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ENHANCING THE PROFESSIONAL DIGNITY OF MIDWIVES IN AN ACADEMIC TERTIARY HOSPITAL

Full research dissertation for the degree M Cur

by

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ABSTRACT

Introduction and background: The professional dignity of midwives is determined by their own perspectives of the contribution that they make to the optimal care of patients, the respect that they get from other members of the health team and the support that hospital management gives them. When midwives are not treated with respect and their professional competencies are not recognised, their professional dignity is violated.

Aim of the study: The study aims to explore and describe how the professional dignity of midwives in the selected hospital can be enhanced.

Methodology: A descriptive phenomenological research design was used. In-depth interviews were conducted once informed consent was obtained with purposively selected participants until data saturation occurred. At least 15 midwives from the antenatal, postnatal and delivery rooms of the selected hospital were interviewed. The interviews were audio-recorded with the permission of the participants and analysed through the method of Giorgi (1997:247). The essence of the phenomenon and the supporting constituents (themes) were identified. The essence and constituents will be described and thereafter the constituents will be discussed. Applicable literature was used to integrate the findings in the knowledge base of the phenomenon.

Findings: The purpose of the research study was to explore how the professional dignity of midwives in the selected hospital can be enhanced. The essence (meaning) of the participants' experiences was disclosed as: To dignify midwives in an academic tertiary hospital. The essence is supported by the following constituents (meaning units): 'to acknowledge the capabilities of midwives', 'to appreciate interventions of midwives', 'to perceive midwives as equal health team members', 'to invest in midwives', 'to enhance collegiality', 'to be cared for by management' and 'to create conducive environments'.

Key words: professional dignity, midwife, academic tertiary hospital, high risk patients, phenomenological research, essence, constituent

CHAPTER 1
ORIENTATION OF THE STUDY

1.1 INTRODUCTION

In academic tertiary hospitals midwives, as members of a health team (also known as a multi-disciplinary team), render antenatal, intra-partum and postnatal care to women with high risk pregnancies (Ergin, Özcan, Acar, Ersoy & Karahan, 2013: 812). Respect for the contributions of each member by the team and the management of the hospital is a prerequisite for the optimal functioning of the team (Stievano, Rocco, Sabatino & Alvaro, 2013: 120). Endeavours of respect also lead to the honouring of their professional dignity (Yalden & McCormack, 2010: 144).

The extent to which health professionals have respect for other health team members and for themselves determine their professional dignity (Sabatino, Kangasniemi, Rocco, Alvaro & Stievano, 2014: 2). Respect for own professional dignity is as important as respect for other team members' professional dignity (Gallagher, 2004: 592). Respect for one's own professional dignity and the professional dignity of the team members create work environments that are conducive for optimal patient care (Jordan, Fenwick, Slavin, Sidebotham & Gamble, 2013: 131). Hospital managers can also create environments conducive for the honouring of the professional dignity of the health team members (Strum & Dellert, 2015: 9). When the professional autonomy of health professionals are ensured by the team and the hospital managers, their professional dignity is respected (Sabatino et al., 2014: 5).

Although midwives have an autonomous practice, they also implement care that is prescribed by obstetricians in an environment that is created by hospital management. Their professional dignity can be violated when their practice is restricted by the obstetricians and hospital management such as when women with high risk pregnancies are cared for (Sarmiento, 2008: 3). The aim of this study is thus to explore and describe what measures can enhance the professional dignity of midwives in an academic tertiary hospital.

1.2 BACKGROUND AND RATIONALE

In this section, the professional dignity of midwives in general and the challenges that they experience to uphold their professional dignity in tertiary care are discussed.

1.2.1 Professional dignity of midwives

The professional dignity of midwives is determined by their professional image and confirmed by other health professionals (Stievano et al., 2013: 120). When they are treated with respect by the health team (consisting of many different types of professions with their own hierarchy, collaborating to provide care to patients).and hospital management, their professional dignity is enhanced. The opposite happens when they are not treated with respect (Khademi, Mohammadi & Vanaki, 2012: 336). The same applies to the recognition of their professional competencies. Recognition of their capabilities by the health team and hospital management also contributes to their experiences of professional dignity (Sabatino, Stievano, Rocco, Kallio, Pietila & Kangasniemi, 2014: 666).

Midwives who feel supported by hospital management and respected by the health team have a positive experience of professional dignity. The sense of professional dignity that is experienced correlates positively, according to Gallagher, Zaboli and Ventura (2012: 54) with the quality of the care that health professionals deliver. A positive sense of professional dignity is associated with optimal patient care (Halldorsdottir & Karlsdottir, 2011: 812; Jordan et al., 2013: 131).

The working environment influences the professional dignity of midwives (Lawless & Moss, 2007: 234). A conducive environment where nurses are supported is necessary for a positive experience of professional dignity (Strum & Dellert, 2015: 9) and good nursing care (Baillie & Gallagher, 2011: 338; Corley, Minick, Elswick & Jacobs, 2005: 388). Nurses also need support for their autonomous practice (Kramer & Schmalenberg, 2008: 70) in order to render quality patient care (Halldorsdottir & Karlsdottir, 2011: 812). Teamwork and involvement in decision making processes improve the working environment (Van Bogaert, Kowalski, Weeks, Van Heusden &

Clarke, 2013: 1675) and play a part in improving professional dignity of nurses (Stievano, De Marinis, Russo, Rocco & Alvaro, 2012: 7).

1.2.2 Challenges that midwives experience in academic tertiary hospitals

In academic tertiary hospitals, women with high risk pregnancies are admitted and managed. They require intensive observation and timeous interventions to prevent complications. Complications with detrimental effects on the women and their unborn infants can develop at any time (Sarmiento, 2008: 3). Midwives are educated and trained to do the observations and to intervene timeously (Griffin-Heslin, 2005: 256). They are also trained to attend to the emotional needs of their patients (Özcan, Akpınar & Ergin, 2012: 400). The women and their infants are respected as unique entities with special health care needs (King, Brucker, Kriebs & Fahey, 2015: 3) that are collaboratively addressed by midwives and other members of the health team (Malott, Kaufman, Thorpe, Saxell, Becker, Paulette, Ashe, Martin, Yeates & Hutton, 2012: 968). Within the team, respect for the professional autonomy of midwives secures the position of the midwives (Stievano et al., 2012: 8) and prevents situations where their scope of practice is restricted due to the compromised health of the women that they take care of (Sarmiento, 2008: 3).

Pregnant women with high risk pregnancies fear complications for themselves and their infants and have to be treated in hospital for prolonged periods of time that can result in elevated levels of stress (Lee, Ayersa & Holden, 2012: 511). While the midwives have to cope with the demands of their patients, they also have to deal with ethical dilemmas such as the execution of a medical termination of pregnancy to save the life of a patient (Goldman & Tabak, 2010: 242).

1.3 PROBLEM STATEMENT

When midwives' competencies are not acknowledged by the health team and hospital management (Sabatino et al., 2014: 666) and they have to work under stressful circumstances, their professional dignity is violated (Strum & Dellert, 2015: 9). Under such circumstances, midwives find it very difficult to continue rendering quality care to their patients (Gallagher et al., 2012: 54). In academic tertiary care,

patients with high risk pregnancies are midwives'responsibility for 24 hours per day, seven days per week. The focus of midwifery care is to ensure that both women and infants do not develop complications, that healthy infants are born and that the women do not have long term health problems (King et al., 2015: 3). Under the South African Nursing Act of 2005 (Act No. 33 of 2005) and the South African Nursing Council Scope of Practice, Regulation 2598 amended by Regulation 260, for a registered midwife also covers this, along with the advocating to obstetricians and hospital management on behalf of the women and their infants to provide an optimal environment for physical, emotional and psychological health during the antenatal, intra-partum and postnatal periods. Monitoring of the unborn infant is part of the scope of practice, although the interpretation of the cardiotocograph and final decision on the management thereof based on this tracing lies with the obstetrician.

The researcher noticed that in the selected academic tertiary hospital, the midwives often have to cope with situations of restricted practice. The obstetricians are not supportive of their autonomous practice. They expect the midwives to follow their prescriptions regarding the care of the patients to the letter. No deviations from prescriptions or autonomous decisions by the midwives are tolerated.

The midwives of the selected academic tertiary hospital feel that the hospital management do not understand how patient-intensive the care that they deliver, is. The patients are admitted to hospital long before the birth of their infants and they often have to stay in hospital long after the birth of their infants in the case of preterm birth. They are very ill and need constant observation and immediate intervention to avoid complications and to manage complications when it could not be prevented. The patients also have emotional and psychological needs that the midwives have to attend to. They are at first worried about the survival of their unborn infants and after birth about the survival of their preterm infants.

Without the respect from the health team and support from the hospital management the midwives of the selected hospital struggle to uphold their professional dignity.

1.4 SIGNIFICANCE OF THE PROPOSED STUDY

This study focused on the views of the midwives on how their professional dignity can be enhanced. The findings may lead to ways of enhancing the self-worth and self-respect of midwives who work in a specific academic tertiary hospital. With a better self-image, midwives may gain more trust and confidence in their abilities. The findings may be communicated to management and obstetricians. This may lead to better teamwork between the health team members, with less restricted practices. This study may also potentially lead to improved nursing care.

1.5 RESEARCH QUESTION

The research question is: How can the professional dignity of the midwives of the selected hospital be enhanced?

1.6 AIM AND OBJECTIVES OF THE STUDY

The aim of the study was to explore how the professional dignity of midwives in the selected hospital can be enhanced.

The objectives of the study were:

- To describe the professional dignity of midwives in a specific academic tertiary hospital.
- To explore the perceptions of midwives on the ways to enhance the dignity of the midwives in a specific academic tertiary hospital.

1.7 CONCEPT CLARIFICATION

In this study the following concepts were referred to:

Professional dignity of midwives refers to the respect that midwives get from other members of the health team and their perceptions of themselves as professional

persons (Stievano et al., 2013: 120). It is revealed by their attitude towards their practice and their behaviour as professional people (Lin, Watson & Tsai, 2012: 171).

A Midwife is a nurse who has received training, education and a qualification in midwifery and is registered and licensed to practice midwifery under the South African Nursing Act of 2005 (Act No. 33 of 2005). Midwives are responsible and accountable for providing care to maintain the optimum health of their patients (women and infants) during the antenatal, intra-partum and postnatal periods. The care involves prevention and detection of complications, promotion of healthy living and providing emergency assistance when needed (the South African Nursing Act, 2005 (Act No. 33 of 2005); International Confederation of Midwives 2011).

Enhancing in nursing, is a concept used to define the process of improving development of staff, services rendered, care of patients, working environments and working relationships (Twigg & McCullough, 2014 88).

An academic tertiary hospital is a hospital that is used for the teaching and training of medical and nursing students. Patients that need specialised treatment are admitted (Hensher, Price & Adomakoh, 2006: 1230).

1.8 PHILOSOPHICAL ASSUMPTIONS

In this section, the research paradigm with the focus on a constructivist paradigm with its underlying meta-theoretical assumptions is discussed briefly. A detailed discussion will follow in Chapter 2.

1.8.1 Ontological assumptions

In this study, phenomenology as research approach was used and a constructivist paradigm structured the methodology of a qualitative research design. The researcher assumed that different people experience reality (in this study the professional dignity of midwives is the studied reality) differently (Mertens, 2015: 19). Every person has his or her own understanding of reality. Some people may have the same interpretation of a certain situation but other people may have a different

interpretation of the same situation. The researcher believes that all people have dignity, that all professional people have professional dignity and that all nurses (thus also midwives) have professional dignity. Professional dignity can be enhanced, respected or violated.

1.8.2 Epistemological assumptions

The researcher believes that professional dignity and its violation or enhancement can best be studied through the experiences of the people involved. When people experience a phenomenon (in this study the studied phenomenon refers to the enhancement of the professional dignity of midwives in an academic tertiary hospital) their consciousness of the phenomenon is intentional. People focus on the phenomenon with the intention to understand it (Solomon & Higgens, 1996: 251). Their understanding of the phenomenon becomes the focus of the phenomenology researcher. In this study the researcher studied the professional dignity of midwives through their experiences thereof as well as how their professional dignity can be enhanced. The researcher, through interaction with the participants, explored how the participants experience the phenomenon. The researcher remained open to the understanding of the phenomenon by the participants through bracketing of her own perceptions about the phenomenon in order to describe the truth regarding the phenomenon (Wojnar & Swanson, 2007: 174).

1.8.3 Methodological assumptions

Although a description of the concrete aspects of the ‘life-world’ of the people (also called the natural dimension of the phenomenon) is obtained within phenomenology research, the researcher is focused on the complexity of the ‘life-world’ and the phenomenon as part thereof in order to describe the phenomenological dimension of the phenomenon (Todres & Wheeler, 2001: 3; Cogswell, 2008: 87). The researcher has ‘intuit’ the essence of the phenomenon by staying open to the meaning of the phenomenon by those who experienced it to attach the same meaning to the phenomenon as the participants did (Wertz, 2005: 168). The researcher believes that only the people who experience the phenomenon can tell what it means to them. She thus conducted interviews with the participants of the study to encourage them

to share with her their understanding of the enhancement of their professional dignity in an academic tertiary hospital.

1.9 DELINEATION

This study is about enhancing the professional dignity of midwives in a specific academic tertiary hospital. Only one academic tertiary hospital was used.

1.10 RESEARCH METHODOLOGY

As a detailed discussion of the research methodology is provided in Chapter 2, only a brief overview of the research design is given here.

A qualitative research study is usually performed when the knowledge surrounding the phenomena is not extensive (Botma, Greeff, Mulaudzi & Wright, 2010: 182). It provides in-depth information on how a phenomenon is experienced and can bring an understanding and meaning to people about the feelings and experiences of others (Klopper, 2008: 63). A qualitative research study was performed as very little is known about the professional dignity of midwives in an academic tertiary hospital setting.

A descriptive phenomenological research design was used to explore and describe how the professional dignity of midwives in an academic tertiary hospital can be enhanced. Midwives were interviewed as only they know what incidents have a detrimental effect on their professional dignity. Additionally, only they know what incidents have a positive effect on their professional dignity. They are therefore the only people who can describe to the researcher how their professional dignity can be enhanced. In phenomenological studies the phenomenon (how the professional dignity of midwives in an academic tertiary hospital can be enhanced) is studied through the experiences of the participants of the phenomenon (Higgs & Smith, 2006: 55). Phenomenological studies are done in real life situations (Giorgi, 2000: 13). Descriptive phenomenology, according to Polit and Beck (2012: 495), describes the experiences of certain phenomena by people. Phenomenology researchers interact with their participants to produce trustworthy findings. The

interconnectedness between the researcher and the researched characterises phenomenological research (Finlay, 2009: 11). Researchers in phenomenology strive to describe “how the phenomenon is and not what the informants said about it” (Dahlberg, Dahlberg & Nystrőm, 2008: 255).

1.11 SUMMARY

In this chapter, the orientation of the study was presented. In the next chapter, the following research methodology will be discussed in detail.

CHAPTER 2
PARADIGMATIC PERSPECTIVE, PHILOSOPHICAL FRAMEWORK AND RESEARCH METHODOLOGY

2.1 INTRODUCTION

The following chapter will provide information used in the study to bring meaning and to clarify concepts used and discovered during this study about enhancing the professional dignity of midwives. The paradigmatic perspective, based on constructivism, will be discussed. The philosophical framework used and the research methodology will also be discussed in detail.

2.2 PARADIGMATIC PERSPECTIVE

The constructivist paradigm is based on the belief that every person faced with a certain experience, in a specific situation, has their respective interpretations of the situation. The interpretation of the experiences may be the same or differ depending on individuality (Polit & Beck, 2012: 12). In this study, the professional dignity of midwives in an academic tertiary hospital was studied. Their individual interpretation of their experiences in the working environment was influenced by their interactions with the health team and nursing and hospital management.

2.2.1 Research paradigm

Ontology is the nature of reality, how the world is viewed by individuals (how midwives view their environment as contributory to or damaging their professional dignity). Epistemology focuses on determining rules and principles for explaining and identifying the knowledge and information gained (how knowledge is constructed regarding the contributory or damaging factors of the professional dignity of midwives). Methodology indicates to the researcher, based on the information needed, what method of research will be used to study and gain knowledge in the selected situation (Botma, Greeff, Mulaudzi & Wright, 2010:40).

2.2.2 Meta-theoretical assumptions of the constructivist paradigm

The constructivist paradigm assumes the relativist ontology (Denzin & Lincoln, 2011: 35) and the supporters of this paradigm assume that there are multiple realities. One can never talk about one reality only. It refers specifically to subjective realities as experienced differently by individuals. Each individual shapes and finds meaning of reality according to his or her experiences of reality and his or her understanding of the reality (Mertens, 2015: 19). Some people may have the same interpretation of a certain situation but other people may have a different interpretation of the same situation. The researcher believes that all people have dignity, that all professional people have professional dignity and that all nurses (thus also midwives) have professional dignity. Professional dignity can be enhanced or violated. It is also assumed that only the participants can tell how they experience their professional dignity and identify the influences of the health team and nursing and hospital management on their experiences.

In the constructivist paradigm, a subjectivist epistemology is assumed (Denzin & Lincoln, 2011: 13). Research participants and the researcher co-create an understanding of the phenomenon (Polit & Beck, 2012: 13) that in this study refer to the experiences of professional dignity and the influences of the health team and nursing and hospital management on the experiences and ultimately how to enhance the professional dignity of midwives. The researcher believes that professional dignity and its violation or enhancement can best be studied through the experiences of the people involved. When people experience a phenomenon (in this study the studied phenomenon refers to the enhancement of the professional dignity of midwives in an academic tertiary hospital), their consciousness of the phenomenon is intentional and they focus on understanding the phenomenon (Solomon & Higgens, 1996: 251). Their understanding of the phenomenon becomes the focus of the researcher. In this study, the researcher plans to study the professional dignity of midwives through their experiences thereof as well as how their professional dignity could be enhanced.

A naturalistic set of methodological procedures are associated with the constructivist paradigm (Denzin & Lincoln, 2011: 13). The understanding of reality is studied in the

natural world. Research should be conducted where the reality is experienced and not in controlled, unnatural contexts. The researcher in this study thus interviewed the research participants (midwives) where they nurse patients on a daily basis and experience their professional dignity and the situations that impact on their experiences.

2.3 PHILOSOPHICAL FRAMEWORK

A descriptive phenomenological research approach enabled the researcher to understand how the professional dignity of the midwives in the selected hospital were experienced and could be enhanced.

2.3.1 Epistemological and ontological assumptions of the philosophical framework

The phenomenological movement, as founded by Husserl (1859-1938) in the beginning of the 20th century, occurred in opposition to the dominance of natural sciences. Husserl emphasized that the way towards understanding existence and human life is through the study of subjective experiences of people of the world (reality) (Moran, 2005: 35; Crane, 2009: 456).

The concepts of consciousness, intentionality, intuition, essence and phenomenological reduction are associated with descriptive phenomenology (Holloway & Wheeler, 2010: 216-219).

2.3.1.1 Consciousness

In phenomenology, the research reality is studied through the consciousness of the participants of the phenomenon to reveal the phenomenological dimension (the meaning of the experience) of the phenomenon instead of the natural dimension (the narrative description) of the phenomenon (Solomon & Higgens, 1996: 251). Through studies of the consciousness of participants of the phenomenon, researchers are able to explore and describe the phenomenon. In this study, the phenomenon refers

to the enhancement of the professional dignity of midwives in a selected academic tertiary hospital.

2.3.1.2 Intended consciousness

Consciousness is intentional. People are not conscious of something without focusing on it in order to determine its meaning and relating it to previous experiences and the meaning of previous experiences. It refers to a person's directed awareness of the phenomenon (Dahlberg, Dahlberg & Nystrőm, 2008: 47).

According to Solomon and Higgens (1996: 251), intentionality of consciousness is essential to Husserl's phenomenology. The acts of consciousness are always focused towards an object whether it is physical or conceptual. The meaning of the object to the person (subject) is intentionally consciously present in the mind of the person who experiences the phenomenon. The mind of the person superimposes the meaning to the object (Cogswell, 2008: 87).

2.3.1.3 Experience

In his quest to prove phenomenology as a scientific method of study, and contrary to the belief that scientific interventions were the only reliable and trusted methods of data collection, Husserl believed that lived experiences can contribute to new knowledge when explored and described (Cogswell, 2008: 86). The personal experiences of the participants are studied to gain a phenomenological understanding of the meaning that the participants attached to the phenomenon. Phenomenology researchers are not interested in the narrative description (the natural dimension of the data), but rather in the meaning that the participants attach to the experience namely the phenomenological understanding of the meaning of the experience (Solomon & Higgens, 1996: 94). Subjective experiences are a reliable and essential component of living. It influences how people interact with others in certain situations (Cogswell, 2008: 85).

2.3.1.4 Phenomenon

It refers to a thing or a part of reality that is studied by the phenomenology researcher and is often referred to as an object that is experienced by a subject (person) (Dahlberg, Dahlberg & Nystrőm, 2008: 33). Different frames of reference can be used to define phenomena, namely transcendental subjectivity (neutrality and openness to the reality of others), eidetic essence (universal truths) and the live-world plane of interaction (of researcher and participants) (Wojnar & Swanson, 2007: 174).

2.3.1.5 Essences

The main aim of phenomenology research is to determine what the meaning of the phenomenon is (Norlyk & Harder, 2010: 428). The meaning is called the essence and is supported by themes (Carlsson, Dahlberg, Lùtzen & Nystrőm, 2004: 193) or constituents (meaning units) that substantiate the essence (Lopez & Willis, 2004: 728). Husserl refers to essences as the essential meaning of a phenomenon (Dahlberg, 2006: 12). Essences are not added to the findings by the researcher and it is also not contributed by the participants. It is "disclosed in the researching act that takes place between the researcher and the phenomenon" (Dahlberg, 2006: 12). The researcher will, through free imaginative variation in her imagination, try to find different descriptive characteristics for the phenomenon in order to see what the truly essential characteristic of the phenomenon are (Beck, 1994: 16).

2.3.1.6 Meaning

The meaning of a phenomenon evolves through the intentional consciousness of a subject of the object (Giorgi, 2005: 82). It refers to the way that the object is experienced by the subject (participants in a study). The researcher studies the meaning of the phenomenon through interaction with the participants and the meaning gets co-created by the researcher and participants (Dahlberg, Dahlberg & Nystrőm, 2008: 47).

2.3.1.7 Intuition

It refers to the process through which researchers pay attention to what is immediately given to them in interaction with participants (Hintikka, 1995: 86). It gives researchers an idea of what the participants lived experience feels like. Therefore, the essence of experiences is not observed, but rather intuited (Solomon & Higgens, 1996: 93). Intuiting occurs when the researcher, remaining open to the phenomenon, attaches the same meaning to a phenomenon as the participants, who experienced the phenomenon (Offredy & Vickers, 2010: 101). Intuition is initiated when researchers start the process of data analysis with a concrete example of the phenomenon of which they want to grasp the essence and imaginatively varies it in every possible way in order to distinguish essential features from those that are incidental. The features that represent the essence of the phenomenon are present in all the experiences and descriptions of the experiences (Wertz, 2005: 168).

2.3.1.8 Life world

This is a complex, interconnected relationship between events that occur in everyday life and the meanings that are attached to these events (Todres & Wheeler, 2001:3). It is also known as the natural dimension of the phenomenon. Every event that the participants are involved in brings meaning and understanding to their experiences (Wertz, 2005:169). Life-world is the experiences of persons, the understanding of the experiences and the feelings that people have regarding their experiences (Todres & Wheeler, 2001: 3).

2.3.2 Methodological assumptions of the philosophical framework

Although a description of the concrete aspects of the ‘life-world’ of the people (also called the natural dimension of the phenomenon) is obtained in phenomenology research, the researcher is focused on the complexity of the ‘life-world’ and the phenomenon as part of it in order to describe the phenomenological dimension of the phenomenon (Todres & Wheeler, 2001: 3; Cogswell, 2008: 87). The researcher will ‘intuit’ the essence of the phenomenon by staying open to the meaning of the phenomenon by those who experienced it to attach the same meaning to the

phenomenon as the participants did (Wertz, 2005: 168). The researcher believes that only the people who experience the phenomenon can tell what it means to them. She thus conducted interviews with the participants to encourage them to share with her their understanding of their professional dignity and the enhancement of their professional dignity in an academic tertiary hospital.

Giorgi (1997: 235) describes three criteria that must be implemented when using descriptive phenomenology research. These are assuming phenomenological reduction, giving description from others and searching for invariant meaning. These criteria are discussed next.

2.3.2.1 Assuming phenomenological reduction

The researcher, during interaction with the participants, explored how the participants experienced the phenomenon. She 'bracketed' her own perceptions about the phenomenon in order to describe the phenomenon as it is portrayed by the participants (Wojnar & Swanson, 2007: 174). Phenomenological reduction is done when 'bracketing' is applied (Streubert-Speziale & Carpenter, 2007: 80). Husserl points out that when we apply phenomenological reduction through 'bracketing', the phenomenon is studied in its pure form (Rapport & Wainwright, 2006: 232). By using this method, Husserl attempts to 'bracket' the natural dimension or 'naïve belief in the reality of things' that takes 'the things' of the world for granted. To change the natural dimension to a phenomenological dimension, Husserl challenges researchers to "begin examining this very presence", i.e. our relationship with the world. The phenomenological dimension makes inquiries into the life-world of phenomenology opposed to the natural dimension (Dahlberg, Dahlberg & Nystrőm, 2008: 55).

During data collection, the researcher did not form premature conclusions as it could lead to inaccuracies in the interpretation of the data and an incorrect essence. Included in this process of phenomenological reduction is withholding existential affirmation; this means that the existence of the essence is not confirmed during the interviews but at the end of the data collection and analysis (Giorgi, 2008: 3).

2.3.2.2 Description from others

The researcher focused on obtaining the participants' descriptions of the event and their perceptions of their experiences of professional dignity and means to enhance it. The focus of the research is in the description of the phenomenon by the participants, uninfluenced by any other external influences (Giorgi, 2005: 80). Phenomenology researchers want to know how people understand their world and life and therefore ask them about it. The interviews thus result in collaboration between the researchers and the participants (Dahlberg, Dahlberg & Nystrőm, 2008: 184). The researcher focused on the experiences of the participants of their professional dignity and the enhancement thereof while she 'bracketed' her own experiences.

2.3.2.4 Search for the invariant meaning

The researcher used eidetic reduction to search for the relationship between the phenomenon and the way that it was consciously experienced by the participants (Zahavi, 2003: 45) to understand the meaning that the participants attached to their experiences. The focus of a phenomenological research study is to find meaning in lived experiences of the participants (Giorgi, 2005: 81). Invariant meanings are searched for to distinguish the essence of the phenomenon from other incidental explanations (Zahavi, 2003: 39).

2.4 RESEARCH DESIGN

Phenomenological inquiry was used to explore and describe how to enhance the professional dignity of the midwives in the selected hospital.

2.4.1 Research method

A qualitative research study is usually performed when the knowledge surrounding the phenomena is not extensive (Botma, Greeff, Mulaudzi & Wright, 2010: 182). It provides in-depth information on how a phenomenon is experienced and can bring understanding and meaning to people about the feelings and experiences of others

(Klopper, 2008: 63). A qualitative research study was performed as very little was known about the enhancement of professional dignity of midwives in an academic tertiary hospital setting.

A descriptive phenomenological research design was used to explore and describe how the professional dignity of midwives in an academic tertiary hospital could be enhanced. Midwives were interviewed as only they know what incidents have a detrimental or enhancing effect on their professional dignity. They are thus the only people who could describe to the researcher how they experienced their professional dignity and what could be done to enhance it. In phenomenological studies, the phenomenon (how the professional dignity of midwives in an academic tertiary hospital could be enhanced) is studied through the experiences of the participants of the phenomenon (Higgs & Smith, 2006: 55). Phenomenological studies are done in real life situations (Giorgi, 2000: 13). Descriptive phenomenology, according to Polit and Beck (2012: 495), describes the experiences of certain phenomena by people.

Phenomenological reduction, also called bracketing, was applied before the phenomenon was researched, to not have preconceived ideas (Wojnar & Swanson, 2007: 174) and to put the researcher's own perceptions (Gearing, 2004: 1433) and theoretical knowledge on hold (Hamill & Sinclair, 2010: 16).

Phenomenology researchers interact with their participants to produce trustworthy findings. The interconnectedness between the researcher and the researched characterizes phenomenological research (Finlay, 2009: 11). Researchers in phenomenology strive to describe "how the phenomenon is and not what the informants said about it" (Dahlberg, Dahlberg & Nystrőm, 2008: 255). Once the findings have been obtained and described the researcher, through 'un-bracketing', used her own experiences and literature to discuss the findings of the study (Gearing, 2004: 1434).

2.4.1.1 Assuming the phenomenological dimension

To resume the phenomenological dimension the researcher used an open life-world approach and bracketing.

An open life-world approach

This is a complex interconnected relationship between events that occur in everyday life and the meanings that are attached to these events (Todres & Wheeler, 2001:3). This is also known as the natural dimension of the phenomenon. Every event that the participants are involved in brings meaning and understanding to their experiences (Wertz, 2005: 169). The events and meanings experienced in the life-world existed there even before researchers formed theories about these experiences (Dahlberg, 2006: 12). The researcher kept an open mind to the experiences of the participants who were interacting with their life-world (Dahlberg, 2006: 16) and experienced their professional dignity and how factors impacted on it. Bracketing is a way of achieving an opened mind approach (Finlay, 2009: 8).

Bracketing

Bracketing refers to the process of identifying and putting on hold by the researcher any preconceived beliefs about the phenomenon (Offredy & Vickers, 2010: 101) to allow the researcher to focus on the experiences of the participants and the meaning that they attached to their experiences (Dowling, 2007: 136). For bracketing to be effective, the researcher had to set aside previous knowledge and personal experience and beliefs that could influence her understanding of the meaning of the phenomenon (Finlay, 2009:12). She also had to withhold premature interpretations of the data that the participants shared with her. Bracketing was accomplished by using field notes and a reflective journal to write down her own perspectives of the phenomenon and premature interpretations of data (Wojnar & Swanson, 2007:175).

According to Gearing (2004: 1432-1433), ‘bracketing’ is done in three phases, namely abstract formulation, research praxis and re-integration. The researcher applied all three phases. She started with the abstract formulation and formulated an abstract orientation standpoint of applicable ontological and epistemological assumptions. Research praxis captured the foundational elements of bracketing including what, when and how. Re-integration was achieved by ‘un-bracketing’ and re-integrating the previously bracketed data into the study, during data analysis. ‘Un-bracketing’ refers to the process when the information that has been obtained from the participants is discussed with literature reference.

2.4.1.2 Researcher's role

The researcher encouraged the participants to share with her their experiences to get a “whole” description of the meaning of the phenomenon. Thereafter the description of the “whole” phenomenon was analysed to identify themes (parts) that best described the “whole” phenomenon. The researcher moved from the “whole” to the parts. Similar themes were linked to form constituents that would substantiate the essence (new whole) of the phenomenon. The constituents were studied and the essence was formulated. The essence represents the whole phenomenon (Dahlberg, Dahlberg & Nystrőm, 2008: 243).

2.4.1.3 Research setting

The study was conducted in a specific academic tertiary hospital in the metropolitan area in the Gauteng province. The maternity section consists of a 21 bed high risk antenatal ward, six one bed labour rooms, a 21 bed postnatal ward and a 10 bed high care ward. The patients that are admitted in these wards come from many areas in the Gauteng province; some patients also come from the Limpopo province, the North West province and from the Mpumalanga province. All the patients have pregnancy related complications. Some of them are diagnosed with preterm labour, preterm pre-labour rupture of membranes, antepartum haemorrhage due to placenta previa, and multiple pregnancies. Others have hypertension, cardiac and renal abnormalities and infections. Some of them are diabetic. The patients need close monitoring of themselves and their unborn infants. In the month of May of 2015, 224 patients received antenatal care and 277 deliveries (via normal vaginal delivery or with caesarean sections) were conducted.

2.4.1.4 Selection of participants

The population for the study were all midwives who work in a selected academic tertiary hospital in the antenatal ward, high care ward, postnatal ward and labour rooms. In May 2015, 45 midwives worked in the wards and labour rooms. Thirty of them at that time had been working there for more than one year. They provided basic midwifery care, assist with deliveries and assist the women with care of their

infants. The population is limited to midwives only. Advanced midwives were excluded.

The midwives that were included in the study had been working in the maternity section of the hospital for at least one year and were registered as professional nurses and midwives with The South African Nursing Council.

A purposive sampling method was used in this study. Purposive sampling is when the individuals in the study are chosen based on a personal judgement by the researcher on who will be the most informative (Polit & Beck, 2012: 739; Botma et al., 2010: 201). This method was chosen because the researcher has knowledge about the population. She is employed full-time in the high risk antenatal ward of the selected hospital. Once the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria approved the proposal (refer to Annexure A) and the relevant authorities, the hospital (refer to Annexure B) gave the researcher permission to conduct the research, appointments were made with the registered nurses in charge of the hospital and the applicable wards and delivery rooms to discuss the planned research and to obtain their cooperation. With management and unit managers permission, the researcher arranged with the staff of the wards and delivery rooms to discuss the research and the sampling inclusion criteria.

The midwives were invited to take part in the research. The researcher recruited specific people from the group of potential participants who to her knowledge would provide her with rich descriptions of their experiences regarding the phenomenon. The participants selected for the study have all worked in the maternity area of the same hospital for at least a year and were all employed at the specific academic tertiary hospital.. In a phenomenological study, a small number of participants are involved as the focus of the research is to study a phenomenon through the experiences of the people involved. The aim is not to generalize the findings to all midwives (Porter, 1999: 798). Fifteen participants took part in the study.

The following inclusion criteria were applicable:

- The participants should be midwives.
- They should have worked in the antenatal, postnatal or delivery rooms for at least one year.

The exclusion criteria were applicable:

- Advanced midwives were not included as their practice differs from that of midwives.
- Midwives who have worked in the antenatal, postnatal or delivery rooms for less than a year.

Demographics of the participants:

The participants in this study were all female because at the time of interviewing there were no male midwives working in this institution. The participants were a mixture of race and ethnicity. Their ages ranged from the youngest being 23 years and the oldest midwife at 55 years. The study excluded people with less than one year of experience and also excluded advanced midwives. The years of experience as a midwife ranged from 18 months to 199 months.

2.4.1.5 Data collection

The aim of data collection is to "elicit phenomenological moments in a deliberate and methodological fashion" (McNamara, 2005: 699). The researcher challenged the participants to describe what they experienced and their perspectives instead of their own account of experiences and perspectives. Researchers in phenomenology strive to describe "how the phenomenon is and not what the informants said about it" (Dahlberg, Dahlberg & Nystrőm 2008: 255). One question was asked: How can the professional dignity of midwives in an academic tertiary hospital be enhanced? Where there were midwives who did not understand what was meant with professional dignity, a brief explanation was given. The researcher also made use of a list of possible probing questions where it was necessary to ensure that a rich description of the phenomenon was obtained (refer to Annexure D). The probing questions were only asked when necessary and not in a specific order. It is not a

questionnaire nor is it an interview guide. The researcher made use of open-ended questions to encourage the participants to fully describe their experiences and perspectives of how to enhance professional dignity, using open-ended questions (Offredy & Vickers, 2010: 102) to focus on 'what is experienced' and 'what are their perspectives' regarding the phenomenon (McNamara, 2005: 699).

Unstructured phenomenological interviews

Unstructured phenomenological interviews, also known as in-depth interviewing, were used to collect data during this study. Unstructured phenomenological interviews are used to explore and describe the participant's experiences and their understanding of their everyday "life world" situations (Botma et al., 2010: 207). A broad question was asked to each participant: How can the professional dignity of the midwives of the selected hospital be enhanced?

The interviews took place in a venue in the hospital on days and at times convenient to the participants. Once the participants had agreed to take part in the interviews, the researcher contacted each one of them and made arrangements that suited them. The room selected for the interview was quiet and encouraged the sharing information as it was not in an area where interruptions could occur.

A connection was established with the participants, making them feel at ease and comfortable in the hope of enhancing the sharing of information. Before the onset of an interview, the informed consent and participation leaflet was discussed (refer to Annexure C). The participants were ensured that all information would be managed in a confidential manner and that they could withdraw from the interviews at any time without being victimised. Permission to audio-record the interview was obtained from each participant. Interviews were conducted with the participants who had agreed to the recording of the interviews so that information was not missed during the interviews. The interviews did not last longer than 30 minutes.

Field notes

In phenomenological research, data is also collected in the form of field notes. Verbal information is one of the types of information that can be collected. The other type of information is based on non-verbal information (Botma et al., 2010: 217) and

together this ensures that the information collected is rich in nature (refer to Annexure F for an example). Field notes reflect and describe the information gathered during the research (Polit & Beck, 2012: 548). Field notes contain what is observed and experienced by the researcher during the interview and in the end form part of the data that was collected. Field notes were used by the researcher to generate and understand the meaning of the data that was collected (Polit & Beck, 2012: 548).

Field notes can be divided into descriptive notes (the information gathered by what the researcher observed during the interviews) and reflective notes (this is based on what the researcher experienced personally) (refer to Annexure D for an example). In Polit and Beck (2012: 549), reflective notes can further be divided into methodological notes, theoretical notes and personal notes. Methodological notes provide guidance and strategies on what was observed, forming thoughts and tactics for different situations. Theoretical notes are based on the thoughts and understandings of the researcher as situations are explored. The last part of reflective notes is personal notes. These are the researcher's feelings, emotions and conclusions that arise during the interviews that are bracketed.

Reflective journal

Reflective journals are used in phenomenological research to ensure that the researcher applies bracketing fully to exclude bias (Speziale, Streubert & Carpenter, 2011: 96). Prior to data collection, the researcher reflected on her own perspectives regarding the enhancement of the professional dignity of midwives in an academic tertiary hospital that enable her to put her own perspectives on hold during data collection and analysis (refer to Annexure G, for an example).

The reflective journal was used throughout the research study with every interview and afterward to record the researcher's feelings, thoughts and ideas that were experienced during the interviews and during the data analysis stage. Personal values were also identified to prevent biased opinions during the data analysis stage.

2.4.1.6 Data analysis

Analysis of data in phenomenology is directed towards finding the meaning (Polit & Beck, 2012: 725) of the phenomenon (in this study the enhancement of the professional dignity of midwives in an academic tertiary hospital). It is a movement from the whole (the natural dimension of the phenomenon as narrated by the participants) to the parts and to the 'new whole' (the phenomenological dimension of the phenomenon).

Eidetic reduction

During data analysis eidetic reduction was used to convert all the data gathered from the participants into essential essences using imaginative variation. This helps bring out the meaning of the phenomenon (in this study the enhancement of the professional dignity of midwives in an academic tertiary hospital) breaking down the information into components and looking at each one independently for variations (Zahavi, 2003: 39). A concrete example of the experiences of the participants was "imaginatively varied in every possible way to distinguish essential features from those that were accidental or incidental" (Wertz, 2005: 168). When a change in the characteristic transforms the identity of the phenomenon, it is considered to be essential.

Identification of essence

The main aim of phenomenology research is to determine the meaning of the phenomenon (Norlyk & Harder, 2010: 428). The meaning is called the essence and is supported by themes (Carlsson, Dahlberg, Lùtzen & Nystrőm, 2004: 193) or constituents (meaning units) that substantiate the essence (Lopez & Willis, 2004: 728). Essences are not added to the findings by the researcher and it is also not contributed by the participants. It is "disclosed in the researching act that takes place between the researcher and the phenomenon" (Dahlberg, 2006: 12). The researcher through free imaginative variation in her imagination tried to find different descriptive characteristics for the phenomenon in order to see what the truly essential characteristic of the phenomenon was (Beck, 1994: 16).

Bridling (withholding premature understanding of the phenomenon) was used to ensure that the essence of the phenomenon revealed itself. The researcher refrained from understanding the phenomenon too quickly and by doing so made definite that which was still indefinite (Dahlberg, Dahlberg & Nystrőm, 2008: 130).

Description of analysis of data

The steps that were used to analyse the data are based on the human scientific phenomenological method of Giorgi (1997: 247). The transcribed interviews and field notes were read and re-read to get a sense of the whole in the narrative description of the participants and the notes of the researcher. The entire description and notes were divided into meaning units. The units are formed during "slower re-reading of the descriptions" so that the researcher when she noticed a transition in meaning in the description could mark the sentence and continue to read until the next meaning unit was identified until the whole description was divided into meaning units. The units were still expressed in the participants' own everyday language (also called the natural dimension of the phenomenon). The meaning units were examined, probed and re-described in the disciplinary language of the researcher to reveal the value of each unit. Phenomenological reduction is applied through bracketing to ensure that the phenomenon is studied in its pure form. The researcher made use of free imaginative variation to understand the meaning units and at the same time of bridling to prevent premature understanding. The meaning units (now described in the disciplinary language of the researcher) were examined to identify the essential meaning units that were clustered and a pattern was identified that lead the researcher to the essence of the phenomenon. The essence represented the meaning of the phenomenon and reflected the "new whole" of the experiences (Dahlberg, Dahlberg & Nystrőm, 2008: 243).

2.4.1.6 Description of findings

The 'new whole' of the phenomenon namely the essence and its substantiating constituents were described. Quotations from the interviews were used to link the constituents to the data (Sandelowski & Barroso, 2002: 217). Thereafter literature was used to discuss the constituents. The essence is abstract and not substantiated by quotations from the interviews and also not discussed with literature. A conclusion

about the enhancement of the professional dignity of midwives in an academic tertiary hospital was formulated.

2.4.1.7 Literature review

A literature review to link the constituents to the existing knowledge base was done and presented in chapter 4. In phenomenology research the findings are presented first (in this study in chapter 3) followed by a literature discussion (in this study in chapter 4).

2.4.2 Measures to ensure trustworthiness

The researcher applied 'bracketing' to her pre-knowledge regarding the understanding of the phenomenon (the enhancement of the professional dignity of midwives in an academic tertiary hospital) (Starks & Trinidad, 2007: 1376). She encouraged the participants to share with her their experiences to get an understanding of the natural dimension of the phenomenon. Through eidetic reduction (a conceptual analysis), the natural dimension was transformed to a phenomenological dimension which she verified against literature from the knowledge base of the phenomenon. The researcher did not return to the participants to do a 'member checking' of the findings as it contained the phenomenological dimension which the participants were not familiar with (Norlyk & Harder, 2010: 428).

According to Streubert-Speziale and Carpenter (2007: 96), trustworthiness is achieved in phenomenological studies when 'bracketing' is applied consistently during data analysis. Once the essence and the supporting constituents were described the researcher completed the last phase of 'bracketing', namely that of re-integration. This phase focused on the re-integration of the 'bracketed' information and a simultaneous comprehensive literature review to integrate the findings of the study into the knowledge base of the phenomenon (Gearing, 2004: 1433).

In this study, rigor is achieved by neutrality (Klopper, 2008: 70) and when 'bracketing' is consistently applied, bias is avoided. Reflective field notes and a

reflective journal were kept to describe the researcher's endeavours to 'bracket' her pre-understanding of the phenomenon.

2.4.3 Ethical Considerations

The researcher supports the implications of the Belmont Report and is committed to follow the prescribed procedures to ensure that ethically sound research is conducted and that the rights of the participants throughout the process are protected (Polit & Beck, 2012: 151). The following ethical principles were strictly adhered to:

Right to self-determination, anonymity, privacy, confidentiality, fair treatment and protection from discomfort.

The participants were provided with a detailed explanation of the purpose of the study in the form of written and verbal explanations. They were informed about their rights to decide to participate in the study without any form of coercion and about their rights to withdraw from the study without fear of being discredited. The researcher ensured that participants participated willingly. She received informed consent from them before they participated in the study. The researcher used pseudonyms during transcription of data so that no information could be linked to a participant. The participants were addressed in their own names during the interview, but the names were not used anywhere in the report. To enhance privacy and dignity, the researcher ensured that the interviews took place at a private place chosen by the participants where they felt comfortable. The researcher did not reveal personal information about the participants. All the information that the participants provided was treated with confidentiality. Audio records were kept in locked cupboards. All participants were treated the same irrespective of their background. No participant was given preference over the others. Participants were treated with respect and the diversity of their contributions as acknowledged. The researcher acknowledged that the context of this study was sensitive. She anticipated the possibility that the participants could be distressed during and/or after the interview. She allowed the interviews to develop at the pace of the participants. No participant was so upset that a debriefing session was necessary.

2.5 SUMMARY

The paradigmatic perspective, philosophical framework and research methodology plays a significant part in the guidance of the research study. The method used helped bring to light the lived experiences of the participants and helped to establish the enhancement of the professional dignity of midwives in an academic tertiary hospital based on their experiences and perceptions. Chapter 3 will discuss the research essence and the constituents that were discovered during the data analysis phase.

CHAPTER 3
PRESENTATION OF FINDINGS OF THE STUDY

3.1 INTRODUCTION

This chapter discloses and presents the findings of the study on enhancing the professional dignity of midwives in an academic tertiary hospital. Data was collected in a selected hospital, in the maternity section, using a purposive sampling method. Data was collected through unstructured, phenomenological interviews with 15 participants. The interviews were audio-recorded with participant's consent and then transcribed before analysis commenced. 'Bridling' was used to prevent premature understanding during data analysis. 'Bracketing' was consistently applied during data collection and analysis to achieve trustworthiness of the findings (Speziale, Streubert & Carpenter, 2011: 96).

Analysis of the data was directed towards finding the meaning (Polit & Beck, 2012: 725) of the phenomenon (in this study the enhancement of the professional dignity). Giorgi's (1997: 247) phenomenological analysis method was used. This is based on the movement from the whole (the natural dimension of the phenomenon as narrated by the participants, dividing the entire description and the notes into units of meaning which were formed during "slower re-reading" of the descriptions) to the parts or constituents and to the 'new whole' (the phenomenological dimension of the phenomenon as constructed by the researcher). The 'new whole' or essence of the phenomenon as it is substantiated by the constituents is described. Quotations from the interviews were used to link it to the data (Sandelowski & Barroso, 2002: 217). The findings are described without a discussion of literature which could provide supporting or contrary findings from literature as is typical of a descriptive phenomenological study (Dahlberg, Dahlberg & Nyström, 2008: 273). The discussion of the constituents is presented in the next chapter.

3.2 DESCRIPTION OF THE ESSENCE OF THE PHENOMENON AND ITS CONSTITUENTS

The essence is described first, followed by the constituents. The essence is not substantiated by quotes from the interviews as it represents the 'new whole' and all the data gathered from the participants is thus applicable. It is important to first present the essence and then the constituents, otherwise it is hard to see what the constituents relate to. The essence is more abstract than the constituents (Dahlberg et al., 2008: 255).

The essence refers to: 'To dignify midwives in an academic tertiary hospital'. During the interviews the researcher identified that the participants had the need to be dignified. In this study, the concept 'dignify' comprises of endeavours that indicate that midwives are valued for their professional expertise, is respected for the contribution that they make to the well-being of pregnant women and their infants and that midwifery is recognized as a profession. The participants experienced the violation of their professional dignity. The participants felt that the main contributors to the violation of their professional dignity were doctors in the health care team and the management of the hospital as well as the nursing staff. The doctors wanted them to follow their orders blindly as if they were not professional people capable of autonomous practice and the hospital and nursing management expected them to work under these circumstances. They had to nurse patients who should have been admitted to intensive care units and also had to cope with limited staff. Their working environment was not constructed by management to show support to them and to indicate that they were valued.

Within the perspective of existentialism as a branch of the phenomenology philosophy, the participants experienced 'being-for-themselves' in the context of 'being-for-others'. They were conscious of how others viewed them and that influenced how they perceived themselves ('being-for-themselves'). All people are continuously confronted with the existence of others, not as objects to which they respond, but also as subjects who perceive them (respond to them) and thus are also capable of reducing them to objects. When one becomes an object to others, he

or she can be judged and even be belittled by others. Under these circumstances, he or she will experience 'being-for-others' in a negative sense. It is fortunately not only in a negative way that 'being-for-others' is experienced. It can also be experienced with dignity and pride. There is an upside to 'being-for-others'. When it is experienced in a positive sense, it contributes to the growth of 'being-for-oneself'. Members of the health team and hospital management can, in their encounter with midwives in a tertiary academic hospital, contribute to positive experiences of 'being-for-others' and because of that, to positive experiences of 'being-for-oneself' in terms of professional dignity. Midwives can be dignified in the interaction with others (health team and management). When the behaviour of others towards them is aimed at dignifying them (enhancing their professional dignity), their perception of themselves as professional persons with dignity, is strengthened.

The following constituents of the essence were discovered and it supported how to dignify midwives in an academic tertiary hospital: 'to acknowledge the capabilities of midwives', 'to appreciate interventions of midwives', 'to perceive midwives as equal health team members', 'to invest in midwives', 'to enhance collegiality', 'to be cared for by management' and 'to create conducive environments'. These constituents are each described and substantiated in this chapter through the use of quotations from the participants. In phenomenology research, the focus is on the understanding of the phenomenon (how the phenomenon is) and not on how people (the participants) describe it. Therefore, not many quotes are used.[1] The use of many quotes and less description of the understanding of the phenomenon is not considered to be within a phenomenological framework (Dahlberg et al., 2008 in Norlyk & Harder, 2010: 428).

3.2.1 To acknowledge the capabilities of midwives

To dignify midwives in an academic tertiary hospital, the capabilities of the midwives need to be acknowledged. The participants experienced a lack of acknowledgement of their capabilities from management as well as from the doctors. Within an academic tertiary hospital, the focus is to provide specialised care to patients with a high-risk condition. Unfortunately for nurses, such care is often associated with the

[1] In the interest of authenticity, all quotes are listed verbatim and no changes were made to grammar.

medical profession: "*An academic tertiary hospital is that it's more medical than nursing"* (P1)*.* Midwives on the other hand are linked to the care of women with low risk pregnancies and deliveries that can be managed at home or at district hospitals. In academic tertiary hospitals, care is rendered to pregnant women who are at risk of developing complications or who have already developed complications. It includes conditions such as preterm labour, preterm pre-labour rupture of membranes, antepartum haemorrhage (bleeding in pregnancy) due to placenta previa, and multiple pregnancies. Others have hypertension, cardiac and renal abnormalities and infections. Some of them are diabetic. The patients need close monitoring of themselves and their unborn infants that midwives are capable of doing. Their experiences are however that they are not trusted by hospital and nursing management and doctors to do it. Their consciousness of themselves as being conscious of the world (academic tertiary hospital including the health team) enables their constitution of their 'being-for-themselves' which in this case is clouded by the reactions of others towards them. They are considered to be less capable of taking care of patients who are at risk to develop complications. Their intentional consciousness of others influences their consciousness of their own capabilities. They were judged by others for whom they were reduced to objects ('being-for-others') to the extent that their own perspectives of themselves ('being-for-oneself') were negatively influenced.

The participants felt that they were equipped with the required knowledge and skills and that it should be part of their job description. They gained much experience over the many months that they have been working in the maternity section of the selected hospital and thus feel competent to observe the patients for possible complications, intervene in cases of emergency and call in the doctors who have specialised or who are specializing in obstetrics when necessary. The participants were in close contact with the patients and are thus in the ideal position to intervene when emergencies develop. They felt that they function as the contact between patients and the doctors and are proud that they have the responsibility to ensure that pregnant women do not develop complications and should they develop complications, timely intervention is done to ensure that healthy infants are born:

"I'm here to make sure that the patient is treated well. The patient goes home with a healthy, bouncy baby, not a dead baby." (P2)

The participants often assisted doctors who are specializing in obstetrics to gain knowledge and skills, but once they feel competent to function without their support they no longer acknowledge the contribution that midwives make to the care of patients with high risk pregnancies. Midwives are expected to assist doctors in training but seldom get credit for their skills. They work very hard to ensure that healthy mothers and infants leave the maternity section, but unfortunately often hear from doctors that they are only supposed to follow their orders. It made the participants feel as if they are only assistants (obstetric nurses) to the doctors and not midwives with an own scope of practice:

"The environment does…. sort of buries your qualification…. because you can't act (as a midwife)…you're like more of an obstetric nurse than a midwife….everything you do must be…..approved by the doctor, and sometimes the doctors are new……and we know more than they do….but because of the institution (academic tertiary hospital) that we are in, we have to wait for them (the doctors) to make a decision."(P13)

With the acknowledgement of midwives' capabilities, doctors who are specialising, can learn from midwives on how to prevent or detect pregnancy and birth complications. Management and doctors need to acknowledge the capabilities of the midwives: "*Midwives are independent practitioners… realise that we are midwives and we went to school for the profession" (P8).* Midwives are professional people trained to assist women before, during and after their infants are born. They deserve to be acknowledged for their training and the skills that they add to the capabilities of the health team. Without acknowledgement of midwives' capabilities by the doctors, as well as the disregard for their skills and knowledge, midwives start to lose trust in their own capabilities:

"We lose our professional dignity because we end up depending on doctors more and we lose our autonomy… everything just needs consent from the doctors." (P4)

It needs to be considered that an academic tertiary hospital consists of many health team members that need to be acknowledged for their capabilities and their role in the patient's care. In this study, the participants experienced the need for the acknowledgement of their capabilities so that they can be dignified and their professional dignity be enhanced. Respect and receiving professional dignity: "*go hand in hand"* (P2).

3.2.2 To appreciate interventions of midwives

In an academic tertiary hospital, midwives spend extended periods of time with high-risk pregnant patients. The more time the midwives spend with these patients the more opportunities they have to identify potential problems and to intervene and prevent further complications. Midwives have the responsibility to carefully monitor the patients and to intervene when necessary in order to ensure that complications do not threaten the well-being of both mothers and infants. Together with the doctors, they ensure that complications are prevented and if that is not possible that timely intervention prevent damage to the patients (pregnant women and infants). Midwives are capable of intervening as far as their scope of practice determines. When midwives, the other members of the health team and nursing and hospital management agree that midwives' job description in the selected academic tertiary hospital enables them to function accordingly, their interventions in patient care will be appreciated. It was, however, not the case in the selected hospital. Their interventions were not appreciated and when they advised the doctors about intervention that they expected the doctors to perform, they were humiliated:

> *"Due to lack of recognition (for midwives) some doctors prefer not to listen to opinions raised by nurses… despite the qualifications (of the midwives)". (P1)*

When the intentional consciousness of reality of the midwives is focused on others who refuse to acknowledge their capabilities and thus consider them as less trained and less capable of professional decision-making they experience that their 'being-for-others' got judged and they become degraded to objects in the world of others (in

this case the others are the doctors that they have to cooperate with on a daily basis). They experience the negative impact thereof on their 'being-for-themselves'. They were judged and are not, according to the decision of those who judged them, considered as competent and capable of making professional contributions to patient care.

Enhancement of professional dignity can, according to existentialism, be done through the acknowledgement of others' capabilities. When midwives experience that their 'being-for-others' is appreciated, a positive 'being-for-oneself', that may result in professional dignity, is experienced. When nursing and hospital management and the doctors in the health team appreciate the capabilities of the midwives they will rely on the midwives' abilities to cope under stressful emergency situations.

It is important to remember that patients may require timely interventions to prevent complications that may have a detrimental effect on the women and their unborn infants. When patients develop complications when doctors are not available to intervene, midwives need to implement measures according to their scope of practice to save their lives. These interventions need to be acknowledged and even appreciated by the health team and management. Unfortunately the hospital regulations specify that even in emergency situations, doctors should prescribe all medication:

> *"There is this regulation that, you wait for the doctor to come and prescribe medication before you give it… but as a midwife, you act upon it, even if the doctor is not there, to save the patient's life… then comes the doctor, you've done everything…..then the doctor comes, then he start shouting at you, "Who told you to do this, who told you like this" but…you've just saved the patient's life….instead of the doctor coming to you, saying: Thank you sister." (P7)*

Appreciation for the interventions of the midwives is important in the continued provision of optimal patient care. The participants strive to provide optimal patient care and advocacy for needed interventions. They know that if they did not advocate

for the patients they could also be held liable for any complication leading to adverse effects and they could be disciplined by the South African Nursing Council. Midwives are obliged to act in the best interest of their patients even when the patients' doctors do not approve it. Situations in which the midwives get threatened by doctors need to be prevented:

> *"Here I can save the patient's life, but because you have such a difficult doctor, you stand back…. you watch the doctor doing the wrong things.... but you know what to do….but because he is a doctor in a tertiary hospital…you don't have any say." (P7)*

It is important for midwives to have the courage to continue to intervene when necessary and to recommend treatment that should be performed by the patients' doctors. They remain with the patients when doctors leave to do consultations elsewhere and are therefore responsible for ensuring that complications are prevented or to intervene when complications are present to ensure a good patient outcome. Doctors need to accept that they cannot always be with their patients in the maternity ward and that to ensure good patient outcomes; they need to trust midwives to perform necessary interventions. Once midwives have performed interventions and reported to the doctors what emergency treatment they have done, their timely intervention that resulted in the good outcome, should be appreciated. When doctors trust the midwives on the health team to be competent to intervene, lives can be saved:

> *"I had an instance once in theatre, where….a baby was delivered and then I did tell the paediatrician that I think we need to start the resuscitation….the heart rate was below sixty….and then because it was coming from me, the doctor felt like I was undermining her; and then she was like, no it's fine, the heart rate is fine sister I'll make the decision as to when to start the compressions….and then by the time we started….it was late and the baby did not make it, and I felt like….if we started immediately with the compressions….this baby could have lived." (P13)*

Midwives desire and strive towards the freedom to be able to independently intervene and care for their patients. When midwives are given the freedom to act and intervene independently, it encourages them in rendering better quality care. Being able to intervene in certain situations ensures the empowerment of the midwives, decreasing the experience of powerlessness. In order for the midwives to feel that they are appreciated, their knowledge and capabilities along with their interventions to save patients' lives need to be recognized by hospital and nursing management and other members of the health team. When their interventions to prevent and manage complications are appreciated, their professional dignity is enhanced.

3.2.3 To perceive midwives as equal health team members

To enhance the professional dignity of the midwives in this academic tertiary hospital, the researcher discovered that the participants wanted to be perceived as equal health team members. They wanted to be treated as if they were on the same level as other members. Their inputs should be recognized as input from all others to patient care gets recognized. Equal collaboration and consideration of each member needs to occur between each individual of the health team to help ensure that midwives are perceived as an equal part of the health team. The 'being-for-oneself' and the 'being-for-others' should correspond. The midwives should believe that they are capable of dealing with patients who may develop complications at any time and the doctors should believe that the midwives would be able to handle complications while they wait for the doctors to assist them.

In an academic tertiary hospital, there are many different types of professions collaborating to provide care to patients. Each of these professions has their own hierarchy. Doctors have their hierarchy as some are consultants (they have completed specialisation and are obstetricians) and others are registrars (they are busy with specialisation). Nurses have their hierarchy. In maternity sections, some work as registered midwives, others as staff nurses and nursing assistants. Student nurses do practical training under supervision of midwives.

Midwives want to be acknowledged as equal health team members because of their unique nursing contributions to the team. All members should be considered as valuable as they all deliver contributions unique to their professions to ensure holistic treatment of high risk pregnant patients.

Midwives have their own scope of practice that guides their nursing care. Part of their duties is to perform interventions that have been prescribed by doctors. They are obliged to inform doctors should they not agree with the prescription. They cannot blame doctors for the mistakes that they make although it has been prescribed by the doctors. They take responsibility for their own practice.

In an academic tertiary hospital, the health team takes care of patients who are at risk of developing complications that can have dire outcomes for either the mother or infant; both can become very ill and even die. Specialized care and effective communication from all members of the team is required. Each member plays an important part in the treatment and should be respected for that. Some are not more important than others. The participants felt that they were considered to be less important members of the team. This was discouraging to the participants; they felt unappreciated and had feelings of worthlessness and inferiority as they often got treated as if they were not part of the decision making activities and were only trusted to perform activities that had been delegated to them:

> *"The doctors….some of them….act like they are our bosses….the one doctor once told me that she is my boss and that I should do whatever she asked me to do….and then I felt very inferior to her….then as far as I am concerned we were all colleagues…she acted as if she's paying my salary every month." (P11)*

Doctors and nurses are valuable members of the health team. The one group within the health team should not be considered as more important. Their practice should be complementary and add value to that of the other groups to the benefit of patients. All groups are well trained according to guidelines of their statutory boards:

"The experience that I have for a tertiary hospital….traffic from doctors, that's coming in to train….most of them when they come….they've got this thing that you can't tell them anything…they know everything….then they look at you and you just a sister….what do you know…..is something that really degrade us as midwives…..I once had a doctor….who was busy telling the patient, don't listen to the sisters, the sisters don't know what to do." (P7)

Midwives should not be considered to be people who can only do what others tell them to do. Their professional dignity should be respected and enhanced. Every member of the health team is important and can make an important contribution to the well-being of patients.

Professional jealousy among midwives can also degrade the value of midwives in the health team. Teamwork amongst midwives from their own maternity unit as well as from other maternity units is essential to the satisfactory outcome of care of high risk pregnant patients. Unfortunately, during the study the researcher discovered that midwives do not always respect fellow midwives:

"For example when you're….in charge of a ward, whether it's night duty or during the day…..the seniors that have been here for long….they undermine you in your own ward….they just come in and feel that they have the authority." (P4)

Midwives, whether they are senior or junior, should function as a team to prevent complications and acknowledge that no matter in which area of maternity they work, they are all equal. Even though seniors may have more work experience, it does not mean that they are as up to date on recent research as the junior midwives:

"When you're new, and especially young, and you're supposed to be their senior, they kind of undermine you." (P4)

All midwives need to be equal in the nursing team. They should all be willing to work equally hard to the benefit of their patients. Through team work, optimal care can be

rendered and each person's contribution is acknowledged. As they do not want to be looked down on by the doctors, they should not do the same to each other. It also refers to their relationships with lower category nurses who work with them in the maternity section:

> *"You find that you work with someone who's just reluctant to work, who is just dragging their feet, which makes it more unbearable for you". (P2)*

The maternity section of the hospital covers the antenatal, labour and postnatal wards. Traditionally, midwives who work in the labour ward consider themselves to be higher in the nursing hierarchy than those who work in the other wards. By not considering themselves to be on the same level they also contribute to the process of degrading some nurses and midwives to lower levels in the health team. Nurses and midwives perform valuable services to patients in need. Each one has a specific and very valuable function that he or she has to attend to in order to render holistic care to patients. Each midwife has an own preference and passion for a certain section in maternity, where they feel they are needed and can perform to the best of their abilities.

> *"You know your passion is in midwifery; your passion is there in the labour ward…. then they say no, go and work in postnatal, or go and work were you're useless, doing nothing…. I don't feel like I'm a midwife anymore". (P7)*

Midwives need to be perceived as equal team members notwithstanding the ward in which they work. Every midwife has her own special role within the team, with the aim of obtaining a satisfactory outcome for this high risk pregnant patient. Midwives need to be perceived as equal health team members to be able to enhance collegiality.

3.2.4 To enhance collegiality

Collegiality refers to the relationship between colleagues (Padgett 2013: 1470). It leads to better teamwork, as the better the relationships are between the members of the team the better they will complement each other's knowledge and skills to benefit patients. This relationship between colleagues includes the interactions and interpersonal relationships between them. In this study, it refers to the relationship between the midwives, management and doctors: "*By building relationships….and not judging people"* (P6), the professional dignity of midwives can be enhanced. In interaction with others 'being-for-oneself' and 'being-for-others' entails that each, when meeting, becomes conscious of the other and for each one 'being-for-others' and 'being-for-oneself' becomes important. Everyone becomes aware of how others perceive him or her. When one is alone, one becomes the centre of the immediate world. When another person enters the 'immediate world', the person becomes aware of the 'one' and thus becomes the 'other' who can from that point onwards be judged by the other person. Everyone is in interaction with others a 'being-for-oneself' and a 'being-for-others'. Equal collegiality implies that the person and the other agree in their intentional consciousness of others that they accept and approve the contributions of the other. It means that each colleague agree that the other can, on an equal basis, contribute to the mutual activity which in this case is the optimal care of patients who may develop complications due to high risk pregnancies.

Relationships where colleagues encourage each other, where they show each other respect and consideration is important to form strong bonds. If you defend and support each other, teamwork becomes possible:

> *"Colleagues, let's work together, lets respect each other; don't think that you know everything; we are all here to learn….and most importantly never ever disrespect a person, never undermine anyone…. learn to respect everyone, treat everyone equally." (P2)*

Enhancing collegiality is essential in teamwork. In this academic tertiary hospital environment, where patients who are at risk of developing complications are cared

for, feelings of collegiality between all members of the health team can contribute to the enhancement of the professional dignity of each member. Ultimately, patients will also benefit as they receive the coordinated care of a team of people who are respected for their professional competence.

Through efficient communication among members of the health team and between nursing and hospital management, equal collegiality can be enhanced. Unfortunately, the participants were aware of problems with communication:

> *"Some people cannot handle pressure… some people they don't know how to talk to each other…. you know, in front of patients… they start shouting at each other, calling each other names." (P7)*

People who shout at each other do not contribute to team work and they also do not respect the other person as a human being who is equal to them. They look down at other people and do not enhance other people's dignity and in the case of professional people, the other people's professional dignity. When such behaviour is displayed in the presence of patients, optimal care is not delivered and all people involved are disrespected. The health team should at all times function as a team and in such a way that patients feel comfortable with the team:

> *"We must be seen to be one, and then work together so that the outside world will say midwives, no matter what, they're a team." (P7)*

Collegiality between all members of the health team is important, but even more so between the doctors and nurses. They work in a very close relationship and have to trust one another. The need to know that the one will always support the other to the benefit of patients. When the doctors are absent, they have to be reassured that the midwives will be vigilant to observe possible complications and that they will be contacted by them as soon as it is necessary. The midwives need to be reassured that the doctors trust their knowledge and skills and that they can depend on the doctors to welcome their input when they are called to come and intervene in an emergency. With a better relationship between the midwives and the doctors, midwives will know that if there is a problem in the ward, the doctor will trust their

diagnosis and care that was delivered while they were on their way to the maternity section:

> *"I think if doctors can work hand in hand with sisters, allow us to be independent practitioners, because even in my scope of practice, it says you are an independent practitioner, I advocate for my patient, I act upon, to save lives, that's what I pledged for." (P7)*

Collegiality between nursing and hospital management and the midwives is also needed. With good relationships, supervisors and supervisees feel free to communicate and discuss challenges such as too few staff and too many responsibilities. Unfortunately, in this section of the academic tertiary hospital, the midwives viewed the relationship with management as strenuous. They do not feel free to approach management with their concerns:

> *"There's no support (from management)….They do not stand up for us. That makes it even worse." (P7)*

The participants felt that they did not receive the support that they needed to optimally care for patients with high risk pregnancies. They wanted to be respected by management as they tried their very best to deal with challenges such as resource shortages and lack of training in certain instances:

> "*We are short of staff, we are short of equipment, we are short of supplies, we are short of medication sometimes, and all of this influences us." (P5).*

> *"Even though I don't even know that machine (ICU-ventilator), I'm supposed (expected) to cope with that situation." (P3)*

Some of the participants were concerned about strenuous relationships with lower category nursing staff: "*nursing assistants can be very cheeky and disrespectful…. be so rude"* (P2)*.* Peoples' attitudes towards each other influence the relationship between them and in this case the individual relationships between the different

members of the nursing team. All members make valuable contributions to the health care of the patients and they should thus be respected for their contributions and their knowledge and skills should be acknowledged.

3.2.5 To invest in midwives

The participants wanted to increase their knowledge and skills and were eager to do courses to learn about the latest trends in midwifery. During interaction with people superior to one, one can get trapped in relationships where one feels that he or she is overpowered by other. In hospitals, a strong hierarchy exists and all communication and requests for improvement of knowledge and skills are handled through channels which mean that repeated requests must be constructed and submitted with the hope that it will be attended to. Situations of enslavement may be experienced when the requests do not bear positive outcomes. The disappointed individual may feel that her 'being-for-herself' (she wanted to enhance her knowledge) were harmed as others did not feel the same. Others did not appreciate her strive to improve herself (her 'being-for-herself'). They viewed her of not deserving the training due to their judgement (her 'being-for-others'). She becomes an object to them and they conceived a judgement about her and in this case the judgement is that they do not want to invest in her.

The yearning for gaining knowledge and skills is associated with professional development and much needed where there is continuously new information and improved methods being discovered. The participants were passionate about gaining knowledge to ensure continued competence in their dynamic working environment. They wanted nursing and hospital management to invest in them by carrying the costs of conference and workshop attendance:

> *"When you work in an environment (midwifery), you must make sure that you familiarize yourself with everything." (P3)*

Midwives who work in academic tertiary hospitals need to update their knowledge and skills on a regular basis. Only patients who are at risk to develop complications are admitted to these hospitals and therefore midwives need opportunities to update

their knowledge and skills to ensure that they will be able to prevent, or detect and manage complications timely:

> *"Initiation of self-development should be encouraged (by management)….this will ensure that they (midwives) will be valued and be equipped with knowledge so that they can be effective and render quality services." (P1)*

When management is prepared to invest in the midwives, they actually show that they respect the professional dignity of the midwives as they are prepared to spend money on them to further develop themselves:

> *"Going for training courses… enhance your knowledge which will obviously enhance your… professional dignity and your skill level." (P6)*

The participants were eager to participate in training opportunities and some considered further study to become advanced midwives. The advanced knowledge and skills could be used in the high care environment of a maternity section of an academic tertiary hospital. At times, the patients who get admitted require intensive care and the midwives are not trained to render such care. They are only trained in midwifery and not in advanced midwifery or intensive care nursing. The participants felt that they were placed in situations within which they can make mistakes and even jeopardize the lives of their patients and unborn infants:

> *"There should at least be more sisters, especially if high care is full. Because of those people (high risk patients) need proper care, the next thing, I'll be mismanaging the patient, because I'm not coping….when you start mismanaging, the patient starts collapsing, patient dies…." (P2)*

Having to work in an environment with equipment that they were not comfortable with, made the participants feel uncertain about their knowledge and skills. Their professional dignity was threatened and they had to ask nurses trained in intensive care to help them:

"But because I was not trained to use that machines, I don't even know what does it says (data on the monitor)….*how am I suppose* (expected) *to act.....a patient can die in my care…….hold me accountable*" (P3).

The participants expressed the need to meet with other midwives at conferences to discuss the challenges that they experience and to gain knowledge and skills. They wanted to know that their knowledge is up to date and that they deliver the best possible care. Should new techniques be taught at workshops, they wanted to be trained in it. They considered it as necessary to know that they are not behind others as far as the latest techniques are concerned as that would be detrimental for their self-esteem as professional people:

> *"They (management) can also arrange for seminars, you know there's this symposium - midwifery…that happens every year. They can arrange for us (midwives) to go there, and meet other midwives, you know. That will also enhance us, you know." (P7)*

Investment in the professional development of the participants may inspire confidence and encourage excellence in the care rendered by midwives. It will illustrate that management care about them and that midwives play an essential part in the care rendered to these patients**.**

3.2.6 To be cared for by management

The participants wanted to experience that the nursing and hospital management care for them:

> *"It's no surprise that the better you are treated (cared for), the better quality care you will deliver." (P6)*

Although the participants considered themselves as independent professional people, they also expressed the need to be cared for and one even stated that management can improve the nursing care of patients by taking care of them. When care is taken of workers, they may become more committed to the institution and

thus also more committed to deliver quality service. It may change the way they view themselves ('being-for-oneself'). In this case, it will enable midwives to overcome obstacles to better care for their patients. Without such care from management, the participants felt disrespected (others view them as not important and a negative 'being-for-others' is experienced) and it had a detrimental effect on their job satisfaction that on its turn may contribute to feelings of being disloyal towards the employer:

> *"Our nurses are leaving, especially midwives, they are leaving our country because of the care that we are (receiving)…" (P3)*

If management cares about the midwives in this high risk academic tertiary hospital, it may lead to the enhancement of their professional dignity. They may feel valued as management considers them worthy of care.

The researcher discovered that the participants had very strong views on the lack of care and support that they were experiencing. They felt that the nursing and hospital management did not care for them:

> *"Management must learn to respect us, must learn to be able to listen to our, complaints when we talk to them, and be able to fix where they can fix, where it's fixable." (P2)*

Management did not listen to them and thus did not consider them worthy of attending to. The participants were depressed when their patients suffered complications and passed away. Under such circumstances, they would have appreciated emotional support from management:

> *"Imagine, you might get let's say have two, three maternal deaths, in a month, they (management) don't do anything, they don't even come to support you, they don't even come and say how do you feel?" (P7)*

In the maternity section of an academic tertiary hospital, only pregnant women with high risk pregnancies are admitted. The midwives are very much aware of the

possibility that the women may suffer serious complications and die before the infant is born, or during birth or soon after birth. The infants may also pass away due to the complications that the women develop. Daily, the midwives are exposed to trauma associated with the care that they render to people who are at risk to be seriously ill or even die. Due to the possibility that the patients can develop complications, they are admitted to the maternity section weeks or even months before the delivery date and the midwives thus develop strong bonds with them. It results in them experiencing stress and emotional turmoil when the patients develop complications and pass away. They wanted the nursing and hospital management to be aware of their trauma and to intervene when necessary:

> *"I once delivered a patient, just after delivering the patient….the patient hold my hand: "Sister I'm dying…!" that patient was gone. We tried to resuscitate, everything…..but the patient is gone. I never received any counselling, I never received any call from any management to say, sister how do you feel about what happened…. I was so close to that patient…." (P7)*

The participants mentioned that nursing and hospital management cares more about the patients than about them as midwives. They agreed that the patients are of course very important, but that they would also want to feel that they can depend on management to support them in cases where patients or their family members lodge complaints against them. Management should investigate complaints from patients and their family, but should at least bear in mind that the midwives should also get their chance to tell what happened:

> *"Maternity is a very sensitive area….let us assume a patient is in labour, and then a relative comes, they find their relatives screaming with pain….they don't talk to you, they run down to management. Management, instead of explaining to the relative (that giving birth is painful and that pain medication has been given)….they come to you, in front of the relative, in front of the patient….they shout at you… this family and the patient….they've lost trust in you already….so I think,*

before they jump to conclusion….they must get to the bottom of the issue." (P7)

If the hospital management does not support the midwives, if they do not show them respect and shout at them in front of patients, the midwives' professional dignity is degraded:

"They do not stand up for us….that makes it even worse….I think if management can address that….I think maybe the community will start…. respecting us and we'll earn our dignity as midwives." (P7)

Nursing and hospital management need to show that they support the midwives and that they respect them as professionals, especially in front of others and patients. Management need to ensure that midwives are functioning within their scope of practice and are not forced to perform tasks that go against their knowledge and training. This will dignify midwives in this academic tertiary hospital:

"Our top management…. they also knew what….is the right thing to do within the scope of practice as a midwife. After the issue was brought forward to the consultants and the registrars and the interns, in the meeting, everyone is there. The….top management of the nursing said, if a medical consultant orders specific things to be done, to the patient or for the patient, like a prescription of some sort, then, you do it." (P9)

Management needs to ensure that they gain knowledge about how every unit in the maternity section functions. The participants expressed that they feel that management is not familiar with the day to day functioning of the section and the challenges that staff experience. In a maternity section of an academic tertiary hospital where patients are admitted that are prone to develop complications, emergency situations develop without prior notice on almost a daily basis. The section can change from nearly empty to overflowing in a few hours. Being a high risk academic tertiary hospital, if one of the referring hospitals closes then this hospital needs to admit all the patients. In an academic tertiary hospital, one can also never predict how many patients may develop complications within a very short

period of time. When such emergency situations develop, the participants would like the nursing and hospital management to immediately step in and allocate more staff to the section. That will be viewed as ways in which management cares for the midwives. It will be considered as a way to tell the midwives that they are valued by management. When the section is almost empty, the participants wanted the nursing and hospital management to know that patients can be admitted at any time and therefore midwives cannot be relocated to other wards where nurses are needed:

> *"The management of this hospital….toss you up and down….today go and work that side….then they say no, go and work in postnatal, or go and work there….you know it also puts our moral down….you don't feel like a midwife anymore….I don't feel like I'm a midwife anymore….because you are forced to do things that you don't like." (P7)*

With midwives being taken to work in other units, it results in a shortage in the maternity section. This shortage will not be as serious if there are few patients but because the admission of pregnant women with complications can happen at any time an influx of patients can be experienced that causes severe problems for the few midwives who remained behind. Suddenly the midwives may not be coping with the situation which causes possibilities for adverse events to occur:

> *"When it's full, the hospital, tertiary hospital, management never says it's full. And you are left to deal with such situations. People are lying on the floor, one of the Professors even told us.… I don't care; I'm not going to close the ward, even if it means people delivering on the floor". (P7)*

Situations like this is demoralising for midwives. They cannot attend to an indefinite number of patients and still render quality care.

3.2.7 To create conducive environments

According to the participants, creating conducive working environments will ensure that optimal patient care can be delivered that make midwives feel dignified. Feelings of not being good enough for others and thus not deserving a conducive working environment is according to existentialism experienced in relationship with others. One feels either worthy or not worthy of conducive working environments before others, who in this case refers to the nursing and hospital management. They experience it in their 'being-for-others' and not in their 'being-for-themselves'. A good deal of people's behaviour is directed to influence their 'being-for-others' as they want others to approve their being and their behaviour. It is thus true that the working environment plays a large role to enable staff (midwives) to render quality care.

> *"(Professional) dignity it starts with where you work…we need to have all the resources so that we can be able to work properly." (P2)*

The environment needs to have certain qualities to be conducive. To create an environment that is conducive, especially in an academic tertiary hospital, there needs to be sufficient human resources (midwives) and there also needs to be sufficient physical resources to take care of high risk patients. When the environment is not considered to be enabling midwives to deliver quality care, the midwives feel that management does not care for them and does not value the work that they do. They felt that their professional dignity got tarnished:

> *"So we are short of staff, we are short of equipment, we are short of supplies, we are short of medication sometimes, and all of this influences us, yes we can make plans and we can do what we can….but in the end sometimes the patient sees it as….we're not doing what we're supposed to do, but our hands are tied….some of the time, so that breaks our dignity in the patient's eyes." (P5)*

When not enough midwives are on duty due to staff shortages, quality patient care can be jeopardized. Staff shortages in any ward results in nurses working under increased pressure. When it is experienced in wards where patients with a high risk

of developing complications are nursed it exaggerates the stress that midwives experience. They have to care for patients that can develop complications at any time and have to compensate for the staff who are not on duty. With a shortage of midwives and the large amount of stress the midwives have to deal with, they become exhausted, powerless and frustrated:

> *"You become frustrated….you start mismanaging….when you start mismanaging….patients start collapsing….patients die." (P2)*

The participants complained about the high number of patients that they have to manage. They blamed it on the influx of refugees from other Southern African countries, as well as patients from other provinces that are not part of the population group the hospital was meant to accommodate. The result of the situation is that they felt that they were overworked:

> *"We are overworked due to the population influx…..in that instance then people start getting exhausted….then they don't actually do what they are supposed to do…most of the important nursing care is missed because of the population influx….and the work load (keeps increasing)." (P8)*

The participants wanted to focus on the nursing needs of the patients and to render quality care to them. When too few midwives were on duty, they could not do that as only routine basic care is delivered. Specialized care requires more time and that is not available. It made the participants feel as if they, under those circumstances, let their patients down. This made their patients complain about the care that they received: "*You cannot please every patient"* (P2). It also made them feel as if they did not function on the level they were capable of and supposed to function on. It impacted negatively on their professional dignity.

To provide optimal care to patients, there needs to be sufficient and appropriate equipment. Especially in a maternity section where patients, who are at risk of developing complications, are nursed. It should include equipment to prevent and

manage emergency situations timely. It should be easily accessible and always be in a working condition:

> *"This hospital, the unit is so small, for a tertiary institute… when it's full, the management never says it's full. And you are left to deal with (challenging) situations. People are lying on the floor……..even if it means people delivering on the floor……Do you think people (patients) will respect you for that? But imagine you are delivering a patient (on the floor)… and the relatives are everywhere….they see you doing this… they will blame you as a midwife." (P7)*

The working environment needs to be free from hazardous situations (shortage of protective attire that can lead to acquiring of infections) to ensure that midwives feel safe to render care. Creating a safe working environment by nursing and hospital management shows midwives that they care for them.

3.3 SUMMARY

The essence that was disclosed is: To dignify midwives in an academic tertiary hospital. This would then lead to enhancing the professional dignity of midwives in an academic tertiary hospital. The following constituents that support the essence, were discovered and were discussed above: to acknowledge the capabilities of midwives, to appreciate interventions of midwives, to perceive midwives as equal health team members, to invest in midwives, to enhance collegiality, to be cared for by management and to create conducive environments.

In Chapter 4, the discussion of the findings will be presented.

CHAPTER 4
DISCUSSION OF FINDINGS

4.1 INTRODUCTION

In the previous chapter, the findings of the study was discussed. The essence that was discovered was: ‘To dignify midwives in an academic tertiary hospital’. During the interviews, the researcher identified that the participants had the need to be dignified. In this study, dignify comprises of endeavours that indicate that the participants wanted to be valued for their professional expertise, be respected for the contribution that they make to the well-being of pregnant women and their infants and for midwifery to be recognized as a profession. The literature refers to both midwives and nurses. The literature that was used is aimed at nurses in general, although this research study was focused on midwives. Thus, for the purpose of this study, only the term midwives will be used. The following constituents that are going to be described in this chapter are based on the essence that was discovered and it supports how to dignify midwives in an academic tertiary hospital: ‘to acknowledge the capabilities of midwives’, ‘to appreciate interventions of midwives’, ‘to perceive midwives as equal health team members’, ‘to invest in midwives’, ‘to enhance collegiality’, ‘to be cared for by management’ and ‘to create conducive environments’. These constituents are each described and substantiated in this chapter with the use of quotations from theoretical knowledge.

In this chapter, the findings are presented using a theoretical discussion to create an improved understanding of the essence and constituents (Dahlberg, Dahlberg & Nystrőm, 2008: 272 - 273). According to the descriptive phenomenological research method, the constituents are discussed using literature references, but the essence is not. The applicable literature was extensively reviewed to serve as literature control for the findings and to link the findings to the existing body of research knowledge (De Vos, Strydom, Fouché & Delport, 2011: 305).

4.2 THE ESSENCE OF THE EXPERIENCE AND ITS CONSTITUENTS

The essence that was discovered was: 'To dignify midwives in an academic tertiary hospital'. Cox (2009: 36-37) explains people as a 'being-for-oneself' that are "conscious of themselves and conscious of the world". They were conscious of how others viewed them and that influenced how they perceived themselves ('being-for-themselves'). In an academic tertiary hospital where there is an intense interaction between the pregnant mother, the midwife and other health team members, the midwife becomes aware of the existence of all of these people that they interact with and how they are perceived by these people. This awareness that is experienced by the midwives influences their professional dignity.

In midwifery the idea of 'being-for-others' is an essential concept, the midwife forms an integral part of the delivery process being there for the mother and baby as well as assisting the doctors during high risk deliveries. The participants experienced the violation of their professional dignity, this lead to the experience of 'being-for-others' in a negative sense. The people who contributed to the participants' experience of the violation of their professional dignity were doctors in the health care team and the management of the hospital and nursing staff. Their working environment was not constructed to show support to them and to indicate that they were valued. With the positive experience of 'being-for-others' there is a contribution to the development of 'being-for-oneself'. In this instance, midwives will experience dignity and pride in their work. Therefore, this is important in dignifying midwives in their working environment.

4.2.1 To acknowledge the capabilities of midwives

The acknowledgement of the capabilities of midwives by the different members of the health team members contribute to the process of dignifying midwives. The participants in this study experienced the acknowledgement of their capabilities to different extents. The participants wanted to be valued for their contributions as well as acknowledged for their capabilities. The participants also wanted to function as autonomous practitioners.

Midwives' capability to perform their work is based on their competence and capabilities (WHO, Module 8, 2011: 7). The capabilities of midwives involve communication between health team members during continuous decision making, based on their theoretical knowledge as well as their practical skills when providing maternal and new-born care (WHO, Module 4, 2011: 6). Midwives are trained to be the first-line management during pregnancy, focussing on the promotion of health during pregnancy, treatment and prevention of illnesses and complications (Renfrew, McFadden, Bastos, Campbell, Channon, Cheung, Silva, Downe, Kennedy, Malata, McCormick, Wick & Declercq, 2014: 1141). The theoretical and practical skills required by midwives in South Africa, are determined by the South African Nursing Council. This is further governed by the South African Nursing Council Scope of Practice (No. R.2598 of 30 November 1984) regulation and the South African Nursing Council regulation on: 'Conditions under which Registered Midwives and Enrolled Midwives may carry on their profession (No. R.2488 of 26 October 1990)'.

The participants experienced a lack of acknowledgement of their capabilities from management as well as from the doctors. In some cases, where the midwife is not respected by doctors or by management, there is a decrease in professional dignity (Sayer 2007: 577). Recognition of their capabilities by the health team and hospital management as well as the value that they can add to optimal patient care, also contributes to their experiences of professional dignity (Sabatino et al., 2014: 666). Professional dignity includes aspects such as: professional competence, interpersonal skills, and extensive knowledge regarding practice (Halldorsdottir & Karlsdottir 2011: 810-811). Within an academic tertiary hospital, the focus is to provide specialised care to patients with a high-risk condition. Unfortunately, the participants experienced that the health team in this academic tertiary hospital considered them not to be capable of taking care of patients who are at risk to develop complications. The participants thus felt that they had the capabilities (the knowledge and skills) needed to manage these high risk patients, but these capabilities were not acknowledged. A Spanish philosopher, Adela Cortina (Gallagher, Zaboli & Ventura, 2012: 55) stated that every person needs to be acknowledged by others to develop and enhance their capabilities. The same applies for the recognition of their professional competencies. The participants felt that they were competent in their area of expertise with the correct competencies to

handle each situation (Fullerton, Ghérissi, Johnson & Thompson, 2011: 6). According to The International Confederation of Midwives (2013: 19) competence is: "*The combination of knowledge, psychomotor, communication and decision-making skills that enable an individual to perform a specific task to a defined level of proficiency."*

In this academic tertiary hospital, the focus of care is based on high-risk pregnancies, deliveries or postpartum periods, where there are either complications already known during these periods or the possibility of developing complications during these periods. Participants in this academic tertiary hospital are with the patient, providing care and support twenty-four hours a day, seven days a week throughout the year along with other members of the health team ensuring optimal care. Participants in this study felt that when their capabilities were acknowledged, their professional dignity was enhanced. When acknowledgement of capabilities occurs and professional dignity is enhanced, the care that is rendered will be improved (Griffen-Heslin, 2005: 256).

Only recently, more recognition is being given to the contribution made by midwives which plays an important role in providing optimal maternal and new-born care, which unfortunately is still being restricted due to a lack of knowledge about the midwifery profession (Renfrew et al., 2014: 1130). There is a general need for the health team members to gain knowledge about midwives and to acknowledge their capabilities. Renfrew et al. (2014: 1130) highlighted that when midwives are licenced and regulated (in South Africa by the South African Nursing Council) and with sufficient knowledge and training, midwifery can be linked to better maternal and new-born outcomes as well as the efficient use of hospital and other resources. The improvement of care and health of the patients as well as their survival when midwifery was correctly applied was established in the study performed by Renfrew et al. (2014: 1130).

Care rendered by midwives to low risk pregnancies has been found to have better outcomes with less interference with the natural process of labour than that of doctor-led care, with less episiotomies and less vacuum extraction deliveries as an example (Sutcliffe, Caird, Kavanagh, Rees, Oliver, Dickson, Woodman, Barnett-

Paige & Thomas, 2012: 2382). With low risk pregnancies, midwives are more readily acknowledged for their capabilities than within a high risk environment. When looking at the participants working in this academic tertiary hospital, the experience and skills that they have developed have not been taken into account. Their autonomous practice is being restricted due to the perceived high risk environment which they are working in. Autonomous nursing practice refers to the midwife's ability to act in the best interest of patients, to make independent decisions based on their scope of practice as well as interdependent decisions when the health team members' care overlap (Kramer & Schmalenberg, 2008: 70).

Being placed in a high risk delivery setting should actually increase the capabilities of these participants as they gain more knowledge, skills and experience that midwives in a low risk setting do not usually attain. Midwives in a low risk setting must always refer high risk patients to an academic tertiary hospital for further management according to protocol. In a study that was done by Sutcliffe et al. (2012: 2382), it was found that there was no evidence of a difference between doctor-led care and that of midwife-led care in the cases of for example antepartum and postpartum haemorrhage, length of labour, and mal-presentation.

In this academic tertiary hospital, the aforementioned are some of the main conditions that are cared for in this hospital, although there are other medical conditions that are also treated that result in pregnancies being high-risk. Midwives have competencies based on the knowledge they gained and their capabilities (WHO, Module 8, 2011: 7) on how to manage these high-risk cases in the best interest of the patients and if needed, can work autonomously to handle an emergency situation (Kramer & Schalenberg, 2008: 70) if a doctor is unavailable (for example when the doctor is busy performing a caesarean section and is unable to attend immediately). In this academic tertiary hospital, the participants do not want to take over the doctor's position, they only want to be acknowledged for their capabilities. They work very hard to ensure that healthy mothers and infants leave the maternity section, but unfortunately often hear from doctors that they are only supposed to follow their orders.

Acknowledgement of the capabilities of the midwives consists of recognition of the capabilities by an observer (in this research the doctor, management as well as other members of the health team). The person who is observing then needs to accept that the capabilities' of the midwife that is being observed is of importance or is necessary within the service that is being provided. Showing respect, listening, trusting as well as appreciating these midwives' capabilities is part of ensuring that the midwives' intrinsic dignity is upheld (Stievano, De Marinis, Russo, Rocco & Alvaro, 2012: 351).

Lack of acknowledgement in the working environment is a factor that leads to a stressful work environment (Badar, 2011: 14). Acknowledgement influences how a person sees themselves and experiences their professional identity (Jessen, 2010: 14). In turn, this then influences midwives' idea of 'being-for-others' and their professional dignity. The participants experienced the violation of their professional dignity; this lead to the experience of 'being-for-others' in a negative sense when they were not acknowledged for their contributions to caring for the patients. When 'being-for-others' is experienced in a positive sense, it contributes to the growth of 'being-for-oneself' (Cox, 2009: 36-37). In this instance, midwives will experience dignity and pride in their work. Therefore, in order to acknowledge the capabilities of midwives, capabilities must be recognised, accepted by those involved as well as appreciated. Without the acceptance of the need for the midwives' capabilities, the process of acknowledgement is not complete.

It is sometimes easy for a person to recognise certain capabilities in others but not always as easy to admit and accept that these capabilities are actually needed. Without acceptance and appreciation, these midwives will feel worthless and humiliated, their professional dignity will be diminished (Killmister, 2010: 162) influencing the relationships between the health team members. Dignity is very important in nursing care in order to provide effective care (Gallagher, 2011: 472). Midwives need to have dignity, so that they can dignify patients (Griffin-Heslin, 2005: 256). It is therefore essential for the health team members of this academic tertiary hospital to acknowledge the capabilities of the participants as well as to appreciate their interventions in order to dignify these participants.

4.2.2 To appreciate interventions of midwives

To appreciate the interventions of the participants was a contributing factor to dignifying midwives within this academic tertiary hospital. The participants in this study experienced that the interventions that they suggested, or in some cases implemented, were not wanted or even appreciated, specifically by the doctors in this working environment. The lack of appreciation for interventions performed diminishes midwives' professional dignity and this leads to the experience of 'being-for-others' in a negative sense (Cox, 2009: 36-37) when they are not appreciated for their contributions.

In this study, the meaning of interventions is focused mainly on the care and advocacy rendered by the midwives to ensure the best possible outcomes for the mother, foetus or infant (WHO, Module 4, 2011: 8). Where midwifery care is applied, there is a decrease in medical interventions as midwives try to take delivery back to the more natural way of birth (Hadjigeorgiou & Coxon, 2014: 988). Midwifery care is focused on ensuring that both women and infants do not develop complications, that healthy infants are born and that the women do not have long term health problems (King et al., 2015: 3). Advocating for the mother and her foetus or new-born is an important function of being a midwife (Hadjigeorgiou & Coxon, 2014: 985). The participants in this study really wanted the best possible outcome for their patients, and they prioritised any interventions and care that could ensure the best possible outcome for the mother and infant. The participants unfortunately felt that this care was not appreciated by all of the doctors involved in the process. It was perceived by the participants that some of the doctors seemed to want total authority in each and every situation.

In this academic tertiary hospital, most of the interventions that the participants mentioned were mainly focused on advocating for the patients and occasionally involved application of a medical nature. The one participant felt that if the doctor had started chest compressions when she had advocated it, the baby may have survived, but the doctor refused to listen to her advocating for the baby. Interventions and patient advocacy by midwives is discouraged and limited (Hadjigeorgiou & Coxon, 2014: 986), especially in an academic tertiary hospital where obstetricians

have the authority. Some obstetricians do listen when midwives advocate for their patients, but this is based more on the midwives perceived experience, competence and their confidence they display when asserting their view on the situation (Hadjigeorgiou & Coxon, 2014: 987).

When investigating the meaning of advocacy, Walsh (2011: 489) stated that it is the process of protecting the mother, giving her support and ensuring that she is well informed of any relevant information to make informed decisions about any interventions. It is important that the midwife needs to be the bridge linking the obstetricians, the patient and a good outcome for the mother and infant by advocating for the patient.

Due to the high risk situation of this academic tertiary hospital, there are times when the doctor is not available because they are either busy with another case they considered more important at that time or they are in theatre doing an emergency caesarean section. The participants are frustrated by the lack of acknowledgement based on their perceived priority for the patients. In this situation, there are times that the participants had to implement care for a patient to ensure that no complications occur, for example giving Magnesium Sulphate to a patient with Imminent-eclampsia to prevent the patient from having a seizure. The participant will implement the care and report this to the doctor, sometimes the doctor does not agree with the management that was applied in this situation even though the participant had been following protocol. When experiencing a lack of trust and a lack of teamwork, frustration and discouragement occurs (Weller, Barrow, & Gasquoine, 2011: 482). In certain cases, interventions will be approved and appreciated by the doctor, but some doctors will have wanted to have the authority (Hadjigeorgiou & Coxon, 2014: 989) to approve the care that was given.

In an academic tertiary hospital, it is important to have set guidelines and protocols to be able to render the specific care needed by certain patients in certain situations, especially in cases where communication is limited (Vardaman, Cornell, Gondo, Amis, Townsend-Gervis & Thetford, 2012: 89) such as in the case where the obstetrician is not available at a specific time when a decision needs to be taken concerning the care of the patient. It is important for all involved, obstetricians and

midwives to keep to the protocols to ensure the safety of the mother and infant. Decreasing communication errors will help decrease negative outcomes (Vardaman, Cornell, Gondo, Amis, Townsend-Gervis & Thetford, 2012: 89).

In this academic tertiary hospital with the rotation of doctors during their studies, there appears to be a lack of trust between the doctors and participants. This can be due to the fact that you need to know a person to be able to know if you can trust them, and consequently there is a lack of trust (Weller, Barrow, & Gasquoine, 2011: 481). There needs to be consensus between the doctors and participants, especially in this high risk working environment, that any care or intervention made by the participants or doctors should be beneficial and in the patient's best interest. This will hopefully play a part in enhancing the trust and communication between the health team members and possibly promote the appreciation of interventions made by participants. Trust is a very personal thing and in most situations trust needs to be earned, it cannot always be given freely. Gaining the doctors' trust based on willing and caring attitudes, along with the knowledge and confidence the midwife displays, there should be an increase in the appreciation of the midwives' interventions. The participants in this study felt that if their interventions were appreciated, their professional dignity would be enhanced. When midwives' interventions are appreciated and they are not humiliated, their professional dignity is enhanced (Farhadi, Elahi, & Jalali, 2016: 23).

In a study done by De Meester, Verspuy, Monsieurs and Van Bogaert (2013: 1196), it was interesting to note that where their study was done, although it is limited and cannot be generalised, there was a perceived increase in effective communication (and other benefits) between doctors and midwives when using a method called SBAR (situation, background, assessment and recommendation). When this method is implemented, when the midwives communicate with the doctor, they will start by stating the current problem or situation that is faced with a certain patient, then give a brief background of the patient followed by the assessment of the patient's condition and ending with the recommendation based on the midwives knowledge and experience, the doctor can then communicate any other instructions or management that they feel is required for the patient that was not mentioned. With this method, if done correctly, it may be beneficial to the participants in this study

when communicating with doctors to enhance trust with the doctors leading to appreciation for any interventions made by the midwives in the future.

In nursing and midwifery, the focus is on doing the best you can for the patients that are being cared for, to forget about yourself and focus on their needs. As a midwife, the focus needs to be completely on the patient ('being-for-others') and the problems they face and to intervene on their behalf. When faced with ethical problems concerning their patients, the midwives need to have the moral courage (Gini, 2015: 5) to advocate and perform interventions for their patients, no matter the consequences to themselves. When the focus is on 'being-for-others', it contributes to the growth of 'being-for-oneself' (Cox, 2009: 36-37) leading to being dignified in the working environment. Within midwifery, the midwife helps to bring a precious life into the world. Love for and caring for the new-born infant and the patient is experienced by the midwife and joy is shared between all involved, especially if the outcome is good where the midwife had the responsibility to serve and to care for the mother and infant with love (Hemberg & Kaarre, 2016: 728). Any interventions performed for the patients are appreciated, especially if the outcome for the infant is good. This also helps the midwife to feel valued and appreciated.

When a person's work is recognized and appreciated, that person feels that they are wanted, valued and also respected, leading to the motivation of the midwife and preventing the midwife from wanting to leave the current working environment (Chimwaza, Chipeta, Ngwira, Kamwendo, Taulo, Bradley & McAuliffe, 2014: 4). Enhancement of professional dignity can, according to existentialism, be done through the acknowledgement of others' capabilities. When midwives experience that their 'being-for-others' is appreciated, a positive 'being-for-oneself' results, leading to the experience of the enhancement of their professional dignity (Cox, 2009: 36-37). Part of enhancing the professional dignity of midwives lies in the process of being valued and appreciated by the doctors for the contributions (in this case the interventions) made by the midwives. Midwives want to be valued, have their interventions acknowledged as well as be appreciated as an equal member of the health team.

4.2.3 To perceive midwives as equal health team members

Acknowledgement influences many people on how a person sees themselves and experiences their professional and social identity (Jessen, 2010: 14). The professional and social identity of a person plays an important part in the promotion of their physical and mental health within their environment (Scarf, Moradi, McGaw, Hewitt, Hayhurst, Boyes, Ruffman & Hunter, 2016: 589). Every person has the need to feel that they are part of a group or belong somewhere (Maslow, 1943: 380). The participants in this study wanted to belong and be equal members of the health team of this academic tertiary hospital. The participants believed that if they were equal health team members providing care to these high risk patients, that their professional dignity would be enhanced and that they would be dignified.

In this study, it was noted that the participants experienced the level of teamwork and being equal members of the health team to different extents. The participants that had been working in this hospital the shortest period of time reported that they were satisfied with the level of teamwork within the health team. The participants who had been there for a long time, who had been receiving respect and acknowledgement, were also mostly satisfied with the teamwork. Unfortunately it was the participants who had been there for a few years but had not really been acknowledged or respected by some doctors that felt the need to be treated as equal health team members. The participants experienced the violation of their professional dignity; this led to the experience of ‘being-for-others’ being experienced in a negative sense when they were not acknowledged for their contributions within the health team when caring for patients. When ‘being-for-others’ is experienced in a positive sense, it contributes to the growth of ‘being-for-oneself’ (Cox, 2009: 36-37).

Within a health team, there are many different members who all have different roles and functions in providing care to the patients. The health team’s members need to collaborate to provide optimal and holistic care based on the idea and the understanding that a single person cannot provide holistic care to a person who has many different needs (Arnold & Boggs, 2015:16). There needs to be a specific shared goal or purpose that the individual members of the health team work towards

for the teamwork to be effective. If the teamwork is effective, there are many possible benefits (Valentine, Nembhard & Edmondson, 2015: e16).

Therefore, the health team is a type of formal social group within which the different members who work together interact (Jetten, Haslam, Haslam, Dingle & Jones, 2014: 103). Nursing staff and doctors have the most hands on roles and functions, especially within this academic tertiary hospital. Each person within the team has a specific personal, professional and social identity. This being: who they are as a person that influences and directs their nested social identity. Social identity within a group has a combination of factors that contribute toward the aspect of social connectedness. One of the main aspects of social identity and connectedness is that the group (health team) has a shared goal (Jetten et al., 2014: 105). A person's nested social identity is based on who the person is within the formal working environment and their interactions with the people around them in this working environment (Willetts & Clarke, 2014: 166), in this case, the participants within the obstetric wards. Within the context of nursing, to be able to experience a satisfactory and positive professional identity, the midwives' personal identity needs to correspond to that of their professional identity (Cowin, Johnson, Wilson & Borgese, 2013: 608). A greater level of work satisfaction and a decrease in burnout is experienced when the person's professional identity is strong and clearly defined (Sabanciogullari & Dogan, 2015: 855). The 'being-for-oneself' and 'being-for-others' should correspond (Cox, 2009: 36-37).

The caring nature of most midwives is what influences their nested social identity (Ten Hoeve, Jansen & Roodbol, 2014: 306). A person's nested social identity is what motivates a person to work together with other colleagues towards the greater good of the patient/organization and not just focusing on the individual self-interest (Willetts & Clarke, 2014: 167). In this study, the greater good lies in providing care to high risk pregnant patients for the best possible outcome. Autonomy within the working environment is part of what is essential in a profession. This unique nested social identity is what should motivate midwives to perform well to work towards autonomy within the health team (Willetts & Clarke, 2014: 167). The function of this health team is to provide care to the patients with high-risk pregnancies, thus each member is equal but very unique based on the caring function of this group with their

shared nested social identity (Jetten, Haslam, Haslam, Dingle & Jones, 2014: 103). According to Scarf et al. (2016: 589), social identities are essential in the promotion of health and well-being.

Each person in the group has their own responsibilities that need to be achieved and completed. When looking at the different members of the health team, especially the doctors and participants within this academic tertiary hospital, it is important to remember that doctors and midwives are not equal based on the hierarchy within the tertiary academic hospital. The doctors have a hierarchy separate than that of the midwives' hierarchy, each with their own scope of practice and protocols (McInnes, Peters, Bonney & Halcomb, 2015: 19). In the past, midwives were thought of as being of a lesser rank than doctors based on their caring stereotype (Willetts & Clarke, 2014: 167) but this is in the process of changing now that nursing is moving in to the Higher Education category. The participants do not want to be seen as equals on a professional level when comparing the doctors' qualifications and their own qualifications, but they want to be seen as equal team members with their own unique contribution to make to the health team with their own unique qualifications (Arnold & Boggs, 2015: 19). The participants wanted the doctors to listen to them when advocating for patients, and to be treated with respect based on their function within the health team.

It was noted that not all the doctors knew the different categories of the nurses and midwives within the health team, with their specific individualized job descriptions, although it was expected of the participants to know the doctors' categories and qualifications. Within this academic tertiary hospital, there have been times when doctors would expect an assistant nurse to know what a midwife knows and consequently when not receiving the correct response that they expected to hear, would become frustrated and disgruntled with the nurses. South Africa has a specific structure for categorizing nursing staff based on qualifications and training, although there are some changes in the process being implemented at the moment (South African Nursing Council, 2016, Information regarding the phasing out of Legacy Nursing Qualifications, Circular 7/2016).

Equal collaboration and consideration of each member's personal and nested social identity needs to occur between each individual of the health team to help ensure that midwives are perceived as an equal part of the health team. This will be based on the health team's shared nested social identity of caring for the patients. The 'being-for-oneself' and 'being-for-others' should correspond (Cox, 2009: 36-37) and be the main priority within this health team. When 'being-for-others' is experienced in a positive sense, it contributes to the growth of 'being-for-oneself' (Cox, 2009: 36-37). When 'being-for-others' is focused on, it also influences collegiality of the different participants within this working environment. This then influences midwives' idea and perception of 'being-for-others' in a positive sense and in turn therefor enhances their professional dignity.

4.2.4 To enhance collegiality

As was seen in the previous section, the participants wanted to be equal team members within the working environment in order for their professional dignity to be enhanced. Collegiality was one of the aspects of teamwork with which the participants of this study experienced problems. The participants wanted to have collegial interactions with their work colleagues and with other members of the health team in order for their professional dignity to be enhanced.

According to Padgett (2013: 1407), collegiality is based on the different cooperative interpersonal relationships within the working environment between the different nursing categories as well as the different members of the health team. Collegiality is also a part of self-regulation that is based on accountability for your actions (Padgett, 2013: 1413). The different work colleagues involved in collegial interactions need to keep each other and everyone else involved with patient care accountable for the care that each and every person on the team provides. The 'being-for-oneself' in collegiality is more directed at the outcome of 'being-for-others' (Cox, 2009: 36-37). The focus of your work needs to be on helping other colleagues within the working environment as well as taking responsibility together for any care given to the patient. That is why advocating for the patient is so important in nursing and especially in midwifery where the midwife and medical team is accountable for the lives and safety of the mother and infant. Every person in the health team needs to

agree to work together for the greater good of the patient to ensure that the interpersonal interactions are as effective as possible. The more effective the interpersonal interactions and accountability of the team members within the working environment, the less errors and unsafe practices will occur (Padgett, 2013: 1408). This will ultimately lead to quality care of patients (Padgett, 2013: 1407).

Within the working environment, teamwork proved to be essential. Nurses and midwives depend on each other's advice, support and assistance. Every participant in this study valued their autonomy but also appreciated the assistance and the cooperation of the other midwives and other staff members. Being accountable for your own and others' actions, influences and possibly promotes autonomy of the midwives involved (Padgett, 2013: 1408). Autonomy in the working environment helps to enhance the professional dignity of the participants as well as the professional dignity of others in this working environment. When a person is dignified it is easier for that person to dignify others, in this case if the participants are dignified they can in turn deliver dignified care to the high risk pregnant patients they are working with.

Midwives experience greater job satisfaction when collegiality is experienced. Part of collegiality is communication and inter-professional relationships between the midwives and doctors. Where there is effective communication between the midwives and the doctors, collegiality is improved and there is greater collaboration between the doctors and midwives (Farahani, Sahragard, Carroll & Mohammadi, 2011: 323). The participants experienced instances where there was difficulty in communicating with the doctors and therefore they felt as if the doctors were not listening to them when they were advocating for the patient, possibly due to lack of knowledge concerning the training of midwives (Schadewaldt, McInnes, Hiller & Gardner, 2014: 1185). This led to the dissatisfaction of the participants who were only trying to do their work and help the patient to the best of their ability and knowledge.

Together with the decrease in autonomy of the midwives, their satisfaction when working with doctors, who did not allow them to perform tasks on their own also decreased, impeding their autonomy (Mallidou, Cummings, Estabrooks &

Giovannetti, 2011: 91). In situations where the doctors listened to the participants advocating for the patients and agreed with the suggestions made by the participant or explained why the suggestion would not be applicable in a certain situation, the participants experienced greater satisfaction based on the fact that the doctor was listening to them. When a midwife experiences acknowledgement of their advocacy, they experience an increase in collegial interactions and inter-professional relationships (Farahani et al., 2011: 323). With increased collegiality and collaboration between the midwives and the doctors, both these professions experience more satisfaction within the working environment. There is also an increase in the satisfactory outcomes for the patients being cared for, with fewer adverse events occurring within the environments where there is collegiality between the doctors and midwives (Mallidou et al., 2011: 90).

Within this academic tertiary hospital, the participants also experienced problems with the collegial interactions with the other midwives and also with the nurses. The midwives who were older and had worked at the hospital for a longer time were not as willing to work and assist other midwives when they needed help. They would leave the work for the younger midwives to do. The lack of collaboration and assistance is very frustrating and demotivates midwives, leading to a decrease in job satisfaction (O'Keeffe, Corry & Moser, 2015: 174). The nurses who were there for a longer time also showed the younger participants less respect and support, especially when they wanted to implement new and better practices based on recent research studies. With the lack of collaboration and decreased support within the team, these participants became demotivated and frustrated, leading to the incorrect practice of doing what was done to them and not supporting the others. This becomes a vicious cycle that leads to poor patient care and dissatisfied staff and even leads to emotional and physical exhaustion and burnout (Mallidou et al., 2011: 90).

Respecting each other within the working environment is very important in collegiality and professional dignity (Clark, 2015: 52). Respecting each other within the working environment was of very high value to each participant in this study. Some of the participants felt that they were not respected by some of the other midwives, nurses, doctors and even management. They wanted to have the respect of their colleagues

as well as the doctors. One of the participants reported that one of the doctors once told a patient not to trust the midwives because they do not know what they are doing. This besmirched the midwives professional image in front of the patient, leading to the degrading of the midwives' professional dignity. It is of the utmost importance, especially with these patients with their high-risk pregnancies, to know that at any time they can trust any member of the health team to assist them and to know that they and their infant are in safe and in good hands (Witt, Litzelman, Cheng, Wakeel & Barker, 2014: 57). If the patient feels that she and her infant are not safe, she becomes emotionally distressed. This leads to a poor psychosocial and even a possible adverse outcome for the mother and infant that is as a result of the emotional distress the patient is experiencing (Glover, 2014: 25). If the professional image of each member of the health team is upheld and they show respect to each other, this will enhance their collegiality as well as enhance their professional dignity.

The participants also wanted to have collegial relationships with management. The participants had experiences where they were not respected or supported by management. Collaboration and communication between the participants and management was very strenuous as they did not feel valued or respected by the unit managers and also by hospital management. Collegiality between management and their nursing staff and the support from management is very important in enhancing the working environment (Twigg & McCullough, 2014: 85). When management has positive inter-professional communication and interactions with their midwifery staff, it enhances the collegiality between management and midwives. When there is a positive working environment created by management in which collaboration between management and midwives occur, staff retention is increased (Heinen, van Achterberg, Schwendimann, Zander, Matthews, Kózka, Ensio, Sjetne, Casbas, Ball & Schoonhoven, 2013: 178). The participants in this research also mentioned that management did not care for them and were not 'on their side'. The care by management will be discussed further in a later section.

Communication between all the people involved is very important in collegiality. If communication is ineffective, errors in care can occur. Different relationships will also be ineffective if there is a decrease in communication, there will be a decrease in trust as well as respect if people start shouting at each other. If a midwife is verbally

diminished or degraded in front of others, they experience resentment and their confidence decreases and it causes uncertainty about their abilities. When this occurs, it damages the relationships between the team members. It also diminishes the collegiality and collaboration which can lead to an increase in the turnover rate of the staff and retention levels will decrease for the other midwives as the midwives communicate with others (Clark, 2015: 20).

When the members of the health team and management care and show respect for each other, collegiality is experienced in a positive sense. The better the relationships are between the members of the team, the better they will complement each other's knowledge and skills to benefit patients. When there is collegiality between all the members of the health team, 'being-for-others' is experienced in a positive sense, which contributes to the growth of 'being-for-oneself' (Cox, 2009: 36-37). Therefore, collegiality enhances the professional dignity of the midwives.

4.2.5 To be cared for by management

To enhance the professional dignity of midwives, the participants in this study also wanted to have collegial interactions with management and have management as part of their team. The participants in this study felt that management did not support them within the working environment. The participants working within this tertiary academic hospital experienced a lack of acknowledgement, teamwork and support from management.

Midwives are more satisfied with managers when there is good communication and collaboration (Farahani, Sahragard, Carroll & Mohammadi, 2011: 323). When a manager degrades a midwife in front of other staff and patients, they experience humiliation, their confidence decreases and it causes uncertainty about their professional abilities (Clark, 2015: 20) and competencies (Sabatino, Stievano, Rocco, Kallio, Pietila & Kangasniemi, 2014: 660). When midwives experience humiliation, their professional relative dignity is degraded or violated. Professional dignity is subjective and is based on relative dignity within the workplace that is influenced by autonomy and competencies (Sabatino et al., 2014: 660). When management wants to discuss an issue concerning the behaviour or action of the

midwife, it is important for management to not address this issue with the midwife in front of others but to rather ask to speak to the midwife in private where the midwife will not feel humiliated in front of others when she is corrected or reprimanded about the issue.

To be cared for by management plays an important role in enhancing the interpersonal relationships between midwives and managers that in turn leads to the enhancement of the working environment and helps to increase job satisfaction within the work place (Sabatino et al., 2014: 665). When management cares for their workers, the workers tend to be more committed and loyal to the institution (Brunetto, Xerri, Shriberg, Farr-Wharton, Shacklock, Newman & Dienger, 2013: 2787). When a person is cared for, they can also deliver a better quality of care. The 'being-for-oneself' is experienced in a positive way, which then also enhances the 'being-for-others' (Cox, 2009: 36-37) and therefor leads to improved patient care. As mentioned before, when 'being-for-oneself' correlates to 'being-for-others' there is an enhancement of professional dignity.

The participants felt that they were not given the emotional support that was needed from management, especially when a patient passed away, no counselling was offered to the participants to help with the loss. The participants felt that management did not care for them. When midwives feel that they are cared for by management they are more capable of caring for others (Baggett, Giambattista, Lobbestael, Pfeiffer, Madani, Modir, Zamora-Flyr & Davidson, 2016: 817). This enhances the care midwives render to patients. Another part of being cared for by management is in supporting their staff. The participants in this study felt that management always took the side of the doctors or patients and did not want to hear what the participants had to say. Some of the instructions from management were to just follow orders even though it went against the participant's scope of practise and even sometimes the safety of the patient. The safety of patients need to come first, especially if everyone is still striving to decrease maternal mortality rates and enhance maternal health according to the Millennium Development Goal 5 (Bryce, Black & Victora, 2013: 225).

When midwives feel that they are cared for by management, they feel valued and appreciated within the working environment. The midwives' 'being-for-oneself' is experienced in a positive way, which then also enhances the 'being-for-others' (Cox, 2009: 36-37). This will improve the care rendered by midwives and also enhance the midwives' professional dignity.

4.2.6 To invest in midwives

When someone invests in something they put in time and money to improve the thing they are investing in. The participants in this study wanted management and the hospital to invest in them. The participants wanted management to send them for training to increase their knowledge and skill base, but on more than one occasion their requests were not granted, causing them to feel that their 'being-for-herself' (she wanted to enhance her knowledge) were harmed.

Part of professional development is associated with the yearning to gain knowledge and skills. The participants wanted the management and hospital to invest in them. The South African Nursing Council is in the process of implementing Continuing Professional Development for all categories of nurses following in the footsteps of other countries like Australia and America in order to ensure access to safe and good quality care (Katsikitis, McAllister, Sharman, Raith, Faithfull-Byrne & Priaulx, 2013: 34). This is now part of The World Health Organization's Global Strategic Directions for Strengthening Nursing and Midwifery 2016-2020 (World Health Organization 2011: 16 & 26, Nkowane & Ferguson, 2016: 206), where the focus is on strengthening midwives, moving towards increased autonomy and enhancing their potential and knowledge in order for them to deliver better care. The fact that the study was conducted in an academic tertiary hospital increased the participants yearning for improving themselves to be able to deliver better quality services for their high-risk patients. The more knowledge a person has, the better they are equipped to manage different situations and also complications.

The participants who work in this academic tertiary hospital are proud of who they are and the knowledge and skills that they have. They just want to be able to give the highest quality of care by gaining knowledge and skills within an ever-changing

environment based on improvements made by research. Unfortunately, the severe staff shortage at the moment is a barrier to this way of investing in midwives as it limits the training that the midwives can attend; this shortage is unfortunately a worldwide problem (Katsikitis et al., 2013: 42).

The South African Nursing Council with the aim of incorporating The World Health Organization's Global Strategic Directions for Strengthening Nursing and Midwifery 2016-2020 (World Health Organization 2011: 16 & 26, Nkowane & Ferguson, 2016: 206) is also in the process of taking nursing education to the Higher Education level and ensuring that all new professional nurses will be trained in midwifery to try to decrease the shortage of midwives within South Africa.

In the end, to invest in midwives will ensure continued quality care for these high-risk pregnant patients. The midwives' 'being-for-oneself' is experienced in a positive way when they are invested in, which then also enhances the 'being-for-others' (Cox, 2009: 36-37). The midwives' professional dignity is also enhanced when they feel valued because they were invested in. Unfortunately, the working environment needs to be conducive for supporting the midwives and patients in order for the midwives to render better quality care. This will be discussed in the next section.

4.2.7 To create conducive environments

The working environment plays a significant role towards the quality of care rendered by midwives as well as job satisfaction and the enhancement of the professional dignity of the midwives. Some other aspects that create a conducive work environment that has already been discussed includes autonomy and interprofessional teamwork. The midwives' 'being-for-oneself' needs to correlate with 'being-for-others' (Cox, 2009: 36-37) within the working environment, because in order to function fully within the working environment, the working environment needs to be conducive for care.

The issue of staff shortages is a global problem that has been mentioned in many research studies. There has been an ever-increasing patient to midwife ratio, to the extent that there are not enough midwives to provide the quality of health care

needed (Aiken, Sloane, Bruyneel, Van den Heede, Sermeus & RN4CAST Consortium, 2013: 151). The staff shortage is having an increasing effect on the amount of serious adverse events that are occurring (Bradley, Kamwendo, Chipeta, Chimwaza, de Pinho & McAuliffe, 2015: 71). In midwifery, this is especially dangerous because you are caring for a mother and a new precious life that is about to start. With midwifery, staff shortage and the patient to staff ratio is very unpredictable, at one moment it can be very quiet but the next it will be overflowing with patients and sometimes more than one emergency can occur that needs attending. Unfortunately, together with the staff shortages this does end in very dangerous situations that put the lives of the patients as well as the career of the midwives at risk if adverse events occur. This then leads to staff dissatisfaction because of the shortage that is resulting in the midwives unintentionally putting patients at risk (Kalisch & Lee, 2014: 5-6).

In the high-risk antenatal, labour and postnatal wards, the women are even more at risk of complications; this causes an increase in responsibility and the need for autonomy in nursing. This then leads to an increase in work related stress. A strenuous, stressful and conflict filled working environment accompanied by fatigue from overworking along with exhaustion because of staff shortages and very long working hours, lead to inaccuracies in patient care and treatment (Kushner & Ruffin, 2015: 170). Interpersonal conflict between staff, management and patients increase stress levels and feelings of frustration and job dissatisfaction (Valizadeh, Zamanzadeh, Habibzadeh, Alilu, Gillespie & Shakibi, 2016: 7). Job dissatisfaction is one of the leading causes of a higher turnover rate (Kushner & Ruffin, 2015: 177). In these high risk situations being part of the health team, feelings of belonging and connectedness to the team enhances dignity and should thus help decrease stress in the working environment as well as enhancing patient care.

The working environment needs to be a place of safety for the patient as well as the nursing staff. This will ensure that midwives feel safe while they render optimal care. A working environment that is not safe, will lead to anxiety and ultimately to unnecessary mistakes and possible adverse events.

According to the participants, creating a conducive, working environment will ensure that optimal patient care can be delivered, which will make midwives feel dignified. Feelings of not being good enough for others and thus not deserving conducive working environments are according to existentialism experienced in relationship with others. Midwives experience conducive, working environments in their 'being-for-others' and not in their 'being-for-themselves'; with the care that midwives want to provide to patients they also strive to make the hospital environment conducive for patient care.

4.3 SUMMARY

In the above chapter a theoretical discussion was given with reference to literature of the findings on the essence of how to dignify midwives in an academic tertiary hospital based on how to enhance the professional dignity of midwives with the following constituents: 'to acknowledge the capabilities of midwives', 'to appreciate interventions of midwives', 'to perceive midwives as equal health team members', 'to invest in midwives', 'to enhance collegiality', 'to be cared for by management' and 'to create conducive environments'. In the next chapter, a summary of findings, limitations and conclusions is presented.

CHAPTER 5
SUMMARY OF FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

In the previous four chapters, the perceptions of the midwives, their experiences of their professional dignity and the means to enhance their professional dignity were explored. The first chapter comprised of the introduction, background information, rationale and the problem statement with the significance of the study. Chapter 2 presented the constructivist paradigmatic perspective and the phenomenological research approach that underpinned the study. In Chapter 3, the findings of the study were described. In Chapter 4, a theoretical discussion of the findings of the study is presented directed by an extensive literature review to provide a deeper understanding of the findings. In Chapter 5, a summary of the findings, limitations, recommendations and conclusions drawn from the study findings are described.

5.2 SUMMARY OF THE FINDINGS

The purpose of the research study was to explore how the professional dignity of midwives in the selected hospital can be enhanced. This was done with the following objectives: to describe the professional dignity of midwives and to explore the perceptions of midwives on the ways to enhance the professional dignity of the midwives in the selected academic tertiary hospital. Unstructured, in-depth interviews were conducted with 15 midwives based on the descriptive, phenomenological research method in order to obtain data. The midwives that were included in the study had been working within the selected academic tertiary hospital for at least one year and had not yet acquired advanced midwifery training. One question was asked: How can the professional dignity of midwives in an academic tertiary hospital be enhanced? Where there were participants who did not understand what was meant with professional dignity, a brief explanation was given. The researcher made use of a list of probing questions to ensure that a rich description of the phenomenon was obtained (refer to Annexure D).

The interviews revealed that the essence of the participants' experiences was: 'To dignify midwives in an academic tertiary hospital'. People are mostly 'being-for-oneself' and are "conscious of themselves and conscious of the world". The participants were conscious of how others viewed them and that influenced how they perceived themselves ('being-for-themselves'). In midwifery, the idea of 'being-for-others' is an essential concept, the midwife forms an integral part of the delivery process, being there for the mother and baby as well as assisting the doctors during high-risk deliveries.

The participants experienced the violation of their professional dignity, and this lead to the experience of 'being-for-others' in a negative sense. The following constituents of the essence were discovered and it supported how to dignify midwives in an academic tertiary hospital: 'to acknowledge the capabilities of midwives', 'to appreciate interventions of midwives', 'to perceive midwives as equal health team members', 'to invest in midwives', 'to enhance collegiality', 'to be cared for by management' and 'to create conducive environments'. The summary of the essence and the constituents are presented as follows:

5.2.1 The essence: 'To dignify midwives in an academic tertiary hospital'

During the use of the descriptive, phenomenological method, the researcher found the essence being: 'To dignify midwives in an academic tertiary hospital.' In this study, dignify comprises of the endeavours that indicate that midwives are valued for their professional expertise, to be respected for the contribution that they make to the well-being of pregnant women and their infants and that midwifery is recognized as a profession. The experience is exemplified in ways of 'being-for-themselves' in the context of 'being-for-others'.

Existentialism, being part of phenomenological philosophy, reveals that the participants experience their 'being-for-themselves' in the context of 'being-for-others'. How others viewed them, influenced how they perceived themselves ('being-for-themselves'). When one is degraded or demeaned they experience 'being-for-others' negatively. There is an upside to 'being-for-others'; when it is

experienced in a positive sense it contributes to the growth of 'being-for-oneself'. Midwives can be dignified in their interaction with the health team and management. When others' behaviour towards them is aimed at dignifying and enhancing the midwives professional dignity, the midwives' perception of themselves as professional persons with dignity, is strengthened.

5.2.2 To acknowledge the capabilities of midwives

To dignify midwives in an academic tertiary hospital, the capabilities of the midwives need to be acknowledged. The participants experienced a lack of acknowledgement of their capabilities by management as well as by the doctors. In this study, in order to enhance the professional dignity of the participants and to dignify them, there was the perceived need for the acknowledgement of the participants' capabilities.

Within an academic tertiary hospital, the main objective is providing specialised care to patients with high-risk conditions. Unfortunately, this specialised care is associated more often with the medical profession. The participants felt that they were equipped with the necessary knowledge and skills and that it should be part of their job description. They work very hard to ensure that healthy mothers and infants leave the maternity section, but unfortunately often hear from doctors that they are there only to follow the doctors' orders. It made the participants feel as if they are only assisting the doctors and not autonomous midwives with their own scope of practice. Their intentional consciousness of others influences their consciousness of their own capabilities.

Midwives are professional people who are trained to assist pregnant women before, during and after their infants are born. They deserve to be acknowledged for their training and the skills that they add to the capabilities of the health team. When midwives' capabilities are not recognised or acknowledged by the doctors and their skills and knowledge are disregarded, midwives start to doubt their own capabilities. When there is self-doubt, a person is less likely to voice their opinion or intervene in certain situations. An academic tertiary hospital consists of many health team members who all need to be acknowledged for their capabilities and their role in the patient's care.

5.2.3 To appreciate interventions of midwives

The participants within this academic tertiary hospital spend extended periods of time with high risk pregnant patients. The extended time these participants spend with these patients leads to opportunities where they have to identify potential problems and then intervene and prevent further complications. Midwives are capable of intervening as far as their scope of practice determines. Unfortunately, the interventions by midwives are not always appreciated. When midwives' interventions are continuously rejected, they also start to doubt their abilities and interventions.

Appreciation for any interventions performed by the midwives is important in the provision of optimal patient care. The participants attempted to provide optimal patient care and advocacy for required interventions for the benefit of the patients. The participants are well acquainted with the risks and any possible disciplinary actions that can be taken against them. The participants know they will be held liable for any complication leading to adverse effects if they do not advocate for the patients and are aware of subsequent disciplinary actions that could be taken against them.

Intervention is part of the key to prevention of serious adverse events and especially unnecessary maternal and new-born deaths. Midwives must have the courage to continue to intervene when necessary and to recommend treatment to be performed by the patients' doctors. Timely interventions that lead to good outcomes for the patients should be appreciated. In the high risk situation that these participants are in, interventions are paramount for the good outcome of the mother and baby. The participants desire and strive towards the freedom to be able to independently intervene and provide autonomous care for their patients. When midwives are given the freedom to act and intervene independently it encourages them in rendering better quality care. When their interventions to prevent and manage complications are appreciated they are dignified and their professional dignity is enhanced.

5.2.4 To perceive midwives as equal health team members

The participants wanted to be perceived as equal health team members. They wanted to be treated as if they were on the same level as other members of the health team. Their inputs should be recognized as all others' input to patient care is recognized. Equal collaboration and consideration of each member needs to occur between each individual of the health team to help ensure that the participants are perceived as an equal part of the health team. The 'being-for-oneself' and the 'being-for-others' should correspond.

Specialized care and effective communication from all members of the team is required. Each member plays an important individual part in the treatment and should be respected for that. The participants felt that they were less important members of the team compared to some of the other health team members. These participants felt discouraged; they felt unappreciated and had feelings of worthlessness and inferiority accompanied by feelings of insignificance when they were treated as if they were not part of the decision making process and were only trusted to perform activities that had been delegated to them.

Midwives need to be acknowledged as equal health team members, especially when they give their unique nursing contributions to the team. All members of the health team should be considered to be valuable entities as they all deliver contributions that are unique to their professions, thereby providing holistic treatment of high-risk pregnant patients. The different contributions made by each individual group member should be complementary and add value to the group contributions that is to the benefit of patients. Teamwork amongst the different multi-disciplinary team members is essential for the satisfactory outcome of care of high-risk pregnant patients. Midwives need to be perceived as equal health team members to be able to enhance collegiality.

5.2.5 To enhance collegiality

Collegiality refers to the relationship between colleagues. Collegiality leads to better teamwork. The better the relationships between the members of the team, the better

they will complement each other's capabilities, knowledge and skills to the benefit of the patients. The participants felt that they did not receive the necessary support that they needed to optimally care for patients with high risk pregnancies. Respect from management was necessary as they tried their very best to deal with challenges. Midwives wanted to work well with other team members. This relationship between colleagues includes the interactions and interpersonal relationships amongst them.

In interaction with others, 'being-for-oneself' and 'being-for-others' entails that each becomes conscious of the other and for each 'being-for-others' and 'being-for-oneself' becomes important. Everyone becomes aware of how others perceive him or her. Equal collegiality implies that the person and the other agree in their intentional consciousness of others that they accept and approve the contributions of the other. Relationships where colleagues encourage each other, where they show each other respect and consideration is important to form strong bonds. If you defend and support each other, teamwork becomes possible. Enhancing collegiality is essential in teamwork.

Within the working environment, teamwork has proved to be essential. Advice, support and assistance are important contributors to the concept of collegiality. Autonomy is greatly valued and appreciated. The assistance and the cooperation of the other midwives and staff members enhance collegiality. When collegiality is experienced, midwives also experience greater job satisfaction. Part of collegiality is communication and inter-professional relationships between the midwives and doctors. Effective communication between the midwives and the doctors leads to the improvement of collegiality and there is greater collaboration. There is also an increase in the satisfactory outcomes for the patients being cared for with less adverse events occurring within the environments where there is collegiality between all health team members.

When there is collegiality between all the members of the health team, 'being-for-others' is experienced in a positive sense, which contributes to the growth of 'being-for-oneself' (Cox, 2009: 36-37). Therefor collegiality enhances the professional dignity of the midwives.

5.2.6 To invest in midwives

When someone invests in something, they invest time and money to improve what they are investing in. In midwifery, it is important to invest in staff development as this will lead to the improvement of care as well as ensuring the optimal care for future generations. The participants in this study expressed a desire for management and the hospital to invest in them. The participants wanted management to send them for training to increase their knowledge and skill base, but on more than one occasion their requests for training were not granted, causing them to feel that their 'being-for-herself' got harmed.

Professional development is associated with the desire to gain knowledge and skills to enhance the professional dignity of staff members. The participants wanted management and the hospital to invest in them. The fact that the study was conducted in an academic tertiary hospital increased the participants yearning for improving themselves to be able to deliver better quality services for their high risk patients. The more knowledge a person has, the better they are equipped to manage different situations and also complications.

Investing in midwives will ensure continued development and quality care for these high-risk pregnant patients. The midwives' 'being-for-oneself' is experienced in a positive way when they are invested in, which then also enhances the 'being-for-others'. The midwives' professional dignity is also enhanced when they feel valued because they were invested in.

5.2.7 To be cared for by management

To enhance the professional dignity of midwives, the participants in this study also wanted to have collegial interactions with management and have management as part of their team. The participants in this study felt that management did not support them within the working environment.

Midwives are more satisfied when there is good communication and collaboration between them and management. When midwives experience humiliation, their

professional dignity is degraded or violated. Professional dignity is based on relative dignity within the workplace, which is influenced by autonomy and competencies that is a very subjective experience. When management cares about their staff, it plays an important role in enhancing the interpersonal relationships between midwives and managers which in turn leads to the enhancement of the working environment and helps to increase job satisfaction. The participants wanted more emotional support; this was specifically needed from management, especially when a patient passed away, when no counselling was offered to the participants to help with the loss. The participants felt that management did not care for them. When midwives feel that they are cared for by management they are more capable of caring for others.

When the participants feel valued and appreciated within the working environment, 'being-for-oneself' is experienced in a positive way, which then also enhances the 'being-for-others'. This will improve the care rendered by midwives and also enhance the midwives' professional dignity.

5.2.8 To create conducive environments

The working environment plays an essential part in ensuring the quality of care rendered by midwives as well as job satisfaction and the enhancement of the professional dignity of the midwives. The working environment needs to be conducive for care.

The issue of staff shortages is a global problem that has been addressed in many research studies. There is an ever increasing patient to midwife ratio, to the extent that there are not enough midwives to provide the quality health care needed. The staff shortage increases the amount of serious adverse events that are occurring as well as the effects thereof. In midwifery, this is especially dangerous because you are caring for a mother and a new precious life that is about to start. This then leads to staff dissatisfaction because of the shortage that is leading the midwives to putting patients at risk although not intentionally.

A strenuous, stressful and conflict filled working environment accompanied by fatigue from overworking along with exhaustion from staff shortages and very long

working hours, leads to inaccuracies in patient care and treatment. Staff shortages, together with being overworked and exhausted, lead to the burnout of the midwives in this high-risk environment. Burnout causes the midwives to not care anymore, and leads to insufficient and non-effective rendering of care as well as an increase in turnover rate.

In these high-risk situations being part of the health team, feelings of belonging and connectedness to the team enhances dignity and should help to decrease the stress in the working environment as well as enhance patient care. According to the participants, creating a conducive, working environment will ensure that optimal patient care can be delivered which will make midwives feel dignified. Feelings of not being good enough for others and thus not deserving of conducive working environments are, according to existentialism, experienced in relationship with others. Midwives experience conducive, working environments in their 'being-for-others' and not in their 'being-for-themselves'; therefor they strive to make the hospital environment conducive for patient care.

5.3 LIMITATIONS OF THE STUDY

The findings of the study were obtained from qualitative phenomenological interviews with 15 midwives within a specific academic tertiary hospital. These experiences may differ from that of other midwives in other institutions and settings. The experiences may also differ from that of advanced midwives due to their training and skills, thus the reason for exclusion.

Using the descriptive phenomenological method, the researcher transformed the data that was presented by the participants with the natural attitude to the phenomenological attitude to produce an understanding of the phenomenon. The researcher served as research tool and the viewpoint was similar to that of the participants.

5.4 RECOMMENDATIONS

The amount of midwives that are resigning from these maternity sections or even transferring to other sections has greatly increased since this research was started. The researcher recommends that “Enhancing the professional dignity of midwives in an academic tertiary hospital” should be included in the curriculum of the nurses. The researcher therefore recommends that the hospital and also nursing management take into account this research about enhancing the professional dignity of midwives. When there is teamwork between the different members of the health team, as well as mutual respect between every person involved, there may be a change within these sections. When midwives and other members of the health team feel they are needed as well as wanted, they will feel valued. When placed in a position where recognition takes place, the person feels valued and more satisfied with the working environment. With a change in the working environments, focusing on making the environment less stressful and caring, the resignation rate and adverse events will also decrease. With support and care of these midwives by enhancing their professional dignity they will strive to render excellent services as well as increasing their commitment to the institution that cares for them.

Further research should be conducted on what strategies could be used in order to ensure the effective implementation of the findings from this study.

5.5 CONCLUSION

The purpose of the research study was to explore how the professional dignity of midwives in the selected hospital can be enhanced. The essence (meaning) of the participants’ experiences was disclosed as: To dignify midwives in an academic tertiary hospital. The essence is supported by the following constituents (meaning units): ‘to acknowledge the capabilities of midwives’, ‘to appreciate interventions of midwives’, ‘to perceive midwives as equal health team members’, ‘to invest in midwives’, ‘to enhance collegiality’, ‘to be cared for by management’ and ‘to create conducive environments’.

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ANNEXURE A: APPROVAL CERTIFICATE FROM ETHICS COMMITTEE

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 20 Oct 2016.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

9/06/2016

Approval Certificate
New Application

Ethics Reference No.: 117/2016

Title: Enhancing the professional dignity of midwives in an academic tertiary hospital

Dear Christelle Froneman

The **New Application** as supported by documents specified in your cover letter dated 15/04/2016 for your research received on the 18/04/2016, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 9/06/2016.

Please note the following about your ethics approval:
- Ethics Approval is valid for 1 year
- Please remember to use your protocol number (**117/2016**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of 6 monthly written Progress Reports, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed.
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

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ANNEXURE B: LETTER OF APPROVAL

Letter of approval

To: Chief Executive Officer Dr Kenoshi,

From: The Researcher
Mrs Christelle Froneman

Re: Permission to conduct research at the Steve Biko Academic Hospital

I am currently a student at the University of Pretoria and I am hereby requesting permission to conduct a study at the Steve Biko Academic Hospital, in the Obstetric wards (8.3, 8.4 and 8.9). The study is for the purpose of fulfilling the requirements of the Master's degree in Advanced Nursing Management at the University of Pretoria.

The title of my research study is: "Enhancing the professional dignity of midwives in an academic tertiary hospital". The study is intended to take place between January and November 2016. A qualitative research design will be used. Interviews will be held with 15 midwives. The participants will be provided with information prior to the study about the nature of the study and will be requested to sign an informed consent to ensure that participation is voluntary. The rights of the participants will be protected by not linking information to any participant's identity.

The results will be shared with representatives of your institution, and I intend to publish findings of the study in a professional journal and/ or at professional meeting like symposia, congresses, or other meetings of such a nature.

I undertake not to proceed with the study until I have received final approval from you and the Faculty of Health Sciences Research Ethics Committee, University of Pretoria.
I hope my request will be taken into your consideration.

Yours sincerely
Mrs Christelle Froneman

Froneman

.....
Signature of the Principle Investigator

Permission to do the research study at this hospital and to access the information as requested, is hereby approved.

Chief Executive Officer:
Steve Biko Academic Hospital

Dr, M. E. Kenoshi

DR ME KENOSHI
CHIEF EXECUTIVE OFFICER
STEVE BIKO
ACADEMIC HOSPITAL

Signature of the CEO

24/5/2016

Hospital Official Stamp

DR ME KENOSHI
CHIEF EXECUTIVE OFFICER
STEVE BIKO
ACADEMIC HOSPITAL

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

STEVE BIKO ACADEMIC HOSPITAL

Enquiries: Mrs. E.A. Pieterse
Tel: 012 354 5501
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Email: Elsa.Pieterse@gauteng.gov.za

Mrs. C. Foreman
338 Malherbe Street
Capital Park
Pretoria
0084

RE : APPLICATION – RESEARCH AT STEVE BIKO ACADEMIC HOSPITAL

"Enhancing the Professional Dignity of Midwives in an Academic Tertiary Hospital "

Your letter regarding the above-mentioned refers :

1. The Chief Executive Officer hereby grants permission for the above-mentioned research to be done at Steve Biko Academic Hospital.

2. Distribution and completion of questionnaires may only take place with the knowledge of the Manager of the Area, and should not interfere with patient care or any ward activities.

3. Please provide one copy of the results of your study to Mrs. E.A. Pieterse, Personnel development.

Good luck with the proposed project.

.....
MRS. E.A. PIETERSE
NURSING DIRECTORATE
2016-05-27

ANNEXURE C: PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT

Title of the Study: "ENHANCING THE PROFESSIONAL DIGNITY OF MIDWIVES IN AN ACADEMIC TERTIARY HOSPITAL"

Dear Participant,

1. INTRODUCTION

You are invited to participate in a research study. This brochure will assist with giving you the relevant information to help you decide to participate in this particular study. It is important to understand what the study entails before you can make a decision to participate. Should this brochure fail to provide all the information you need to know, feel free to ask the researcher.

2. THE NATURE AND PURPOSE OF THIS STUDY

The purpose of the study is to explore and describe how the professional dignity of midwives can be enhanced. You are considered as a very important source of information and are thus approached to take part in this study.

3. EXPLANATION OF PROCEDURES TO BE FOLLOWED

The participants in this study will comprise of midwives who work in an academic tertiary hospital. Individual interviews will be conducted in a private venue and will not last longer than 30 minutes. The participants will be asked questions about the way the professional dignity of midwives can be enhanced. The interviews will be conducted by the researcher. The interviews will be conducted in English. Interviews will be voice recorded, and later typed to be studied. Participation is voluntary. If you wish to withdraw from the study at any time, or wish to withhold information, you can do so without explanation.

4. RISK AND DISCOMFORT INVOLVED

Possible risks for participants are emotional discomfort. You will be free to stop the interview at any time should you find it difficult to talk about situations in which your professional dignity was violated.

5. POSSIBLE BENEFITS OF THIS STUDY

A possible benefit of participating could be an opportunity to talk to somebody who is interested in your experiences.

6. WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the interview without giving any reason. Your withdrawal will not affect you in any way.

7. HAS THE STUDY RECEIVED ETHICAL APPROVAL?

This study received written approval from the Research Ethics Committee of the Faculty of Health Sciences at the University of Pretoria and the Steve Biko Hospital management. Copies of the approval letters are available if you wish to have one.

8. INFORMATION AND CONTACT PERSON

The contact person for the study is Mrs Christelle Froneman. If you have any questions about the study please contact her at (071557 787). Alternatively you may contact her supervisor Prof Neltjie van Wyk at cell 082 776 1649.

9. COMPENSATION

Your participation is voluntary. No compensation will be given for your participation.

10. CONFIDENTIALITY

All information that you give will be kept strictly confidential. Once the information has been analysed no one will be able to identify you. Research reports and articles in scientific journals will not include any information that may identify you.

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the person asking my consent to take part in this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way.
I have received a signed copy of this informed consent agreement.

Participant's name …….....(Please print)

Participant's signature: .....…… Date.....

Investigator's name .....……...(Please print)

Investigator's signature .....…… Date.….....

Witness's Name .....…….....(Please print)

Witness's signature .....……...Date.….....

ANNEXURE D: INSTRUMENT FOR DEMOGRAPHIC INFORMATION, MAIN AND PROBING QUESTIONS

Demographic information

Age: .....

Time involvement in caring for maternity patients in Steve Biko Hospital: .....months

Ward: ……

Academic qualifications: ……

Professional qualifications: ……...

Main question

How can the professional dignity of midwives in an academic tertiary hospital be enhanced?

Probing questions

NB!! This is not a questionnaire. These questions will only be asked when necessary and not in a specific manner. The researcher will only use questions when participants find difficulty to tell about the experience.

What will make you feel that you are respected as a midwife by hospital management?

What will make you feel that you are respected as a midwife by the obstetricians?

What make you feel that your professional dignity is violated?

What are your experiences regarding the acknowledgement of your knowledge and skills by the obstetricians?

What are your experiences regarding the acknowledgment of your knowledge and skills by hospital management?

What support is needed from hospital management to enhance the professional dignity of midwives in your hospital?

What support is needed from obstetricians to enhance the professional dignity of midwives in your hospital?

ANNEXURE E: UNIVERSITY OF PRETORIA DECLARATION OF ORIGINALITY

This document must be signed and submitted with every
essay, report, project, assignment, dissertation and/or thesis.

Full names of student:
Christelle Froneman

Student number: u24132162

Declaration

1. I understand what plagiarism is and am aware of the University's policy in this regard.
2. I declare that this ……dissertation… (e.g. essay, report, project, assignment, dissertation, thesis, etc.) is my own original work. Where other people's work has been used (either from a printed source, Internet or any other source), this has been properly acknowledged and referenced in accordance with departmental requirements.
3. I have not used work previously produced by another student or any other person to hand in as my own.
4. I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.

SIGNATURE STUDENT: Christelle Froneman

C Froneman

ANNEXURE F: EXAMPLE OF INTERVIEW AND FIELD NOTES

In phenomenological research, data is also collected in the form of field notes. Verbal information is one of the types of information that can be collected. The other type of information is based on non-verbal information (Botma et al. 2010: 217). According to Polit & Beck (2012: 549) reflective notes can be divided into methodological notes, theoretical notes and personal notes. Methodological notes provide guidance and strategies on what was observed, forming thoughts and tactics for different situations. Theoretical notes are based on the thoughts and understandings of the researcher as situations are explored. The last part of reflective notes is personal notes. These are the researcher's feelings, emotions and conclusions that arise during the interviews that are bracketed.

Methodological notes: With prior interviews it was noticed that the participants were unsure what was wanted when the research question was asked and that more information was gathered when they were asked about their experiences and then to correlate these experiences with how they think midwives professional dignity could be enhanced.

Theoretical notes: The participants that were selected were midwives who did not have advanced midwifery. The participants had at least a year experience in this setting. It was noticed that the newer the participants had less experience concerning the experiences of their professional dignity being influenced in the working environment. The midwives who were given more authority or responsibility, where they received recognition, were also more content with the experiences concerning their professional dignity than those who were there for a longer time but had not really been given recognition for their contributions within this working environment.

Personal notes:
As being a member of this specific population where the participants were selected it was important not to influence the participant's answers before or during the interview.

Interview sample:

Researcher: How you think your dignity has been violated …, by management, by doctors and by work colleagues and then how you think that we can enhance the professional dignity of the midwives?
Participant 9: Um, as a midwife working in maternity, we're working with a variety of team members of the other, what do you call, the multi-disciplinary team, so, I have personally encountered moments where I've felt that my dignity was like, taking down a lot. For instance, ah, mostly it will be coming from the, the medical doctor's side, where they don't see you as a profession, within their own... a professional within their own profession, most of the time.

Participant 9: Eh, I don't, I don't know, it's like they do not understand that we are, as midwives, professionals in, you know, in our own cases. Where they'll just carry out orders of which you are holding a qualification of a midwife, and you are taught what is wrong and what is right and you have protocols that guide you into doing certain things. But if a doctor would make orders that goes against your protocol, your guidelines as a midwife, or rather as an advocate for a patient, and should you correct that or make a suggestion, in a very professional manner, or even, not even telling them what to do, but suggesting in a professional way, they just don't want to hear it. You do not tell them anything. They are the doctors, and they make the order, you just follow the order. They expect you to follow orders blindly (Participant had an expression and tone of disbelief while saying this). Where else, unfortunately, we have regulations guiding us and who have SANC to answer to, otherwise, you know, you are at risk of losing your epaulettes. And, what, what really, I would say, crushed my dignity, at most moments, is when I approach them in, as I said earlier, a professional manner, and they will just go out of the roof, especially in front of patients, yes. Not just looking at the medical doctors, but also my colleagues, you know, fellow midwives or nurses, whereas people I always feel that, you... we don't always know everything. We learn every day…

I remember very well that the unit manager was agreeing with ah, me and the rest of the team, regarding the protocol.

Our top management, which the unit manager reports to, they also knew what is, ah, what is the right thing to do within the scope of practice as a midwife. After the issue was brought forward to the consultants and the registrars and the interns, in the meeting, everyone is there. The, ah, the top management of the nursing said, if a medical consultant orders specific things to be done, to the patient or for the patient, like a prescription of some sort, then, you do it blindly (Participant had an expression and tone of shock and disbelief while saying this).

Researcher, personal note: There was total shock at hearing this, that management would be willing to risk a situation that could possibly be harmful to the patient, it was important not to show emotion at this time that could influence further discussion.

Participant 9: Eh, I'll, that day, it was… I was just... I, I don't know how to explain it, I will never forget that day. Because they know what is right and what is wrong, but they said it in front of interns, in front of registers, in front consultants. Listen here Sisters; if a consultant orders Pitocin, augmentation of labour, to be done on a grand multipara, or twin pregnancy, then you do it. Top management, nursing management in a big hospital like this, where does that leave you? You can imagine how you as a mere midwife, who's working in labour word. You, you are powerless, you know. Now it is like you don't know what you are about in this field, what you are supposed to do, because you've got protocols and you've got management. So ja. So I think for us to maybe um, deal with such instances, is if we, if we hold meetings, just like that meeting that is held on a weekly basis, the only things that are discussed in that meeting, are, patient cases, diagnosis, how they were managed and all that. Nothing regarding the team as a whole, you know, the relationships we have ah, amongst each other, how, how, how, how, the team is like in the wards. Is there people who are having specific problems that they would like to raise? You know, such meetings being held in a more professional manner and not being taken personally, because they should be viewed as a way to rather create a strong bond as a team, so that we, we become a stronger team that works together, at the end of the day for the patient's benefit.

Researcher, personal note:

This was a very interesting idea on creating teamwork between the health team.

ANNEXURE G: REFLECTIVE JOURNAL

Date: 23 July 2016

First entry:

Final permission was received from the hospital and the Faculty of Health Sciences Research Ethics Committee of the University of Pretoria to conduct research on the enhancement of the professional dignity of the midwives within the academic tertiary hospital. The first appointment was made with a midwife in the antenatal ward for the 27th July.

The following inclusion criteria are applicable:

- The participants should be midwives.
- They should have worked for at least one year in the antenatal, postnatal and delivery rooms

Only one exclusion criteria is applicable:

- Advanced midwives will not be included as their practice differs from that of midwives.

The reflective journal is used in phenomenological research to ensure that bracketing is applied to fully to exclude bias. The reflective journal is used to reflect on own perspectives regarding the enhancement of the professional dignity of midwives in an academic tertiary hospital and to put own perspectives on hold during data collection and analysis.

One question will be asked: **How can the professional dignity of midwives in an academic tertiary hospital be enhanced?**

Should there be midwives who do not understand what is meant with professional dignity, a brief explanation will be given. A list of possible probing questions will be used should it be necessary to ensure that a rich description of the phenomenon is

obtained (refer to Annexure D). The probing questions will only be asked when necessary and not in a specific order. It is not a questionnaire nor is it an interview guide. Open questions will be used to encourage the participants to fully describe their perspectives of how to enhance professional dignity.

Personal experiences and views on enhancing the professional dignity of midwives in an academic tertiary hospital:

The researcher's personal experience is that there are quite a few times where her professional dignity was degraded. This happened often when the doctors as well as other work colleagues did not recognise and acknowledge my training and practical experience. The work colleagues telling you in front of others and the patient that you are wrong, just because they do not agree with your assessment, this severely degrades your professional dignity because the patient will wonder how they can trust you. Here the approach was incorrect; if the colleague did not agree with your findings do not say so in front of others where humiliation takes place in such an instance, talk to that person in private. If no humiliation takes place the person's professional dignity will be upheld.

As a midwife your duty is to ensure that the mothers and infants have a good obstetric outcome. There is a need to advocate for the patient and render care to ensure good obstetric outcomes. If this care and advocating for patients is not appreciated, feelings that you are not needed or important in the care of the patients, leads to feelings of worthlessness and this also degrades you're professional dignity. When you feel that you are needed and wanted, you're professional dignity will be enhanced. If there is a shortage of stock or staff you as the midwife, feels that you cannot render effective care and thus feels that you are not rendering dignified care to the patient.