks as well as decision making and conflict resolution.

The following chapter examines in more detail what is known about partnerships themselves in terms of core values, partnership dynamics as well as personnel and environmental factors that help and hinder any partnership. From establishing the current research on

partnerships, the thesis then focuses in Chapter Three on the study itself further describing in detail the methodology used. Chapter Four presents the results of the study and organizes the participants' responses according to the interview guide questions. This chapter includes examples of experiences of the participants as an aggregate as well as quotations from individual participants. The final chapter, Chapter Five, discusses the significance and implications for the study to give a broader context of partnership for Ontario RMs and the larger midwifery community. Last, the limitations of the study are examined and recommendations are made for future studies examining midwifery partnerships.

CHAPTER TWO

REVIEW OF LITERATURE

Introduction

Partnerships are increasingly being formed across industries to maximize efficiency through collaborative effort (Gardner, 2005; Selin & Chavez, 1994; Spink & Merrill-Sands, 1999). They are formed to share planning, make decisions and achieve goals through partners assuming mutual responsibility (Gardner; Selin & Chavez; Spink & Merrill-Sands). Underlying any partnership, whether formed casually or bound through a formal working relationship as expressed in a contract or agreement, and regardless of the context, there are general elements that influence partnership success. To better understand the experience of being a partner for an Ontario RM, it is valuable to understand the fundamental elements that shape any partnership.

The purpose of this chapter is to present a literature review that provides context and a framework for the research study. The main body of the chapter consists of a review of literature related to eight concepts: (1) the underlying core values in a partnership, (2) the value of trust in partnerships, (3) personnel factors and the influence of interpersonal relationships in partnerships, (4) conflict resolution strategies in partnerships, (5) the impact of environmental factors on partnerships, (6) partnership and developmental stages, (7) barriers to successful partnerships and (8) benefits of partnership. A theoretical framework is described to give a broader overview of partnerships including aspects such as preconditions and necessary processes. The chapter concludes with a discussion of how this theoretical framework relates to Ontario midwifery partnerships.

In examining the research literature on RMs as practice owners and their experience as partners, I was unable to find any published studies despite an exhaustive search. I accessed Athabasca University's library using electronic databases including Pro Quest, Pub Med, CINAHL and Google Scholar. The following phrases and key words were used as search terms: partners, RMs, business owners, collaboration, partnership self-assessment, characteristics of success, and shared leadership.

Although examples are available in the literature of innovative shared clinical practice for RMs with other care providers such as family physicians, these alliances do not entail any shared business ownership and therefore are useful only for their general comments on effective partnerships in a health care setting (Keleher, 1998). However, studies do exist from sectors such as business and nursing which bring to light the shared principles of any partnership. These principles include the core underlying values which are essential for successful partnerships to achieve their goals.

Literature Review – Eight Components of Partnership

Underlying core values in a partnership

All collaborative partnerships have key mutual values that contribute to their success. A willingness and commitment to participate in the partnership is vital. Partners need to be personally invested and accountable to the goals of the partnership (Campbell et al., 1999; Hattori & Lapidus, 2004; Way et al., 2001). Partners need to demonstrate that they are willing to put in effort to build relationships within the partnership since partnership entails an active process (Mohr & Spekman, 1994). Partners need to feel positive about the collaboration and recognize it as useful and productive (Russell & Flynn, 2000). Trust and respect for all members

in the partnership particularly those with diverse viewpoints are core to partnership success (Brown et al., 2006; Kirschner, Dickinson & Blosser, 1996; Selin & Chavez, 1994). Open, transparent and authentic communication, active listening and the sharing and integration of information are viewed as critical to building consensus and developing collective goals and vision in partnerships (Hattori & Lapidus; Russell & Flynn; Way et al.). Partners need to be motivated towards results and have a high level of integrity and investment to achieve their goals and create a sustainable partnership (Brown et al.; Russell & Flynn). They need to be active in joint planning and co-operative efforts (Mohr & Spekman). Each member of the partnership needs to be recognized and valued for their unique contributions, skills, capabilities and expertise (Brown et al.; Way et al.). The work and goals of the partnership needs to be viewed as compelling, timely, mutually beneficial and relevant by the members with the necessary time dedicated to maintaining the partnership (Brown et al.). Leadership is considered essential to partnership success with power shared equally among members with no one individual dominating (Brown et al.; Chrislip, 2002; Hattori & Lapidus; Henneman et al.; Roussos & Fawcett, 2000). As such, all partners need to be treated as peers and not as subordinates with all partners having an opportunity to be heard and to shape decisions (Brown et al.; Chrislip; Hattori & Lapidus; Henneman et al.; Roussos & Fawcett). The collaborative effort must be valued by all partners by working together to promote success (Brown et al.; Way et al.).

Participants need to come to a partnership with a spirit of readiness to work with one another (Henneman et al., 1995). This may mean assertively breaking down or challenging any pre-existing hierarchies or assumptions between members to facilitate shared power and leadership as well as being open and flexible to change (Hattori & Lapidus, 2004; Henneman et al.; Keleher, 1998; Russell & Flynn, 2000; Way et al., 2001). Partners must be willing to make

compromises and remain flexible (Wildridge, Childs, Cawthra & Madge, 2004). Individuals in a partnership need to work in a group and manage group dynamics including being able to confront members assertively and to address and resolve conflicts (Hattori & Lapidus; Keleher; Henneman et al.). They need to be willing to give up personal autonomy for the sake of the group and be invested for the duration for the partnership (Campbell et al., 1999). Any language and cultural barriers need to be addressed and reconciled wherein specific knowledge such as technical language is made clear so as to promote a unified understanding among the partnership's members (Brown et al., 2006).

These principles reflect an approach and a belief system that needs to be assumed by all partners in their interactions with one another. These enacted values are felt to lend themselves to the success of the partnership. Although all of these core values contribute to partnership success, trust is considered critical and is therefore examined more closely.

The value of trust in partnerships

Partnerships need to build trust as it is inherent to a successful collaborative process (Selin & Chavez, 1994; Spink & Merrill-Sands, 1999; Vangen & Huxham, 2003). Trust develops cyclically meaning that as a goal is reached, or as individual partners fulfill their commitments to the partnership, trust is reinforced. This motivates and inspires the partners to seek more challenges or risks which if successful further enhances trust (Spink & Merrill-Sands; Vangen & Huxham). Trust therefore is built in increments and in combination with other important elements of partnership such as conflict resolution. It takes shared power, interdependence, and an investment of time to build trust. In contrast, trust is hindered in cases of domination of one

partner over another when individuals take credit for successes of the collaboration, or when partners seek glory for themselves (Selin & Chavez; Vangen & Huxham).

At the early stages of partnership, trust is anticipated as members expect others to fulfill their promises and come to the partnership with a readiness to commit (Vangen & Huxham, 2003). Ideally goals for the partnership initially should be modest, low risk and easy to attain as a means of establishing a level of trust within the partnership. Later riskier goals and expectations can be set (Vangen & Huxham). To maintain an ongoing high level of trust, partners need to pay close attention to how they work together and not assume that trust will be continued (Huxham & Vangen, 2005). They need to be aware of potential threats to trust when the status of the partnership changes as when a member leaves or a new partner joins and continue to nurture relationships through these periods of transition (Huxham & Vangen).

Trust is also enhanced through partners being honest about their limitations and realistic about what roles and responsibilities they can assume (Gardner, 2005). They need to avoid over-extending themselves or misrepresenting their available time, resources or abilities (Spink & Merrill-Sands, 1999). Finally, should a partner make a mistake, it is imperative that that person take ownership for the error and seek out a remedy to avoid trust being hampered within the partnership (Spink & Merrill-Sands).

Trust within partnerships is seen to be cyclical in nature involving shared power and honest communication. These attributes reflect the human element of partnerships. As partnerships are ultimately a group of people working together to achieve common goals, it is helpful to understand the impact of personnel factors to partnership success.

Personnel factors and the influence of interpersonal relationships

Regardless of the specific context, any partnership is comprised of individuals working together. Researchers agree it is how effectively these individuals work together that ultimately influences outcomes and determines whether collaborative *synergy* to maximize success is achieved (Brown et al., 2006; Henneman et al., 1995; Huxham & Vangen, 2006; Mattessich, 2005; Wistow & Hardy, 1991). Collaborative synergy or a collaborative advantage is achieved when new and innovative solutions or outcomes are achieved through the collective effort of the partnership to create a whole that is greater than the sum of its parts (Lasker, Weis, & Miller, 2001; Spink & Merrill-Sands, 1999; Vangen & Huxham, 2003). To create synergy, partners need to recognize dependence for each other and a willingness to lose autonomy for the sake of the partnership as synergy balances individualism with integration or collaboration (Mintzberg, Dougherty, Jorgensen, Westley, 1996; Mohr & Spekman, 1994). Partners should ideally complement each other and build on each other's contributions (Brown et al.). Partners need to be prepared to invest the necessary time and resources (ideally long-term) into the partnership (Brown et al.). Roles and assignments, as well as the partnership's goals and purpose, need to be clearly defined and explicitly understood by all of the members to better ensure that tasks are distributed across the collaboration and are completed (Henneman et al.; Way et al., 2000).

In effective partnerships, there is recognition that solutions may develop out of confronting differences versus denying them (Jamal & Getz, 1995). For example, when an elementary school that offered placements to teachers formed a partnership with a local university, the participants first needed to examine their previous relationships and roles whereby the university members had been seen as having power and specialized knowledge above that of the placement co-ordinators (Kirschener et al, 1996). By valuing all of the members` knowledge

and skills, the group was able to work together more collaboratively (Kirschener et al.). Without addressing these issues, a barrier would have been reinforced in the group thereby limiting the partnership`s success (Kirschener et al.). This previous association of faculty as experts needed to be challenged by recognizing the placement co-ordinators as equal members of the collaboration (Kirschener et al.). This example illustrates how a past relationship cannot be assumed an advantage to creating partnership synergy. Past relationships may need to be revised and changed in order for partnerships to succeed.

As partnerships involve individuals working closely together to meet goals, there comes a tendency to exhibit strong personal bonds due to frequent contact and interactions between partners, investment of time, as well as open communication (Mohr & Spekman, 1994). This is in contrast to traditional business relationships in which personal exchanges are more standardized in terms of roles and less personalized (Mohr & Spekman). In cases where the partnerships are successful with meeting objectives, relationships tend to be even closer with bonds formed (Mohr & Spekman). The partners may exhibit attributes that demonstrate high levels of energy being directed to the partnership in such forms as commitment, coordination, interdependence, trust, information sharing, participation, and joint problem solving (Mohr & Spekman). These attributes combined add to the close ties between the partners.

While personnel qualities can enhance partnerships especially when close ties are formed, challenges exist that create threats to partners' relationships. These partnership threats can include conflicts. While the source of the conflict is important, the approach taken by partners to resolve their differences is viewed as critical.

Conflict resolution strategies in partnership

Conflict resolution techniques need to be well developed in a partnership. This is in part due to the inherent nature of conflicts within a partnership due in part to the interdependence of members (Mohr & Spekman, 1995; Selin & Chavez, 1994). Just as partners need each other to achieve successful outcomes, they must also all take responsibility to resolve their issues through integrating multiple perspectives (Mintzberg et al., 1996; Selin & Chavez).

Since how conflicts are resolved can be either productive or destructive to a partnership, it is critical to find ways that help partnerships to find solutions that are mutually satisfactory to all members (Gardner, 2005; Mohr & Spekman, 1994). Those more productive techniques for conflict resolution involve addressing the conflict directly - unless it is of a personal nature – and utilizing joint problem solving. Conflicts surrounding tasks are generally easier to resolve than those surrounding emotions (Gardner; Mohr & Spekman). In the case of emotional conflicts the focus needs to be redirected from a personal level but dealt with directly by focusing on the specifics of the conflict (Gardner; Mohr & Spekman). When dealt with constructively, conflict can positively affect relationships (Gardner; Mohr & Spekman).

In contrast, confrontation or dominating is felt to be a counter-productive means of conflict resolution as it can leave a partner feeling defeated by the power imbalance. These approaches can strain partners' relationships (Gardner, 2005; Mohr & Spekman, 1994). Unlike co-operation, dominating or using power coercively can also in effect shut down multiple perspectives therefore limiting creative problem solving within the partnership (Gardner; Mohr & Spekman). Other less effective techniques for conflict resolution include ignoring or avoiding

issues. These methods fail to address the underlying cause of the conflict and can undermine the partnership as a whole and should not be used (Mohr &Spekman).

In cases where a conflict cannot be resolved some partnerships may involve an arbitrator (Mohr & Spekman, 1994). In other cases it is a standard to use mediation (Mohr & Spekman). However, it is felt that although effective at finding solutions, using outside arbitration regularly may suggest inherent problems within the partnership (Mohr & Spekman). Similarly partnerships that are able to resolve conflicts internally demonstrate strength and improved odds of long-term success (Mohr & Spekman)

To manage conflict effectively, partners need to act responsibly recognizing conflict as healthy and inevitable, as well as an indication of change occurring (Connor & Kadel-Taras, 2003). Partners need to commit to constructive conflict resolution strategies to be able to find creative solutions that satisfy all of the members and address conflicts as soon as possible (Connor & Kadel-Taras). They need to be aware of signs of conflict including plans stalling, progress slowing, decreased commitment, and trust issues developing (Connor & Kadel-Taras). Partners need to keep a close watch for common sources of conflict including unclear roles and expectations, a lack of progress in achieving goals and power imbalances (Collaboration Roundtable, 2001). By keeping members engaged in a collaborative process, an environment of collective ownership is created which also impacts partnership success.

The impact of environmental factors

Surrounding any partnership are environmental factors that also influence the likelihood of their success. The reason or rationale for the partnership needs to be well defined and valued by all members with objectives and priorities well defined (Brown et al., 2006). This motivation

lends itself to partners prioritizing attending meetings and making any necessary resources available to the partnership (Brown et al.; Roussos & Fawcett, 2000). Meetings, which are organized to reflect the partnership's non-hierarchical structure and focus on agenda and priorities, should be recognized by all members as key to ensuring frequent, non-fragmented communication and to supporting ongoing interest in the partnership (Campbell et al., 1999; Hattori & Lapidus, 2004; Henneman et al., 1995; Mohr & Spekman, 1994; Russell & Flynn, 2000). Such meetings allow for information to be shared systematically which contributes to tasks being completed more effectively through co-ordinated efforts to reach goals (Mohr & Spekman).

For some partnerships, a more formalized structure and relationship may be felt necessary (Brown et al., 2006; Wistow & Hardy, 1991). This may include a contract or supportive documentation with roles and responsibilities outlined. Such a contract could also be used to detail the process for activities such as decision-making, purchasing or conflict resolution (Brown et al.; Wistow & Hardy).

Structures within the partnership as well as group size can also be environmental factors (Wistow & Hardy, 1991). As previously discussed, any pre-existing relationships may work for or against a partnership (Kirschener et al., 1996). Differing levels of partnership (i.e. senior versus junior) may also impact dynamics. Group size can be also influence the collaboration (Wistow & Hardy). A partnership that is too small may be overwhelmed with tasks and responsibilities and partners may feel they have insufficient resources to the meet the demands. In contrast, a larger partnership may struggle to ensure sufficient time for group communication and to build strong relationships within the team (Wistow & Hardy).

With the necessary values including trust, appropriate personnel and environmental factors, and proactive conflict resolution approaches in place, it would be tempting to believe that a successful collaborative partnership is guaranteed. However, as a partnership is ultimately made up of individual relationships, it is seldom constant and predictable. Instead partnerships are fuelled by changing dynamics comprised of ongoing interactions between participants which must also be considered (Wistow & Hardy, 1991). These dynamics are also influenced by the developmental stage of the partnership.

Partnership dynamics and developmental stages

Partnership*s* are rarely static (Gardner, 2005; Wistow & Hardy, 1991). Instead, they are constantly evolving as roles, responsibilities, and participants change and develop (Gardner; Wistow & Hardy). New members may bring alternative ideas or agendas that may influence the partnership's overall priorities. Individual perceptions and relationships with the partners may change over time and impact status and role (Wistow & Hardy). Members may be more or less invested at times due to varying levels of interest, personal time demands, or conflict with another partner thereby creating a continuum of collaborative effort and contribution to the partnership (Wistow & Hardy).

Partnerships also develop in stages or developmental phases with different terms used to describe these multiple steps (Gardner, 2005; Spink & Merrill-Sands, 1999; Wildridge et al., 2004). These stages reflect the partnership's evolution over time. Specific tasks associated with each phase need to be addressed as the partnership develops (Gardner; Spink & Merrill-Sands; Wildridge et al.). In the initial stages time must be invested to form the building blocks of any

partnership. Acting as the foundation for a partnership, these building blocks include the following actions:

1. develop a vision that gives a partnership purpose and is based on partners' communal values;
2. build shared leadership while recognizing the diversity of individuals' skills and expertise;
3. understand the partnership's focus or goals and seek out each partner's perspective to better ensure a collaborative process;
4. establish power as equitable whereby each partner feels valued;
5. recognize that partners need to work together interdependently building on one another's strengths and limitations to be able to most effective; and
6. create a culture of accountability in which each partner is expected to fulfill their roles and responsibilities (Gardner; Selin & Chavez; Spink & Merrill-Sands).

These steps help partners to connect with one another and start making plans together (connecting). They also allow partners to determine roles and rules within the partnership (contracting) (Wildridge et al., 2004). In such a situation partners use strategic planning to help realize vision and objectives by determining how objectives will be reached by best utilizing resources, responding to barriers and using time and energy most efficiently (Nagy & Fawcett, 2010). The partnership's strategic plan needs to be consistent with the overall vision, mission and objectives of the partnership (Nagy & Fawcett).

Once the foundation for the partnership has been established, attention must be directed to sustaining the partnership to better ensure success (Spink & Merrill-Sands, 1994). Further steps that help sustain successful partnerships include:

1. paying attention to process by developing guidelines that details aspects such as communication, decision-making, conflict resolution and giving feedback;
2. formalizing means of information sharing through nurturing interpersonal relationships and regular communication;
3. considering using consensus building for decisions to create active participation within the partnership by seeking widespread agreement amongst all of the members;
4. developing trust and commitment through direct communication and accountability; and
5. recognizing partners for their contributions and celebrate successes (Spink & Merrill-Sands).

Similarly Gray (1989) describes partnership development using a three stage approach: problem setting, direction setting and structuring. As the preliminary stage, problem setting involves the partnership securing their need to exist (Gray). During the direction setting stage partners determine what the task and broad focus of the partnership will be (Gray). Finally, in the structuring phase, specific roles and responsibilities are allocated (Gray).

These additional steps are critical to partnerships reaching their goals and potentially creating partnership synergy. By paying attention to these aspects partnerships are better able to work collaboratively and keep up momentum to build on successes (Spink & Merrill-Sands, 1994; Wildridge et al., 2004). As success breeds success, each step taken by a partnership that is

collaborative and effective builds on future successful collaborations (Gardner, 2005). Nonetheless, despite success, partners also need to be aware of barriers that can hinder their success.

Barriers to successful partnerships

To aid in the development of successful partnerships, it can be helpful to identify those qualities that act as barriers to partners working together collaboratively. Examples of barriers to partnerships can include members with little interest in a partnership and workload imbalance. Additionally, involving partnerships unnecessarily and hastily constructed partnerships can be other barriers.

Barriers act as hindrances to partnership and can impact partnership success (Wildridge et al., 2004). One example of a barrier is a lack of interest or commitment from one member of the partnership (Wildridge et al.). Partners may also lack sufficient time or resources to contribute optimally to the partnership due to factors such as competing time demands or lack of interest (Hudson & Hardy, 2002). This also negatively impacts the partnership. A partnership struck purely for a political purpose that is not supported by the individuals themselves may make for a weak partnership since partnerships cannot be mandated or programmed and be successful (Mintzberg et al., 1996; Wildridge et al.). Similarly if the partnership is entered into simply to receive incentives or other self interests without any commitment to the partnership's mission and goals, success may be limited (Hudson & Hardy). A 'shotgun' style partnership that develops too quickly with insufficient forethought as to its purpose, or where individual partners have different values, can also be a barrier (Hudson & Hardy; Wildridge et al.).

Work load imbalance for partners is another barrier particularly if it is in part due to complicated bureaucracy (Hudson & Hardy, 2002). The imbalance of work is more perceivable when the individual does not see any value or personal benefits to be gained by all the work they are assigned to do (Hudson & Hardy). Tasks may remain incomplete if partner roles are unclear or the extent of one's responsibilities is not clarified or valued (Hudson & Hardy). Another facet to workload imbalance can stem from an imbalance of power within the partnership in which the most powerful partner is awarded the most benefits and those with the least amount of power – sometime the newest members – are given minimal rewards and maximum burden in terms of workload (Hudson & Hardy).

A partnership that is involved in work that can be best done by an individual is another barrier as partnerships are best used for complex problems (Gardner, 2005). As partnerships can be complex with sometimes slow process, it is important for group decision-making to be used only when necessary (Mintzberg et al., 1996). For matters that are simpler, there can be a place for autonomous decision making by individual partners that does not weigh the partnership down (Gardner). Partners need to have sufficient power to make decisions in appropriate instances (Selin & Chavez, 1994). The best use of a partnership needs to be assessed as partnerships are not always beneficial or necessary. An approach that adopts both shared decision-making and autonomy may be more helpful in some scenarios (Gardner).

Finally, partnerships that are struck without appropriate preplanning are another barrier as they typically lack any vision, mission and planning (Gardner, 2005; Selin & Chavez, 1994). As they are often riddled with conflict and poorly defined roles, partners often become more focused on the conflicts and the partnerships fails to achieve its goals (Gardner; Selin & Chavez). Partners in such hastily constructed partnerships can spend more time on the mechanisms of

partnership than on the end goals of the partnership (Selin & Chavez). With any of these barriers, a partnership may experience collaborative inertia in which little is accomplished (Selin & Chavez).

Barriers to partnership success can be addressed through regular evaluation of the partnership (Selin & Chavez, 1994; Wildridge et al., 2004). Areas of partnership strength and those areas needing improvement need to be assessed (Selin & Chavez; Wildridge et al.) This can be achieved through a partnership self-assessment or as part of strategic planning (Center for the Advancement of Collaborative Strategies in Health, 2007; Nagy & Fawcett, 2010; Selin & Chavez).

Benefits of partnerships

When partnerships are not weighed down by barriers or conflicts, benefits become apparent and members realize the rewards of working together collaboratively and achieving results they could not accomplish independently (Wildridge et al., 2004). Further benefits of partnership success include improved solutions, increased influence, and capability (Wildridge et al.). Partners value the creative approaches that develop as a result of pooling resources (Wildridge et al.). This is particularly of benefit when resources are scarce. In addition, another benefit is higher levels of personal satisfaction in achieving goals through the development of innovative ideas (Mohr & Spekman, 1994).

Examination of all of these components provides an understanding of what contributes to partnerships' success and synergy. Elements that undermine or are destructive to partnerships are also seen. To give a broader overview of partnerships, the chapter concludes with a theoretical framework that examines the necessity for, and development of, partnerships in general.

Theoretical Framework

Collaborative partnership theory as a theoretical framework

Researchers Gray and Wood (1991a,b) have examined the theoretical perspectives surrounding partnerships to better understand their broader purpose. Utilizing different theories, the researchers have incorporated a multi-pronged approach to explain the key components of partnerships. These components include the preconditions (i.e. what is needed for a partnership to exist and the motivating factors that support it), the process of partnership, and partnership outcomes.

The principles of the theories include the following and reflect the complex nature of partnerships: 1) resource dependence theory which asserts that as there are limited resources available (whether material, human, financial or time), individuals or organizations choose to work together in partnerships to maximize return and as a means of managing with limited resources; 2) microeconomics theory which asserts that organizations can achieve financial efficiency and reduce expenses through collaborative partnerships; 3) institutional theory which focuses on the establishment of partnerships to help individuals achieve legitimacy and recognition through their mutual alliance and lastly; 4) political theory which asserts that collaborations are developed as a means of gaining power but also setting parameters of control by defining and limiting partners' decision-making rights (Gray & Wood, 1991a,b).

These theories can be applied to explain the aspects of the experience of being in a partnership including preconditions and process of collaboration. The preconditions of partnership according to Gray and Wood (1991a,b) are influenced by a high interdependence for materials in a competitive market as per the resource dependence and institutional theories.

Additionally a precondition is a recognized need for change and a shared interest in achieving change through joint and mutual actions according to the political theory. Last, as a precondition efficiency needs to be maximized and costs reduced which reflects the microeconomics theory.

The process of partnership includes how individuals or organizations interact to achieve shared goals and vision. According to political theory, partnerships require that the 'right' members are found and that there is agreement with regards to the process for decision-making and time frames for decision-making. Institutional theory asserts that organizations seek institutional legitimacy through establishing partnerships.

This theoretical framework and the components of preconditions, process and outcomes can be applied to midwifery partnerships. The preconditions include those previously discussed concerns regarding long-term associate RMs and consideration for expanded partnership to manage partner liability (AOM, 2008). As well, practice management is a time-consuming task particularly for RMs with demanding clinical responsibilities. By working together as partners, the many aspects of running a business can be better maintained with multiple players. The theories of partnership process include the careful selection of those RMs committed to a practice to become partners as well as emphasizing joint legal and fiscal responsibility as business owners. It also includes setting limitations for partners in terms of decision-making and spending. It also gives partners legitimacy through the establishment of their practice groups.

Chapter Summary

Partnerships are inherently complex. They evolve over time as relationships develop and trust becomes established. Conflict needs to be recognized as a natural and expected part of any partnership. Successful partnerships will find and utilize effective conflict resolution techniques

to address problems that promote multiple perspectives and open dialogue. Partnerships that achieve success avoid conflict resolution approaches that promote dominance or avoidance. Successful partnerships also value trust and understand that it is built cyclically in increments as risks are taken and aims are achieved. Partnerships with poorly defined roles or those struck simply for political gain or incentives often lack the necessary foundations for success. Finally, the collaborative partnership theory explains partnerships develop out of necessity for resources, financial efficiency and legitimacy as well as to secure power. These theoretical components were linked to Ontario midwifery partners seeking to mange resources and finances as well as developing power balances within their individual partnerships.

CHAPTER THREE

METHODS

Introduction

Partnership has been the focus of many studies across multiple sectors such as business, health care and the environment (Gardner, 2005; Mintzberg et al., 1996; Mohr & Spekman, 1994; Selin & Chavez, 1994; Spink & Merrill, 1999; Vangen & Huxham, 2006; Way, Jones & Busing, 2000). None however has examined Ontario RMs as business partners responsible for managing midwifery practice groups. Describing selected aspects of the experience of RMs as partners creates new knowledge and insight into their experience and their needs and is therefore of value.

Chapter Three begins with a rationale for choosing a qualitative approach for this descriptive exploratory study. The research aims are restated. Next, the design and methods are described including sampling, ethical considerations and data collection techniques. The steps undertaken during thematic analysis are reviewed as well as the chosen criteria for validity. The chapter concludes with a discussion of the researcher as analyst as a qualitative research process is interactive creating a potential for investigator biases and personal influence on findings.

A descriptive, exploratory qualitative approach was taken since there is very little known about this topic and rich description will help begin the process of better understanding the midwife partner's experiences. Since no previous studies were found despite an exhaustive search, findings from this preliminary study can help us better understand the complexity of the midwife's experiences in their practices from their perspectives (Leedy & Ormrod, 2005). This approach recognizes the multiple subjective realities as constructed by the participants through a

social construct with a focus on detail and personal perspective (Leedy & Ormrod; Tilley, 2011). As a foundational study, it is meant as a starting point and may lay the groundwork for developing hypothesis for future studies (Tilley).

The purpose of this qualitative study is to describe aspects of the experience of being an Ontario RM partner. The aims of the study are as follows:

4. to describe the inner workings of midwifery partnerships in particular decision-making and conflict resolution processes;
5. to detail how RMs learn the role and develop the skills of being a partner and
6. to illustrate the benefits and drawbacks of being a partner.

Design

Recruitment

Convenience sampling, a non-probable method, was used. This allowed the researcher to locate individuals who represented the group under examination and who were able to provide the most information about the topic of RMs as partners (Mateo & Kirchhoff, 2009). Participants were chosen who were immersed in their role as a partner and whom the researcher felt confident would have the knowledge, familiarity and ability to articulate their experience. The participants were homogenous in terms of selection criteria (Byrne, 2006; Leedy & Ormrod, 2005; Palys, 2003; Richards & Morse, 2007; Trochim & Donnelly, 2007).

A sample size of nine participants was recruited to ensure that there was sufficient depth of description of the phenomenon under study. The optimum sample size was based on the several principles including the scope of the study, the focus and degree of sensitivity of the

subject matter and the quality of the data (Morse, 2000). From the recruited sample of nine partners, all of the participants were interviewed as they gave consent and met inclusion criteria. The scope of the study was felt by the researcher to be fairly narrowly defined and therefore requiring fewer participants to reach saturation. The nature of the topic was reasoned by the researcher not to be too controversial (except perhaps for questions pertaining to trust level and conflict resolution) which would also support a smaller sample size. Last, it was hoped that the inclusion criteria of being a partner for at least two years would render responses to the experience of being a partner that were articulate and reflective. Nonetheless, this small sample size had its limitations as it is quite feasible that non-participants have very different experiences. Therefore the sample of participants cannot be considered to represent all possible experiences (Trochim & Donnelly. 2007).

Inclusion Criteria

The inclusion criteria of the study were Ontario RMs who had been a partner for at least two years and who were in a partnership with at least one other RM. It was important that they were not a sole proprietor (i.e. one RM responsible for ownership of the practice as a business) as the study's focus also included an examination of partners' interactions and dynamics. Two years was chosen as the minimum time frame to better ensure that participants would be informed as to their roles and responsibilities and have some history as a partner. A target was set to interview between five to 10 partners. To better ensure representation provincially, the researcher also aimed to have partners from an array of practices including urban and rural, small (maximum of five RMs) and large, and partners with varying years of experience in their role.

Establishing contact with potential participants

The researcher utilized the AOM website (www.aom.on.ca) to access current contact information for all Ontario midwifery practices including mail and email addresses. As well, the AOM's database included the names of all of the RMs currently working at a practice. However, the RMs who were also the partners at each practice were not identified on the AOM website. The researcher then chose 30 practices that had at least two or more RMs listed on the AOM's website as per the inclusion criteria. Careful attention was paid to include practices from all of the regions of Ontario as listed on the AOM's website (North, South, South West, East, South East, and South Central Toronto) as well as practices of varying sizes. Practices were omitted if they had only a solo RM as listed on the AOM website. As well, any satellite clinics, or those opened recently were also excluded.

In early March 2010 the 30 chosen midwifery practices were sent a three page 'Letter of Invitation' via email (see Appendix B). This invitation included a request to participate in the study. Within the body of the email an overview of the study was provided with a request to practice administrators to forward the email to all the partners at the practice. Email was used as an initial point of contact for its flexibility, easy access to practices, and low cost (Palys, 2003). However the researcher was also mindful of the limitations of choosing to utilize email including that it could be easily ignored or deleted and that there was less ability to ensure the email was in fact forwarded to the partners as requested (Palys, 2003). When the researcher received no replies from this initial contact she then mailed the 'Letter of Invitation' to the same 30 practices. As well, the researcher sent a follow-up reminder email approximately seven to 10 days later again with the `Letter of Invitation `attached. In mid-April, an additional 20 practices were

contacted in a similar manner utilizing both mail and email bringing the total number of midwifery practices contacted to 50 out of the total of 79 existing Ontario midwifery practices.

Following the second invitation potential participants began to contact the researcher via personal email with an expressed interest in the study. Each participant was contacted by the researcher via email to confirm that the partner met the inclusion criteria and to obtain consent. Once confirmed, the participant was asked for a contact phone number and a date was set for the interview. A total of nine partners contacted the researcher to participate in the study and all were included as they met the inclusion criteria.

Ethical considerations

Prior to making contact with any of the practices, the study was reviewed and approved through Athabasca University`s Ethics Review Board. Participants were made aware of their rights including access to a representative at the Ethics Review Board should they have any concerns as to their treatment throughout the course of the study. In addition, considerations specific to the study were emphasized including that as the study's focus included discussion of conflict and erosion of trust, that it was feasible that participation could cause distress and upset, although not intentional. Each participant was therefore reminded to access their local Distress Centre or Lifeworks (an employee-assistance type organization for which all Ontario RMs have access through their benefits program) should they feel it was necessary.

Additionally, each participant was reminded that although any identifiers such as names of individuals or practice groups would be deleted from interview transcripts, it was still feasible that RMs could be recognizable to one another as the Ontario midwifery community is small with approximately 500 RMs. All interview transcripts were returned to participants for

verification that all of the midwifery practice groups were renamed 'XXX Midwives' and that they had blank lines inputted when a participant named another RM. Similarly ethical process was followed when one participant gave an example of conflict for illustration during her interview. The participant then asked that the example not be included in the thesis as she felt it was highly identifiable. In response the researcher chose to omit this description of this conflict from the transcript to ensure it was not included in the thesis. Finally, all of the transcripts and digital recordings of the interviews were kept in the researcher's locked home office to ensure confidentiality and will be destroyed according to the procedures the researcher committed to in receiving ethical approval for the study.

Data collection techniques – interview guide

The questions that made up the study's interview guide were adapted from The Partnership Self-Assessment Tool (Center for the Advancement of Collaborative Strategies in Health, 2007). This is a web-based tool that is valid and accessible at no cost (http://partnershiptool.net). It is meant for any partnership that has been working together for at least six months with a minimum of five partners (Center for the Advancement of Collaborative Strategies in Health). The tool is intended to be used by the partners themselves and not by an external reviewer. The Partnership Self-Assessment Tool allows any partnership to assess how well the partners are collaborating and what (if anything) needs to change. The tool utilizes a series of Likert-scale type questions examining key aspects of partnership such as leadership, efficiency, administration and resources (Center for the Advancement of Collaborative Strategies in Health). The tool also examines partners` perceptions regarding decision-making, benefits, drawbacks, and partnership overall satisfaction levels (Center for the Advancement of Collaborative Strategies in Health).

As this research study was intentionally developed with a qualitative design to garner rich description, The Partnership Self-Assessment Tool was adapted for use in this study by developing open-ended questions based on the tool's main areas of focus such as benefits, drawbacks, available resources and conflict resolution strategies. The questions comprising the interview guide are included in Appendix A and consist of a series of open-ended questions to better allow a wide range of responses (Palys, 2003).

Semi-structured interviews

The interview was developed using a semi-structured format with approximately nine open-ended questions. Each interview began with the researcher reading each participant a statement that summarized the study`s purpose and goals, and reminded them of their rights to confidentiality and to refuse to answer any questions without consequences (see Appendix C). Verbal consent from each participant was obtained. Once consent was given, the interviews typically began with the researcher inquiring as to the practice and partnership demographics. In the event that other details regarding the partnership had been shared by the participant in an earlier email the researcher would also inquire as to these details. There was no set order of questions although to build trust and rapport the researcher usually followed the participant's flow in terms of topics or prompts as they emerged over the course of the interview and utilized her list of questions that comprised the interview guide as central but not the sole ones to be asked (Boswell, 2011). Typically the participant was first asked about how she became a partner, how she learnt her role, and to list her current partner-related responsibilities. Intentionally topics of a seemingly more sensitive area (for example, illustrations of conflict or trust erosion) were asked later in the interview once more trust had been built.

This more fluid approach to interviewing provided several advantages. For example, it was flexible and allowed for issues to be raised and new experiences to emerge while utilizing the interview guide to give some structure and focus to the discussion (Bowling & Ebrahim, 2005; Holloway & Wheeler, 2010; Horton, Maeve & Struyven, 2004; Morse & Field, 1995). As interviews are “a conversation with a purpose” (Holloway & Wheeler, 2010, p.82), an opportunity was created for participants to express their viewpoints freely, to highlight and expand on pertinent areas, and to illustrate their ideas through examples and with stories (Horton et al., Maeve & Struyven; Morse & Field). The one-on-one setting was an ideal format for one-time only interviews. This private approach allowed the researcher to delve into more personal matters and to produce reliable qualitative data (Cohen & Crabtree, 2008).

There are some limitations to any semi-structured interview in light of its social context (Holloway & Wheeler, 2010). It is inherently feasible that participants may not present facts accurately or that they may be selective in their disclosure of an event during an interview (Holloway & Wheeler). Participants may also be reacting to the researcher and modifying their answers to please the researcher or state what is socially desirable versus speaking the truth (Boswell, 2011; Holloway & Wheeler). This effect can be minimized by the researcher maintaining a consistent positive supportive manner with the participant and being accepting of any of their remarks (Boswell).

Each of the interviews was digitally recorded using a Sony IC Recorder. Recording preserved the interview and captured most accurately the participant’s remarks (Holloway & Wheeler, 2010). The researcher placed telephone calls from her home office to each participant at an agreed upon date and time. No interviews were cancelled or needed to be rescheduled due to births or other on-call demands. In cases where participants were contacted at their respective

midwifery clinic, the researcher asked that they consider shutting a door to ensure quiet and privacy. The researcher used her Blackberry to make the phone calls as it has a speaker allowing the device to be placed on the desk to better allow the researcher to take notes during the interview. Participants were reassured that no one else was present during the taping of their interview (aside from the researcher's dog Wesley) and that the recordings would only ever be heard by the researcher, the participant and the transcriptionist. None of the interviews were done in person as all of the participants lived beyond the 50 kilometres radius that the researcher had designated as the travel limit. This was despite sending out the 'Letter of Invitation' to partners working within this radius.

This process of interviewing participants over the telephone was recognized for its advantages and disadvantages (Holloway & Wheeler, 2010; Opdenakker, 2006). It is convenient allowing for wider access to more harder-to-reach populations and sensitive issues may be more comfortably discussed than if the interview were conducted in-person (Holloway & Wheeler; Opdenakker). The response is immediate and makes for an effective use of time (Holloway & Wheeler; Opdenakker). However, the researcher is disadvantaged by fewer social cues or body language therefore the interaction may not be as deep or personal as the researcher must rely solely on voice, tone, and words (Holloway & Wheeler; Opdenakker). Also there may be challenges to create ambiance because the researcher cannot see the participant. With this lack of face-to-face interaction, there may be less spontaneity. Extended pauses may be hard to interpret over the telephone and the researcher may rush on to another question unable to interpret the meaning of the gap in the discussion (Holloway & Wheeler; Opdenakker).

Once completed each of the interview recordings were downloaded to an mp3 file. A secure professional transcription service was employed to create a written transcription of each

of the interviews. A total of 186 pages were generated from the eight transcribed interviews. The interviews were transcribed within a seven to 10 day return time with a cost of approximately $600 paid for with a funding grant from Athabasca University. The one exception was the final interview which had loud buzzing in the background throughout most of the interview creating very poor sound quality making an accurate transcription very challenging. For this interview the researcher reviewed the tape and where possible documented what she could and emailed these notes to the participant for review. Once verified for accuracy by the participant the responses were included in the thematic analysis. However as there was no transcript for this interview, no quotes were used from this particular interview in the results. In contrast, where the recording was clear and the researcher felt the participant's words captured their experience evocatively quotes were used to articulate personal experiences (Guba & Lincoln, 1981).

Once the transcription was available it was reviewed by the researcher for accuracy with any necessary changes made. Each participant was then sent via email a copy of the edited transcript as well as the digitally recorded interview as an attached mp3 file. They were asked to review transcripts of their interviews for accuracy. In cases where there was a gap in the transcript (when neither the transcriptionist nor the researcher could decipher the words) a blank line was indicated on the transcript and the participant was asked to fill in the gap where possible. Each participant was asked to review the transcript within a one to two week time frame with an understanding that a lack of response indicated that accuracy had been met. In cases where the participant could not make out the words a gap remained and the section was read for content only with no direct quotes used. The researcher did receive input from five of the participants verifying accuracy. One to two reminder emails were sent to the other participants however they did not respond. In one case the participant asked that a word be

changed from the interview as she felt upon further reflection that her initial language was too strong. This change was made at her request. Otherwise no further changes were made to any of the transcripts during the verification process. This process was followed for each of the participants to better ensure consistency and validity. Finally two of the participants were asked to verify themes from their interview after analysis. Both of the participants replied to this request and verified the themes without any changes.

Once the transcripts and themes were verified by the participants, the researcher created pseudonyms for all of the participants. These names were chosen randomly and did not include any of the participants' real names. The pseudonyms were chosen alphabetically starting with the letter 'a' in a sequential order that followed the order that the transcripts were prepared. (The first transcript, labelled interview one, was given a pseudonym starting with the letter 'a', the second with the letter 'b' etc...). A complete listing of the participants' pseudonyms is included in Table 1.

Table1. Study participants' demographics

Participant Number	Pseudonym Given	AOM Region	Number of Partners at Participant's Practice
1	Anne	North	3
2	Beth	South West	6
3	Cathy	South West	4
4	Debbie	South West	2
5	Elizabeth	East	6
6	Frances	South West	2
7	Georgia	South Central Toronto	5
8	Helen	South Central Toronto	3
9	No pseudonym given – no transcript available therefore no quotations used	South Central Toronto	>2 (exact number not asked)

Pseudonym Given – Each participant was given a pseudonym for confidentiality. Names were assigned alphabetically in the order that the interviews were transcribed.

AOM Region: Midwifery practices are described on the AOM website (www.aom.on.ca) according to region or geographical area in the province of Ontario. AOM regions include North, South, East, West, South West, and South Central Toronto

Thematic Analysis

Once the interviews had been verified by the participants as accurate, the researcher then listened to the entire tape and read the transcript to gain a broad overview. From there the transcript was re-read and systematically coded by hand for themes based on each of the interview questions as outlined in the interview guide. Coding followed three distinct stages (Miles & Huberman, 1994). Data reduction was used as a preliminary step to be able to cope with the large volume of transcribed data. This helped to decrease the quantity and complexity of the interview data from the study that totalled 186 pages. In the second step similar topics or answers in the data were compared and recorded to allow for similarities and differences across participants to be noted. Finally, in the third stage, conclusion drawing, conclusions were drawn through further analysis and theorizing. These steps were used to analyze the transcripts and to be able to group the responses and report on the findings (Miles & Huberman).

In addition the researcher also noted any overarching themes that were not included within the interview questions themselves. To better ensure valid interpretation the researcher went back to the recorded interview to check that her interpretation was accurate. In cases where participants gave specific examples which the researcher felt highlighted their experiences, quotations were developed to use as illustration of the themes. This process was to ensure major ideas and themes were identified and clearly shared (Trochim & Donnelly, 2007). Through analysis central themes emerged which reveal aspects of partners` experiences.

The researcher as the analyst

As the process of qualitative research is an interactive one between the participant and the researcher, it is critical to examine the researcher’s biases and potential personal influences on

data collection and analysis (Tilley, 2011). As a novice researcher the author was keenly aware of her lack of experience in this role. Although confident in her developed communication skills in her capacity as a RM and practice partner, she had never been personally involved in any research studies and felt a little nervous taking on this new role independently. She was aware of multiple factors that influenced and impacted how she may have interacted with the participants or the communication dynamics. These included factors such as whether the researcher knew that the participant was in a position of authority or leadership or was a more experienced RM (and typically had been a partner longer than the researcher); whether the participant was known to the researcher; and time constraints or the mood of the participant. The researcher was also aware that as a partner herself she had beliefs and opinions regarding partnerships. She tried carefully to use her position as a partner to gain the confidence of the participants as an insider personally aware of the responsibilities while also remaining in a more neutral researcher role. The researcher was aware that being a RM partner herself could also be an asset as she has some familiarity with the topic and has shared knowledge and insight with the participants (Palys, 2003). For these reasons she encouraged participant feedback regarding interpretation of the interviews.

The researcher therefore was reflective throughout the interviewing process. Reflexivity is unique and integral to qualitative research as the researcher plays a part in the study and her presence needs to be accounted for (Donovan & Sanders, 2005). As the analysis of a qualitative study is an interpretive process, it is essential that the researcher remain aware of her role as she infers meaning and draws conclusions and insights into the participants’ responses (Pitney & Parker, 2009).

The researcher was aware of many examples of where her role may have had influence during the interviews. For example, as a novice researcher, she was aware of how her lack of experience doing research might have made her more focused on conducting the interview versus always listening intently to the participant. Also when the participant raised an issue that could have veered the interview in two different directions, the researcher was sometimes unclear as to how best to guide the conversation to avoid missing any of the questions in the interview guide. Finally, the researcher was mindful to try and avoid performing dual roles of both a researcher and a partner herself. Although some examples given by participants were of interest to the researcher in her role as partner, she tried to refrain herself from asking these follow-up questions that were not related to the purpose of the study and the planned interview questions. Also she used active listening, respect and interest for each participant as a means of establishing rapport and creating equality between herself and the participant. She was also mindful that the shared world and culture of the researcher and the participant created inter-subjectivity but that the researcher needed to focus on the participants' thoughts and to seek clarity and meaning of ideas versus basing conclusions on assumptions (Holloway & Wheeler, 2010).

Trustworthiness

Examination of the validity of qualitative research is considered critical as rigour and quality cannot be judged in accordance with a quantitative approach as the methods of data collection are not necessarily standardized or structured (Moule & Goodman, 2009). Instead, the validity of the study was examined using the following criteria: credibility, authenticity, criticality, and integrity. Credibility or assuring the accuracy of the interpretation of the text was sought by having two participants review and confirm identified themes after data analysis. As

well credibility was demonstrated when the last participant verified the accuracy of the researcher's notes because the participant`s interview sound quality was poor. As well, quotes were only used when the sound quality was excellent and the participant's words could be clearly heard. Last, the researcher read and re-read the transcript to be sure when paraphrasing the participant that she was accurately portraying their experience. Authenticity was evident by trying to accurately reflect the experiences of the participants using their own words to reflect an emic perspective. Quotes were used throughout the results section to better enunciate the participant's experience. Criticality was included with a focus on critical appraisal and the researcher seeking to find any alternate meaning or interpretation and being aware of personal bias. Finally integrity was demonstrated through the presentation of recurring and repetitive findings of participants with similar experiences (Trochim & Donnelly, 2007).

Validity is also supported with a secondary criterion including explicitness, congruence and thoroughness. The explicitness of the findings is evident by the researcher being transparent in her interpretation. Congruency is apparent by the researcher seeking to find themes that fit by having two of the participants review the researcher's thematic analysis for accuracy. Finally thoroughness is made noticeable by the researcher seeking rich description to reflect completeness and saturation in description (Trochim & Donnelly, 2007). Thoroughness was however limited by the sample size as it is feasible that the inclusion of more participants would have furthered understanding of the aspects of being a partner for an Ontario RM.

Chapter Summary

The study's focus of selected aspects of RMs in Ontario as practice partners has never been studied. Using a qualitative design, the study examines selected aspects of partnership

experience for Ontario RMs including benefits and drawbacks, decision-making processes and conflict resolution. The study uses semi-structured interviews to develop rich description. Through thematic analysis, the results generated from the participants are prepared as an aggregate as well as according to individual experiences. In the following chapter, Chapter Four, the results are presented for the reader.

CHAPTER FOUR

FINDINGS

Introduction

The results presented in this chapter are categorized according to the questions that were asked to each of the nine participants. The questions, which reflect the major aspects of partnership, were adapted from The Self-Assessment Partnership Tool (Center for the Collaboration of Health Strategies, 2007). Aspects of the experience of partnership that were focused on in this study include the following: how the participants became partners; how they learned the role of being a partner; their current personal tasks and partner responsibilities; how information is disseminated amongst the partners, their experiences with decision-making and conflict resolution within the partnership; the benefits and drawbacks of partnership; the historical level of trust within the partnership and what factors have contributed to it being strengthened or eroded; how well each participant felt the partners in their practice work together; overall satisfaction level with the partnership and what each partner would change about their partnership; and finally their thoughts on moving away from long-term associate RMs to an expanded partnership structure within their practice. In order to give the study context, an overview of the participants is presented as a starting point. To develop rich description, detailed responses including participants' quotations are included. The participants' responses are reported as an aggregate except where quotations were used to further illustrate examples. The researcher was attentive to presenting as many of the participants' experiences as possible in order to reflect both the diversity and similarities of their experiences.

Data analysis

Participant Demographics

A total of nine partners responded to the ‘Letter of Invitation’ and gave their expressed consent to participate. All met the inclusion criteria and spoke with the researcher at an agreed upon time and completed the interview in one sitting. None of the participants refused to answer any of the questions from the interview guide. The participants were all RMs with a range of six to 26 years of experience. All of the participants currently were working in practices in Ontario within a partnership of at least two or more partners. They worked in practices that were classified as urban or rural. Their years of experience of being a partner ranged from two to 26. Six of the nine participants were founding partners meaning they had opened a new practice. All but one of these founding partners were still working at that same practice while the rest of the participants had worked at two or three other practices previously either as partners or as associate RMs. The size of their practices in terms of numbers of RMs ranged from four to 10 with the majority working in practices of seven or more RMs. (See Table 1 for an overview of study participants’ demographics).

Geographical location of practices as per the AOM’s categorization of regions was predominately in South Western Ontario. Participants also were from practice groups situated in South Central Toronto, East, and North. None of the participants were from the same practice or from the West region. (A complete description of the AOM’s regions can be found at their website www.aom.on.ca).

Becoming a partner

Participants were asked to describe the steps they took to become a partner in their practice. Respondents indicated that the process has overall become more formalized and

structured over recent years in part in response to the AOM's` Effective Practice Management` presentation regarding partnership and practice structures (2008). The results demonstrated a variance in how partnerships are currently being developed and structured. Also expectations varied across practices as described by the respondents in terms of number of years a RM would work at a practice before being offered partnership as well as any financial or in-kind contribution required from a new partner.

Six of the nine participants were the founding RMs of the practice. They described being involved in the process of writing the budget proposal to secure the funds to open the practice as well as setting up the clinic. As founding members, these RMs were also the first partners in the practice. They had therefore no track to partnership since as the original RMs, they automatically were the self-proclaimed partners sharing the roles and responsibilities with their other founding partners in their practices. One respondent Debbie described this process of becoming a founding partner as quite simple and perhaps retrospectively too casual:

We were just 2 people who were interested in working in the same city and there was no practice here yet. So we just met at a coffee shop and within about 15 minutes decided to open a practice together. Naive, but it worked. (Debbie)

For those that were not the founding partners, their time track to partnership varied. The shortest time was one year as the respondent completed her NR year and then became a partner. Another was an associate RM for one year and then became a partner.

In contrast, the current time frame of track to partnership was typically much longer as described by the participants. For most of the respondents who were not founding partners, becoming a partner meant working as an associate RM often for at least two or three years before

being offered partnership. During that time, the partners and the associate RM meet on occasions to evaluate and offer feedback as to the associate RM's 'fit' with the partnership including components such as her level of personal investment and interest in the practice and long-term plans as a RM. Most of the respondents cited a minimum five year commitment to the practice as being a requirement before being offered a partnership. If, after this period of time, the associate RM and current partners agreed then the RM was offered partnership. For some practices this time frame was longer ranging from five to eight before a position of partnership was offered. In other practice groups, newly named partners spent an additional one to two years in training before becoming a full partner with more higher level responsibilities such as financial management.

Some respondents described that new partners had to be willing and able to make a financial or in-kind contribution to the practice group. For one practice the participant indicated that an investment of $5,000 to $8,000 was expected from any new partner to be used as cash collateral or to cover the line of credit. This collateral was earmarked for uses such as a financial crisis or to cover payroll advances. RMs at this practice were made aware of this expected financial contribution when they were being considered for partnership and were asked to save up these funds in preparation for being named a partner. In another practice a new partner's surplus or profit share was retained by the practice until it was equal to the share originally invested by the other partners. This participant explained that this could take a number of years and then at that time the partner would be paid her surplus. This process was again made aware to all of the RMs at the practice when they were joining the partnership so expectations were clear in advance.

How partners learned their role

Participants explained that the process of learning the roles and responsibilities of being a partner has changed over time and has generally become more formalized. While some participants had some prior work experience in business settings before becoming partners, many respondents described becoming a partner and a business owner as a completely new experience for them. Collectively they reported that they did not feel well prepared for the partner role when they first became partners.

In general participants who had been partners for many years described the process of learning to be a partner as quite casual. These partners learned by doing and through trial and error in a ‘sink or swim’ manner. One participant described attending partner’s meetings as the new partner and taking on jobs as they emerged utilizing her partner colleagues as needed if she had concerns or questions. Another respondent described accessing partners from area practices and meeting sometimes socially to form a reference group to discuss partner-related matters. These gatherings would often occur on a weeknight evening and were an opportunity for partners to collectively talk about business matters. The respondent indicated that these area practices continue to meet for informal discussions on an ad hoc basis. As well, these practices had met more formally in preparing their new PAs to discuss and compare advice and recommendations they had received from lawyers and accountants. Debbie described the meetings this way,

“We rented a room and all the area partners got together ...we just pick each other’s brains about stuff we’re going through.”(Debbie)

Participants reported that they had few tools or resources available to them to aid with learning business management. One respondent cited making use of the AOM’s Business Manual while another found her local TPA representative to be helpful telling her what

documents needed to be submitted to meet her practice group's contractual obligations to the TPA. Another partner who had gone on to form a new practice as a founding partner reported accessing the accountant and bookkeeper hired from her previous practice in addition to her former partners for advice. Others followed recommendations from spouses, family, and friends regarding running a practice business.

For most of the participants, this lack of formalized training or access to reference materials was challenging as they had no prior experience working in a business setting. In contrast, three of the respondents had some business related work experience. One worked at a financial institution, another ran a small business and the third was formerly an office manager. However, despite these work experiences that gave these future partners some hands-on business experience, they too still all felt they had much to learn as partners. No respondents reported feeling well equipped to run partnerships and none had a full sense of all of what business ownership entailed. Overall, regardless of whether the respondents had any or no past business experience, the learning was described as organic.

This organic learning on the job experience as described by the participants was sharply contrasted to how many new partners are currently learning their role today. More recently named partners reported learning their role in a more formalized manner. New partners or partners in training are learning through shadowing or mentoring. With participants as the more experienced partners, they now acted as role-models and teachers. Specific partner roles and responsibilities were now being double slotted in some practices as described by the respondents so that new partners can learn these tasks. To ensure the continuation of the stability of the partnership, some participants were also involved in writing their own practices' business manual that included components such as partner job descriptions and practice business policies

and procedures. These manuals were being developed by the practice members for a number of reasons including as a safeguard in the event of a catastrophic happening to one of the partners. In such a situation the remaining partners would know how to carry on and fulfill that partner's responsibilities. In addition, as some of the participants were anticipating retirement, they wanted some documentation available to partners to ensure ongoing partnership stability and succession. Similarly some participants reported that in their practices partners were now learning other partner's responsibilities by cross training key partner tasks regularly to create more 'teachers' and expertise within the practice. The documentation in the business manual also assisted with this. One participant, Elizabeth, described her concerns for founding partners who have little experience or resources as business owners. Elizabeth said,

It's a really scary thing when three of four young RMs set up a practice on their own with absolutely nothing in the way of financial education. And despite the lack of experience, they are just as responsible for that practice and its finances as if they had lots of experience. (Elizabeth)

This more formalized process of learning and developing partner roles was also evident in how the participants were currently modifying their partnership contracts and agreements as a point of reference and as a resource. Many of the respondents made reference to accessing the 2008 'Effective Practice Management' presentation hosted by the AOM as well as the PA template available on the AOM website. Participants reported seeking out legal and in some cases also accounting consultations in order to develop their own practice's PA as well as associate RM contracts. In some cases these agreements included how new partners would learn their role as well as more clearly defining partner responsibilities and expectations.

Current tasks and responsibilities as a partner

Participants were asked to describe their personal roles and responsibilities as a partner as well as to list the tasks the other partners at their practice fulfilled. The result is a lengthy inventory of tasks that reflect the workload and level of accountability for Ontario midwifery partners (see appendix D). These tasks reflect the day to day maintenance of a midwifery practice as a business as well as the investment in future goals and the long-term strategic plan of the partnerships and the practice groups.

Participants described partners as the backbone of the practice as partners are ultimately responsible for all aspects of the practice including both provision of midwifery care (in the event of a RM leaving suddenly) and managing the practice group. Furthermore, the respondents noted that partners ensure that their practice continues to function while facing any issues or crisis such as a RM leaving (or being asked to leave) or a financial shortfall. This was differentiated from an associate RM or a NR who is primarily responsible for clinical care of her clients carrying no financial liability for the practice although she may have some assigned non-clinical tasks. Anne describes a partner's responsibility as,

The thing about partners is you have the responsibility to your practice to ensure that when issues come up you will find a way to allow the rest of the practice to continue to function. You are the person who helps them not come to their knees. (Anne)

In smaller partnerships, participants described responsibilities often being split along lines of money versus contracts. For example in these situations, while one partner was responsible for the budget proposal, bank reconciliations, the monthly invoices and the day to day finances of the practice, her counterpart was involved in RM and staff contracts focusing on

contractual details. In general as practices and partnerships grew, more roles were added and responsibilities for these new roles were divided among the partners. Examples of new roles described include: outreach and promotion, hospital relations including Head RM, as well as scheduling and caseload management.

Some participants described that they held specific roles within the practice on a continual basis while others stated that roles were cross-trained to build in more mentors and to ensure more than one partner could function in that role should a partner be on vacation, leave the practice, or become ill. While all participants could list the many jobs done by partners, some conceded that any job list created could never be considered comprehensive as the responsibilities of partners changed and evolved over time. Instead participants felt that partners must be willing to take on new (and therefore more) tasks as this is a reality for partners.

There was variance in terms of what jobs were done by partners versus those done by administrative staff. Generally in larger practices that typically had a higher number of BCCs and therefore more operating revenue generated from those BCCs, there was more opportunity to have more paid hours of administrative staff support. (This is also recognized as a choice made by the partners as to how to spend these operational funds). In some cases administrative staff assumed some of the duties listed in appendix D but under the supervision of the partners. Some of tasks performed by administrative staff included ordering supplies and medications, doing the monthly invoice and quarterly reports and assigning clients. These same practices with higher BCCs also had varying number of hours invested in bookkeepers or accountants specifically to support partners in their work. Frances described her administrator in this way,

"...my administrator is definitely our [sic the partnership] *backbone. There's no question that the only other person who is involved in the running of the business and business decisions is my administrator." (Frances)*

In contrast, smaller practices with fewer BCCs have fewer administrative staff hours. In these practices, partners assumed responsibility for all partner duties as well as some clerical ones.

Partner responsibilities also varied depending on other factors such as whether they were a founding partner opening a new practice. Founding partners opening a new practice described the workload as very heavy taking on all partner tasks at once and putting in many hours per week doing non-clinical tasks simply to set up the practice and clinic space. One of the participants who was a founding partner described spending upwards of 60 hours per week when her practice first opened setting up the clinic. This was in contrast to established practices in which participants reported spending on average between two to 10 hours per week doing partner-related work.

Similarly, in cases where founding partners had no admitting privileges at the local hospitals, one or more partners were responsible for securing privileges, orientating the other RMs at the practice, and ensuring all of them were current in terms of hospital protocols. This again was a major initial investment of time and energy. It contrasted those practices where there were already RMs from a neighbouring practice with admitting privileges. In these cases, it was typically far less onerous for these founding partners to secure privileges and start admitting clients in the hospital.

According to the participants, tasks and workload also varied depending on how practices organized their partnerships. Some participants described the structure of their partnerships as

horizontal with no tiers or levels. For these partnerships, tasks and responsibilities were assigned based on partners' interests and abilities with an expectation of shared workload. Other respondents noted that their partnerships were structured vertically with tiers based on a hierarchical arrangement. Typically the more senior or experienced partners were referred to as core partners or as managing partners and their specific responsibilities differed from the newer, less experienced partners. Core or managing partner roles might include financial management such as signing officer or being named on the lease agreement or overseeing caseload management.

Finally, participants reported that partner work took up much of their time as is evident from the number of partner responsibilities listed. These duties were made more challenging as in addition to partner tasks participants were also RMs working on-call and attending births. One participant Georgia made an analogy of the workload inherent with partnership to that of home ownership and the fact that only partners really know and understand the hours of work involved. Georgia remarked,

*When you buy a house everyone [*sic says] *'well there's so many hidden costs'. I feel like that's exactly what partner work is. It's so much work and on the outside you're like 'how much work can it be – write a budget, sign a contract'?(Georgia)*

Another participant Helen described the many hours of partner work she did including while on vacation. In describing her work as a partner, Helen said,

"It's still continues to be a lot of hours. I'm still working on the schedules, and <u>that's my goal for my vacation</u> [emphasis added] *is to get the next set of schedules finished." (Helen)*

How partner's share information

Participants were asked how they shared information with one another to help facilitate communication, keep up-to-date on practice group business matters, and make decisions. As the participants also worked on-call attending labour and births, their working hours were sometimes unpredictable and irregular. Therefore they recognized the need to establish processes and systems for ensuring ongoing communication with one another.

Most of the participants described having scheduled partner meetings as one way of ensuring partners met together regularly. The frequency of these meetings varied from weekly to monthly to quarterly. Variance was also seen in terms of the length of these partner meetings from two hours weekly to three hours quarterly. In general, participants described minutes being taken for every partner meeting and distributed to all of the partners. All of those partners who reported having partner meetings also stated that they had an agenda consisting of some recurring items as well as some new business. Typical standing agenda items included reviewing the budget and income statements, practice planning, NR hiring, preceptor or student-related issues, hospital relations, and if applicable, a report from the Head RM (who would typically also be a partner). AOM or CMO related concerns were also regularly covered at these meetings as needed as well as updates or reports from partners on tasks that they were undertaking independently. Practice administrators might attend all or part of the meeting.

As in other aspects of partnership, partners' communication was described as evolving and becoming more formalized over time typically as partnerships developed and increased in size. Some participants felt the increased formalization was due to the increase in the number of partners. They felt formal meetings were necessary to ensure everyone was updated on practice

business. As well, meetings provided an opportunity for the partners as a group to discuss matters, make decisions efficiently and build in peer accountability. Overall respondents felt partner meetings were useful and needed.

This was contrasted by respondents who reported that in the past communication and 'meetings' were much more causal and on an as needed basis as described below. For example, Debbie noted when talking about past communication practices,

"After a birth, we'd be in the hallway, we'd grab a room, we'd take 15, 20 minutes to catch up. We'd go 'OK, I guess that was a partner meeting'."(Debbie)

Another partner participant described that in the past partners would meet over lunch but that these meetings would sometimes lack in efficiency because they did not use an agenda. Helen said,

"I felt we lost our efficiency at meetings, we often had lunch and bounced all over the place, then after realized 'oh, we didn't talk about this, and we didn't talk about that'." (Helen)

In addition to partner's formalized scheduled meetings with minutes taken, respondents described that the partners at their practices also used other communication tools to share information and stay updated. These included impromptu meetings and speaking over the telephone. Email was reported as being frequently used to communicate partner to partner although one participant had had some experiences with email that left her feeling that in-person communication was preferred. She felt that although email had the advantages of being quick and an easy way to disseminate information, it was open to misinterpretation and flat because it lacked tone or context. Participants also reported using their Blackberries to text or 'pin' one another or they accessed Short Message Systems (SMS) to communicate.

Some participants also described that their practices had annual or semi-annual retreats as part of strategic planning and maintaining an overview or ‘bird’s eye view’ of their practices. These day long retreats were attended by partners only in some cases or by partners plus administrative staff and all of the other RMs at the practice at other times. The retreats also served as an opportunity to examine inter-partner dynamics in more detail when attended just by the partners. When a larger group or practice personnel attended the retreats, they were meant as a means of building rapport and connections within the practice group. Retreats typically occurred outside of the practice setting and included food and sometimes a social component. Retreats were generally felt to be an important means of building a stronger team for all in attendance.

Decision-making processes within the partnership

The participant`s discussions regarding decision-making processes revealed that different strategies were used making decisions including consensus, autonomous versus all partner decisions, voting and conceding. Underlying decision-making processes were key driving principles held by the partners such as prioritizing practice`s goals and the need for consistency and transparency. Finally the participants discussed the guidelines in place with regards to financial decisions.

All of the participants described different methods used within their partnerships to make decisions. Many used consensus to give all of the partners a chance to voice their concerns and in recognition of their shared liability as a partnership. Another respondent described sometimes conceding or bending if she did not have strong feelings on an issue or if the majority of the partners were leaning a particular way. Another participant said that in her practice the most

senior and experienced RM was recognized and respected for having an expert viewpoint and that partners would rethink decisions if this senior partner had a different perspective. Another respondent indicated that decisions were sometimes made by voting. Should there be no majority or a split vote then each partner`s vote would instead be weighted based on their shares owned within the partnership. In this scenario it meant that the most senior and founding partners with the highest number of shares could use their votes to override decisions. In the event that a final decision could not be reached by one of these strategies, the matter would be taken to a mediation style process.

Some of the decisions participants described were made within their respective partnerships as a group while others could make discreet decisions autonomously. Examples of group decisions included capital cost purchases for the practice or any purchases greater than $500. This was contrasted by another participant who described that all financial decisions regardless of the dollar value had to be discussed with all the partners as their budget was quite tight. This participant gave an example of an associate RM wanting to buy a new toaster for the clinic. The associate RM thought she could just make the purchase and be reimbursed. Instead all of the partners contacted one another and the purchase was later approved but not until all of the partners had had a chance to review and agree to the purchase.

In other cases, respondents indicated that decisions were made more autonomously either by one partner or by a small group of partners. This was cited as occurring in the interest of efficiency and also for more time-sensitive matters. Most of the participants cited a cost range of $100 to $500 that could be spent without seeking approval from other partners. This ability to make purchases independently as partners was described by the participants reflecting an

underlying trust within partnerships and a belief that any purchases made would be made in the best interest of the partnerships.

Another example of a type of autonomous decision included one partner charged with overseeing the archiving of old client charts. The participant described that once this partner committed to taking on this responsibility she would not necessarily bring it back to the partnership for discussion as it was just assumed that she would spend the budgeted funds appropriately and within the allotted time frame. The exception this participant indicated was if a partner was spending beyond the allocated budget then she was expected to bring it back to the partnership for review and discussion. Another factor surrounding autonomous decisions revealed by the respondents was that partners had to remain open to feedback from their partner colleagues and be willing to make concessions.

Some participants expressed concerns as to the efficiency of decision-making especially as their partnerships grew. For example, Cathy who worked in a larger partnership said,

It`s a lot more work in terms of decision-making, right, because whereas before I would just get on the phone with my other partner and we`d hash over stuff on the phone. We`d make a decision and it was done, that`s it. Now, it`s a big production because there are more people. (Cathy)

In response to the decreased decision-making efficiency of larger partnerships some participants described restructuring their partnerships more vertically with different tiers or levels. Each tier would have its own set of assigned responsibilities including one or more tiers responsible for making decisions. Others indicated forming a managing partnership or core partnership group primarily for the purpose of making decisions.

Participants also described the guidelines for decisions regarding money and purchases. These were established to better ensure safe structure limitations were placed on specific financial decisions. These guidelines included a maximum amount that could be spent by one individual partner as laid out in their PA. One respondent described that her practice had a bank card but that there was only one card and that it could only be used by the partners. Additionally, most of the participant`s practices had a limited number of partners who had signing authority. Finally another check was the participants' administrators would bring any purchases of question to the attention of one or more of the partners to ensure they had been approved.

Conflict resolution processes within the partnership

Participants were asked about how conflicts were resolved within the partnership and to describe some of the typical underlying sources of conflict. Sources of conflict included an imbalance of partner work, disagreement regarding the most equitable sharing of profits, working with inexperienced partners or partners with varying levels of commitment to partner work, and newer partnerships that were still building relationships through shared history. Strategies to resolve conflict included keeping better track of partner jobs and hours logged, creating and maintaining a practice culture that emphasizes accountability, spending time together specifically addressing conflict and also spending time apart.

Sources of conflict raised by the participants varied. One cited burnout as contributing to conflict. This burnout could be caused from being a partner and the relentless work demands. Burnout also could be triggered from the demands of being a RM working on-call and being fatigued. Another frequently mentioned source of conflict was in partnerships where there was an imbalance of partner related work. These participants often described feeling overwhelmed

and resentful that their partner colleagues were not doing their fair share. These feelings of resentment were furthered if they felt the profit shares did not accurately reflect the work and time the participant had invested in the partnership. Cathy reported,

It definitely builds resentment when people aren`t pulling their weight and then it`s not addressed. With my other partner, we sort of divided everything in half, but what would happen was she would either forget or not do it, or start it but not finish it. It just wouldn't get done, because there wasn't enough hours in the day. (Cathy)

This sense of work imbalance was caused by many factors as identified by the participants. These included that partners being new and not realizing the amount of work involved in the partnership and underestimating the amount of time it would take to complete partner tasks in addition to doing their work as a RM. A sense of imbalance also occurred when the overwhelmed partner, although feeling resentful, did not necessarily want to give up some of her jobs and picked up the jobs the other partner(s) was not doing without saying anything. Another source of imbalance was the recognition that not all RMs have the drive, interest, commitment or motivation to be partners.

Other factors contributing to conflict discussed included having limited history working together in cases of newer practice groups (and therefore newer partnerships). This could mean that partners were still determining one another`s conflict resolution styles. For example, one partner might want to address a conflict in the moment while another might prefer time to think it over. This could sometimes cause some `head butting` when styles collided. This further raised stress levels associated with the underlying issue of conflict.

Another contributor to conflict according to one participant was partners who stated they were flexible about a decision and were willing to concede until a decision was made with which they did not agree. To illustrate this Georgia said,

It`s the old midwifery problem with people saying `No, no, you take on that task, I don`t want to be involved'. But then they`re miserable, they want to be involved, but they don`t want to have to do it. (Georgia)

Fortunately each of the participants had solutions or at least ideas to help combat partner-related conflicts. Some of these solutions addressed the conflicts directly while others took a more indirect approach. As well, some participants felt giving partners time away from each other would help them gain perspective and allow conflicts to resolve without intervention. Being away from other partners and the situation for a while (for example, on vacation) helped participants gain distance and a renewed perspective.

To solve or prevent conflict from real or perceived workload imbalance, participants described creating a log to document the number of hours partners spent working to better track what jobs they had been doing and how much time they were invested in their non-clinical responsibilities. For another participant partners were expected as part of their partner's meeting agenda to regularly update their colleagues on work they had been doing. In another practice, the respondent described that a retreat was organized as a means of looking at the work imbalance specifically so as to re-establish some balance within the partnership. These processes all involved creating more transparency in partner work and a better awareness of the roles and responsibilities each partner was undertaking.

Another means of addressing partner conflicts as discussed by the participants was to create and maintain a culture not only for the partners but also for the practice itself that supported honest, direct communication. Such an organizational culture was committed to naming problems and seeking solutions. Anne described this saying,

"There may be tears, there may be hard words, but we don't leave until we've actually found a resolution that each of us can live with." (Anne)

Further to this Beth said,

"So it's just getting it all out in the open and acknowledging , 'yes, I can see how you'd be upset about that so how could we have handled it differently'?" (Beth)

As partners, participants described that there was a higher level of expectation that they role-model this behaviour of direct communication and being open to feedback consistently not only with their partner colleagues but also with all of the RMs at the practice as well as the staff. Similarly, partners were expected to realistically assess what partner tasks they could manage and also to voice issues about which they felt strongly. This process again reflects an emphasis on transparency and directness as a means of better prevent and address conflicts.

Participants also described ways of resolving conflict less directly through working together as RMs at births or through chart reviews. This helped to increase partners' respect for one another. Working together in these ways helped the partners to get to know each other in their clinical role. Also partners differentiated clinical decisions and felt strongly that in terms of clinical decisions, all RMs had equal power unlike those matters pertaining to business decisions which they considered the domain of the partners. One participant Frances described this differentiation of clinical versus business decisions as such,

"...running this business has nothing to do with you [sic the rest of the RMs who are not partners] *clinically. We like our clinical group and we feel that we're equals with our clinical group, but that has nothing to do with running the business." (Frances)*

Benefits of partnership

Participants were asked to discuss the benefits of being a partner. Benefits cited included profit sharing and pride and comfort in growing a practice that reflected the respondent's values and vision. As well participants cited decision-making authority, entitlements or perks and newly developed skills as other benefits.

All of the participants had viewpoints regarding profit sharing (also called compensation or being paid a stipend). This was paid to partners (or in some cases other RMs as well) for non-clinical work done at their practices. For practices that posted a surplus, some participants described that partners were recognized for their non-clinical work using different formulas or criteria. This was described as being based on factors such as a partner's caseload (i.e. if a partner did 20 BCCs then they were entitled to 50% of profits as divided amongst the partners as a group). Another respondent indicated that in her practice payment of profit shares was based on tasks done as a partner and the number of hours worked fulfilling those duties. In another cases, the profit was determined based on the tasks performed with some tasks paying out a higher return. For the participant at the self-incorporated practice, profit was divided according to their percentage share of ownership of the practice. Another practice participant described recognizing financially work done by partners and all of the other RMs at her practice including additional non-clinical roles that required advanced expertise as well as political work. All of these tasks

were acknowledged financially at this practice as they were viewed as contributions of equal value and worth.

Profits were paid out from different sources. In some cases, participants commented that the payout was from the surplus at year end. For others, financial recognition was sourced from the operating revenue attached to a BCC. Still another approach described was to use CV funding as a source of money. In contrast, funds for precepting were not used towards profit but were earmarked either to those RMs directly involved in clinical teaching or paid out to all of the RMs as it was felt that precepting was a shared responsibility amongst all of the RMs at the practice.

In other cases participants described that profit was not paid out. This was because there had been no surplus as yet at their practices or that it was reinvested in the practices. (In some cases, some respondent's practice groups did both paying out profit shares and reinvesting). Profit was reinvested for items such as rental costs, administrative support, lunches for weekly practice meetings for all of the RMs and staff, homeopathies, Entonox, paying RMs biweekly and having a financial cushion in the event of an unanticipated shortfall or crisis (e.g. RM suddenly leaving the practice or a bookkeeping error). One participant felt strongly that paying partners out for work done was simply not right. This participant Anne explained,

We always felt it was a bit like stripping the practice of cash. The government, it's a non-profit process. You receive money for care provided and so when there's a surplus of it, really, you have to look at does that surplus belong to everybody or just to those parties. And in our practice, we believe it sort of belongs to everyone to allow it to be used within the practice. (Anne)

Other financial-type perks were cited by participants. These included having their professional fees paid for by the practice including their AOM and CMO annual fees. Additionally, the participants' hospital parking was paid out beyond the travel disbursement attached to a BCC.

Other perks cited were not of a financial nature but were valued by RMs. One participant who was a senior partner was given additional vacation days. In addition, this participant described being able to choose to take on leadership opportunities (e.g. a core team member for a hospital based multidisciplinary initiative) which might also include time off-call to fulfill this role. (Time off was however not the motivation for taking on these leadership opportunities. Instead the partner felt that taking on these roles would benefit the practice). Another participant reported that partners at their practice had first choice as to whether they would be a preceptor. Another perk described was first pick of a clinic room. Another participant reported that the partners at her practice had their own office space which was a non-financial benefit. Another had her caseload filled first while other respondents reported that this was a non-issue as all of the RMs had full caseloads on a regular basis. Others had first pick of vacation but not any additional time off. Similarly most participants said that they would not get particular weekends off as this was worked out with all of the RMs at the practice.

Other recognized benefits described did not carry any financial benefit but could be categorized as fulfillment of a philosophical vision for the practice. Participants felt that the ability to make decisions and shape the development of their practices was a significant benefit. This included working in practices with deeply entrenched values that the participants held themselves. Participants described with pride seeing their practice reach milestones or realize their vision in terms of clientele and outreach or the way in which they practiced midwifery.

Holding decision-making authority that shaped and developed the practice was a perceived benefit. One participant felt this decision-making opportunity had made her more confident and assertive being able to hold others accountable. Others reported job security and flexibility for partners in terms of being able to take leaves or work under different on / off call models as a benefit. One participant Beth said, for me the major benefits of being a partner are a *"sense of ownership, a sense of job security."(Beth)*

Drawbacks of partnership

Participants were asked to discuss the drawbacks of being a partner. Areas cited included additional work and increased financial liability. Additionally, drawbacks reported involved having to manage human resources including dealing with conflicts.

Participants all described an increase in workload as a partner. These were the specific responsibilities as outlined in appendix D with the list of partner tasks and responsibilities. As stated partners had many tasks and responsibilities especially for those when they were just opening their practice. A participant felt the additional responsibilities of mentoring and being a role model was a big responsibility and time consuming. For some, partners worked many hours for no financial gain at year end when no surplus funds were available. For those practices with a profit, partners would either post a profit on paper only but pay additional taxes or take a profit in dollars and also pay higher personal income tax. Partners also sometimes gave up vacation days to do partner work or were called back from their vacation to deal with a practice crisis such as a RM leaving the practice.

Financial liability was another aspect partners were ultimately responsible. They needed to ensure practice bills got paid. They took responsibility for any deficit. Partners, unlike

associate RMs or NRs, were responsible for ensuring the clinic had all the necessary supplies and that the rent had been paid. Helen described this drawback saying,

"The partners were the ones who were ultimately on for providing whatever had to happen." (Helen)

Frances also described as a partner the level of responsibility she held,

"if this business [sic her practice] *can't buy the ergot etc..., etc..., then it's me that on the hook for that." (Frances)*

Partners may also take responsibility when starting a new practice for fronting some of start up money to establish the practice. Helen said,

I was the partner at the time who had the credit available to finance the practice and if I hadn`t we wouldn`t have made it and so I put my house up to finance the practice. All of us personally and from our families put in so much – the three of us. (Helen)

Another large focus of practice work and a cited drawback was dealing with human resource management particularly in terms of conflict. Being responsible for giving bad news to RMs was another drawback described such as informing an associate RM that she was not being offered partnership at the practice. This often also meant that this associate RM would be asked to leave the practice to avoid maintaining long-standing associate RMs. Partner participants also felt responsible for administrative staff and dealing with their issues. This included roles such as performance reviews and sometimes having to fire an administrative staff person. Participants did not feel they always had the skills to handle these responsibilities and found them challenging. Anne described the drawbacks this way,

"If you ask any partner, they`d say it's the money and the conflicts. That`s always the hardest stuff to deal with and often they come hand in hand." (Anne)

Historical level of trust and contributors to strengthening or eroding trust

In general, when participants were asked about the level of trust within their partnerships and what had contributed to trust being strengthened or eroded, their responses were split. Those who reported a high level of trust gave examples of how trust had been strengthened. In contrast those who reported a lower level of level of trust typically cited areas where trust had been eroded.

For those participants who reported high levels of trust, it was strengthened thorough supporting one another, through consensus, through working together as RMs, through having high practice morale and through celebration of practice achievements and milestones. Partners built trust through supporting one another in multiple ways. Examples of these included support through personal health crisis (for example, cancer) and through taking on other responsibilities and opportunities for the overall benefit of the practice. In both of these cases, partners (and the rest of the RMs in the practice) took over caseloads and provided the same high quality care that the partner would have given in her absence. Trust was also developed through a commitment to open honest dialogue and processing thoughts and feelings. This included exposing one`s humility and vulnerability. Trust was also strengthened through shared decision-making and backing each other in difficult decisions. This reflected keeping matters amongst the partners as confidential and behind closed doors. One participant described having the "*dirty work*" of ending a contract with a RM. She reported that although this was very difficult she felt supported by her partners throughout this process. Partners also felt working together as RMs built respect

for their clinical skills and management as well as served as a means of reinforcing their shared commitment to their work as RMs and for the practice. Finally trust was built through achieving goals set by the practice and seeing the fulfillment of key milestones as a reflection of the collaborative effort of the partners. Anne felt that trust in her partnership had developed over time sometimes through difficult times, "*Hardships have increased our longevity and strength." (Anne)*

For another respondent Helen trust was reflected in a celebration at her practice with her two other practice partners,

The three of us we had our fifth anniversary and we cried, like I can`t believe we got here and we`ve done this`` .... it`s a source of pride .... Our holding to our original goals around who we serve and how we act as a group. (Helen)

In contrast, other participants described trust levels that were on occasions much lower and gave examples of how trust had been eroded within the partnership. Examples typically centered around unfulfilled promises, divergent opinions on important matters or power inequities. One participant shared that her buddy partner had a habit of promising to fulfill her partner-related duties but often fell short leaving even more work and responsibilities to her. Another respondent experienced varying opinions regarding whether associate RMs would be named future partners (or not) and felt this caused somewhat of a rift in her partnership. Another partner cited having to involve the CMO in a disciplinary matter pertaining to another partner and this process was long spanning several years and was very challenging. The negative effect on the partnership was an erosion of trust and a hesitation to add more partners to her partnership for fear of a recurrence. In terms of power inequities, one respondent felt from her past

experiences that partnerships in general were eroded when there was an imbalance of power despite having PAs stating that power was to be shared equally. One participant Georgia had been promised partnership in her previous practice but it was never formally offered to her. Georgia reflected,

"You`re relying on people being altruistic and when you attach money and profit to that, it doesn`t work out that way." (Georgia)

Elizabeth, another participant, felt that making RMs partners did not necessarily create a balance of power within a partnership. She commented,

"You still have real inequities of power but we`re pretending not [sic with an all-partner structure]." *(Elizabeth)*

In terms of confronting these erosions of trust, participants cited some examples of how they had found solutions. Some participants felt that documenting partner roles and responsibilities was a means of building accountability and eventually trust. The written documentation was also felt to create more transparency which also fostered trust. Another way that participants developed trust was through open dialogue that encourages divergent opinions and helps to resolve conflicts.

Overall how well do the partners work together

Participants were asked to comment on how well the partners at their practice worked together and all were mostly satisfied with their working relationships. Contributors to successful working relationships included the years spent working together, having shared history, as well as having found strategies that promoted fair process within the partnership. Some of the

participants likened working in a partnership to a marriage with its shared history and time spent together. Additionally, participants felt respecting each other as partners regardless of seniority or years working at the practice helped them work well together.

One participant who felt that the partners at her practice worked very well together attributed it to their shared history. She realized that she and her practice partners would not always agree on all matters. She was accepting that over time there would be inevitable disagreements but that they would continue to work together as functional, happy partners.

Several of the participants made analogies of their partnerships as marriages as a reflection of their close working relationships together as partners. This was in part due to the amount of time the partners spend with their fellow partners and their shared histories. Helen described the relationship with her fellow practice partners as,

"We're committed to each other. We always joke about no divorces in the partnership. Whatever you do in your private life, that's ok, but no divorces from the partnership." (Helen)

Frances also made reference to a marriage analogy in her partnership for the amount of time they spend together. She remarked,

"There were definitely times where I spent more time with her than I do with my significant other. It's like being married to her." (Frances)

Similarly Anne remarked on the amount of time she spent with her practice partners stating,

"I've worked with the same two partners now for so long....I spend more time with them then I do my family." (Anne)

As a founding partner, Georgia initially considered briefly leaving her partnership due to the many stressors surrounding opening a new practice. She too used a marriage analogy stating,

"I know many times in the first few weeks I really considered just leaving. It was like, we're not even married, we'll just get it annulled." (Georgia)

Another participant cited the open communication that was involved in examining partner workload and the goal of achieving an equitable division as key to a healthy partnership. Similarly, another respondent also reported fairness as a contributor to her partner colleagues working well together as exemplified by their agreement to divide profit shares according to work done as a partner.

Another component described was the careful selection of which associate RMs to add to an existing partnership. Choosing new partners who exemplified the practice's culture and values was the goal. By spending time determining if there was a good 'fit' between a new potential partner and the partnership before making a RM a partner was felt a good investment of time and a better assurance of continued good working relations. This was also reflected in another participant`s partnership founded in principles of equality. She felt that the commitment to making all partners, whether new or more senior, equal would contribute to them working well together and avoid unnecessary power inequities. She conceded though to understanding where such power imbalances could be derived. Georgia described it this way,

This mentality that some partners are like,' you don`t know what I did to start the practice, you guys* [sic the newer partners] *can be forever and it doesn`t matter'. I can see feeling like that having built the practice. I can see feeling like `you`re joking, you`ve been here two years and you think you`re equal`. (Georgia)

Partners' satisfaction level with being a partner and changes they would make

Participants were asked how satisfied they were with being a partner and what (if anything) they would change about being a partner in terms of their role and responsibilities or their partnership itself. Their responses reflected a continuum of satisfaction with most being quite satisfied. Changes they would make included trying to find ways to manage partner workload differently and wanting more support from the AOM surrounding partnership management.

Overall participants reported being satisfied with being a partner. Their rationale for their satisfaction included being able to shape and direct how their practice was growing and developing. They felt invested in their practice and found partner work to be challenging at times but interesting. They enjoyed their working relationships with their partner colleagues. Beth said,

"I'm excited about being a partner because I like to have a role in shaping how our partnership works. I feel quite personally invested in this practice group." (Beth)

Helen described her satisfaction this way,

"I'm satisfied with my partners I'm working with.... There's lots of challenges but we're committed to working through them. I'm pretty proud of all of us." (Helen)

However there were participants who were not as satisfied with being a partner. Reasons included: workload issues and imbalance, feeling ambivalent as to whether change and improvements could occur or feeling dissatisfied with the perceived current political climate surrounding partnership for Ontario RMs. Georgia said,

"I would really think twice about whether I would want to be a partner [sic again]*." (Georgia)*

At the time of the interview Debbie was considering leaving Ontario as a RM and partner. Debbie said,

"I don't know that anything can make it better...I'm only 42, and I will be out of this as quick as I can." (Debbie)

Regardless of their level of satisfaction there were areas that all participants wanted to change. Respondents felt partner workload could ideally change to make it more manageable through increasing the number of partners in the practice or clarifying partner tasks with documented job descriptions. Another participant wished that there was better uniformity in partners' level of commitment to their work and investment in the practice. The respondent felt that if all of the partners took on their responsibilities as they had promised then she would feel less stress in her role as a partner.

Another participant was very concerned about expanding the partnership and felt as a partner she was at an increased risk of potential lawsuits from either current unhappy RMs or from a past disgruntled RM suing her practice. The participant attributed this in part to the current funding agreement from the Ontario Midwifery Program and the fact that RMs as partners ultimately do not own their practice because of how the funding flows through practices and not through individual RMs. She therefore felt that RMs were not truly ICs and that it was impossible to ever move completely away from a structure that does not feel employee-like. Debbie expressed that the funding structure sets partners up to be vulnerable. Debbie said,

And if anybody's mad enough at me, I think they won't have trouble convincing a court that they were as an employee, even though I have no other way to treat. There's no other, the way this is set up, I feel set up to fail. (Debbie)

Participants' views on the suggestion of expanding their partnerships

The final area of discussion for each of the participants was in regards to the suggestion of an expanded partnership model except for NRs and locum RMs to manage the liability of partners appearing as employers and to maintain RMs' status as ICs. In general participants had lots of reactions. Their responses were categorized according to what they wanted in response to this suggestion in terms of direction and leadership from their professional organization as well as their reasons for supporting or opposing the suggestion.

Participants identified that they wanted the AOM to take a leadership role in regards to managing a potential liability risk for long-term associate RMs. They wanted for the AOM to keep abreast of changes occurring within the province in terms of partnerships and to maintain a legal expertise that partners and practices could access provincially. Debbie remarked,

"There is just a void of leadership on this issue [sic the AOM keeping on top of changes occurring within the province regarding partnership legal-related matters]*"*. *(Debbie)*

Respondents wanted the AOM to have a lawyer that they could access for legal questions pertaining to PAs. They also wanted the AOM to create more educational forums such as webinars or manuals to address partnership matters. Similarly, they reported wanting the AOM's Business Manual to be revised to include matters pertaining to potential financial and legal risks. Still, they acknowledged that the AOM's Business Manual should not be too specific or directive as each practice is its own business but they felt the manual could be a good general resource for all partnerships. The participants wanted the AOM's Business Manual to cover such broad matters such as laws that govern partnerships.

Participants also requested more training in terms of running a small business and the availability of courses to teach them the key components such as human resource processes, the Employment Standards Act and financial management. Additionally, respondents felt having access to a list of recommended accountants knowledgeable about Ontario RMs' funding model would be helpful. They also felt senior partners could be an excellent resource and could be used as mentors. Creating a midwifery practice management liaison at the AOM was another recommendation to build into the professional organization a resource person.

Respondents also wanted the risk management program at the AOM to be more involved in partnership matters including assisting with conflict resolution. Participants felt this could be especially helpful for partnerships coping with the aftermath of a RM leaving or being asked to leave a practice. Similarly participants felt access to an arbitrator from the AOM or names of recommended arbitrators in their communities would also be helpful. They wanted the AOM to take some role in mediation if only in terms of having known resources available in a partner's region.

Participants who identified as founding partners wanted for the AOM to create more tools for new practices to help ease the significant workload associated with opening a new practice. They asked for templates to be made available so partners were not left scrambling trying to create new forms and documents when they could be made available on a disc or website prepared by the AOM. They also asked that the workshop geared to opening a new practice be held regularly as another resource. Another suggestion by a participant was that the AOM create a checklist of some of the typical considerations for a new practice such as hiring an IT consultant, on-off call schedules and protocols. Debbie remarked,

"I could see them [sic the AOM] *creating a course, webinars or different speaker series. I see it as their role, and I think they are the people to do it." (Debbie)*

Finally, another participant wanted the AOM to invest more time and focus on this aspect of practice partnership and felt the AOM had neglected to give as much attention to the benefits of self-incorporation for RMs. Frances stated,

The AOM sort of said, well you can do an all partnership model or you can be incorporated, but they spent all their time talking and promoting about an all partnership model. Like it's honestly 99% versus 1% split on their time and attention and that's not good enough for me. So there are two potentials and then only focus on one. (Frances)

There was a continuum of reaction voiced by participants regarding partnership restructuring and avoiding long-term associate RMs. Those opposed felt the existing partner / associate RM structure worked fine or feared that expanded partnerships could lead to dysfunction within practices. Participants who voiced opposition said they felt vulnerable to be told to partner with all of the RMs in their practice. Their objection in part was born out of having had the experience in a partnership in which a partner was asked to leave and all of the aftermath that had had on their practice. Anne remarked,

We were shocked when the AOM suggested then that we should just partner up with who's ever around. Having done it, having been very badly burned really brought us to a place where we were no longer willing to just have anybody as a partner. (Anne)

Another viewpoint was an expanded partnership would not address the inequities in a practice and failed to address underlying power imbalances or change the dynamics within a

group of partners. Elizabeth felt that "*just pretending that everybody is a partner doesn't remove the inequities.*"

Another standpoint from some respondents was that the existing structure of partners and associate RMs within a practice worked well and was effective. They felt by expanding the partnership by making experienced associate RMs partners would centralize the power within the partnership leaving the rest of the RMs in the practice (i.e. NRs, associates or locums) vulnerable. One possible solution to this as suggested by a participant was to make all RMs in a practice strictly clinical partners with no attached financial liability. This suggestion meant a business model in which midwifery practices would be run with no profit or loss risk and would in essence return to an earlier funding agreement in which midwifery practices were run as not for profit organizations.

Another criticism was a perception that an expanded partnership model would make partnerships very large in some practices and make decision-making onerous and inefficient. Frances said,

"...whether we buy paper at Costco versus Staples because it's cheaper, that kind of staff. I don't get paid for running this practice, so having additional partners carrying on the business side of things is an absolute logistical nightmare." (Frances)

Similarly Beth said,

We [sic participant and her other partner RM] *just felt it was so difficult to be a partner, that to involve more people in the process, it just felt overwhelming. We can get things done in the evenings over the phone. We're not having to dispatch in four other people ... and having a 10 hour discussion on whether we should get one size of blue pads versus another. (Beth)*

Another participant commented on a trend she saw that even with partnerships struck that RMs are still looking for one partner to be a leader making the decisions and taking charge. This respondent felt this was healthy and created efficiency. Cathy commented,

"....most organizations have some kind of structured leadership team where there's somebody who accountable for the bottom line... it almost seems like they're [sic the AOM] *shying away from that .... I don't know whether that's done us a favour or not." (Cathy)*

In contrast other participants supported and welcomed the suggestion of moving away from maintaining long-term associate RMs. The respondents' rationale included that it supported partners to have the conviction to take on new partners; that it gave protection to partners to no longer look like potential employers and therefore be vulnerable; that an expanded partnership promoted a model of equality which supported the founding partner's vision for their practice and that by expanding the partnership it created a more of a broader base in terms of decision-making and workload which ultimately benefited the practice.

Respondents who adopted changes within their practice expanded their partnership as a means of not sustaining long-standing associate RMs to reduce their liability risk. For one participant who felt reluctant to expand the partnership at her practice because she felt it would be too much work taking on teaching new partners their roles, she found the AOM's recommendations gave her the backing she and her partner colleagues needed to take the step. Cathy felt,

"...the idea of everybody becoming partners did appeal to me, but I couldn't have initialled it on my own, because there was this AOM recommendation, it really helped." (Cathy)

One more perspective was that the information some participants gleaned from the 2008 AOM's 'Effective Practice Management` presentation helped them to protect themselves as partners by giving them the knowledge of what steps to take to avoid appearing as employers to associate RMs and to enforce all RMs as ICs. Steps taken included ceasing payment for expenses such as AOM and CMO fees or professional development. Costs associated with maintenance for RMs' equipment was also stopped. They were also in support of capping the number of years a RM could work as an associate at their practice.

Some respondents felt partnerships would benefit from long-term associate RMs becoming partners because this structural change emphasized shared decision-making. The participants believed this overall promoted equality amongst the RMs. This was in part due to decision-making being shared through a broader partnership which would create a more balanced viewpoint and be more representative for the practice. It also would mean a shared workload for partners which would alleviate some stress. Debbie commented,

"Now that we've done it [sic expanded their partnership], *I'm happy to have more partners on board...* [sic because of the] *shared work load and shared decision-making." (Debbie)*

Another respondent described the change she saw in her newest partners as they started to take on more responsibilities. She noted a newly developed sense of maturity in them as RMs. The respondent attributed this to their awareness that they now had a duty and a controlling interest in the practice.

Other participants were in support of the suggestion regarding long-term associate RMs but were unsure as to what to do with associate RMs that had no expressed interest in becoming a partner. Reasons cited were that they did not intend to work long-term in the practice wanting

instead to travel in the future and work as a RM internationally or to have their own children in the next few years and were unable to make any long-term commitment. Respondents felt they were not as partners financially in a position to lose that associate RM and that the associate RM was a good clinician and therefore an asset to the practice. Participants were looking at creative solutions to this matter. These included considering making these RMs locums, foregoing contracts entirely or just hoping that the associate RM would never take legal action against the practice. Another respondent had developed additional categories of partnership that were discreet and focused more on lead clinical responsibilities versus financial ones for new partners who did not feel ready to take on the financial liability associated with being a partner.

Overarching themes

A review of the findings indicated some overarching themes that recurred in the participants' discussion of selected aspects of partnership. These were as follows:

- There is a trend towards more formalized processes regarding partnerships for Ontario RMs. This was seen in regards to the more structured learning processes for partnership; the more systematic track to partnership; the division of roles and responsibilities as well as the accountability for these roles. PAs are also more formalized with many of the partners engaged in reviewing their contracts with advice from legal counsel. In some cases, these PAs included a 'formula' for profit shares division amongst the partners where applicable.
- Another trend seen was an emphasis on transparency as a means of promoting fair processes within the partnership. This transparency was also a means of supporting accountability.

- Partners demonstrated an investment in daily maintenance of their practice but were also invested in support structures to ensure the sustainability of the practice through strong partnership. This was evident by some participants' emphasis on 'fit' for future partners, learning through role modeling as well as developing essential business and practice documentation to ensure ongoing processes are followed and understood.
- Finally participants enjoy for the most part being partners as well as being RMs. Working together clinically helped to build relationships and strengthened ties within the partnership (as well as within the practice).

Chapter Summary

The results overall demonstrate the divergence of experience of participants as partners. Their results reflect the variance in partner structures, in decision-making processes and in risks and benefits. The results also reflect the timeliness of the study as many midwifery partnerships are currently in a time of change and flux. These changes are a reflection of how participants as partners were managing the liability of long-term associate RMs and what (if any) impact this was having on their partnerships in terms of membership and structure. The next chapter examines what these results tell us about partnership for Ontario RMs and its future.

CHAPTER FIVE

DISCUSSION AND CONCLUSION

Chapter Five begins with a summary of the study. The collaborative partnership theory – its key components and four theories - are discussed as they pertain to the experience of partnerships for Ontario midwives as described by the participants. The results from Chapter Four are re-examined for trends and their implications for Ontario midwives. Where applicable, links to the studies discussed in the review of the literature in Chapter Two are included. The chapter concludes with an examination of limitations of the study and recommendations for future research in the area of partnership for Ontario RMs.

Summary of the Study

The study was foundational since no prior published research examining aspects of the experience of being a partner for an Ontario midwife were available. As an exploratory, descriptive study, the researcher interviewed nine Ontario midwifery partners who had been partners for at least two years in a practice group with at least one other partner. The interview guide used in the study consisted of nine questions and was adapted from The Partnership Self-Assessment Tool (The Center for Collaborative Strategies in Health, 2007). This web-based tool is designed to assess the collaborative nature of partnerships and is recognized as a valid tool. The interviews were transcribed and verified by the participants for accuracy. Two participants also confirmed themes from their own interview following analysis. The main themes from the nine interviews were presented in the previous chapter and reflect selected aspects of the partnership experience including benefits and drawbacks, roles and responsibilities, decision-

making processes, and strategies used for conflict resolution. The results demonstrate a range of experiences as illustrated through rich description.

Study findings and collaborative partnership theory

As described in Chapter Two, Gray and Wood's collaborative partnership theory (1991a, b) is comprised of multiple theories. These theories are utilized by Gray and Wood to explain partnerships including their pre-conditions, processes, and outcomes. As a theoretical framework, collaborative partnership theory can further our understanding of aspects of the experience of partnership for Ontario RMs.

Gray and Wood (1991a, b) describe four theories that comprise their collaborative partnership theory including resource dependency theory, microeconomics theory, institutional theory and political theory. The findings of the study are considered using the lens of each of these theories.

Resource Dependency Theory

Resource dependency theory asserts that partnerships are needed due to limited available resources. With restrictions on resources available such as time and skills, partnerships are struck to more efficiently achieve outcomes through collaborative efforts. By working together resources can be utilized more economically and proficiently.

Resource dependency theory can be seen in the study as participants described working with their partner colleagues to manage the multiple roles and responsibilities of partnership (see appendix D). With the demands of partner work in addition to clinical responsibilities as RMs, participants described relying on their partner colleagues to manage their practice groups. Some

participants also relied on administrative staff and other professionals to help manage the workload.

Several respondents noted that a benefit of working in partnership was effective use of available resources such as time and skills which increased efficiency. Some participants described dividing partner roles according to categories such as caseload management, finances and promotion, and outreach. Taking a ‘divide and conquer’ approach, tasks and expectations for each category were assigned. Some participants described division of partner roles and responsibilities according to partners’ skills and interests to maximize efficient use of resources. Others incorporated cross-training within their partnerships to build skills internally as a resource.

The importance of successful management of partner work as it impacts time as a limited resource is considered critical as it is also a source of conflict. Unclear roles and expectations were cited in the review of the literature as a leading source of conflict which undermines partnership productivity and efficiency (Collaboration Roundtable, 2001). Workload imbalance was also named by several participants as a source of conflict as well as a drawback and an aspect of partnership the participants wished they could change. By mismanaging partners’ work distribution, time may be wasted and partners may not achieve their goals.

Participants also described accessing other professionals and utilizing administrative staff to support partners and give them more time as a resource. One respondent indicated that partners at her practice group hired an accountant and a bookkeeper to help them with more complex financial management. This supported the partners with discreet tasks of practice management. Similarly, other participants utilized information technology specialists to aid

communication among partners (as well as the other RMs in their practices). Other partners in the study utilized administrative staff to complete some clerical duties to allow partners more time to focus on less clerical tasks. Utilizing other partners, administrative staff, and other professionals are all steps participants described in the study to manage the demands of partner workload with available resources. By managing time as a resource, partners are able to achieve their goals by incorporating other staff and professionals to their benefit.

Microeconomics Theory

The microeconomics theory states partnership establishment is rooted in economics so as to decrease costs and to manage risks (Gray & Wood, 1991 a, b). The theory articulates a need to utilize resources efficiently to maximize outcomes. Microeconomics theory explains partnership as a means of optimizing return through collaboratively managing resources.

The nine participants in the study described being ultimately liable for their practice groups in terms of expenses, losses, and profits. With shared responsibility for partnership economics, midwifery partnerships, unlike sole midwifery proprietors, are able to divide these risks amongst the partners according to their PAs. Participants gave several examples of how loss risk was navigated as a collaboration including partners providing personal funds for cash collateral for the practice group, partners paying income tax on surplus funds at year end but profits being reinvested in the practice group, and partners' profit shares being held back until equity equal to those of the other partners had been accumulated. An example of where this liability risk was seen as shared was reported by one participant who described a shortfall at her practice of over $80,000 due to a book keeping error. The participant felt the money that each partner contributed to the practice as cash collateral helped the practice as a business to remain

financially stable despite this considerable deficit. Another participant as a founding partner indicated that her practice had required a substantial line of credit to cover start-up costs beyond the funding received from the OMP. This liability was shared among all of the founding partners to reduce personal risk. By managing partners` financial resources collaboratively (as suggested by microeconomic theory), participants were able to maximize outcomes while maintaining stability in their practices despite these economic threats.

Institutional Theory

The institutional theory focuses on establishing partnerships to gain legitimacy and identity (Gray & Wood, 1991a, b). Partnerships give individuals working together recognition and authority as a group. According to institutional theory, partnerships are formed to gain status (sometimes in a legal sense) for the individual members through their collaborative efforts.

The components of institutional theory were evident in the study with examples of participants gaining status as partners and acquiring authority collectively within the partnership and practice group. One participant had her offer for partnership rescinded in her previous practice. However, when she as a founding partner opened a new practice she secured partner status for herself with decision-making authority and recognition. Like most of the other participants, she and her partner colleagues entered into a PA detailing their partnership as a formalized structure. This use of contracts was described in the review of the literature as a supportive environmental factor for partnerships which detail processes such as decision-making and conflict resolution strategies (Brown et al., 2006; Wistow & Hardy, 1991). In some cases, these contracts – the PAs – were under review as several participants were involved in changes within their partnership structure at the time of the study interviews. These changes to the

participants` PAs reflected in part making long-term associate RMs partners to give them status as ICs and for partners to not appear as employers. However, the establishment of formal contracts added to the legitimacy and the identity of each partner as institutional theory suggests.

Another aspect of institutional theory seen in the study was several participants describing having the authority to develop a partnership that reflected partners' strongly held beliefs about midwifery care and midwifery practice groups. Participants discussed having the influence to shape a practice – its values, beliefs, and cultural norms – which gave the practice group through the partner's vision its identity. Examples of this partner influence included caring for a specific targeted clientele such as Francophone women or teen mothers or practising midwifery according to partner's shared set of values and beliefs as defined by the partners. One participant identified that she and her partners held strong feminist beliefs that shaped their identity as a partnership and as a practice group. Participants also described seeking out future partners who 'fit' this same value system. The creation of these second generation partners with similar ideologies reinforces the partnership as an authority and promotes its collective identity. By establishing partnerships, midwife partners command the ability through their designated status to determine their practice groups` values according to chosen principles. As institutional theory points out the collective shared culture that forms when a group of similar-minded professionals unite furthers the legitimacy and identity of that partnership.

Political Theory

Lastly, political theory asserts that partnerships are created to establish power but also to control power within the partnership (Gray & Wood, 1991a, b). Political theory examines inter-partnership dynamics and relationships to determine which partners hold the power. As well, this

theory asserts that to maintain collaborative efforts and partner interdependence, power needs to be shared.

The findings provide many examples of how partners have power in a practice group. Evidence of power within partnerships as described by the participants includes the decision-making authority founding partners have to open and set up a new practice. These partners also determined the criteria for becoming a partner (for future partners), selected and contracted with NRs (assuming approved funding), as well as decided if an associate RM was offered partnership or was asked to leave. Partners also determined how finances within the practice group from sources such as CVs and OF funding will be spent. This included decisions regarding profit shares and whether to reinvest them in the practice or to split the funds among partners. Respondents also discussed other perks of partnership which exemplify power such as access to additional time off call, first choice of vacation time or having professional fees paid for by the practice group. (This differed from associate or locum RMs or NRs who did not receive these incentives).

Examples of political theory are also evidenced in the findings about how power is managed within partnerships to maintain collaborative efforts. Some participants described a cap on how much money any one partner could spend autonomously without gaining approval from her partner colleagues. These independent decisions were however controlled with practice-defined guidelines that were determined by the partnership members and set out in the PA. Additionally, decision-making generally involved consensus which shared power among the partners equally. In cases where a decision could not be reached through consensus, some participants utilized other methods such as voting or mediation.

Findings also provided examples of where power within partnership has been used to strengthen or erode the partnership. Examples of power being used favourably within a partnership as described by the respondents included one partnership with a horizontal structure in which all members were seen as equals regardless of seniority. Another participant described appreciating her newest partner colleagues presenting diverging opinions instead of conceding with her as a senior partner. She felt this reflected a partnership that was flexible and open to new ideas and where power was shared.

Respondents also gave examples of where power within their partnerships had been used destructively to undermine the partnership. One example was a participant who left her previous practice after being offered partnership but never named a partner because of conflict between herself and a partner. Another participant described taking legal action against her previous partner colleagues when she was asked to leave her practice after she questioned the privilege a senior partner held. This participant, in forming a new partnership, was determined to work in a model of shared power and high moral integrity in part as a result of her experience of power inequity in her former partnership. For other respondents, their practice had only recently named new partners and therefore they were unable to determine if any power inequities existed.

By becoming a RM partner, participants were able to exert power as evidenced by decision-making authority and by determining the allocation of profits. Autonomous power was seen with individual partner`s ability to make purchases independently with spending caps in place as power controls. This favourable use of power was contrasted with power that was misused through maintained privilege status or unfulfilled promises. These examples of power within partnerships reflect how its use and misuse can impact collaborative efforts and make it clear that political theory does influence midwifery partnerships.

Preconditions, processes and outcomes in the Collaborative Partnership Theory

These examples from the study findings demonstrate congruence with Gray and Wood's collaborative partnership theory (1991a, b). This theory is also used by Gray and Wood to describe the components of partnership including preconditions, processes and outcomes. The preconditions refer to the underlying rationale for partnerships. Preconditions can refer to the motivators to be in a partnership including a recognized need and benefit for interdependence while being mutually satisfying to all of the members of the partnership. Processes refer to the interactions within the partnership including communication, shared responsibility, and decision-making. These processes need to be organized and agreed upon within the partnership. Last, outcomes refer to not only the goals of the partnership being achieved but also the partnership surviving and not dissolving (Gray & Wood).

For Ontario midwives one of the preconditions or needs for partnership (or for sole proprietors) is that one or more RMs must bear the responsibility for taking on the responsibility of opening a new practice group. These responsibilities include writing a budget proposal and securing community support for developing a new practice group. Another precondition for RM partners as described by the participants is a desire to work together sharing accountability for the development of the practice. Many respondents described partnership like a marriage with a strong interdependence and close ties to their partner colleagues. This is also in part because RMs work together with typically two RMs attending a birth. Therefore a culture of joint responsibility is inherently part of Ontario midwifery.

The processes of partnership refer to how partners interact, achieve goals and visions, make decisions, and resolve conflicts. These processes have been formalized in contracts such as

PAs which detail mutually agreed upon processes such as communication, decision-making and conflict resolution and partnership dissolution. Examples include regular partner meetings with minutes; the division of partner tasks according to level of partner (where applicable); and the splitting of profit shares based on a variety of criteria including caseload, number of partner hours contributed or shares owned by each partner. Decision-making processes are detailed for many participants in their PAs with consensus as their first step, followed by voting, then mediation if necessary. Decision-making was also detailed by the participants with some partnerships having a core or managing team of partners to make decisions more efficiently while other partnerships include all of their partner colleagues in decisions. Decisions involving all of the partners tended to be in smaller partnerships of approximately two or three partners or in situations where there was minimal profits predicted.

Outcomes refer to the goals and objectives accomplished by the partnership. The participants in the study describe partners as ultimately responsible for ensuring that the practice group continues as a business providing maternity care as well as surviving any crisis. Examples of crisis management included absorbing the caseload of a RM who left the practice suddenly due to illness or by choice; or managing a large unexpected deficit. Also, some participants anticipated retiring from midwifery over the next five to 10 years and wanted to build partnership succession by expanding the partnership. This was to ensure as partners that the practice would continue after the founding partners were gone.

From this theoretical framework, multiple theories surrounding partnership are established and partnerships' preconditions, processes and outcomes are recognized. From examples in the study, this framework is also found to be relevant for Ontario midwives as partners. These examples also demonstrate partnership trends and implications.

Examining the study results for trends and their implications for Ontario midwives as partners

In examining the results from Chapter Four, the aspects of the experiences of Ontario midwives as partners are discussed as trends. Links are made where applicable to the studies reviewed in Chapter Two. As six of the nine participants were founding partners, the discussion begins with the demands of becoming a founding partner opening a practice and their specific needs. Learning to become a partner was examined for how it has evolved and become more structured. Tasks and responsibilities are discussed as well as how information is shared and decisions are made. Conflict resolution strategies and partnership benefits and drawbacks are examined in addition to partner's satisfaction level. Partners' views on the proposed changes to practice group structure involving moving away from long-term associate RMs are examined.

Becoming a partner – demands on and needs of founding partners

The study results indicated that six of the nine participants were founding partners involved in opening a new practice. Their comments exemplified a heavy workload juggling the multiple competing demands. Most participants were first time partners which also meant learning to own and oversee running a practice with little experience.

As liability for the partnership begins upon opening a practice, there is pressure on RM partners to develop operational partnerships, make decisions, and work together sometimes with little shared history (AOM, 2003). This can be a potential barrier for a partnership as roles and responsibilities may not be fully defined (Selin & Chavez, 1994). This may result in more conflict as partners spend more time on the mechanisms of partnership than on reaching goals (Selin & Chavez). It also means that often these new partnerships are forced to develop quickly

leaving little time for the developmental stages of partnerships to evolve (Gardner, 2005; Selin & Chavez; Spink & Merrill-Sands, 1999).

To overcome these barriers, partners setting up new partnerships require resources and support. Examples of resources and support that might be helpful include pre-formulated chart and form templates, business manuals, or workshops on opening a new practice. In light of the trend seen by the participants of partnerships for Ontario RMs moving to a more formalized process, ready access to these types of resources might be especially important to reduce liability risk and enhance partnership success.

Learning to be a partner

In terms of participants' experience of learning to be a partner, the findings indicate that these learning processes have become more formalized in recent years as partnerships evolve. Those participants who had been partners for many years described taking on and learning partnership roles as an informal experience. They accessed support for learning to be a partner from their partners at their previous practices, their TPA representatives, and from family and friends. In contrast, the partners in the study who had taken on partnership roles more recently described learning strategies such as shadowing and mentoring for new partners. According to some participants, partner tasks are now being double assigned with a less experienced partner working alongside a more senior partner to learn partnership skills. Partners are also cross-training to build in more mentors and to ensure more than one partner can accomplish a task. In another practice group, the participant described that new partners are in training for the first one to two years to learn their roles during which their liability risks are minimal.

In addition to these more structured processes for new partners learning to be partners, some participants described developing business manuals or business policies for their practice groups. These written policies provide all members of the partnership with a safeguard for knowledge. The written documents aided partnership stability and succession planning.

All of these actions help partners to learn their roles. Written documentation provided clarity for responsibilities. Combined with cross-training and mentoring, these steps support sustainability of partnerships and improved successful outcomes (Mohr & Spekman, 1994; Roussos & Fawcett, 2000; Spink & Merrill-Sands, 1994).

Roles and responsibilities for partners

In describing partners' roles and responsibilities, a lengthy list was created during this study that demonstrates the workload demands for partners and the multiple skills needed to be a partner (see appendix D). The tasks reflect the day to day management of the practice group as well as planning for the future through visioning and goal setting. The roles and responsibilities generated from the list demonstrate that some tasks are common to all practice groups (for example, the monthly invoice or the quarterly report). In contrast, other responsibilities are unique to specific practices such as active outreach for underserviced clientele, securing new privileges at a hospital for founding partners or reading practice email for one participant who had a smaller operating fund and minimal regular administrative support available. The list of partners' roles and responsibilities created during this study may prove useful for developing a partner job description or assist existing partnerships to divide tasks equitably. However as many participants noted the tasks for partners is never ending so any list cannot be considered

complete and partners need to remain flexible and adaptable (Hattori & Lapidus, 2004; Keleher, 1998; Russell & Flynn, 2000).

It is apparent from the study partners in larger partnerships spent more time engaged in professional activities and less time on clerical tasks. This was in part due to often having larger operating funds available which granted partners the option to designate more hours to weekly administrative support staff salaries. This contrasted partners at smaller practice groups who typically have less operating funds available to pay for more hours of administrative support. The demands could be higher on partners from smaller practice groups as they have additional administrative duties such as reading practice email. Similarly, founding partners in the process of opening a practice and building caseload also have smaller operating funds available. This results in founding partners taking on supplementary roles and responsibilities which increase their workload demands. It may be possible that there is an optimal size for a partnership that helps to balance these demands and provides adequate administrative support through available operating funds.

Information sharing for partners

In terms of information sharing, the participants described holding regular partner meetings with documented minutes to ensure the partners were informed. The minute taking also reflected partners seeking to be accountable and transparent with roles and expectations clearly defined. Partner meetings were also recognized in the literature as an environmental factor that supports partnerships as key to ensuring communication is not fragmented amongst members. The communication facilitated by regular meetings improves efficiency with task completion

through co-ordinated efforts (Hattori & Lapidus, 2004; Henneman et al., 1995; Mohr & Spekman, 1994; Russell & Flynn, 2000).

Other tools used for communication emphasized partners` need for both quick updates as well as more in-depth discussions. Partners utilized their Blackberries for SMS, texting, or pinning to communicate with other members of the practice. They demonstrated using new technologies to support their work and to make use of time and resources efficiently. The importance of technology to communicate as partners is reinforced as they are also RMs working on-call with unpredictable hours outside of a practice clinic setting. Having mobile communication devices available allows partners to continuously have contact with one another to help support communication and improve efficiency with information sharing and decision-making.

In contrast, participants described retreats as typically a whole day devoted to discussing issues such as practice development, specific partner-related concerns or strategic planning. Retreats were a means of building a stronger team through communication and sharing. Participating in retreats involved a commitment of the resource of time to the partnership. The effectiveness (or importance) of developing the partnership through shared information, collaboration and time was also supported in the research (Hattori & Lapidus, 2004; Russell & Flynn, 2000; Way et al., 2001).

Partners` decision-making

Most participants indicated that the decision-making processes used in their partnerships were consensus. When consensus was unsuccessful, voting or mediation were used to make decisions in the partnership. Consensus was valued by the participants for actively involving

partners to make joint decisions. Consensus is supported by research literature as a means of sustaining a partnership (Spink & Merrill-Sands, 1999) and is recognized as by the AOM as a process that emphasizes goodwill, individual responsibility, listening and trying to understand one another (2003). Overall being open and flexible to others` input with decision-making was recognized as important by the respondents.

Conflict and conflict resolution strategies for partners

Sources of conflict identified by the respondents included burnout which resulted in decreased interest in being a partner and in doing partner work, and imbalance of partner workload. In addition, workload imbalance was also considered a drawback and an aspect of partnership some respondents wanted to change. Workload imbalance was due to many factors including the volume of partner work and partners not fulfilling their commitments or being unaware of how much time and work were involved in taking on a task. The participants described how they had resolved this conflict by steps such as creating a log book to keep track of partner hours and to build in accountability to the partnership and holding a retreat to address work imbalance. These solutions reflect an attempt to maintain open communication to create transparency and increased awareness among partners related to workload.

This source of conflict and the steps taken to try and the resolve workload imbalance are also reflected in the research. An identified barrier to a partnership occurs when members lack sufficient time for their partner responsibilities (Henneman et al., 1995; Way et al., 2000). Collaboration can be threatened when roles are not clearly defined and understood by members as accountability to the partnership is critical (Gardner, 2005; Selin & Chavez, 1994; Spink &

Merrill-Sands, 1999). Finally it is important for partnership members to not misrepresent their available time, resources or abilities (Selin & Chavez; Spink & Merrill-Sands).

Benefits of partnership

There were many benefits as described by the partners in the study. Some were of a more financial nature such as profit shares or other perks such as some coverage for some specific expenses such as professional fees. The participants described the manner in which profits were split which reflected attention to equity and transparency. Different `formulas` were used for profit sharing. These formulas included splitting the profits equally among the partners or basing the split of profits on owned shares of the partnership. For some the benefits were more organic rooted in being able to grow and develop a practice group that reflected their personal values and beliefs as a RM because they held decision-making authority. For others, partner work was recognized with additional time off call, first choice of vacation or being able to take on other leadership roles that enhanced their career as a RM. These partners reported experiencing these incentives as benefits.

The study demonstrates the many ways that RMs as partners can be recognized for their partner work. Although some partners focus largely on financial recognition as the primary benefit, (albeit with the additional taxes), other partners may be more interested in other incentives. Having a variety of benefits could be helpful for partners that wish an alternative to profit shares or where profit shares are not available. These could include other incentives described by the respondents such as additional time off-call, first choice of vacation or other fees paid for by the practice group. Additionally, the findings of the study suggests that for partners overwhelmed and resentful due what they perceive as an imbalance in partner workload,

financial recognition does not resolve the underlying effects of the belief that they are performing a disproportionate amount of work. Money cannot be used to resolve conflicts or perceived inequities in partnerships.

Drawbacks

Respondents had a lengthy list of drawbacks of being a partner including the heavy workload, dealing with conflict within the partnership, managing human resources including having to fire staff, and carrying the financial liability for the practice as a business. The participants` remarks reflect the ultimate responsibility for their practices and coping with the many facets of managing a business. While some of these aspects of practice management could be ameliorated through attendance at workshops and training seminars to build skills and knowledge, some of these drawbacks are the inherent reality of business ownership and cannot be resolved. Partners that can find ways to work together in ways which accentuate each partner`s strengths and interests may help navigate some of these drawbacks or even turn potential drawbacks into positives for the partners and the partnership (Way et al., 2001).

Partners` level of satisfaction

Overall participants described being satisfied with being a partner. Those who felt positive about being a partner give some insight into the attributes of a satisfied partner including feeling invested in their practice, finding partner work challenging but rewarding and working with colleagues they enjoy. These findings are supported in the research as it was found that partners who exemplify core qualities such as feeling positive about the collaboration and recognizing it as useful and meaningful are associated with successful partnerships (Russell & Flynn, 2000).

Similarly, those participants who were less satisfied with being partners indicated factors that undermine the experience of being a partner such as eroded trust, workload imbalance, or work overload. The results of the study suggest that partners need to be mindful of their feelings about being a partner as they can impact the partnership`s overall success. Additionally, partners need to clarify expectations in terms of work load and be committed to periodically re-examining partner work load if a partner feels there is an imbalance. These steps to address perceived partner work load imbalance supports partners to achieve equity and create a culture within the partnership of mutual responsibility and shared tasks.

Reactions to moving away from long-term associate RMs through expanded partnerships

The 2008 ` Effective Practice Management` presentation alerted RMs to the potential liability risk of maintaining long-standing associate RMs (AOM). Suggested options provided in the presentation to reduce this risk included making associate RMs partners or considering creating a tiered partnership structure that included silent or nominal partners, junior and senior partners to stagger the level of responsibility and accountability. While making long-term associate RMs partners may reduce partners` risk of appearing as employers, there may be ramifications for partnerships when new partners are fast-tracked into their roles. New partners may be unsuited to partnership or not ready for these additional work demands which can act as a barrier for the partnership and create other challenges or conflicts (Hudson & Hardy, 2002; Wildridge et al., 2004). While the option of silent partners may be another means of mitigating the liability risk and be a viable option for those associate RMs not ready to be partners, it too could have a detrimental ripple effect on partnerships unless these members are assigned discreet roles or responsibilities so as to still be active contributing participants within the partnership (Hudson & Hardy; Wildridge et al.). Partners could consider capping the number of years a RM

can be a silent partner or the number of silent partners in a practice group as a means of fostering partnerships with involved collaborative members.

Limitations of the study

Certain limitations were inherent in the study related to both the methods and the researcher. Biases may have been created through the homogeneity of the participants as well as the use of convenience sampling. All of the semi-structured interviews were conducted over the telephone and within a time limit of approximately one hour each which placed restrictions on the length of time spent on each of the nine questions in the interview guide. Not being able to visualize the participants limited the amount of non-verbal cues the researcher was able to capture during data collection. The convenience sample where partners contacted the researcher if they were interested in participating meant that those who ultimately were part of the study had strong feelings or experiences with partnership (either positive or negative). The findings cannot be generalized because they are from a qualitative study. Finally the fact of the researcher was a novice investigator who herself was a RM practice partner certainly influenced the study.

The descriptions gathered from the study were based on a small sample size of only nine participants who had similarities in their demographics (see Table 1). Although it was the hope of the PI to include partners with varying levels of partnership, all nine participants, except one, were the most senior partners with six being founding partners. Six of the nine also held positions of authority outside of their practice group such as MEP faculty or they were involved in political work which could also influence their partnership experiences. It is feasible that their experiences could differ from those with less seniority, decision-making authority or experience. Similarly, only one of the nine participants worked in a rural region. It is again feasible that

experiences could have differed if more rural partners were included in the sample as they face additional demands. Rural partner sometimes face much longer driving times, cover larger catchment areas and have fewer nearby resources. It is possible that these additional clinical demands could impact the experience of being a partner for rural RMs.

Using semi-structured interviews, the researcher explored select aspects of being a partner for an Ontario midwife. The interviews were conducted over the telephone as the participants all lived beyond the researcher's study catchment area. It is possible that if the interviews were done in person that other aspects of the experience of being a partner could have been conveyed through body language. As well, the researcher was mindful of time and of addressing all of the interview questions. This meant that some responses from the participants could have been explored in further detail but were not in the interest of time. Additionally, although no participant refused to answer a question, there were less detailed examples provided by the participants regarding conflicts within partnerships. This could reflect the participants' reluctance to share these more private details of their partnerships for fear the details could be identifiable. Therefore, it is possible that if fewer questions were chosen for the interview guide that the experiences could have revealed richer description than in the study. Alternatively the findings might have been different if two interviews were held with each participant or if the interviews were held in person.

Finally, the researcher was a novice still learning her role. While the researcher identified that she too was a RM and a partner to gain the confidence of her participants, it is possible that the researcher's closeness to the subject matter could have made her not delve into aspects discussed by the participants because she felt she understood these based on her own experience.

This could have introduced a bias based on assumptions for which another researcher who was not a RM or a partner would not have.

These limitations indicate where potential bias could have been introduced or where the researcher could have influenced the data collection and data analysis. They also give direction to where further areas of study could be directed in the future.

Implications for practicing midwife partners, education and research

The results of the study as well as the review of the literature available provide insight into Ontario RM partners' experiences. Implications for currently practicing partners as well as midwifery education and research are elicited from the study findings and discussion and may be worthy of consideration. These are as follows:

- In every midwifery partnership, partners will seek other partners who 'fit' with the values and beliefs of the partnership. Consideration could also be given to the core values of partnership as another indicator of potential partner 'fit' and improved likelihood of partnership success. This is compounded by partnerships ultimately being comprised of individuals seeking ways of working together making the selection of those individuals critical.
- Trust is built in partnerships in increments. Trust can be threatened by individual partners who are dominant or who seek personal glory. Also, trust within the partnership can change during times of transition when members leave or new member join. Partners need to pay attention to trust as it impacts the function and success of their partnerships.

- Conflict is a healthy, inevitable part of partnership and reflects the interdependent nature of partnerships. Partners need to watch carefully for any common signs of conflict including plans stalling, progress slowing, decreased commitment of members and trust issues surfacing. Conflict most often is caused by unclear roles and expectations, goals not being achieved and power imbalances. As well, for RMs, burnout should always be considered as a factor that can precipitate conflict. To address conflicts and divergent opinions, partner meetings need to be prioritized for the opportunity for in-person discussion. In cases where a conflict is considered critical to the partnership, partners need to commit to attending additional ad hoc meetings to resolve the conflict. These unscheduled meetings will better ensure that conflicts are addressed and resolved (ideally) in a timely manner so as to strengthen the partnership and recognize conflict as a positive force.
- Regular communication within a partnership is critical. Consider all means of e-communication to enhance communication between partners especially when on-call. Emails, texting or pinning can be means of keeping partners updated quickly but can be emotionally flat and may create misunderstandings. Partners need to become skilled with e-communication to ensure it is used effectively. As well, retreats provide a means of more in-depth communication for partners and practice groups including administrative staff.
- Although benefits most often cited for partners include profit sharing, some partners may also appreciate other non-financial perks such as time off-call or choice of vacation time. Financial rewards may not be the only way to

acknowledge partner time and work. Rewards should be individualized to the priorities of partners.

- The drawbacks to partnership as cited by the participants included high workload and imbalance of responsibilities, financial liability and managing intra-practice and staff conflicts. In the case of human resource management, partners could consider training workshops to develop skills to decrease the stress managing these situations.
- Shared history, time together, fair processes and respect for divergent viewpoints were all described by respondents as contributors of working well with their partner colleagues. Partners can consider spending time at partner meetings defining `fair` processes. They may utilize round table discussions as a means of ensuring each partner has an opportunity to articulate ideas to encourage multiple perspectives.
- Partnership size and structure can impact efficiency and create challenges. While a larger partnership allows for more division in roles and responsibilities, communication and forming working relationships can take longer when more people are involved. In contrast, smaller partnerships may be overwhelmed with tasks but may find decision-making is more efficient with fewer partners. Considerations should be given to the optimum partnership size.
- Barriers to successful partnerships include those formed too hastily (‘shotgun’); too incentive-driven; or partnerships that include partners who have too little time or commitment to the partnership. Consideration could be made to a tiered

partnership with various levels of responsibilities so as to utilize each partner`s available time most efficiently.

- There are multiple responsibilities for partners. Workload imbalance was found by the participants to be a source of conflict, a drawback and something partners wanted to change. Careful and regular examination of workload may be helpful. Financial rewards in terms of profit sharing cannot address the resentment and power inequities that can surround workload imbalance.
- Finally, partnerships are complex. Decision-making can be slow and time-consuming in partnerships. Partners could consider decision-making mechanisms that emphasize efficiency while still resulting in quality decisions to support partnership success.

Recommendations for future studies

The current study provides a starting point for further research examining aspects of the experience of being a partner for an Ontario midwife. The findings presented are preliminary with no prior published studies focused on this context of midwife partnership. In light of the foundational quality of this study and its limitations, the following recommendations are offered for further studies on this topic. These include an investigation related to how to best prepare associate RMs and new partners for partnership; ways to teach new partners the tacit knowledge of partnership; a further exploration of partner workload imbalance and its impact on relationships within partnerships and partnerships success, and a comparison of the experience of partnership for specific subgroups such as rural RMs or partners in an incorporated partnership structure.

How to best prepare associate RMs and new partners for partnership

A variance was seen in the results in the number of years before an associate RM was named a partner and the different criteria for partnership at each of the participants' practice groups. The number of years ranged from one to two years to as high as five to eight years as an associate RM before being named a partner. One participant described new partners having an additional one to two years of training to become a full partner while others were full partners once named. Some new partners were expected to make a financial contribution to the practice while others were not.

The variance in years to becoming a partner raises a question regarding whether there is an ideal number of years for RMs' track to partnership. As midwifery in Ontario has only been regulated since 1994, the concept of legal partnerships for midwives as business owners is relatively new. In contrast, professionals such as accountants and lawyers have had partnerships much longer. It may be worthwhile therefore to examine these other professionals' track to partnership to gain insights relevant to midwifery partnership. For example, an accountant can typically expect to invest 10 years of practice (or more) before being offered partnership in order to have developed the breadth and depth of knowledge and the skills of client management and developed conflict resolution skills (M. Walke, CA, personal communication, July 13, 2010). While the concept of partnership is taught in accountant education programs, the specific mechanisms and track to partnership are not discussed until an individual is employed at an accounting firm. Once named a partner, accountants are assigned a mentor who is a more senior partner for ongoing coaching. Similarly, a lawyer can expect to spend a similar number of years before being offered partnership in a legal firm. Similar to accountants, this time is used to

develop the needed professional traits before partnership is offered (American Bar Association, 2006; C. Collins, LLB, personal communication, July 17, 2010).

The seven to 10 year track to partnership is considerably longer for accountants and lawyers in comparison to as little as one to two years for RM partners. It raises concerns as to whether this compressed time frame for RMs to become partners could be expecting too much too soon. While one of the study participant`s stated that as faculty she has presented the concept of partnership to midwifery students through the MEP, like accountants and lawyers, the exact mechanisms to become a partner are not discussed until associate RMs are working at a practice group. Overall, it raises a question regarding the ideal way to prepare future RMs for partnership. This question could be addressed in future research studies.

Ways to teach new partners the tacit knowledge of partnership

The study generated a lengthy list or tasks completed by partners (see appendix D). In addition, partners have more broadly defined responsibilities such as role-modeling partner behaviour to new or less experienced partners as well as managing intra-practice conflicts, RM burnout and other crises. Some participants described developing business policies and procedures for their practice group that detailed the ‘how-to’s’ of partner tasks such as completing the monthly invoices. However, beyond these documented skills there seems to be another level of partner knowledge that is as essential to running a practice group successfully yet that remains tacit. A study that examines this tacit knowledge and explores what is meant by `partner behaviour` and how senior partners role model these behaviours could be beneficial to all partners.

Partner workload imbalance and its impact on partnership`s relationships for RMs

Participants described the imbalance of partner work including partners not doing their share or being less invested in their partner work as a drawback to being a partner. Some of the respondents also noted partner workload inequities as a source of conflict and as something they would like to change about being a partner. As workload inequities and a lack of full commitment from all of the partners has been found in the literature to be a barrier to success and a source of conflict within partnerships, it could be beneficial to study partner workload imbalance for RMs and how it impacts the functioning (or not) of the partnership in further detail (Mohr & Spekman, 1994).

Experience of partnership for specific midwifery subgroups

One identified limitation for the study was that eight of the nine participants worked in urban centres. As well, only one of the nine respondents was from a self-incorporated practice. Six of the participants were founding partners and were therefore the most senior partners. It is feasible that their experiences were not those of partners from the rural catchment areas or from self-incorporated practice groups. Similarly, less senior partners who may not have the same level of decision–making authority could have different experiences of partnership than those respondents in the study. Therefore, a study that examines aspects of the experience of being a partner for each of these other subgroups could illuminate different experiences.

Chapter Summary

The research examined selected aspects of being a partner for an Ontario RM. The study included nine participants from across the province of Ontario who participated in semi-structured interviews. The interviews consisted of nine questions adapted from The Partnership Self-Assessment Tool and included aspects such as benefits and drawbacks, decision-making and

conflict resolution strategies (Center for Collaborative Strategies in Health, 2007). The participants' responses once verified were hand coded by the researcher by hand. The results indicated that most of the respondents were satisfied with being a partner. Most felt they worked well with their partner colleagues. The majority of the partners in the study found partner work demanding particularly when there was an imbalance in the workload. When the respondents reported high levels of trust they were able to give examples of how trust had been strengthened within the partnership. Conversely, where trust levels were reported as low, participants gave examples of how trust had been eroded. Most respondents described learning to be a partner quite informally by trial and error. The participants contrasted this informal learning with a more formalized learning plan currently in use in their practice groups with assigned mentors and double assigned tasks. Benefits of being a partner included financial recognition through profit sharing while drawbacks included a heavy workload, carrying the liability for the practice group and managing inter-practice conflicts.

The study was conducted during a time of change for Ontario partnerships as partners struggle with managing a potential liability for maintaining long-term associate RMs in their partnerships. In some cases, participants described making sweeping changes in their practice groups in light of this concern while others felt their partnership structure protected them against this risk and did not require change. Overall, a trend was seen in partnerships becoming more formalized with attention to written documentation and transparency. The results of this study need to be understood as a reflection of this time of change and development for Ontario RMs as partners.

References

Asper, V. (2002). Ladders of collaboration. *Library Talk, 15(*2), 10-1.

Association of Ontario Midwives. (2003). *AOM Business Guide for Midwives.* Toronto: Author.

Association of Ontario Midwives. (2008). Effective practice management: Consideration as independent contractors. Retrieved from www.aom.on.ca/files/members_only-secureFolders/Business_Admin/Efective_Practice_Management_Webinar_slides_08.pdf.

Boswell, C. (2011). Data collection. In C. Boswell, S. Cannon (Eds.). *Nursing research incorporating evidence-based practice* (pp.217-247). Boston: Jones & Bartlett.

Bowling, A., & Ebrahim, S. (2005). *Handbook of health research methods, investigation, measurement and analysis.* Berkshire, England: Open University Press.

Brown, D., White, J., & Leibbrandt, L. (2006). Collaborative partnerships for nursing faculties a and health service providers: What can nursing learn from business literature? *Journal of Nursing Management, 14* (3), 170-9.

Byrne, B. (2006). Qualitative interviewing. In C. Seale (Ed.). *Researching society and culture.* (pp. 179-92). London: Sage.

Campbell, J., Dienemann, J., Kub, J., Wurmser, T., & Loy, E. (1999). Collaboration as a partnership. *Violence against women, 5*(10), 1140-57.

Center for the Advancement of Collaborative Strategies in Health. (2009). The Partnership Self-Assessment Tool. Retrieved from www.partnershiptool.net.

Chrislip, D. (2002). *The collaborative leadership field book.* New York: Jossey-Bass.

Cohen, D., & Crabtree, B. (2008). Evaluative criteria for qualitative research in health care: Controversies and recommendations. *Annals of Family Medicine, 6,* 331-9.

Collaboration Roundtable. (2001). *The partnership toolkit: Tools for building and sustaining successful partnerships.* Vancouver: Author.

College of Midwives of Ontario. (2008). *Registrant`s binder.* Toronto: Author.

Connor, J., & Kadel-Taras. (2003). *Community visions, community solutions: Grant making for a comprehensive impact.* Ann Arbor, MI: Amherst H. Wilder Foundation.

Cooper, M., & Gardner, J. (1993). Building good business relationships – more than just partnering or strategic alliances? *International Journal of Physical Distribution and Logistics Management, 23*(6), 14-27.

Donovan, J., & Sanders, (2005). Key issues in the analysis of qualitative services research. In A. Bowling, A., & S. Ebrahim. (Eds.). *Handbook of health research methods, investigation, measurement and analysis.* Berkshire, England: Open University Press.

Gardner, D. (2005). Ten Lessons in collaboration. *Journal of Issues in Nursing, 10* (1). Retrieved from http://www.nursingworld.org/ojin/topic26/tpc_26.htm

Gray, B. (1989). *Collaborating.* San Francisco: Jossey-Bass.

Gray, B., & Wood, D. (1991a). Collaborative alliances: Moving from practice to theory. *Journal of Applied Behavioural Science, 27*(1), 3-22.

Gray, B., & Wood, D. (1991b). Toward a comprehensive theory of collaboration. *Journal of*

Applied Behavioural Science, 27(2), 139-62.

Griggs, C. (2010). Community nurses' perception of a good death: A qualitative exploratory study. *International Journal of Palliative Nursing, 40*(3), 139-48.

Guba, E., & Lincoln, Y. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Communication and Technology Journal, 29* (2), 75 - 91.

Hattori, R., & Lapidus, T. (2004). Collaboration, trust and innovative change. *Journal of Change Management, 4*(2), 97-104.

Henneman, E., Lee, J., & Cohen, J. (1995). Collaboration: A concept analysis. *Journal of Advanced Nursing, 21*(1), 103-9.

Holloway, I., & Wheeler, S. (2010). *Qualitative research in nursing and healthcare.* (3rd ed.). Oxford, UK: Blackwell.

Horton, J., Maeve, R., & Struyven, G. (2004). Qualitative research interviewing. In C. Humphrey, C. Lee, & H. Bill. (Eds). *The real life guide to accounting research: A behind-the-scenes view of using qualitative research methods* (pp.339-58). Amsterdam, The Netherlands: Elsevier Science.

Hudson, B. & Hardy, B. (2002). What is a successful partnership and how can it be measured? In C. Glendinning, M. Powell, & K. Rummery. (Eds.). *Partnership, new labour and the governance of welfare.* Bristol, England: The Policy Press.

Huxham, C., & Vangen, S. (2005). *Managing to collaborate: Theory and practice of collaborative advantage.* New York: Routledge.

Huxham, C., & Vangen, S. (2006). Ambiguity, complexity and dynamics in collaboration. *Human Relations, 53* (6), 771-806.

Jamal, T., & Getz, D. (1995). Collaborative theory and community tourism planning. *Annals of Tourism Research, 22* (1), 186-204.

Keleher, K. (1998). Collaborative practice. *Journal of Nurse-Midwifery, 43* (1), 8-11.

Kirchhoff, K. (2005). Sampling methods. In M Mateo, K. Kirchhoff (Eds.). *Research for advanced practice nurses* (pp 155-66). New York, NY: Springer.

Kirschner, B., Dickinson, R., & Blosser, C. (1996). From cooperation to collaboration: The c changing culture of a school / university partnership. *Theory into Practice, 35*(3), 205-13.

Lasker, R. (1997). *Medicine and public health: The power of collaboration.* New York: The New York Academy of Medicine.

Lasker, R., Weiss, E., & Miller, R. (2001). Partnership synergy: A practical framework for studying and strengthening the collaborative advantage. *The Millbank Quarterly, 79* (2), 179-205.

Leedy, P., & Ormrod, J. (2005). *Practical research planning and design.* Upper Saddle River, NJ: Pearson Merrill Prentice Hall.

Liamputtong, P., & Ezzy, D. (2005). *Qualitative research methods.* (2nd ed.). Melbourne, Australia: Oxford University Press.

Marshall, M. (1996). Sampling for qualitative research. *Family Practice, 13*(6), 522-5.

Mateo, M., & Kirchoff, K. (2009). *Research for advanced practice nurses.* New York: Springer.

Mattessich, P. (2005). Collaboration: What makes it work? *Wilder Research Center.* Retrieved from www.orau.gov/hsc/hdspinstitute/2005/PlenarySessions/CollaborationPlenarySlidesSept2005foo rdisplay.pdf.

Miles, M., & Huberman, A. (1994). *Qualitative data analysis*. (2nd ed.). Thousand Oaks, CA: Sage.

Mintzberg, H., Dougherty, D., Jorgensen, J., & Westley, F. (1996). "Some surprising things about collaboration - knowing how people connect makes it work better". *Organizational Dynamics, 25* (1), 60-71.

Mohr, J., & Spekman, R. (1994). Characteristics of partnership success: Partnership attributes, communication behaviour, and conflict resolution techniques. *Strategic Management Journal, 15* (2), 135-52.

Morse, J. (2000). Determining sample size. *Qualitative Health Research, 10* (1), 3-5.

Morse, J. & Field, P. (1995). *Qualitative research methods for health professionals.* (2nd ed.). Thousand Oaks, CA: Sage.

Moule, P. & Goodman, M. (2009). *Nursing research: An introduction.* London, England: Sage.

Nagy, J., & Fawcett, S. (2010). Developing successful strategies: planning to win. *Community Tool Box*. Retrieved from http://ctb.ku.edu.

Opdenakker, R. (2006). Advantages and disadvantages of four interview techniques in qualitative research. *Forum Qualitative Social Research, 7* (4), Art. 11.

Palys, T. (2003). *Research decisions quantitative and qualitative perspectives.* Scarborough, Ontario: Thomson.

Pitney, W., & Parker, J. (2009). *Qualitative research in physical activity and the health professions.* Champaign, IL: Human Kinetics.

Richards, L., & Morse, J. (2007). *Users guide to qualitative methods. (2nd ed.).* Thousand Oaks, CA: Sage.

Roussos, S., & Fawcett, S. (2000). A review of collaborative partnerships as a strategy for improving community health. *Annual Review of Public Health, 21*(1), 369-402.

Russell, J., & Flynn, R. (2000). Commonalities across effective collaborations. *Peabody Journal of Education, 75* (3), 196-204.

Selin, S., & Chavez, D. (1994). Characteristics of successful tourism partnerships: A multiple case study design. *Journal of Park and Recreation Administration, 12* (2), 51-61.

Spink, L., & Merrill-Sands, D. (1999). *Successful collaborative partnerships: Key elements and a self-assessment inventory.* Boston: Simmons Institute for Leadership and Change.

Sykes, J. (Ed.). (1989). *The concise Oxford dictionary* (7th ed.). Avon: Oxford University.

Tilley, S. (2011). Qualitative research methods. In C. Boswell, & S. Cannon (Eds.), *Nursing research incorporating evidence-based practice* (pp.193-215). Boston: Jones & Bartlett.

Trochim, W., & Donnelly, J. (2007). *The research methods knowledge base.* NY: Thomson.

Vangen, S., & Huxham, C. (2003). Nurturing collaborative relations Building trust in interorganizational collaboration. *The Journal of Applied Behavioral Science, 39* (1), 5-31.

Way, D., Jones, L., & Busing, N. (2000). *Implementation strategies: Collaborating in primary care – family physicians and NP delivery of shared care.* Toronto, ON: Ontario College of Family Physicians.

Way, D., Jones, L., & Busing, N. (2001). Essential elements for collaboration. *Canadian Medical Association Journal, 151*(1), 29-34.

Weiss, E., Anderson, R., & Lasker, R. (2002). Making the most of collaboration: Exploring the relationship between partnership synergy and partnership functioning. *Health Education and Behaviour, 29*(6), 683-98.

Whittemore, R., Chase, S., & Mandle, C. (2001). Validity in qualitative research. *Qualitative Research in Health, 11*(4), 522-37.

Wildridge, V., Childs, S., Cawthra, L., & Madge, B. (2004). How to create successful partnerships – a review of the literature. *Health Information and Libraries Journal, 21,* 3-19.

Wistow, G., & Hardy, B. (1991). Joint management in community care. *Journal of Management in Medicine, 5*(4), 40-8.

Appendix A: Interview Guide Questions

The following questions to be asked to each consenting participant:

PART 1 – Demographic Information and Background Questions

1. For the purpose of meeting the inclusion criteria, please indicate the number of years you have been a midwife and a partner at your current practice, the number of partners in the practice and whether you are a junior or senior partner (if applicable). Also what geographical area does your practice serve – urban, rural or a mix?

2. Describe the process or requirements within your practice to become a partner.
3. In a typical week, how many hours would you devote to partner-related work? What types of tasks and responsibilities are you involved with as a partner?

PART 2 – Questions Related to Learning the Role of a Partner, Benefits and Drawbacks, Decision-Making and Conflict Resolution

4. How did you learn to become a partner? Did your practice utilize any documents or manuals as reference tools? Were you mentored in your role?
5. Thinking about decision-making within the partnership: how comfortable are you typically with how decisions are made? Do you have a process in place to reach consensus when there are divergent viewpoints among the partners? What efforts are made to ensure partners participate in decision-making? Are some decisions made only by certain partners (e.g. senior versus junior partners)?
6. How has being a partner benefited you as a midwife?
7. What do you see as the drawbacks of being a partner?

8. Thinking of an example when the partners didn't agree how was this conflict resolved?
9. How did your practice respond to the liability risk of long-term associate midwives? Did it impact your current track to partnership? Did your partnership expand as a result?

Appendix B: Letter of Invitation

Dear prospective research participant,

Selected aspects of being an Ontario Registered Midwife Practice Partner

In 2008 the Association of Ontario Midwives (AOM) hosted a webinar encouraging Ontario midwives to consider the option of restructuring their practice groups to an expanded partners model (except for locums and New Registrants). As midwives contemplate this change, it would be very timely and valuable to understand aspects of the experience of midwives as partners in their practice including the perceived benefits and drawbacks and to understand how decisions are made and conflicts are resolved.

As part of my Masters of Health Studies at Athabasca University, I am conducting an exploratory, descriptive qualitative research project to detail selected aspects of the experience of being a partner for an Ontario midwife. **You are invited to participate in this study if you have been a partner for at least two years in your current practice and there are a minimum of two partners in your practice. If you would be willing to participate, you are asked to email the Research Investigator with your contact information as well as the number of years you have been a partner, whether you work in a rural or urban practice and the total number of midwives in your practice. The Research Investigator reasons that requesting this preliminary data will facilitate achieving a broader spectrum of experiences. Once the names of potential participants have been collected, a sample of 5-10 participants will be chosen. You will receive an email letting you know if you have been chosen or not.**

Participation involves participating in an interview with the research investigator. This interview may take place in person if you live within 50 kilometres of London, Ontario or via telephone. All interviews will be audio-tape recorded and transcribed either using a software program called Dragon Voice or by a transcriptionist. The interview should take no more than one hour. It is anticipated that data collection will be conducted between February to April, 2010.

A select number of participants would be asked to verify themes from their responses after data analysis. All others would only be asked to review their transcribed interview for accuracy. This transcript will be forwarded to you confidentially via personal email.

All data will be coded by the Research Investigator and analyzed for themes. In recognition of the small midwifery community in Ontario, any personal and organizational identifiers will be removed. The research results will be reported in publications and presentations to professional and academic audiences. All data will be reported in aggregate form.

There are no known risks anticipated from your participation in this project. You will not receive any compensation for participation. As there is no available data examining Ontario midwives in their role as partners engaged in practice management, it is expected that the outcomes of this research will benefit both current and future partners.

Your participation in this research project is completely voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time without any negative repercussions.

By returning this consent form electronically with your name and contact information attached, you will be considered to be consenting to participate.

Your participation will be treated confidentially, and data will be securely stored in an electronic database located in my locked home office with electronic data in a password-protected computer. All data pertaining to the study will be destroyed by the Research Investigator by file deletion after one year (December, 2010). Personal identifiers and identifiable quotes will not be included in any publications arising from the research, without your explicit permission. However, your personal and practice's anonymity cannot be guaranteed because there is the possibility that others in the midwifery community might successfully guess the origin of certain reported information.

If you wish to request regular updates on the progress of the project and to receive electronic copies of any working papers, published papers or presentations emerging from this project, please contact me at kwall65@hotmail.com.

This research study proposal has been reviewed by the Athabasca University Research Ethics Board (REB). Both The College of Midwives and The Association of Ontario Midwives have been made aware of the study however approval was not required from either organization. If you have questions with regard to your rights or treatment as a participant in this study, please contact the research ethics administrator by writing at rebsec@athabascau.ca or by calling 1-780-675-6718. If you have questions with regard to this study, please contact me at kwall65@hotmail.com or my research supervisor Dr. Beth Perry at bethp@athabascau.ca.

Thank you in advance for your consideration to participate in this research study.

Sincerely,

Katherine Wallace, RM

What are the benefits or drawbacks to being a midwifery partner?

How did you learn the skills of being a partner?

How do the partners at your practice make decisions and resolve conflicts?

If you have been a partner at your practice for at least two years and there is a minimum of two partners at your practice, you are invited to participate in a research study towards a Master's thesis. Participation consists of completing a confidential semi-structured taped interview either in-person or on the phone.

I am interested in speaking to a variety of Ontario midwifery partners from small or large practices, urban or rural settings and junior or senior partners.

I am a registered midwife currently in my eighth year of practice in London, Ontario and have also been a partner since 2006. As there is currently no research available regarding midwives as partners and business owners, I feel this study is relevant and timely to all current and future partners.

Please see the attached Letter of Invitation for further details

Appendix C: Study Summary and Consent Statement

As a means of ensuring consent I have prepared the following summary as means of introduction to the study.

The purpose of this descriptive exploratory study is to describe the experience of being a partner for an Ontario midwife including aspects such as perceived benefits and drawbacks, how midwives acquired partner-related knowledge and skill as well as decision-making and conflict resolution between partners. The study's format consists of 14 questions as part of a semi-structured interview with an opportunity for other areas of discussion to evolve based on the participant's responses. Each interview should take approximately one hour. Confidentiality is assured. Each digitally recorded interview will be kept in a secure location in the PI's locked home office. Once each interview has been transcribed using a secure transcription service a copy will be available to the participant. Approximately 2 or 3 participants will also be asked to verify themes as determined by the PI from the transcript. Any identifiers such as names of individual midwives, partners or practice groups will be deleted to better ensure confidentiality. However, participants are reminded that as the Ontario midwifery community is small, it is possible that some details of partner dynamics may still be recognizable to other midwives. Each participant is reminded of their right to ask for clarification regarding any of the interview questions as well as to decline answering any or all of the interview questions without consequence. Finally although this study does not intend any emotional distress, it is feasible that any discussion of issues such as conflict or distrust may raise difficult emotions. Participants are encouraged where necessary to seek out supportive resources such as their local Distress Centre or LifeWorks if felt necessary.

Do you still feel ready to consent to participating in this study? Thank you.

Appendix D: Partner Roles and Responsibilities

TPA and OMP representative;

Negotiating and signing off on clinic lease;

Signing officer;

Financial management - writing annual budget; monthly invoice; paying bills / writing cheques;

Conflict resolution with administrative staff and other midwives;

Privacy officer;

Quality Assurance – reviewing client evaluations; ‘unhappy’ clients;

Reading practice email;

Clinic management – setting up clinic space (and finding space if new practice); daily maintenance;

Ordering supplies and drugs - ensuring correct supplies and medications are being ordered and received and within budget; ordering New Registrant supplies;

Quarterly reports;

Caseload Variable reporting;

Meeting with Associates to evaluate their ‘fit’ with the practice and discuss their track to partnership (if applicable);

Partnership co-ordinator – oversees which partner is doing what job and monitors that tasks are being completed. This midwife also schedules partner meetings, takes and distributes minutes, imposes and enforces deadlines on partner jobs;

Human Resources – hires and fires administrative staff; posts positions for administrative staff as well as New Registrants and General Registrants and interviews; organizes and conducts performance reviews for staff;

MEP Co-ordinator – planning number of student placements for the practice;

Outreach – oversees practice website or Face book page; public speaking engagements at schools, health centers or universities; prenatal health fairs;

Hospital relations and / or Head Midwife – committee representative; securing privileges if a new practice as well as orientating new midwives and ensuring all midwives are current in hospital policies; managing hospital politics;

Scheduling – on-off call and partnering midwives; weekends; vacations;

Caseload management – requests and client assignment;

Orientation for new midwives, partners and second attendants;

Retreat or strategic planning;

Overseeing archiving of client charts;

Client education – keeping library and handouts updated and current with evidence;

Mentoring – new midwives as New Registrants or International Midwifery PP Clerks and

Role-model of professional partner behaviour.