

Identifying barriers and facilitators towards implementing guidelines to reduce caesarean section rates in Quebec

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Objective To investigate obstetricians' perceptions of clinical practice guidelines targeting management of labour and vaginal birth after previous caesarean birth, and to identify the barriers to, facilitators of and obstetricians' solutions for implementing these guidelines in practice.

Methods This qualitative study was conducted in three hospitals in Montreal that represent around 10% of births in Quebec. Data was collected from 10 focus groups, followed by six semi-structured interviews. Two researchers jointly analysed the verbatim transcripts according to *A manual for the use of focus groups*.

Findings The identified barriers to and facilitators of the implementation of guidelines can be classified into four categories: 1) the hospital level, including management and hospital policies; 2) the departmental level, including local policies, leadership, organizational factors, economic incentive, and availability of equipment and staff; 3) the health professionals' motivations and attitudes, including medico-legal concerns, skill levels, acceptance of guidelines and strategies used to implement recommendations; and 4) patients' motivations.

Conclusion Identifying the barriers to and facilitators of the adoption of recommendations is an important way to guide the development of efficient strategies. The findings of this study suggest that the adoption of guidelines may be improved if local health professionals' perceptions are considered to make recommendations more acceptable and useful. Our findings also support the assumption that obstetricians seek to implement best practices, but require evidence tools and support to assess their practices and enhance their performance. In addition, peer review activities championed by opinion leaders have been identified by obstetricians as the most suitable strategy to improve the use of the guidelines in their practices.

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Une traduction en français de ce résumé figure à la fin de l'article. Al final del artículo se facilita una traducción al español. الترجمة العربية لهذه الخلاصة في نهاية النص الكامل لهذه المقالة.

Background

The World Health Organization recommends that the caesarean section rate should not be higher than 10% to 15%.¹ The caesarean delivery rate in Canada increased steadily from 17.5% of deliveries in 1994–1995 to 23.7% in 2002–2003.^{2,3} Moreover, caesarean delivery was associated with high maternal and neonatal complication rates and increased health-care costs.^{4–9}

According to the Society of Obstetricians and Gynaecologists of Canada (SOGC), vaginal delivery represents the safest route for the fetus and newborn in the first and subsequent pregnancies.¹⁰ SOGC clinical practices guidelines contribute to the promotion of evidence-

based practice and represent an appropriate means for reducing caesarean section rates in Canada. The challenge lies in implementing these guidelines.^{11–15} Each clinical environment presents organizational, professional, maternal and cultural particularities. The identification of specific barriers and facilitators represents a new approach for identifying the determinants of guidelines use by health professionals.^{7,15–18}

This study's premise is that strategies to implement guidelines and reduce caesarean section rates should take into account physicians' perceptions in order to identify different forces and variables influencing their behaviour. Consequently, we carried out an exploratory study to investigate obstetricians' perceptions of

SOGC guidelines, and to identify barriers to, facilitators of and obstetricians' solutions for their implementation.

Methods

We used a qualitative study design to explore and describe obstetricians' perceptions in three Montreal hospitals (one primary-level, one secondary-level and one tertiary-level),¹⁹ with annual deliveries ≥ 1000 , caesarean section rates $\geq 20\%$, and where 75% of obstetricians agreed to participate. Data was obtained from two focus group sessions, with obstetricians from each of the three hospitals, dealing with induction of labour at term and fetal health surveillance in labour guidelines, and

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operative vaginal birth and vaginal birth after previous caesarean birth guidelines. For secondary-level and tertiary-level hospitals, with more than 10 clinicians, focus groups were divided into two sessions; thus there were four focus groups in each hospital. All obstetricians were approached to participate in the study.

Data sources and collection

A focus group gathers people from similar backgrounds or experiences to discuss a specific topic of interest.¹⁹ Focus groups conducted at each unit were scheduled at the convenience of participants. Semi-structured interviews were conducted with clinicians who were not able to take part in the focus groups. The focus groups and personal interviews lasted approximately 90 minutes. A moderator, also referred to as an interviewer, conducted each focus group in the presence of an observer, but only the moderator conducted the semi-structured interviews. The moderator was in control of the session and was responsible for the direction taken by the focus group. The main tasks of the observer were to take notes, including non-verbal observations, to record and observe the session. All focus groups and interviews were audio-taped and transcribed verbatim. The interviewer and observer reconstructed detailed notes of each interview immediately after the session. An interview guide was used for all focus groups and interviews (Annex 1, available at <http://www.who.int/bulletin/volumes/85/10/06-039289/en/index.html>).

Focus groups and interviews about SOGC guidelines were structured in the following manner: respondents were asked to describe their perceptions about the adoption of recommendations, barriers and challenges encountered when following the recommendations, and factors and interventions they believed important for facilitating and supporting use of the recommendations.

Guidelines recommendations

This study focused on four SOGC evidence-based guidelines (available at: <http://www.sogc.org>) for improving best practice in obstetric care:^{20–24} induction of labour at term, fetal health surveillance in labour, guidelines for operative vaginal birth and guidelines for vaginal birth after previous caesarean birth (Annex 1).

Data analysis

Analysis of transcripts was planned according to Graham 2004.¹⁸ The tapes were transcribed, and their accuracy was verified. Analysing the data from one hospital at a time, two researchers (NC, ED) jointly coded and categorized ideas into broader themes through consensus until all the transcripts were reviewed. To ensure study rigor and reduce limitations, we used the logbook method in *A manual for the use of focus groups* to help analyse transcripts;¹⁹ this consists of a table used to record answers on selected topics. Focus groups and semi-directed interviews were separately analysed. Once all transcripts were analysed, results were reviewed to describe findings that apply to the study as a whole. As hypotheses were generated, we sought confirmation by returning to the transcripts to find evidence to refute or support these. One obstetrician (AD) on the research team reviewed the analysis to ensure the accuracy of our interpretations and critical analysis during the entire process.

Findings

Ten focus groups divided into two sessions (Annex 1) and six semi-structured interviews were conducted in the three hospitals. On the 33 available obstetricians, 27 (80%) agreed to participate, ensuring that the sample is highly representative (Table 1).

Interviewed obstetricians noted that the clinical practice guidelines were generally easy to understand and that they preserve obstetricians' discretion to judge appropriate treatment. Moreover, the guidelines are perceived as evidence-based and as a legal reference. However, obstetricians identified specific barriers to and facilitating factors for implementing the guidelines' recommendations in practice (Tables 2 and 3). Obstetricians also said the focus group sessions acted as strong facilitating factors, and that these should constitute the first step for improving the use of recommendations in practice.

Induction of labour at term

Obstetricians said the augmentation of induction of labour before 41 complete gestation weeks, mainly explained by the increase in maternal requests and the unavailability of induction during the weekend, is an important barrier to change. Induction at term, especially

with unfavourable cervix (i.e. Bishop Score < 6), may increase the risk of failure to progress and the need for a caesarean section.²⁰

According to obstetricians, the augmentation of maternal request for induction at term was explained by maternal insecurity or logistic factors (end of maternity leave) because of insufficient information about the delay between estimated and real birth dates. Consequently, providing the latest expected birth date to women instead of the mean expected birth date has been perceived as a potential facilitator to reduce induction on maternal request. Moreover, obstetricians said that when they were planning an induction, explanations about the method to be used, side-effects, risks of caesarean section and possible complications were insufficiently discussed with the woman.

Medico-legal concerns also encouraged induction for convenience and the rise of induction of labour before 41 complete gestation weeks. Indeed, a general proactive approach was seen by obstetricians as a means to reduce potential risk of lawsuits. The unavailability of induction during the weekend has also been perceived as an important barrier to change, increasing the risk of induction failure because women may be induced two days before the expected date. This may lead to an interruption of labour, then to a caesarean section. The adoption of a departmental policy in hospital B promoting the standardization of induction at term positively influenced the use of recommendations. Staff meetings, formal protocols for induction at term and standardized information to women contributed to enhance the adoption of the recommendations and to reduce induction at maternal request.

Fetal health surveillance in labour

Obstetricians noted a slow uptake of intermittent auscultation in the delivery unit. There is some evidence that the use of continuous electronic fetal monitoring may lead to increased false positives for fetal hypoxemia and to resulting caesarean sections.^{21,22}

Human resources and organizational factors have been seen as the main barriers to performing intermittent auscultation, as a one-to-one nurse-patient ratio is uncommon in the three hospitals. Moreover, obstetricians noted that the use of continuous electronic fetal

Table 1. Setting and respondent participation in focus groups and semi-directed interviews

Setting characteristics	Hospital A	Hospital B	Hospital C
Beds (maternity unit)	86	29	28
Beds (nursery)	72	35	30
Services	High-risk obstetric and paediatric care	Intermediary obstetric care	Obstetric care, family medicine
Availability of neonatal care	Yes	Yes	Yes
Availability of neonatal intensive care unit	Yes	No	No
Availability of midwifery services	No	No	No
Births in 2004–2005	2893	2595	1764
Nurse–patient ratio in delivery unit	1:1 to 1:2	1:1 to 1:3	1:1 to 1:2
Academic status	Yes	Yes	Yes
No. of obstetricians	18	13	6
No. of family physicians	1	6	13
No. of nurses in delivery unit	53	45	58
Anesthetists on site	Yes	Yes	Yes
Pediatricists on site	Yes	Yes	No
Availability of EFM machine	Yes	Yes	Yes
Central EFM	No	No	Yes
Availability of fetal scalp blood sampling	Yes	No	Yes
Rate of caesarean section (2004–2005)	27.2%	24.0%	22.6%
Payment method	In transition from pool to blended	Blended	Individual
Number of available obstetricians	15	13	6
% of agreement to participate	93%	85%	100%
% of participation of agreed obstetricians	86%	91%	83%
% of participation of available obstetricians	80%	77%	83%
Number of included obstetricians	12	10	5
No. of focus group	4	4	2
No. of semi-structured interviews	4	2	0

EFM, electronic fetal monitoring.

monitoring and the presence of a unit's central monitoring system may permit a nurse to attend to several women simultaneously. However, it could have negative effects on the progress of labour because of the lack of psychological support to the mother.²⁸ Another identified barrier was that some anaesthesiologists prefer the use of continuous electronic fetal monitoring when women receive an epidural. Obstetricians also noted that unavailability of equipment was an important barrier to accurately diagnosing fetal hypoxemia. The absence of a pH meter at hospital B was identified as a practical impediment to an optimal use of recommendations because obstetricians cannot use fetal scalp blood sampling to investigate non-reassuring patterns of the electronic fetal monitoring. Moreover, when a pH meter was available, the use of fetal scalp blood sampling might be limited because of technical limitations, including the skill level of operators, anatomical difficulties associated with the procedure and associated pain experienced by the woman.

Fear of lawsuits was also suggested as a factor that limits the use of intermittent auscultation. Obstetricians described continuous electronic fetal monitoring as reassuring because this method is based on objective criteria, and an electronic fetal monitoring paper strip represents a strong evidence of good practice in case of lawsuits. Obstetricians also noted that continuous electronic fetal monitoring helps to supervise students and residents in the delivery unit. However, some obstetricians thought that medico-legal concerns may also encourage the use of intermittent auscultation because interpretation of the strip is difficult and variable. For them, the use of intermittent auscultation as described in the guidelines represents the best practice and the optimal way to avoid the charges of malpractice.

Obstetricians commented that the growing number of less experienced junior nurses, especially during the night, has also slowed the adoption of the recommendations because they seem more comfortable using continuous electronic fetal monitoring. In contrast,

senior nurses seem more comfortable with the use of intermittent auscultation, because of their experience, and this may influence their colleagues to adopt the recommendations. Equally, obstetricians stated that senior obstetricians may have stronger influence than junior obstetricians in promoting the adoption of intermittent auscultation. Finally, obstetricians noted that strong nursing and obstetric leadership is an important facilitator for encouraging the adoption of guidelines.

Moreover, maternal preference to have continuous electronic fetal monitoring has been perceived as a potential barrier to the adoption of recommendations. Obstetricians thought that the women may be reassured by continuous electronic fetal monitoring, especially when they receive weak labour support.

Operative vaginal birth

Obstetricians noted a weak adoption of operative vaginal birth recommendations, especially for breech presentation and the use of forceps.

Conclusions of the term breech trial of Hannah et al.²⁵ stating that planned caesarean sections are seen as a means to reduce potential risks of morbidity and lawsuits also affected adoption of the recommendations. Obstetricians indicated that they await more evidence about maternal and neonatal morbidity before fully adopting the guidelines. Not having a blended payment method also has been perceived as an economic incentive to recommend caesarean sections, because they are easier to schedule than vaginal deliveries and generate additional income.

Obstetricians also noted that the use of mid forceps may not be compatible with their philosophy because of their personal experiences or convictions. Another identified barrier to using forceps was the loss of skills or unwillingness to offer instrumental vaginal birth. Indeed, some resident obstetricians and junior obstetricians may experience stress at the prospect of using mid forceps or manual rotations because of their lack of experience and their concerns about legal consequences. However, the possibility of referring a patient to a more experienced colleague has been identified as a potential facilitator to improve the use of these recommendations.

Maternal refusal to attempt an external cephalic version was also seen as a potential barrier to reduce caesarean section rate for breech presentation. Obstetricians said explanations about the risks and benefits of external cephalic version versus a planned caesarean section were insufficiently discussed with women.

Vaginal birth after caesarean

The need of complex infrastructures necessary to offer a safe vaginal birth after previous caesarean birth was perceived as an important barrier to change. Obstetricians noted that the recommendations cannot be adopted everywhere, especially when many hospitals do not have an available anaesthetist on call around the clock. Moreover, the guideline recommends that “a trial of labour *should* be offered to a woman with one previous transverse low-segment caesarean section”.²⁴ The use of conditional verb tense in the guideline has been identified as a potential barrier to adopting the recommendations, refusing any sort of obligation.

Fear of lawsuits and concerns about the legal consequences of uterine rup-

Table 2. Identified barriers to the implementation of practical guidelines

Topics
<p>Factors influencing use of induction of labour at term guideline</p> <ul style="list-style-type: none"> • Induction of labour before 41 complete gestation weeks • Maternal request for induction at term • Possible complications insufficiently discussed with women when planning an induction • Medico-legal concerns • Adoption of a proactive approach to reduce potential risks of lawsuits • Unavailability of induction during the weekend
<p>Factors influencing use of fetal health surveillance in labour guideline</p> <ul style="list-style-type: none"> • Not having a one-to-one nurse–patient ratio • Use of a central monitoring system • Anaesthesia department preferences for the use of continuous electronic fetal monitoring • Availability of equipment (i.e. pH metre) • Limited use of fetal scalp blood sampling • Fear of lawsuits • Availability of experienced nurses • Maternal preferences for the use of continuous electronic fetal monitoring
<p>Factors influencing use of operative vaginal birth guideline</p> <ul style="list-style-type: none"> • Conclusions of the term breech trial of Marie Hannah et al.²⁵ • Need of more evidence about maternal and neonatal morbidity • Not having a blended remuneration mode • Lack of skills or unwillingness to offer instrumental vaginal birth • Maternal refusal to attempt an external cephalic version
<p>Factors influencing use of vaginal birth after previous caesarean birth guideline</p> <ul style="list-style-type: none"> • Need of a high-level infrastructure necessary to offer a safe vaginal birth after caesarean section • Availability of an anaesthetist at all times • Use of a conditional verb tense “<i>should</i> be offered to a woman” in the guideline • Fear of lawsuits in case of uterine rupture • Women’s preference for a repeat caesarean section

ture have been perceived as important barriers to adopting the recommendations because obstetricians are more sensitive to maternal and fetal health during trial of labour, and privilege the faster decision of caesarean section. Obstetricians commented that they wanted more evidence about the benefits of a trial of labour compared to a planned caesarean section, and that they need an accurate method for predicting uterine rupture to fully adopt the recommendations.

Obstetricians also said that informing the women about the risks and benefits of trial of labour versus planned caesarean section is time-consuming, and may have a low effect on the final decision, particularly when the women request a repeat caesarean section. Women who had undergone a previous caesarean section without complication may ask for a new caesarean section, and reject the offer of trial of labour. Fear of uterine rupture and newborn morbidity, fear of childbirth, fear of emergency caesarean section or pain during labour,

and potential request for additional surgery were perceived as factors contributing to maternal rejection of a trial of labour.

However, the possibility of requesting a second opinion was suggested to be a strong facilitator for encouraging women to attempt a trial of labour (adopted in hospital A) by providing personalized explanations about risks and benefits, and creating a supportive climate for influencing women to choose the safest mode of delivery. However, obstetricians at hospital C suggested that a second opinion should only be obtained between a family practitioner and an obstetrician because of the difficulties in identifying the medico-legal responsibilities between two obstetricians. Moreover, the difficulty in providing a second opinion for women who have already decided to have a planned caesarean section has also been seen as a potential barrier to influencing women’s choices.

Implementation interventions

In each hospital, obstetricians seek to improve quality of care. However, medical culture and local environment can modify the nature of the improvement adopted by health professionals.^{16,26} Obstetricians suggested several strategies for improving the use of guidelines and enhancing their practice. In each hospital, health professionals' education was identified as an important factor in improvement. Obstetricians suggested that educational workshops focusing on the recommendations in practice would make the guidelines more acceptable and useful to health professionals. In addition, promoting women's education about the risks and benefits of vaginal delivery compared to caesarean section, with informational materials available in waiting rooms, was perceived as an efficient strategy for sensitizing women and enhancing communication between health professionals and women. Finally, peer review activity (audit and feedback) championed by opinion leaders has been identified as the most important contributor to improve the use of recommendations. Obstetricians recognized that guidelines represent national or international evidence; this sensitized them to change their own practices. However, obstetricians also said that they need more local evidence to effectively change their practices, because they wanted to validate the transferability of the guidelines in their own practices. The local evidence generated by the audit and feedback process, representing a systematic review of local care against explicit criteria,¹⁵ was perceived as a strong key factor to assess the transferability and the adoption of the recommendations. Moreover, the identification of opinion leaders, defined as change agents who have significant social influence,²⁷ was seen as a strong facilitator to support the guidelines and to improve the acceptance of the audit and feedback process. Equally, it has been suggested that involving key members of the hospital administration in the feedback activities of the audit process could facilitate potential institutional changes at the level of the hospital.

Transferability of the findings

The findings of this study may not be transferable to all hospital settings. However, the inclusion of hospitals offering different levels of care, representing

Table 3. Identified facilitators to the implementation of practical guidelines

Topics
<p>Factors influencing use of induction of labour at term guideline</p> <ul style="list-style-type: none"> • Provide the highest expected birth date to women instead of the mean expected birth date • Adoption of a departmental policy of induction at term, including standardization of information provided to women
<p>Factors influencing use of fetal health surveillance in labour guideline</p> <ul style="list-style-type: none"> • Following the guidelines represents the best practice and the optimal way to avoid the charges of malpractice (lawsuits) • Possibility for senior obstetricians to promote the adoption of intermittent auscultation to junior obstetricians • Presence of strong nursing and obstetric leadership to support the guidelines recommendations
<p>Factors influencing use of operative vaginal birth guideline</p> <ul style="list-style-type: none"> • Possibility to refer a patient to a more experienced colleague
<p>Factors influencing use of vaginal birth after previous caesarean birth guideline</p> <ul style="list-style-type: none"> • Possibility for women to request a second opinion

around 10% of the births in Quebec province, should increase the validity of the findings. Moreover, a qualitative study in Ontario also explored barriers and facilitators influencing the use of intermittent auscultation among nurses identified findings similar to those obtained in this study.²⁸ In addition, a systematic review to maintain high-quality performance of health workers in low- and middle-income countries suggested that audit with feedback in a multifaceted intervention was effective in improving the use of recommendations.²⁹ Likewise, qualitative methods for describing contextual factors and barriers to change have also been identified as a key factor in low- and middle-income countries adopting guidelines. The results of these studies are consistent with those presented in this paper and support the validity of this methodology and the transferability of the findings in Canada and in low- and middle-income countries.

Study limitations

The nature of the focus group increases the possibility that the respondents may have been influenced by a member with a high social influence. To limit this bias, all focus group sessions were validated considering non-verbal observations, and no major influence was identified. Data was also jointly coded and classified by categories by two researchers to limit potential bias and inappropriate interpretation of transcripts. Moreover, throughout the analytical process the

findings were discussed with the research team, including obstetricians, to improve the critical analysis and to ensure the accuracy of the interpretations. Finally, obstetricians said women's motivations are an important factor in effectively adopting the recommendations. However, a qualitative study should be conducted with women to ensure the validity of this finding.

Conclusion

Identified barriers to and facilitators for the implementation of the SOGC guidelines can be classified into four categories: 1) the hospital level, including management and hospital policies; 2) the departmental level, including local policies, leadership, organizational factors, economic incentives and availability of equipment and staff; 3) the health professionals' motivations and attitudes, including medico-legal concerns, skill levels, acceptance of guidelines and strategies used to implement recommendations; and 4) women's motivations, including the nature of medical explanations provided, and the management of maternal request for medical interventions.

Implementing the use of recommendations is a complex process influenced by multiple factors. Identifying the potential barriers to and facilitators for the adoption of recommendations is an important approach for guiding the development of efficient strategies to improve local acceptance of guidelines. The findings of this study suggest that

the implementation of guidelines may be improved if local health professionals' perceptions are considered in order to make recommendations more acceptable and useful. Our findings also support the assumption that obstetricians seek to implement best practices but that they require evidence, tools and support to assess their practices and enhance their performance. In addition, peer review activities championed by opinion leaders have been recommended by obstetricians for improving the use of the guidelines in their practices. ■

Ethical approval

This study was approved by the ethics committees of the three hospitals.

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Competing interests: None declared.

Résumé

Identification des éléments empêchant ou facilitant la mise en œuvre des directives visant à réduire les taux d'accouchement par césarienne au Québec

Objectifs Étudier la perception par les obstétriciens des directives en matière de pratiques cliniques visant la prise en charge du travail et l'accouchement par les voies naturelles des femmes ayant antérieurement accouché par césarienne et identifier les éléments qui, dans la pratique, entravent ou facilitent la mise en œuvre de solutions obstétricales conformes à ces directives.

Méthodes L'étude qualitative a été menée dans trois hôpitaux de Montréal représentant environ 10 % des naissances au Québec. On a procédé à une collecte de données parmi 10 groupes thématiques, puis à 6 entretiens semi-structurés. Deux chercheurs ont en commun analysé les transcriptions intégrales de ces entretiens selon *A manual for the use of focus groups*.

Résultats Les éléments empêchant ou facilitant la mise en œuvre des directives qui ont été identifiés peuvent être classés en trois catégories : 1) niveau hospitalier (politiques de prise en charge et de l'établissement notamment) ; 2) niveau du département (politiques locales, facteurs liés à l'encadrement et à l'organisation, incitations économiques et disponibilités en équipements et en personnel

notamment) ; 3) motivations et mentalités des professionnels de santé (préoccupations médico-légales, niveaux de compétences, acceptation des directives et stratégies utilisées pour appliquer les recommandations notamment) et 4) motivations des patientes.

Conclusion L'identification des éléments empêchant ou facilitant l'adoption des directives est un moyen important pour guider le développement de stratégies efficaces. Les résultats de cette étude laissent à penser que cette adoption peut s'effectuer mieux si les perceptions des professionnels de la santé locaux sont prises en compte dans l'élaboration de recommandations plus acceptables et plus utiles. Nos résultats étayent aussi l'hypothèse selon laquelle les obstétriciens cherchent à mettre en œuvre les meilleures pratiques, mais ont besoin d'outils et d'aides reposant sur des éléments factuels pour évaluer leurs pratiques et améliorer leurs performances. En outre, le contrôle par des pairs des pratiques, préconisé par des dirigeants politiques, a été identifié par les obstétriciens comme la stratégie la plus appropriée pour améliorer l'application des directives dans leur activité.

Resumen

Identificación de los factores que impiden o favorecen la aplicación de protocolos orientados a reducir las tasas de cesárea en Quebec

Objetivo Investigar las ideas de los obstetras acerca de los protocolos clínicos relativos al manejo del trabajo de parto y el parto vaginal tras una cesárea anterior, e identificar los factores que impiden o favorecen la aplicación de esos protocolos en la práctica y las soluciones de los obstetras a ese fin.

Métodos Este estudio cualitativo se llevó a cabo en tres hospitales de Montreal que concentran alrededor del 10% de los nacimientos en Quebec. Se reunieron datos de 10 grupos de discusión, a lo que siguieron seis entrevistas semiestructuradas. Dos investigadores analizaron conjuntamente las transcripciones literales ateniéndose a un manual de manejo de grupos de discusión.

Resultados Los factores que impiden o favorecen la aplicación de los protocolos pueden clasificarse en cuatro categorías: 1) el nivel hospitalario, en particular la gestión y las políticas hospitalarias; 2) el nivel departamental, con inclusión de las políticas locales, el liderazgo, los factores organizacionales, los incentivos económicos y la disponibilidad de equipo y personal;

3) las motivaciones y actitudes de los profesionales sanitarios, incluidos los problemas médico-legales, los niveles de aptitud, la aceptación de las directrices y las estrategias usadas para poner en práctica las recomendaciones, y 4) las motivaciones de las pacientes.

Conclusión La identificación de los factores que impiden o facilitan la adopción de las recomendaciones ayuda a orientar la formulación de estrategias eficaces. Los resultados de este estudio parecen indicar que, cuando se tienen en cuenta las impresiones de los profesionales sanitarios locales, es posible fomentar la adopción de los protocolos. Nuestros resultados respaldan también la idea de que los obstetras procuran aplicar las prácticas óptimas, pero requieren datos probatorios y apoyo para evaluar su forma de trabajar y mejorar su desempeño. Además, dichos profesionales han identificado las actividades de examen por homólogos preconizadas por personas de reconocida influencia como la estrategia más apropiada para fomentar el uso de los protocolos en el ejercicio de su trabajo.

ملخص

التعرُّف على المعيّقات والميسّرات تجاه تطبيق الدلائل الإرشادية،
لخفض معدلات العمليات القيصرية في إقليم كوبيك

والعاملين، (3) دوافع المهنيين الصحيين ومواقفهم، بما يشمل الشواغل المتعلقة بالطب الشرعي، ومستويات المهارة، وقبول الدلائل الإرشادية والاستراتيجيات المستخدمة في تنفيذ التوصيات، (4) الدوافع لدى المرضى. **الاستنتاج:** يعدّ التعرُّف على المعيّقات والميسّرات الخاصة بتبني التوصيات، أحد السُّبل الهامة التي يُستهدى بها في وضع الاستراتيجيات الفعّالة. وتشير موجودات هذه الدراسة إلى أن تبني الدلائل الإرشادية يمكن أن يتحسن إذا أخذت تصورات المهنيين الصحيين المحليين بعين الاعتبار من أجل جعل التوصيات أكثر مقبولة وأكبر فائدة. وتدعم الموجودات التي توصل إليها الباحثون الافتراض القائل بأن أطباء التوليد يسعون إلى تطبيق أفضل الممارسات، إلا أنهم بحاجة إلى أدوات لتوفير البيّنات والدعم، لتقييم ممارساتهم وتحسين أدائهم. وعلاوة على ذلك، فقد وجد أطباء التوليد أن الأنشطة الخاصة بمراجعة الزملاء، والتي تجد التأييد والمناصرة من قادة الرأي، تمثّل أكثر الاستراتيجيات ملاءمة لتحسين استخدام الدلائل الإرشادية في ممارستهم الطبية.

الأهداف: استقصاء تصورات أطباء التوليد حول الدلائل الإرشادية للممارسة السريرية (الإكلينيكية) التي تستهدف التدبير العلاجي للمخاض والولادة عن طريق المهبل، بعد ولادة قيصرية سابقة، والتعرُّف على المعيّقات والميسّرات، والحلول التي يقدها أطباء التوليد حيال تطبيق هذه الدلائل الإرشادية في الممارسة. **الطرق:** أجريت هذه الدراسة النوعية في ثلاثة مستشفيات في مدينة مونتريال، تمثّل حوالي 10% من الولادات التي تتم في إقليم كوبيك. وجمعت البيانات من عشر مجموعات تركيز، تبعها ست مقابلات شبه منظمة. وأجرى باحثان، بشكل مشترك، تحليلاً للنصوص الحرفية، وفقاً للدليل أ لاستخدام مجموعات التركيز.

الموجودات: يمكن تصنيف المعيّقات، والميسّرات التي تمّ التعرُّف عليها الخاصة بتطبيق الدلائل الإرشادية في فئات أربع هي: (1) مستوى المستشفى، بما يشمل إدارة المستشفى وسياساته، (2) مستوى القسم، بما يشمل السياسات الداخلية، والقيادة، والعوامل التنظيمية، والحافز الاقتصادي، وتوفر المعدات

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Annex 1. Focus groups and interviews guide

The Society of Obstetricians and Gynaecologists of Canada (SOGC) developed evidence-based Clinical Practices Guidelines for improving best practices. These guidelines represent an appropriate means to enhance intrapartum care and reduce caesarean section rates in Canada. The purpose of this study is to investigate obstetricians' perceptions about the implementation in their department of the SOGC guidelines targeting management of labour, operative vaginal delivery and vaginal birth after previous caesarean birth.

Session I: Guidelines targeting management of labour

1. In your department, what are the factors responsible of the rise of the primary caesarean section rate?
2. SOGC Guideline for the Induction of Labour at Term (107) was developed to review indications and contraindications of induction of labour, and to summarize methods of cervical ripening and labour induction, including their effectiveness and safety (2001).
 - a. Could you describe your perception about the adoption of these recommendations?
 - b. What are the barriers and challenges encountered in your practice to following these recommendations?
 - c. What are the factors and interventions that you believe to be important for facilitating and supporting the use of these recommendations in your practice?
3. SOGC Guideline for the Fetal Health Surveillance in Labour (112) developed to define the standards pertaining to the application and documentation of fetal surveillance in labour for all health professionals providing intrapartum care (2002).
 - a. Could you describe your perception about the adoption of these recommendations?
 - b. What are the barriers and challenges encountered in your practice to following these recommendations?
 - c. What are the factors and interventions that you believe to be important for facilitating and supporting the use of these recommendations in your practice?

Session II: Guidelines targeting operative vaginal birth and vaginal birth after previous caesarean birth

4. In your department, what are the factors responsible of the rise of repeat caesarean section rate?
5. SOGC recommendations of the Guideline for the Operative Vaginal Birth (148) was developed to provide guidelines for operative vaginal birth in the management of the second stage of labour (2004).
 - a. Could you describe your perception about the adoption of these recommendations?
 - b. What are the barriers and challenges encountered in your practice to following these recommendations?
 - c. What are the factors and interventions that you believe to be important for facilitating and supporting the use of these recommendations in your practice?
6. SOGC Guideline for the Vaginal Birth After Previous Caesarean Birth (155) was developed to provide evidence-based guidelines for the provision of a trial of labour after caesarean section (2005).
 - a. Could you describe your perception about the adoption of these recommendations?
 - b. What are the barriers and challenges encountered in your practice to following these recommendations?
 - c. What are the factors and interventions that you believe to be important for facilitating and supporting the use of these recommendations in your practice?