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**USING A CONSENSUS METHOD TO PROMOTE PROFESSIONAL
CONDUCT IN MIDWIFERY IN A SOUTH AFRICAN CONTEXT**

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ABBREVIATIONS

Abbreviation	Meaning
ICM	International Confederation of Midwives
MDG	Millennial Development Goal
NDoH	National Department of Health
NGT	Nominal Group Technique
SANC	South African Nursing Council
SDG	Sustainable Development Goals
UN	United Nations
WHO	World Health Organization

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DECLARATION

I hereby wish to declare that this dissertation “**Using a consensus method to promote professional conduct in midwifery in a South African context**” is genuine original work done by me under the guidance of my supervisors Professor Carin Maree and Doctor Mariatha Yazbek at the University of Pretoria Nursing Department.

Naomi Hattingh

ABSTRACT

USING A CONSENSUS METHOD TO PROMOTE PROFESSIONAL CONDUCT IN MIDWIFERY IN A SOUTH AFRICAN CONTEXT

ABSTRACT

Aim

The aim was to obtain consensus on how professional conduct can be improved in midwifery.

Background

Although a decrease in maternal mortality is seen in South Africa, it is still unacceptably high in comparison with first world countries. The aim is to reduce maternal deaths to 100 per 100 000 deaths by 2030. The role of midwives in the care of mothers and babies has been recognised worldwide and therefore they also play a crucial role in the reduction of maternal deaths. Programmes have been rolled out to ensure that midwives are skilled and knowledgeable. However, it seems that professional conduct is a contributing factor in maternal mortality and needs to be improved in order to reduce maternal death. Therefore, the goal of the study was to reach consensus on how professional conduct can be improved.

Methods

The methodology utilised was a consensus method, namely the nominal group technique. The question was asked; "How can professional conduct be improved in South Africa?" Three nominal group sessions were scheduled consisting of midwives of different age groups, and years of experience working in any context of midwifery care in South Africa. Thirteen midwives participated and generated 19 themes that were finally put into two main themes. Data collection and analysis were done simultaneous.

Findings

Two main themes emerged: Basic education and training and work environment. Basic education remains a high priority, but needs to include more aspects focused on interpersonal skill, such as communication, stress management, team work, compassion, attitude and leadership. It also needs to focus on a selection process that evaluates character to ensure that the most suitable candidates are selected.

The work environment also plays a significant role in the professional conduct of midwives. Excessive workload, lack of staff, poor work environment and limited support from management are some of the aspects that make it difficult for a midwife to be kept accountable. This difficult work environment causes feelings of stress and guilt and corrodes the motivation and work satisfaction of midwives. Furthermore, conflict between what is expected of a midwife in a professional sense and what is allowed in practice causes confusion, specifically in newly qualified midwives. In hospital settings the practice is task-orientated and doctor-centred, moving away from a professionalism that is autonomous and allows for decisions to be made on needs and care of patients. Often company values will differ from the midwife's focus on patient-centred, individualised care to a bigger focus on productivity and financial efficiency.

Conclusion

The recommendations made focused on education, clinical practice and research development. Apart from the already existing curriculum that includes professional practice, it is important to include extensive modules on the development of interpersonal skills such as communication, team work, stress management and leadership. Clinical mentors are needed to guide students and demonstrate ethical principles and interpersonal skills. Recommendations for clinical practice include the improvement of clinical facilities with sufficient stock and equipment so that students can learn, but also for the best care of patients. To create a culture of excellence, practice must ensure clear guidelines on responsibility, well established processes for accountability and an environment that allows midwives to render safe and compassionate care.

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION

Globally there has been an increased focus on the health and well-being of mothers and babies. With the Millennium Development Goals (MDG) (United Nations 2015:3) not been reached and replaced by the Sustainable Development Goals (SDG) (United Nations 2015:3), it is clear that there is still a lot to be done to improve care of mothers and babies.

It has been widely recognised that there is a link between better outcomes for mothers and babies when they are cared for by skilled, competent midwives (World Health Organization 2013:804). Midwives are health care professionals trained to care for families from pre-conception to post-natal care (Lockey 2013:1073). Competence includes a combination of knowledge, skills, values and attitudes. Except for midwives being able to perform certain tasks, it is also necessary for them to work within a certain set of ethical and professional values (World Health Organization 2011:5). Patients must be the highest priority of every midwife and need to be cared for in a respectful and dignified way. Midwives need to be open and honest, following the highest standards in meeting the needs of patients (Woogara 2011).

Professional conduct is crucial in the care of patients to ensure a high standard of care and safeguard patients against harm. Professional values strengthen professional identity which guides the professional conduct of midwives (Poochangizi, Farokhzadian, Abbaszadeh, Mirzaee, Borhani 2017:1). Professional conduct is to follow a specific code, standard of practice and conduct, which includes a set of ethical values to safeguard patients that are cared for by midwives (Woogara 2011).

1.2 BACKGROUND AND RATIONALE

Nurses and midwives form the biggest part of the health personnel worldwide, specifically in low-income countries where there is tremendous pressure due to the burden of diseases and the shortage of trained medical staff (Ng'ang'a 2015:1). They play a crucial role to ensure the best outcomes for mothers and babies. Unfortunately, there is evidence of verbal and physical abuse, lack of confidentiality and privacy (Amnesty International 2014:24–30; Bohren, Vogel, Hunter, Lutsiv & Makh 2015:641; Honikman, Fawcus & Meintjes 2015:284; Human Rights Watch 2011a:1; Miller & Lalonde 2015:549). If care is not rendered within the prescribed ethical value system and proper professional conduct, it may contribute to substandard care, resulting in poor maternal and child outcomes (Bohren *et al.* 2015:550).

According to the World Health Organization (WHO), 830 women die daily of avoidable causes related to pregnancy and childbirth. Of those deaths, 99% occur in developing countries. Although there has been a worldwide decrease of 44% in maternal deaths during the period 1990 to 2015, the maternal mortality rate remains excessively high in sub-Saharan countries (World Health Organization 2017). The country with the highest rate is Sierra Leone at 1360 deaths per 100 000 (World Bank Data 2017). In South Africa there has been a steady decline in maternal deaths, from 188/100 000 in 2008–2010 to 154/100 000 in 2011–2013 (Department of Health 2013a:v) and 134/100 000 in 2017 (Department of Health 2017:iii). The aim is to reduce maternal mortality to less than 100/100 000 by 2030 (Department of Health 2017:iii).

Several contributing factors to maternal mortality have been identified. Schoon and Motlolometsi (2012:785) describe the factors as being training done in professional silos with medical practitioners heading the team, which leads to a diffusion of responsibility and a tendency to shift blame in cases of complications. Other reasons indicated are lack of staff, equipment and stock.

Data from the 2017 Saving Mothers Report indicate the reasons mostly relate to poorly trained doctors and midwives and an unequal distribution of professionals in the health care system. Furthermore, inter-facility transport remains a challenge and needs to be addressed. (Department of Health 2017:v). Despite efforts to increase facility-based deliveries by skilled professionals, the rate of adverse events is still high. International organisations and several studies reported on the lack of care, verbal and physical abuse during labour, forced interventions and discrimination (Human Rights Watch 2011a:33; Bohren *et al.* 2015:549; Amnesty International 2014:24; Honikman *et al.* 2015:284; Ng'ang'a 2015:2), as well as disrespectful/abusive care during childbirth in facilities (DACF) (Miller & Lalonde 2015:550).

Quality of care does not only refer to skills and knowledge, but considers all rights of a patient. Care must be rendered on a basis of ethical morals and values. What has been done to improve outcomes for mothers and babies? Since 2000, with the acceptance of the Millennium Development Goals, 421 million people have been lifted out of extreme poverty and more than 21 million lives have been saved, mostly in the developing countries (McArthur & Rasmussen 2018:132). In South Africa there has been an increased focus to improve maternal and child health, especially to reduce the high rate of maternal deaths, including the following:

- In 1998, the first *Saving Mothers: Report on confidential inquiries on maternal deaths in South Africa* was published, with an increasingly positive effect on improving the health care for pregnant mothers. Thereafter six reports were published, one every

third year, describing possible causes of maternal deaths, disease patterns, midwifery and medical care rendered and recommendations on how deaths could have been avoided (Department of Health 2013a:iii).

- The National Roll-out Programme with the introduction of HAART (Highly Active Antiretroviral Therapy) programme, led to successful testing and treatment of pregnant women and decreased the numbers of deaths due to infections (Department of Health 2013a:vi).
- The National Maternity Guidelines for District Hospitals and Clinics were published (Department of Health 2013a:15), including the Essential Steps in the Management of Common Causes of Maternal Deaths (Department of Health 2011-2013a:13).
- To improve antenatal care, the University of Pretoria and the Medical Research Council led a programme called Basic Antenatal Care (BANC) (Sellers 2018:224). Early antenatal care is very important to identify risks in pregnancy, determine the growth and health of the mother and baby and address life style issues to prevent complications (EBCOG Scientific Committee 2015:5).

All these efforts had a positive effect that is visible in the decline of maternal deaths (Department of Health 2013a:v). Current statistics show that out of the 92% of patients who attend antenatal clinics, 87% give birth in facilities provided by government (EBCOG Scientific Committee 2015:6).

Despite the mentioned progress, the Human Rights Watch brought out a report in August 2011 on the physical and verbal abuse that drive patients away from health institutions and put mothers and babies at high risk of complications and death (Amnesty International 2014:24). To address the issue of verbal and physical abuse in some institutions, the WHO has issued a statement for the prevention and elimination of disrespect and abuse during childbirth (World Health Organization 2016). The UN has released a report on technical guidance on the application of a human rights-based approach to reduce maternal abuse. (United Nations 2012).

The role of the midwife in all these efforts to improve the outcomes of mothers and babies are undeniable. The scope of practice of a midwife is broadly described by the International Confederation of Midwives (ICM 2014:1–3) aligned with the World Health Organization (WHO) (WHO 2016) and United Nations (UN) (UN 2015). They furthermore define the standards and professional guidelines for midwives worldwide and provide guidance in the development of midwifery education and competencies to ensure safe practice of midwives (International Confederation of Midwives 2014:1).

The unique role of the midwife is to “promote, maintain, restore and support the health status of a women and her baby during pregnancy, labour and puerperium” (Department of Health 2013b:13). This implies the necessity of a solid base of scientific knowledge and well-developed skills. However, skills and knowledge as described by the ICM have an ethical base: respect and dignity for all women, irrespective of culture, education or background, and form the foundation of midwifery care. Midwives need to partner with women, build relationships of trust, and in doing so, take responsibility for care rendered (International Confederation of Midwives 2014:1).

Since the 1970s, midwives recognised the link between compassionate care and better maternal outcomes. An increased focus on cultural sensitivity, allowing for birth companions, assistance with breastfeeding and the treatment of patients with dignity and respect is necessary, paving the way for better relationships and trust (Miller & Lalonde 2015:549). Since 2000 there has been an increased focus on the impact of human rights violations in maternal health care and the link it has to poor maternal outcomes. A study done in the Dominican Republic indicated that, despite well-equipped institutions with skilled and knowledgeable midwives, good transport and 98% facility deliveries, they still had high rates of maternal mortality. They found hospital care with dignity and respect for patient privacy was neglected and informed consent was not part of practice (Miller & Lalonde 2015:550).

A study done by Amnesty International in South Africa to determine the reasons for patients not attending antenatal care found that unethical and unprofessional behaviour of midwives play a definite role. Patients were forced to do HIV testing and if they did not test they were not allowed to see the doctor and would be sent home without care and counselling. They were denied the rights of informed consent, the right to decline testing, and the right of medical care. They also were afraid to go for testing because the nurses at the clinic would discuss results with others. In this regard they were discriminated against and denied the right of privacy and confidentiality (Amnesty International 2014:24). Furthermore, this poor ethical behaviour continued into intrapartum care with evidence of physical and verbal abuse (Human Rights Watch 2011a:33). The lack of ethical and professional conduct was found to be a strong factor in maternal mortality (Miller & Lalonde 2015:549).

To ensure better maternal outcomes, it is important to consider the effect of professional conduct in midwifery care. Care rendered needs to be done in the context of human rights without consideration of race, age, sexual orientation, culture and gender. Ethical principles (veracity, justice, benevolence, non-maleficence, caring and autonomy) must be interwoven and must determine ethical decisions made. Professional conduct of nurses and midwives is determined by these decisions and has a direct influence on the relationship between the

nurse and patient, the multi-disciplinary team and members of the health care system (South African Nursing Council 2013a:4).

Midwives are guided by the scope of practice stated by the South African Nursing Council (SANC), to “protect the human rights of individuals and groups within the health care environment, practise midwifery in an ethical manner, create and maintain an enabling environment for ethical practice and assume full responsibility and accountability for actions and omissions” (Department of Health 2013b:14). This needs to be practised in the context of present best practices and available information. Irrespective of the environment and its challenges, choices and practices must be in the best interest of the mother and baby (Iliadi 2010:131). Moral responsibility for choices and actions is an integral part of professional practice. For any system to succeed, it is very important for each individual to take ownership of responsibilities and be accountable for each decision and action taken (Aveling, Parker & Dixon-Woods 2016:220). If we want to make a difference in maternal care, it is of utmost importance to ensure that midwives conduct themselves in a professional manner according to prescribed ethical guidelines.

Professional conduct and the code of ethics are integral parts of nursing training. The challenges are that in a multi-cultural setting, groups are formed by people of different walks of life with their own values, ideas and concepts of right and wrong (Plante 2015). This is true in nursing too. Nurses enter the profession with their own unique set of morals and values, religious beliefs and perception of the world. However, they are influenced by the people who train them, but even more by the models they see in practice. Albert Bandura suggested that we behave in a certain way because that is what we have seen. He also believed that people have the ability to understand that their behaviour has consequences and know when there is a need to change (McLeod 2016).

Professor Denny, Head of the Department of Obstetrics and Gynaecology at the University of Cape Town, described the occurrence of disrespect and abuse as “one of the world’s great disgraces” (Honikman *et al.* 2015:284). It is therefore of utmost importance to answer the question posed by this research on how to improve the professional conduct of midwives.

1.3 PROBLEM STATEMENT

Maternal mortality is a worldwide problem. According to the WHO, 830 women die daily. These deaths, of which many can be avoided, occur mostly in sub-Saharan countries (World Health Organization 2017). Several contributing factors have been identified and systems developed to improve services to pregnant women. Although progress has been made

worldwide to decline maternal mortality rate, it is still high in sub-Saharan countries, associated with multiple reasons, including the conduct of nurses and midwives. Evidence of unethical and unprofessional conduct in maternity care remains a concern. Apart from a lack of proper assessment, delay in referral and not following protocols, there is evidence of physical and verbal abuse. Several studies have been done referring to these institutions as disrespectful or abusive care during childbirth in facilities (Miller & Lalonde 2015:549; Bohren *et al.* 2015:285; Amnesty International 2014:33; Bowser & Hill 2010:3).

The midwife plays a vital role to ensure that the Sustainable Development Goals are reached, specifically to decrease the number of maternal deaths. The midwife's knowledge and skills are very important (International Federation of Gynaecology and Obstetrics 2015), but the role that ethical and professional conduct may play in the drive to improve the quality of midwifery care in South Africa is crucial (Honikman *et al.* 2015:284). To have skills and knowledge is of the utmost importance, but these skills and knowledge can only be effective when done within a framework of ethical and professional conduct. Despite a profession with clear ethical and professional guidelines (South African Nursing Council 2013a:14) and a constitution with clearly defined human rights (Department of Justice 1996), it seems that these very aspects remain a challenge (Amnesty International 2014:33; Human Rights Watch 2011a:2).

Many studies have been done to prove that verbal and physical abuse do exist (Amnesty International 2014:33; Bohren *et al.* 2015:549; Honikman *et al.* 2015:284; Human Rights Watch 2011a:24). Some focused on the possible reasons and underlying motivation for the unethical behaviour in midwifery care, but it is very important to find ways on how to improve professional conduct in midwifery, which was the focus of this study.

1.4 SIGNIFICANCE OF THE PROPOSED STUDY

The midwife plays a vital role to ensure that the Sustainable Development Goals are reached, specifically to decrease the number of maternal deaths (International Federation of Gynaecology and Obstetrics 2015) using her knowledge, skills and professional conduct to improve the quality of midwifery in South Africa (Honikman *et al.* 2015:285). By using a nominal group technique, consensus is expected to be obtained on priorities from experts in the field of midwifery to improve professional conduct in midwifery. This information is expected to add to the body of knowledge and provide a basis on which to build strategies to improve the professional conduct of midwives. Consciousness might be raised on the equal importance of knowledge and skills, health care system strategies and guidelines and the improvement of professional conduct. A summary of the study might assist nursing

administrators, as well as midwifery educators to implement strategies on how to improve professional conduct of midwives.

1.5 RESEARCH QUESTION

The research question was therefore: How can professional conduct in midwifery be improved?

1.6 AIM

The aim was to obtain consensus on how professional conduct can be improved in midwifery.

1.7 CONCEPT CLARIFICATION

The following concepts are of importance to this study:

1.7.1 PROFESSIONAL CONDUCT

According to the Cambridge Dictionary, 'professional' is defined as following a career that needs very particular and distinctive training in order for that person to be able to do what is required (Cambridge Dictionary 2018). In the context of the study, 'professional' relates to a nursing practitioner. Conduct is defined as "... management of an activity or behaviour, to carry out a task" (O'Neill & Summers 2016:170). In the midwifery context, midwives' behaviour must be guided by the ethical values clearly defined by the South African Nursing Council (South African Nursing Council 2013a:5). The code of ethics is based on ethical principles that are universal and determine the professional conduct of nurses and midwives. The following principles are included: justice, veracity, non-maleficence, beneficence, fidelity, altruism, autonomy and caring (South African Nursing Council 2013a:4). In midwifery, the focus is on a relationship of respect, dignity and trust irrespective of culture, age, economic status or education (International Confederation of Midwives 2014:1). It is the duty of the midwife to be accountable for the integrity, with which she will be able to answer to what has been done, assuming that the account will be based on truth and honesty (Department of Health 2013b:14). Furthermore guided by ethical values "the midwife is responsible to give the necessary support, care and advice during pregnancy, labour and postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and infant. This care includes preventative measures, the promotion of normal physiologic labour and birth, the detection of complications the accessing of medical care or other appropriate assistance and the carrying out of emergency measures" (International Confederation of

Midwives 2010:2). This description is accepted to represent the meaning of 'professional conduct of midwives in this study.

Unprofessional conduct means conduct which, regarding the profession of a practitioner, is improper, dishonourable, disgraceful or unworthy (South African Nursing Council 2018). Examples of professional misconduct are as follows: Failure to document all aspects in patient care and to keep all legal documents; improper disclosure of confidential information of a patient; neglect or delay in obtaining medical assistance for a patient; failure to prevent harm to a patient; theft from a patient; physical, verbal or sexual assault; forcing a patient to sign consent; attempted murder or arson; or leaving a patient unattended (South African Nursing Council 2018).

1.7.2 MIDWIFERY

In South Africa the title 'midwife' may only be used by/for a person who has met the following requirements:

- She has met the educational requirements for registration as a midwife.
- She has acquired and maintains competence to practise as a midwife.
- She is registered as a midwife in terms of section 31(1) b of the Nursing Act 33 of 2005 (Department of Health 2013b:13).

The midwife is a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and infant (International Confederation of Midwives 2010:2).

In this study the concept midwife is used to refer to a midwife rendering a midwifery function in any health care service in the South African context and is registered with SANC.

Midwifery refers to the care of women during all phases of pregnancy and care of the newborn baby after birth. The focus is to prevent complications, identify risks and abnormalities, and refer for medical help when needed and management of emergencies (World Health Organization 2017). According to the Merriam-Webster Dictionary, midwifery is the profession of assisting with childbirth (Merriam-Webster Dictionary 2018). In this study midwifery includes all aspects of care rendered to mothers and babies and in all settings where care is rendered.

1.8 PHILOSOPHICAL ASSUMPTIONS

The study departed from the assumptions of pragmatism. “Pragmatism is based on the principle that the usefulness, workability, and practicality of ideas, policies, and proposals are the criteria of their merit” (Thayer & Rosenthal 2018). The focus fell on action and understanding. The process is also driven by the question posed in the research (Polit & Beck 2017:604). “There is no distinction of meaning so fine as to consist in anything but a possible difference in practice” (Thayer & Rosenthal 2018). In this study the focus is on the reality of midwifery practice as perceived by midwives.

1.8.1 ONTOLOGICAL ASSUMPTIONS

The ontological assumption is that there is a reality which is influenced by natural processes, causing certain outcomes (Polit & Beck 2017:14). Midwifery is a profession that focuses on the care of women during all phases of pregnancy. The combination of knowledge and skills based on professional and ethical conduct ensures the best outcomes for mothers and babies, and so every midwife’s focus should be for the best interest of the patient. Professional conduct should be guided by the ethical principles of autonomy, beneficence, non-maleficence, justice and veracity (Mashigo & Mathibe-Neke 2016:5). The reality though is that there is often a lack of professional conduct in midwifery that needs to be improved. Consensuses from experts in midwifery care were therefore deemed valuable to determine what can be done to improve professional conduct in midwifery.

1.8.2 EPISTEMOLOGICAL ASSUMPTIONS

The epistemological assumption relates to the interaction between the researcher and those being researched (Polit & Beck 2017:14). Midwifery is a profession with a complex and diverse field of knowledge to be able to care for a patient effectively during pregnancy. Professional conduct is a crucial, but abstract concept in the delivery of midwifery care. Interaction, discussion and debate among midwifery experts were considered as important to be used to reach consensus on how professional conduct can be improved in midwifery.

1.8.3 METHODOLOGICAL ASSUMPTIONS

Pragmatism is mostly used in mixed methods research. The research question must drive the inquiry and is more important than the method used. It is what the name suggests: a practical or the most practical and workable method, the practical imperative of the “dictatorship of the research question” (Polit & Beck 2017:739). Therefore, a nominal group technique was used to gather rich data from a group of experts in the midwifery field.

1.9 DELINEATION

Data collection was done in Gauteng Province during three different group sessions. Midwives involved in different areas of midwifery care were invited, including the private and public sector, and also independent midwives. Though representation from different sectors was achieved, the sample size was small, and verification with a bigger sample is recommended to increase the potential of generalising the information.

1.10 RESEARCH DESIGN

1.10.1 TYPE OF RESEARCH DESIGN

Consensus research was used in this study. Consensus methods have been developed during the past 60 years to agree or assist in decision-making on topics that are not well researched or that are controversial (Waggoner, Carline & Durning 2016:663). The sharing of ideas among experts increase ownership and might lead to changes in clinical practice (Harvey & Holmes 2012:188).

There are three commonly used consensus methods, namely nominal group technique, consensus development panels and the Delphi technique, all three of which have been proven highly effective in health care research (Waggoner *et al.* 2016:663). In this research the nominal group technique was used to answer the research question.

1.10.2 METHODOLOGY

The nominal group technique provides an opportunity for experts to have an individual input but also an opportunity to listen and generate ideas in a group of experts with equal interest regarding the research question. The common goal is to create ideas, generate solutions and establish priorities (McMillan, King & Tully 2016:656). This was also the case in this study.

1.10.3 CONTEXT

In this study midwifery referred to antenatal, intrapartum, postnatal and neonatal care in the public and private sectors, as well as independent midwifery practice. Reference to the professional conduct of midwives was made in general and did not refer to a specific facility.

1.10.4 POPULATION AND SAMPLING

The population constituted of all experts in the field of midwifery working in different sectors that rendered care in the Gauteng province. Inclusion criteria for participants were as follows: midwives who were task-orientated, highly motivated and known as role models in professional positions and participation in professional bodies; midwives with at least five

years' experience in a maternity unit in public or private sector, private practice or primary health care clinics; and midwives who participated voluntarily. Recruitment and sampling are discussed in more detail in Chapter 3.

1.10.5 DATA COLLECTION AND ANALYSIS

With the nominal group technique, data collection and analysis were done concurrently. The process was designed by Delbecq and Van de Ven and consists of four stages: silent generation, round robin, clarification and voting (ranking or rating) (Van de Ven & Delbecq 1972:338). The execution of the process in this study, as well as the literature control to confirm or disconfirm the findings are discussed in detail in Chapter 3.

1.11 TRUSTWORTHINESS

The main purpose of a nominal group technique is to gather data in a structured fashion on a specific topic from a group of experts who are interested and focused and share a commitment and passion to have the question answered. This method is reliable to collect data with the purpose to reach consensus and prioritise problems, and in doing so, might lead to change in practice and policy (Harvey & Holmes 2012:188). However, it is crucial to ensure the study is not accused of "sloppiness", undisciplined or subjective (Lincoln & Guba 1985:289).

In an article written by Pandey & Patnaik, the generally accepted concepts of trustworthiness are discussed as follows (Pandey & Patnaik 2014:5743):

- **Credibility**

Credibility indicates whether the study conveys the truth and if it conveys the actual reality of the situation (Pandey & Patnaik 2014:5747). The selection of participants must focus on their insight and expertise of the topic. Expert participants can provide insightful and focused information (McMillan *et al.* 2016:659).

These participants were selected from different midwifery settings to ensure a comprehensive insight. The nominal group process was driven by an objective and knowledgeable facilitator, not only on the topic, but also on the nominal group process. The researcher was not involved in the process itself, but was an observer, and as such did not have any influence on the outcomes of the research question and therefore eliminated bias.

The data between the three groups were also triangulated. Three groups were held in three different settings to ensure the inclusion of experts from different fields of expertise. The final

results of the nominal group technique were measured against data found during a literature search and therefore ensured the objectivity of the research.

- **Transferability**

Transferability refers to the extent to which the study can be applied in a different context (Pandey & Patnaik 2014:5749).

In this study, selection of the participants was documented in detail. Observations of participant's reactions and participation were captured during the nominal group. Documenting the processes that have been followed makes it possible for a reader to decide whether the research findings can be transferred to other settings.

- **Dependability**

Dependability refers to whether the findings would be consistent should the study be repeated (Pandey & Patnaik 2014:5749).

To enhance dependability, clear guidelines set out for nominal group technique were followed. The question was clear and concise and the groups were constantly reminded to remain focused on the question. Thick description of the exact methodology was captured and made it possible for the research to be repeated.

- **Confirmability**

Confirmability indicates whether the findings are due to the insight of the participants (Pandey & Patnaik 2014:5750).

A knowledgeable and objective facilitator was used to ensure a process whereby the participants were allowed to share their views. The researcher did not participate in the discussions and the facilitator only guided and kept the focus during discussions. Equal opportunity was given to all group members to share and explain insights. The nominal group technique reduced possible negative group influence that might have occurred in groups. It was important to consider which participants to group together in a group. Representation from different settings was enhanced, but the participants in a group had equal authority to prevent any imbalances. To ensure confirmability, all notes, planning of processes, observations and analysis excersises were kept to be audited and a clear step-by-step description of the research was done to ensure transparency of the process.

- **Authenticity**

This aspect refers to the way the researcher has conveyed the truth or reality as experienced by the participants. A text has authenticity when the readers have a sense of what took place during the research study (Polit & Beck 2017:560).

Effort was made by the researcher to convey exactly what happened during discussion of topics and detail was being described. The same wording was used to ensure that no meaning would have been lost during the interpretation of the research findings.

1.12 ETHICAL CONSIDERATIONS

The World Medical Association developed the Declaration of Helsinki in 1964 with the purpose of protecting people during medical research (World Medical Association 2018). The detailed principles on the protection of human subjects of research as discussed in the Belmont report are as follows:

1.12.1 BENEFICENCE AND NON-MALEFICENCE

A very important ethical consideration is the balance between the protection of the participant while maximising the benefit to the same participant without compromising the research results (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979:5).

During this study effort was made to consider the comfort and safety of each participant. Care was taken to select venues that were suitable in terms of safety, comfort and cost, and basic needs were met. The nominal group technique does not pose any physical harm, but participants might feel exposed or threatened during discussion.

Group discussions were led by competent and knowledgeable researchers with the proper training and qualifications. They were also experienced in techniques to ensure that participants have sufficient opportunity to give their input and share their ideas. Group discussions were conducted on an ethical basis of being "value neutral" and so avoided feelings of being criticised or accused. Considering the possibility that participants might feel threatened by status or professional standing, no personal details were shared other than participant names.

The focus of research must be to improve the circumstances for the participants or the communities they represent (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979:5). The participants indicated the sense of value

in participating in the study by playing a valuable role in answering the question, and, in doing so, added value to the community of midwives and the patients they care for.

Research integrity is also very important and beneficial to the research community. Therefore, research integrity should be protected from false information, fabrication or distortion of data or results, plagiarism and financial conflict. Findings gathered during a nominal group session might be very informative and valuable, but it does not necessarily mean that a final solution will be found. It is therefore important to communicate findings objective and truthful.

1.12.2 DISTRIBUTIVE JUSTICE (EQUALITY)

Justice indicates fairness to all participants, communities and to the society as a whole (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979:6).

Participants indicated that participation was of free will and with a belief that they could contribute to science in general, but more specifically to midwifery as their field of expertise. By assisting to answer the question of how to improve professional conduct in midwifery, participants felt that mothers and their babies would receive better care.

1.12.3 RESPECT FOR PEOPLE (DIGNITY AND AUTONOMY)

The rights of the research participants were protected. No mention of personal details was made in the study. Participants were included in the research group in their personal capacity as midwives, and therefore no consent was required from any institutions. However, consent was signed by each participant before the discussions commenced. The process was transparent at all times and a detailed description of the process, the time it would take and the fact that they could leave at any time, was made clear to them well ahead of time.

1.13 CONCLUSION

This chapter provides an overview of the study. In Chapter 2 a comprehensive review of the literature related to the study is given. The layout of the chapters is as follows:

- Chapter 1: Overview of the study
- Chapter 2: Literature review
- Chapter 3: Research methodology
- Chapter 4: Presentation and analysis of the research findings
- Chapter 5: Conclusion and recommendation

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

In the previous chapter, an overview of the study was provided. This chapter describes the findings of a literature search related to the study. This enabled the researcher to establish what research had been done previously and to develop a full understanding of the research being undertaken (Polit & Beck 2017:733). A search for applicable data was undertaken to put the research question into perspective.

It is important to understand the role of the midwife in the care of the patient and the importance of professional conduct with which the care is rendered. To ensure a full understanding of the topic it is also important to understand the factors that might influence professional conduct and the negative effects of unprofessional conduct. The following will be addressed in the chapter: the role of the midwife, professionalism, professional conduct, manifestations of unprofessional conduct, impact of unprofessional conduct and factors affecting professional conduct.

2.2 THE ROLE OF THE MIDWIFE

A midwife is a person who has completed a midwifery education programme based on the ICM Essential Competencies within the framework of Global Standards for Midwifery Education and has acquired a qualification to be registered and licenced to practise midwifery (International Confederation of Midwives 2014:1). The role of the midwife is “to render safe, high quality and individualised care for every woman, every time” (The Royal College of Midwives 2014:4). The midwife plays a pivotal role in the care of pregnant patients and is underscored by the principle that “all women need a midwife and some need a doctor too” (The Royal College of Midwives 2014:5). The scope of practice of a midwife is broadly described by the International Confederation of Midwives (ICM) (International Confederation of Midwives 2010:2) aligned with the World Health Organization (WHO) (World Health Organization 2016) and United Nations (UN) (United Nations 2015). They furthermore define the standards and professional guidelines for midwives worldwide and provide guidance in the development of midwifery education and competencies to ensure safe practice of midwives (International Confederation of Midwives 2010:3-19).

In South Africa the role of the midwife is being described by the South African Nursing Council as to “promote, maintain, restore and support the health status of a women and her baby during pregnancy, labour and puerperium” (Department of Health 2013b:13).

The foundation of midwifery care rests on knowledge and skills, but cannot be maintained without a strong ethical basis. As the role of the midwife described by the ICM has an ethical base, namely respect and dignity for all women, irrespective of culture, education or background (International Confederation of Midwives 2014:1), so is emphasis placed on ethical care as discussed in the ethical code published by SANC (South African Nursing Council 2013a:3). Midwives need to partner with women, build relationships of trust and in doing so, take responsibility for care rendered (International Confederation of Midwives 2010:2; Department of Health 2013b:14).

Since the late seventies, more emphasis was placed on maternal and neonatal outcomes, and several studies were undertaken to determine the possible contributing factors leading to high numbers of deaths. In midwifery care, the link between compassionate care and maternal and neonatal outcomes has been recognised (Miller & Lalonde 2015:549). According to the Respectful Maternity Care Council, disrespect and abuse is defined as “humiliating or undignified” manner in which care is rendered (Manning & Schaaf 2016:1). Several studies indicated the severe impact disrespect and abuse has on the outcomes for mothers and babies (Amnesty International 2014:30-33; Human Rights Watch 2011a:33; Miller & Lalonde 2015:549; Manojlovich & Ketefian 2002:16; Sida-Improving maternal and new-born health by strengthening midwifery 2013).

The lack of ethical and professional conduct leads to mistrust and impact the decision to utilisation of health care facilities, directly influencing the maternal and neonatal mortality rates. It is therefore of utmost importance for a midwife to render obstetric care not only skilfully, but in a relationship of trust and respect.

2.3 PROFESSIONALISM

In order to have a full understanding of the research question, it is important to understand the concept of professionalism. According to the Merriam-Webster Dictionary, professionalism is the conduct that is required from a specific profession and that is characteristic of that profession. It also means to follow a specific career path as a way of earning a livelihood (Merriam-Webster Dictionary 2018). Professionalism can also be defined as a list of responsibilities that needs to be done in a respectful and sensitive way considering the specific needs of the patient, and that exceeds the needs of the health care professional (Muhamad 2009:1). A profession is “a type of work, such as being a doctor that needs special training” (O'Neill & Summers 2016:690). Therefore professionalism refers to a skill, ability or competence to do a certain work. A profession refers to a group of people with these specific skills or expertise.

The criteria for a profession were already described in 1969 by an American researcher, Ward Darley. He stated that a professional person should have a certain level of intellect and educational background to enable him or her to make a professional and moral judgment in a situation and takes responsibility for it. Judgement must be grounded in broad knowledge and wisdom about individual situations and a clear understanding of the impact and consequences of one's actions (Searle 1978:5). These two concepts, profession and professionalism, cannot be separated.

Nursing as a profession has been questioned for several years (Searle 1978:4). Until 1970, nursing was seen as a female work with unclear scientific fundamental guidelines and differences on opinion of what a curriculum should look like. There was a lack of a theoretical and research foundation and therefore nursing could at most be seen as semi-professional (Ghadirian, Salsali & Cheraghi 2014:1). Over the years, the development of nursing courses with strong theoretical and practical components led to professional certification and the recognition of nursing as a profession. Society was led to see nurses as essential health care providers that have the ability to work independently and make decisions, govern themselves and nursing, therefore, can be deemed as a profession (Ghadirian *et al.* 2014:1).

Since then the nursing profession has been well established and regulated by SANC. The function of the regulatory bodies is to ensure that patients are safe and protected, and that standards and education are of the highest quality (South African Nursing Council 2006:7). Professional standards reflect a preferred and attainable level of performance against which a nurse's actual performance can be compared and will guide the clinical practice (Davis 2014).

The scope of practice of nurses and midwives are being described to ensure clear guidelines on the functions of these professionals. Part of the function is also to act when rule and regulations were breached as described in the Nursing Act 33 of 2005 (Department of Health 2013b:3).

Considering the definition of professionalism which refers to conduct and the description of a profession as "... moral judgement at a high level of responsibility" (Searle 1978:5), it is very clear that professionalism does not only focus on knowledge and skills, but has a clear ethical component.

The development of a code of ethics by a profession is essential and proves the acceptance of responsibility (Halldorsdottir & Karlsdottir 2011:807). The ICM developed an international ethical code of conduct with the main purpose to improve the standard of care rendered to

mothers and their babies. They include several aspects of professionalism: midwifery relationships, midwifery practice, professional responsibilities and advancement of midwifery knowledge and skills (International Confederation of Midwives 2008). The South African code of ethics serves as a reminder to nurses and midwives of their responsibility “towards families, groups and communities”. They need to “protect, promote and restore health, to prevent illness, preserve life and alleviate suffering”. These professional duties must be fulfilled based on ethical principles in order to prove their commitment towards people (South African Nursing Council 2013a:6-8).

According to the theory developed by Halldorsdottir and Karisdottir, a midwife’s professionalism is based on five main aspects: caring, competence, professional wisdom, interpersonal competence and professional development (Halldorsdottir & Karlsdottir 2011:806). If this summary of professionalism is accepted as a standard for midwifery practice, it is of great importance to address the concept of professional conduct.

2.4 PROFESSIONAL CONDUCT

The word professional refers to “taking part in activity “(O’Neill & Summers 2016:690) as part of a certain profession, while conduct refers to “... behaviour” (O’Neill & Summers 2016:170). One can gather that professional conduct speaks of itself. If professionalism is being described as caring, competence, professional wisdom, interpersonal competence and professional development (Halldorsdottir & Karlsdottir 2011:807), professional conduct is the way in which these aspects of professionalism have been translated in the clinical practice. According to the scope of practice of midwives, “... midwifery must be practised in an ethical and just manner” (Department of Health 2013b:14).

To ensure better maternal outcomes, it is important to consider the effect of professional conduct on midwifery care. Care rendered needs to be done in the context of human rights without consideration of race, age, sexual orientation, culture and gender. Ethical principles (veracity, justice, benevolence, non-maleficence, caring and autonomy) must be interwoven and will determine ethical decisions made (South African Nursing Council 2013a:3). The professional conduct of nurses and midwives will be determined by these decisions directly and will have a direct influence on the relationship between the midwife and patient, the multi-disciplinary team and members of the health care system.

Midwives are guided by the scope of practice as stated by the South African Nursing Council (SANC), to “... protect the human rights of individuals and groups within the health care environment, practise midwifery in an ethical manner, create and maintain an enabling environment for ethical practice and assume full responsibility and accountability for actions

and omissions” (Department of Health 2013b:14). These needs to be practised in the context of present best practices and available information (Nursing and Midwifery Council n.d.b:9).

The most definite purpose of professional conduct is to safeguard that every mother and her family will be provided with the best care, meaning safe and effective care. This care must be family-centred and personalised, supported by informed consent and involvement in the decision-making process. Professional care will ensure that people are having optimal health and quality of life, ultimately ensuring healthy communities. Professional care will also ensure satisfaction in the health services rendered, and when families feel satisfied with the care rendered they will trust the health care providers and will most likely utilise the services needed during pregnancy and during the child-rearing phase of life (Nursing and Midwifery Council n.d.b:3). Ultimately, better use of resources will be ensured. If not so, they may delay to seek help, which may directly affect their health and the health of their babies (Manning & Schaaf 2016:3; Nursing and Midwifery Council 2015:5).

2.5 MANIFESTATION OF UNPROFESSIONAL CONDUCT

The South African Nursing Council is responsible to set and maintain safe standards and ensure optimal professionalism in midwifery care in South Africa. Therefore a system is put into place whereby the public can lodge complains of unprofessional conduct to the Nursing Council with a promise of investigation into allegations. The following examples of unprofessional conduct are mentioned (South African Nursing Council 2018):

- Failure to give needed treatment
- Failure to document nursing care provided
- Failure to keep personal information confidential
- Neglect to obtain medical assistance
- Failure to prevent injury or accident
- Theft of patients belongings
- Physical, verbal or sexual assault
- Arson or attempted murder
- Patients left unattended
- Misuse of medication
- Forcing a patient to give consent for any procedure.

Unfortunately, the above-mentioned unprofessional conduct has been all too clearly displayed in midwifery care worldwide. Disrespect and abuse of women making use of health facilities during pregnancy and birth is nothing new. This trend has been described

since 1950, but only recently progress has been made to define and document “disrespect and abuse” (Manning & Schaaf 2016:1). According to the Respectful Maternity Care Council, disrespect and abuse is described in terms such as mistreatment, obstetric violence or dehumanised care. In the broader sense, it has been defined as “interactions of facility condition that local consensus judges to be humiliating or undignified” (Manning & Schaaf 2016:1). A 2015 systematic review of 65 qualitative, quantitative and mixed-methods studies developed a model describing seven categories of examples of disrespect and abuse:

- Physical abuse
- Sexual abuse
- Verbal abuse
- Stigma and prejudice
- Failure to meet required standards, e.g. lack of confidentiality and informed consent, painful or excessive procedures, failure to manage pain in an appropriate manner, abandonment or carelessness in management of patients
- Poor midwife-patient relationship
- Failure of system to deliver mandatory supplies, e.g. lack of equipment, poor infrastructure and poorly trained midwives, allowing health care workers to extort and mistreat patients or not to be open and transparent in terms of costs of health services (Bohren *et al.* 2015:32).

A study done by Reed (Reed, Sharman & Inglis 2017:1888) on women’s perceptions of traumatic childbirth came up with four common themes:

- Prioritizing the care agenda: women felt that the agenda of the doctor or midwife always had precedence over the wishes of the patient.
- Discarding embodied knowledge: women felt that their instinct and knowledge of their bodies and what was happening to their bodies were not regarded and they were often demeaned and ridiculed.
- Lies and threats: the most common threat related in the research to get consent from a patient was that the baby would die or come to harm if they did not consent to procedures.
- Violation: non-consensual care had been described in words such as bullying, violated, being choked, and held down by midwives.

However, one must consider the complexity of the phenomenon. Sociological issues such as gender discrimination that places women in an inferior position comparing to men permit the

use of violence and disempower women (Bohren *et al.* 2016:641). Another aspect to be taken into account is the way women perceive their treatment and how normal acts of abuse might appear because of its common occurrence (Manning & Schaaf 2016:1).

Health care providers may perceive their treatment of women as acceptable behaviour, because the practice is so entrenched in their manner of doing (Manning & Schaaf 2016:1; Miller & Lalonde 2015:549).

Studies found an underlying ideology of patient inferiority and the perceived need to control patient behaviour (Bohren *et al.* 2016:641). Many midwives live in difficult personal circumstances that need to be dealt with on a daily basis; they are underpaid and do not get the support they need from the health care system in which they are working. Abuse may be linked to the abuse of the health care provider (Miller & Lalonde 2015:550). The phenomenon of disrespect and abuse is found in public and private health care settings. It may present itself differently in a different context, but is at its core still a violation of human rights (Manning & Schaaf 2016:1).

2.6 IMPACT OF UNPROFESSIONAL CONDUCT

Irrespective of the environment and its challenges, choices and practices must be in the best interest of the mother and baby (Iliadi 2010:130). Moral responsibility for choices and actions is an integral part of professional practice. For any system to succeed, it is very important for each individual to take ownership of their responsibilities and be accountable for each decision and action taken (Aveling *et al.*, 2016:216). Considering the importance of a code of ethics for any profession to be able to regulate itself (Halldorsdottir & Karlsdottir 2011:807), unprofessional conduct has a detrimental effect on trust and satisfaction in the health care system and may question the integrity of the nursing profession (Malherbe 2013:83). If we want to make a difference in maternal care, it is of the utmost importance to ensure that midwives conduct themselves in a professional manner according to prescribed ethical guidelines.

Professor Denny, Head of the Department of Obstetrics and Gynaecology at the University of Cape Town, described it as “one of the world’s great disgraces” (Honikman *et al.* 2015:285), considering the fact that mothers in labour are vulnerable and in need of respect, security and dignity and protection of the mother and baby bond. Part of the disgrace is the fact that marginalised women (teenagers, ethnic minorities and women with physical and mental disabilities) are even more exposed to ill treatment which is directly opposed to the ethical values of the midwifery profession (White Ribbon Alliance 2011).

Disrespect and abuse in midwifery care have numerous detrimental consequences, which will be discussed below.

2.6.1 VIOLATION OF HUMAN RIGHTS OF WOMEN

Irrespective of a woman's beliefs, culture or community she lives in, pregnancy and birth is of great magnitude and a profound personal event. Apart from the fact that every woman has the right of basic human dignity, respect, privacy, self-determination, family life and spiritual freedom, they also have the right to enjoy the experiences motherhood bring in an environment that is not only physically safe, but also emotionally welcoming and warm. In this environment the women needs to be treated with respect and dignity; respect for her autonomy, feelings, choices and preferences. Beyond the motivation to decrease the mortality and morbidity of mothers and their babies must also lay the driving force to protect their experience of motherhood (White Ribbon Alliance 2011; Freedman 2003:111; Manning & Schaaf 2016:2).

Furthermore, privacy and confidentiality are two of the most basic ethical principles discussed as part of human and patients' rights. The International Code of Ethics describes confidentiality and privacy in the context of professional responsibilities of the midwife: "Midwives hold in confidence client information in order to protect the right to privacy, and use judgment in sharing this information except, when mandated by law" (International Confederation of Midwives 2014:2).

There are clear ethical guidelines when it comes to HIV testing; for example, privacy and confidentiality are of utmost importance. Information is shared during counselling and even then testing remains voluntary. These guidelines are endorsed by the WHO and UNAIDS and must be uphold by health services (World Health Organization 2007).

However, Amnesty International has found that patients are threatened that services will be withheld if a patient does not allow testing. Patients delay testing due to fear of disclosure of their status and of discrimination (Amnesty International 2014:25). A delay in testing results in the increased possibility of the transmission of HIV to the foetus in utero and an increase in neonatal complications. In 2003, Miller noted high rates of maternal mortality in the Dominican Republic despite highly skilled health care professionals delivering 98% of babies in well-equipped facilities. Results from qualitative studies found the conditions to be without privacy, dignity and with no effort to protect basic human rights (Miller *et al.*, 2003:90).

When these rights are undermined and medical care is insufficient and even harmful, it contributes to a negative cycle of decisions made by mothers, which has a direct influence on her life and the life of her baby (Manning & Schaaf 2016:2; Human Rights Watch 2011a).

2.6.2 PREVENTABLE DEATHS AND UNNECESSARY SUFFERING

Unprofessional behaviour influences the decisions of women to rather deliver at home or delay seeking help in fear of mistreatment and so doing, increasing the risk of a late identification of complications leading to adverse events during births (Sida-Improving maternal and newborn health by strengthening midwifery 2013:1; Manning & Schaaf 2016:2; Miller & Lalonde 2015:550; The population Council 2014; Human Rights Watch 2011a:36). Mistreatment leads to high stress levels in labouring women and an increase in the inappropriate use of medical interventions, for example, augmentation or induction of labour, which may lead to maternal and neonatal complications (Manning & Schaaf 2016:2).

Already in the 1970's the importance of compassionate, patient-centred care has been highlighted. Improved outcomes are seen when patients are treated with respect and dignity and their wishes are catered for. Quality of care is not only described in terms of physical care rendered, but also refers to the midwife-patient-relationship within an ethical framework of care (Freedman 2003:111).

As part of the national drive to improve the outcomes for mothers and babies in South Africa, the Department of Health has put together Maternal Guidelines with specific focus to manage the main causes of death, namely, non-pregnancy related infections, haemorrhage and hypertension (Department of Health Republic of South Africa 2015:14). However two important aspects also mentioned are health care system inadequacies and the need to ensure competent health care workers. Quality of care refers specifically to the way in which care must be rendered. "Health workers administering care to pregnant women must demonstrate respect and a genuine interest in their clients, and avoid an arrogant, rude or judgmental attitude. This principle applies even in the context of a poor working environment or perceived unsafe practices of certain pregnant women" (Department of Health 2015:19).

2.6.3 SATISFACTION AND TRUST IN HEALTH CARE FACILITIES AND HEALTH CARE WORKERS

The most important factor that influences women's satisfaction with the care that was rendered during childbirth is related to the attitude of the midwives rendering that care. Women who feel supported need less pain medication and remember childbirth more positively (Halldorsdottir & Karlsdottir 2011:813). A study done in Tanzania found that

women who had experienced unprofessional behaviour from health care workers, reported a low satisfaction in care rendered and would delay in making use of the health care facility in future. This might have a detrimental effect in the health of mothers and babies and might even lead to death (Manning & Schaaf 2016:2). Similar studies done elsewhere in Africa, including South Africa, indicate the same findings (Human Rights Watch 2011b; Amnesty International 2014; Bohren *et al.* 2015:21; Honikman *et al.* 2015).

Studies done in developed countries reflect the same discontent with maternity services rendered (Reed *et al.* 2017:1186). There is a rise in the incidence of post-traumatic stress among women who gave birth. These women relate stories of uncaring midwives who treated them with disrespect and in an undignified way (Halldorsdottir & Karlsdottir 2011:813). Qualitative studies investigating women's experiences of traumatic birth identified interpersonal relationships or lack thereof as the most important factor in the perception of trauma. Negative interpersonal occurrences have a significant impact on post-traumatic stress disorder in postpartum women (Reed *et al.* 2017:1186; Schetzer 2017).

Moreover, the increase in legal claims against medical professionals is directly linked to unprofessional conduct of the health care workers. The general public are made aware of their rights on national radio, and other awareness programmes are creating mistrust in the medical profession (Malherbe 2013:83).

2.6.4 UTILISATION OF SERVICES

Women who are scared to go to hospital to deliver, have a higher risk for complications and delay in treatment which will have an impact on the health of mother and baby (Human Rights Watch 2011a:37; Bohren *et al.* 2016:645). Moreover, it has been proven that abuse and unprofessional conduct during pregnancy may lead to poor utilisation of services for their children during the developing years (Manning & Schaaf 2016:2).

Women are being forced to travel long distances to clinics outside of their communities due to a lack of privacy and confidentiality (Amnesty International 2014:24). Some will altogether abandon the idea of seeking medical help and make use of traditional healers and birth attendants instead (Peltzer & Henda 2006). A new trend is seen in developed countries whereby mothers are delivering their babies at home without any medical assistance. This is partly due to a decrease in the number of private midwives due to the increase of litigation and the increased cost of insurance for midwives. Women feel they are exposed, disempowered and bullied in the hospitals, and if a private midwife is not available, they would rather deliver without medical assistance (Schetzer 2017). It seems that the

improvements made to maternal care during the last few decades may be lost due to unprofessional conduct of midwives.

2.6.5 EFFECTS ON MENTAL HEALTH

Childbirth is a deep and emotional experience for every woman irrespective of age, culture or educational level. Labouring women are very vulnerable during labour and childbirth and therefore are very reliant on the assistance, support and protection of the midwife. The relationship between the patient and midwife is important to protect both the mother and baby not only against adverse events, but also against emotional trauma. It is important to instil confidence and an awareness of the ability to work through the pain of labour, and in doing so, ensure a positive outcome in terms of experience (White Ribbon Alliance 2011:1).

A study done by Reed and fellow researchers on childbirth trauma described the feelings of “isolation, helplessness and disconnection” when there is a lack of connection between a midwife and her patient (Reed *et al.* 2017:1186). This experience will have a lasting impact on her emotional and psychological experience of birth, how she perceives her ability to bond with her child and raises her child (White Ribbon Alliance 2011:1). If the experience of childbirth is negative and tainted with disrespect and abuse, it may lead to a fear of childbirth, affecting sexual practices and influences the willingness to have more children. Feelings of grief and guilt may overshadow the experience (Manning & Schaaf 2016:2). Some women even related the experience to experiences of previous assault and rape (Reed *et al.* 2017:1186).

Several studies done on post-traumatic stress syndrome related to childbirth indicated interpersonal relationships as the dominant factor (Reed *et al.* 2017:1188; Thomson & Downe 2008:268; Harris & Ayers 2012:1168).

2.6.6 IMPACT ON ECONOMICS

The use of unwarranted and costly procedures is also seen as unprofessional conduct and is not only unethical, but can be detrimental to the outcome of the baby and mother. Women are often misled to the need of these procedures (Reed *et al.* 2017:1890), which can have a cost implication for the patient and the health facility (Manning & Schaaf 2016:2). When the misuse of high risk practices leads to preventable harm, a cascade of events can increase costs even more (Manning & Schaaf 2016:2). It has been proven that skilful and knowledgeable midwives reduce the incidence of unnecessary and harmful practices such as caesarean sections and induction of labour, and, in doing so, reduce costs (Maree, Yazbek & Leech 2018:2).

2.7 FACTORS AFFECTING PROFESSIONALISM

Although it is very clear that unprofessional conduct has a detrimental effect on maternal and neonatal outcomes and needs to be addressed, it is also very clear that the situation is complex, with several contributing factors. To answer the question on how professional conduct can be improved, it is important to look at these factors:

2.7.1 MIDWIFERY EDUCATION

Comprehensive and extensive training is of the utmost importance in order to reach the standards set by ICM. Midwives are described as professionals that practise in their own right and therefore are responsible and accountable for each decision made. They need to work in partnership with other members of the health team, but may practise independently in case of emergencies or when working with low-risk patients (International Confederation of Midwives 2014:2). Skilled, knowledgeable midwives can reduce maternal and neonatal mortality and morbidity, whereas poorly trained midwives may lead to increases in mortality and morbidity (Maree *et al.* 2018:1).

A clear, comprehensive curriculum is needed in an increasing multifaceted world (Maree *et al.* 2018:1) and must also consider the unique needs of the community and the country (Maree *et al.* 2018:2). Potential midwives need to be trained for a current world, within an academic discipline, and have to be prepared for constant change (Halldorsdottir & Karlsdottir 2011:816).

However, the necessity of ethical behaviour has already been established. Health professionals' training socialises students in their professional conduct and develops their professional identity (Halldorsdottir & Karlsdottir 2011:807). In this process, professional caring, wisdom, relational competence and personal and professional development must be part of the curriculum (Halldorsdottir & Karlsdottir 2011:816). The challenges are that in a multi-cultural setting, groups are formed by people from different walks of life with their own values, ideas and concepts of right and wrong (Plante 2015). Nurses enter the profession with their own unique set of morals and values, religious beliefs and perception of the world. Through a process of professional socialisation during training, nursing values and beliefs are instilled (Manojlovich & Ketefian 2002:20), changing their behaviour and their response to the nursing environment (Halldorsdottir & Karlsdottir 2011:807). This socialisation process is very important and is directly influenced by environmental factors such as professionalism seen in the setting where they train (Manojlovich & Ketefian 2002:16).

Students are influenced by the people who train them, but even more by the models they see in practice. Albert Bandura suggested that human behaviour is learned by observing the

people around them. This information will be recalled later and be used as a reference for future behaviour. He also believed that people have the ability to understand that their behaviour has consequences and know when there is a need to change (Bandura 1977:22). This statement does not only relate to skills and knowledge, and therefore emphasis should also be placed on evaluation of attitudes and interpersonal competence, and not only cognitive skill (Halldorsdottir & Karlsdottir 2011:816).

Several challenges regarding education and training of midwives have been identified, specifically in developing countries:

- **Lack of investment in midwifery training and education**

In a systematic review questioning the reasons for poor quality in midwifery care it was found that lack of investment in training and education is a critical barrier to quality care. The study mentioned Asian and African countries. A lack of training leads to midwives lacking an understanding of their professional role, uncertainty of procedures and skills, leading to poor confidence (Filby, McConville & Portela. 2016:9). Also found was a lack of certified registration, regulatory bodies and professional associations. This has a direct influence on training and education with no process to ensure that standards are set and met by professional midwives. There are no accountability measures and little professional development (Filby *et al.* 2016:10).

- **Curriculum**

Another very important factor that relates to the challenge of poor investment in training and education is the lack of a curriculum that can train midwives to comply with WHO standards (Schoon & Motlolometsi 2012:784). Courses are found to be short, ranging from six weeks to one year, with a clear lack of the decision-making skills which are required of a midwife during the management of obstetric emergencies (Filby *et al.* 2016:9). Midwives struggle with the management of basic emergency obstetrics due to a lack of theoretical basis and skills (Schoon & Motlolometsi 2012:784).

In South Africa, the integrated course for registered nurses is seen as part of the problem. It is not midwifery-focused, leaving maternity units in the hands of incompetent, unmotivated and poorly skilled midwives with no interest in midwifery care (Schoon & Motlolometsi 2012:785). Articles from India and Jordan also suggest that the integrated course makes midwifery secondary to nursing and therefore denies midwifery its unique identity and prevents strong leadership to develop (Filby *et al.* 2016:10).

Another aspect mentioned is that training is often done in urban areas with medical assistance readily available, which leave the midwives incompetent in managing obstetric emergencies; yet they will be deployed to rural areas with no medical assistance (Filby *et al.* 2016:10).

- **Lack of investment in faculty**

Training is often done by nurse educators or doctors with limited or no clinical experience who lack current best-evidence practices. A systematic search (Filby *et al.* 2016:9) found midwives unable to do neonatal resuscitation due to a lack of training. In Uganda only 60% of midwives have emergency training, 25% without any in-service training and only 33% can plot a partogram effectively. In Pakistan a one year course with no clinical component is offered (Filby *et al.* 2016:11).

- **Poor working conditions**

Other factors are poor facilities, lack of equipment, staffing shortages (Filby *et al.* 2016:20) and training in a typical environment where disrespect is tolerated, with a lack of accountability systems (Bohren *et al.* 2016:643).

2.7.2 HEALTH CARE SYSTEMS

South Africa has a unique challenge when it comes to health care systems. A comparative analysis was done in the public and private health sectors of South Africa by Williams (2018:17). This study found that 82% of the population is treated within the public sector, with only 40% of the total health costs, whereas less than 20% of the population is treated in the private sector. The health expenditure of the private sector is 60% of the total health costs of the country (Williams 2018:17). Therefore, the public sector is clearly under huge pressure with understaffing, lack of resources and poorly maintained infrastructure. Furthermore, health workers are poorly paid and have low motivation (Human Rights Watch 2011a:3).

Another aspect adding more pressure to the South African health care system is the quadruple burden of disease which is characterised by communicable, non-communicable, perinatal and maternal injury-related disorders (Mayosi *et al.* 2009:934). The concurrent rise of communicable disease, for example HIV and Tuberculosis, and non-communicable diseases such as cardiovascular disorders and Diabetes mellitus Type 2, places an almost unbearable burden on a health care system already under pressure due to maternal and neonatal disorders, injuries and violence (Mayosi *et al.* 2009:934).

An additional aspect that needs to be considered is the migration of people across borders. It places an extra burden on the already struggling health care system, adding to the workload of the already overworked staff (Vearey, Modisenyane & Hunter-Adams 2017:89). Furthermore, it was found that areas with the highest rates of poverty also have the highest rates of HIV and the most severe lack of health care services (Wabiri, Nieri; Chersich, Matthew; Shisana, Olice; Blaauw, Duane; Rees, Helen; Dwane, Ntabozuko. 2016:1). This is especially concerning considering the high risk for mother-to-child transmission of HIV. All of these factors may contribute to the perception of unprofessional conduct.

2.7.3 INTER-DISCIPLINARY RELATIONSHIPS

Provision of health care has become increasingly more complex. To render effective care, collaboration among the different health care professionals is essential. Different studies proved that care can be more effective and beneficial to patients if teams of different health care professionals work together to render a service. It also creates a more satisfying environment for the staff to work in (Iliadi 2010:130). A challenge is the fact that the different professions involved in the care of patients often work in silos, with the medical profession in charge (Schoon & Motlolometsi 2012:784). Midwives and doctors do not necessarily share the same philosophy when it comes to care of women in labour (Schoon & Motlolometsi 2012:784; Halldorsdottir & Karlsdottir 2011:815), causing nursing professionals to move away from their autonomous role and a loss of professionalism. Midwives perceive birth as a natural process, whereas doctors often medicalise the process (Iliadi 2010:131). Midwives have always seen themselves as independent practitioners and were always, as women, the traditional birth attendants. They were trained to be “with the women” and do not want to be seen as the doctors’ assistant (Halldorsdottir & Karlsdottir 2011:807). Instead of putting the labouring mother first, a struggle for power might lead to poor judgement and decision-making processes. This conflict leads to high stress levels and job dissatisfaction, ultimately resulting in anger, anxiety and irritation (Halldorsdottir & Karlsdottir 2011:815).

In the public sector, discrimination from other professions such as doctors, forces midwives to defer decisions to inexperienced young doctors. This is stripping away midwives’ sense of responsibility and professional identity (Manojlovich & Ketefian 2002:16).

Iranian studies done on factors that affect professional behaviour refer to unfair and abusive treatment of midwives and nurses by doctors and the lack of managerial support. This leads to poor communication and ultimately puts the patient in harm’s way (Dehghani, Mosalanejad & Dehghan-Nayeri 2015:8).

2.7.4 INDIVIDUAL CHARACTER AND MOTIVATION

Nursing is said to be a caring profession and that means “empathy for and a connection with people” (Fahrenwald *et al.* 2005:46). Teaching students the art of caring may prove to be a challenge. In a study done in Iran to determine the factors that are affecting professional ethics in nursing, the participants argued that character is one such factor. Character is formed during childhood by family and society and will have an influence on ethical values in later life (Dehghani *et al.* 2015:4).

But what is character and how is it formed? Character is defined as something that cannot be separated from a person. It is who you are and determines and is determined by how you act, unique to each individual (Dehghani *et al.* 2015:4; Mitchell 2015:149). In Bandura’s social learning theory, he suggests that in children, behaviour is learned from the environment through observation (Bandura 1977:22). The people observed are called role models and the most significant of them may be imitated by children. If the behaviour is reinforced, they will most likely repeat the behaviour, and when punished, the behaviour will be stopped. A connection with another person will establish itself, and behaviour, beliefs and values will be incorporated in who they are (Bandura 1977:22).

Furthermore, character is been formed by recurring patterns of emotional interaction with the caregiver or parents in the pre-reflective years. These interactions give rise to themes. If these themes are repeated frequently, it will shape the emotional experiences in future. In the developing child, certain principles will be laid down and the character will be developed (Stolorow 2012).

Considering that professionalism in midwifery starts with caring (Halldorsdottir & Karlsdottir 2011:806) and that evaluation of a “good midwife” mainly refers to aspects in the affective domain, such as “caring, warm and supportive” (Halldorsdottir & Karlsdottir 2011:808), the question of character remains important to be answered. Interpersonal competence that is clearly linked to character and personality forms an important component of professionalism in midwifery care (Halldorsdottir & Karlsdottir 2011:810).

The development of autonomy is also linked to character and it is found that midwives with high levels of autonomy and social integration are most likely to have better work motivation and greater commitment to their patients and the organisation they work for. These two factors relate directly to job satisfaction (Manojlovich & Ketefian 2002:20).

Motivation links to the personal investment theory considering the willingness to invest time and energy into a task. Staff members who work towards excellence can be described as motivated and they will often describe this motivation as a “sense of a calling to the work”

(Manojlovich & Ketefian 2002:19). Therefore one can argue that the commitment and motivation in which professionalism is pursued are to some extent linked to character.

However, the process of socialisation during nursing and midwifery education includes the teaching of ethical principles such as autonomy, veracity justice, respect and dignity. In broad it teaches what it means to be a nurse or a midwife. One can argue on the principles of Bandura's social learning theory (Bandura 1977:22) that midwives can be taught basic ethical principles, and if they are also seen in the behaviour of excellent role models such as mentors and preceptors and enforced in a positive way, they will identify with the role model and display the same ethical behaviour (Poochangizi *et al.* 2017:2). Unfortunately, the opposite might also be true. If they do not have good role models, they may abandon the basic ethical principles altogether (Manojlovich & Ketefian 2002:19). Therefore character can be seen as an important factor, but the influence of organisational culture cannot be ignored.

2.7.5 ORGANISATIONAL CULTURE

Considering the definition of what a midwife is, a professional that is autonomous and who is required to take responsibility for decisions made in nursing care and who will be kept accountable for those decisions (International Confederation of Midwives 2010:2), there is often a conflict between what professionalism is and what is expected of a midwife in a hospital setting (Manojlovich & Ketefian 2002:16).

In order for a midwife to fulfil her professional duty, she needs an environment that is created by the organisation to enable professionalism. One such organisational factor is strong, supportive and visible leadership (Manojlovich & Ketefian 2002:17). It is important that an organisation has a clear set of values (Plante 2015) that will determine the culture of that organisation and will positively influence the clinical performance of staff. These values will guide the midwife in her acceptance of authority and responsibility and will enhance her personal motivation as a professional person (Manojlovich & Ketefian 2002:18). People who are driven are more focused and dedicated in what they do. Personal investment theory is grounded in "accomplishment, recognition, power and affiliation" which will determine the degree of motivation and personal investment in any activity (Manojlovich & Ketefian 2002:20). "The greater the personal investment, the better the outcome, for nurses, hospitals, and people they serve" (Manojlovich & Ketefian 2002:22).

However, in a hospital environment, midwives often do not have the autonomy the profession requires and have limited control over their work environment. Ethical conflict may develop when there is a conflict between what they perceive as their professional duty and values that are driven by a bureaucratic system (Manojlovich & Ketefian 2002:16). One

of the many conflicts new nurses face is the constant effort to resolve contradictory values between the professional and organisational demands (Manojlovich & Ketefian 2002:19). While professionalism can be instilled during training, the work environment also has an influence in determining professional conduct (Manojlovich & Ketefian 2002:19). A good example of such conflict is the statement by hospitals that patient care is at its core, while in reality working conditions do not allow for midwives to be with women in labour support (The Royal College of Midwives 2014:22).

Many studies refer to the influence of organisational inability to create a healthy environment for midwives to work in (The Population Council 2014:2; Bohren *et al.* 2015:32), leaving midwives demoralised and unmotivated, putting patients at risk (Manojlovich & Ketefian 2002:17; Bohren *et al.* 2015:19). On the other hand it is also expected from an organisation to monitor the effectiveness and safety of the health care rendered. Systems to supervise and keep staff accountable are very important. The high rate of maternal and neonatal deaths has been directly linked to the failure of the health care system in South Africa to put these accountability measures into place (Human Rights Watch 2011b:2).

If an organisation lacks clear values and guidelines, decisions will be made in view of individual values and may create conflict between an organisation and its employees (Manojlovich & Ketefian 2002:22), with detrimental effect on patients. It is important that an organisation will re-enforce the behaviour they want and not the behaviour they don't want. The best way to do this is for the leadership to demonstrate the preferred behaviour (Plante 2015). Mentors and preceptors can also play an important role. The reality is that in services with midwife shortages, the role of mentors and preceptors are often neglected (The Royal College of Midwives 2014:21), leaving midwives without the necessary guidance and role models.

Several other factors might have an influence on the work environment, which in turn has an influence on the professional conduct of midwives. One such aspect is the hospital facilities and equipment that are available to the midwives and very necessary to provide proper care. Midwives are well aware of their responsibilities, but are often confronted with the problem of poorly maintained and ineffective equipment (Dehghani *et al.* 2015:8). Lack of supplies, including medicine, protective gear such as gloves and aprons and blood keep midwives from fulfilling their duties and create the perception that they do not want to help patients. In a mixed-method systematic review, the authors found a variety of settings where patients were required to bring their own supplies, linen and food. Those patients would then be managed first, and other patients perceive this as unfair and unprofessional. Health care facilities are also referred to as "overcrowded, noisy and dirty" (Bohren *et al.* 2015:1). In

some South African facilities, similar conditions are found, preventing midwives to render needed care and uphold privacy and confidentiality when working with patients (Amnesty International 2014:33). Weakened health care systems are seen as the underlying reason for abuse and disrespectful care (Miller & Lalonde 2015:550).

The shortage of midwives worldwide is a grave concern and a factor that cannot be ignored. In 2011 a report published by the United Nations Population Fund (UNPF) indicated a shortage of 350 000 midwives in the 58 countries that were analysed. Most of these shortages occur in Asia and Africa (World Health Organization 2013:804). However, many developed countries, for example the United Kingdom, report on the challenges of staff shortages (The Royal College of Midwives 2014:13). The already current shortage is worsened by the aging population of midwives that will retire soon. Shortage of staff leads to increased workload and creates low morale, stress and poor health in midwives.

A study done by the Royal College of Midwives indicates that staff shortages were the most common reason for midwives to resign from their positions. Fifty two percent of the midwives indicated that they could no longer function under the severe pressure (The Royal College of Midwives 2014:13). This in itself creates an ethical dilemma for midwives, because, although they want to care for patients, they are unable to do so (Dehghani *et al.* 2015:8). Studies done on disrespectful and abusive care found staff shortages a contributing factor. Patients had to wait for extended periods to be assessed, leading to late identification of health needs with often severe outcomes for mothers and babies (Bohren *et al.* 2015:19; Filby *et al.* 2016:9; Manning & Schaaf 2016:1; Miller & Lalonde 2015:549). Staff is forced to manage the high-risk patients first, leaving the patient in normal labour unattended and neglected. This may contribute to negative attitudes and poor motivation in health care workers (Bohren *et al.* 2015:19).

2.7.6 FEAR OF LITIGATION

Another factor that has a direct influence in midwifery care in South Africa is the steep rise in medical malpractice litigation which includes obstetricians as well as midwives (Malherbe 2013:83). In a poll done by the Royal College of Midwives in 2010, the following question was asked: “*Are midwives practising defensively because of the fear of litigation?*” The majority answered positive and felt that they could not be blamed. Because of litigation it is increasingly more difficult to keep normal birth normal (The Royal College of Midwives 2010). The cost of reported claims has more than doubled (Malherbe 2013:83), with a direct influence in the decision-making process during labour. Due to the fear of litigation the focus is more on perceived risks for the mother and baby than on the mother’s experience of birth

(Reed *et al.* 2017:1199). Unnecessary tests are done to prove that standards of care were met and so the care focus shifts from patient-centred care to defensive medicine (Malherbe 2013:85). This leads to an increased dissatisfaction, with care rendered developing in a trend to not utilise any medical care. It is called “free birth”.

In several developed countries midwives have a challenge with insurance and in the United Kingdom it is now illegal to practise without insurance. The number of private midwives has dropped dramatically, leading to the decision of some patients to rather have a free birth than utilise hospital care (Peltzer & Henda 2006).

Circumstances are aggravated by factors such as poor management, staff shortages, inadequate infrastructure and low morale (Human Rights Watch 2011a:3).

2.7.7 COMMUNICATION

At the core of professionalism lies the ability to communicate. The ethical code described by the ICM states the first priority of the midwife, namely the ability to form professional midwifery relationships with the women and their families and also with the multidisciplinary team (International Confederation of Midwives 2014:2; Oyetunde & Nkwonta 2014:44). This will enable her to fulfil her professional responsibility in providing safe, effective and patient-centred care that supports the women and their families and ensures the best outcomes (Nursing and Midwifery Council n.d.b:3).

One of the aspects in the theory of professionalism (Halldorsdottir & Karlsdottir 2011:806) is interpersonal competence. This relates directly to the fact that the midwife must be able to connect with her patient. She needs to listen to her patient, and teach and guide her patient. This will create a relationship of trust and will determine the satisfaction with the experience (Halldorsdottir & Karlsdottir 2011:812). None of the above is possible if the midwife is unable to communicate with her patient.

According to the International Migration Report 2017, the number of international migrants has risen rapidly over the last 17 years. Numbers escalated from 173 million in 2000 to 220 million in 2010, and in 2017 reached the all-time high of 258 million (United Nations 2017). South Africa is seen in Africa as a resourceful country, and many migrants come to South Africa. Apart from the pressure that is placed on an already suffering health care system, communication becomes a challenge for health care workers. People who cannot speak English are less likely to receive the needed care, are less satisfied with care and may more likely become victims of medical errors (Jacobs, Shepard, Suaya & Stone. 2004:866). Often health care institutions do not have adequate interpreter services or none at all and will

make use of other patients or staff members to interpret for the patient. This unprofessional method may have negative clinical outcomes for patients (Jacobs *et al.* 2004:866).

Apart from the migration issue, South Africa in itself is a country of diversity with 44 living languages of which 11 are official. IsiZulu is the most commonly spoken language in South Africa. The medical profession favours English, and over 80% of medical interaction occurs in this language. Only 6% of medical interactions are done in the preferred language of the patient (Benjamin, Swartz, Chiliza & Hering 2016:74) and many errors and adverse outcomes may be due to the lack of effective communication (Rowe, Garcia, Macfarlan & Davidson 2001:23).

2.8 CONCLUSION

The literature review provided a clear overview of professional conduct, the factors that influence professional conduct and the negative impact unprofessional conduct can have on midwifery care. Although the study considered the fact that professionalism is complex with many factors that need to be taken into account, it was of utmost importance to ensure that patients were rendered the best quality care based on strong ethical values. It was not possible to address the matter of maternal and neonatal mortality and morbidity without considering the improvement of professional conduct in midwifery care.

The following chapter will focus on the methodology followed to answer the research question on how to improve professional conduct in South Africa.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

In the previous chapter, the role of the midwife, professionalism, professional conduct and the factors influencing professional conduct were discussed. A comprehensive discussion on the manifestation of unprofessional conduct and the impact on midwifery care were outlined. In this chapter the research methodology will be presented and will consist of the following; research design, population, sampling technique, data collection and analysis and ethical considerations.

3.2 RESEARCH DESIGN

Research design is the method decided on to address the research question and also to proof the integrity of the study (Polit & Beck 2017:743). In this study consensus research was used as an approach to answer the research question.

Nominal group technique was utilised during this study as a consensus method. Consensus methods have been used more frequently during the past 60 years (Waggoner *et al.* 2016:663; Potter, Gordon & Hamer 2004:126) and are often used in health care settings where evidence from research may be inadequate and inconsistent (Humphrey-Murto, Varpio, Gonsalves & Wood 2017:14). Sometimes empirical evidence do not exist, or topics may be unclear and debatable (Waggoner *et al.* 2016:663).

If the purpose of the study is to create ideas with regard to a problem or question, the nominal group technique is the consensus method of choice (McMillan *et al.* 2016:655). This method may lead to improving clinical practice by finding solutions to problems (Potter *et al.* 2004:126) and establishing new policies (Harvey & Holmes 2012:188). This method may also serve to overcome the gap between clinicians and researchers (Harvey & Holmes 2012:190), but can also provide valuable and profound experiences of clinicians and patients (Potter *et al.* 2004:130). The main aim was to obtain consensus and determine priorities from experts in midwifery on ways to improve professional conduct in midwifery in South Africa.

3.3 RESEARCH METHODS

Several other methods are available, for example consensus development panels or the Delphi technique. However, the choice to use the nominal group technique was made due to the following reasons:

- When a topic is complex with several contributing factors involved and finding solutions becomes increasingly difficult, it is of great help to use expert opinion to come to group consensus. The advantage of such groups is a wide range of knowledge and expertise. (Humphrey-Murto *et al.* 2017:14; Harvey & Holmes 2012:188). Considering the complexity of the South African situation, the choice fell on the nominal group technique. A diverse group might bring insight to the discussions from various settings and therefore might prove valuable in finding solutions. Every effort was made to ensure that the selection of participants was focused on their expertise in the field of midwifery. It was also ensured that they would come from different areas of practice in the midwifery field to ensure a comprehensive insight into the question. Midwives were invited from the private and public sector and also those who practise independently.
- New ideas may be generated in the process (McMillan *et al.* 2016:655). These ideas will come from clinicians working with the question at hand on a daily basis who share the same passion to improve care (Harvey & Holmes 2012:190). Discussion challenges opinions and stimulates new thinking (Humphrey-Murto *et al.* 2017:14). The selection of participants was therefore purposive to ensure that suggestions would be relevant and practical to the clinical setting.
- This process allows for all participants to have equal input (Harvey & Holmes 2012:188; McMillan *et al.* 2016:655). One of the main functions of the moderator is to ensure that group dynamics are conducive for sharing ideas (Humphrey-Murto *et al.* 2017:190; Potter *et al.* 2004:127). The group sessions were led by skilled and knowledgeable moderators, ensuring that every participant had time to share their ideas and thoughts, and effort was made to ensure that every participant felt valued.
- The process lends itself to determine priorities (McMillan *et al.* 2016:655; Potter *et al.* 2004:128). After each session discussions were led to a point where priorities were set and agreed upon.
- Face-to-face contact gives an opportunity to discuss the research question and to form new ideas (Allen, Dyas & Jones 2004:110; Harvey & Holmes 2012:188; Potter *et al.* 2004:128). During group sessions, a comfortable atmosphere was created to enhance participation. The moderators were skilled in leading the discussions and stimulating thinking.
- As part of the process, experts are given time to have a period of silent generation of ideas. That gives an assurance that the expert opinion is true and not influenced by other experts (Waggoner *et al.* 2016:664). This process was followed during all three sessions.
- There is also time to clarify concepts and ideas (Waggoner *et al.* 2016:664). This principle was held to during group sessions.

- Minimal pre-meeting preparations are needed (Potter *et al.* 2004:126) and this method is time-efficient. One or two sessions may be needed to gather information and experts are kept focused to produce their best during these two sessions (Waggoner *et al.* 2016:664; Potter *et al.* 2004). This is an important aspect to consider if experts are clinicians or academics with very busy work schedules (Harvey & Holmes 2012:190). Three sessions were scheduled during the research at different locations to consider cost and time.
- Group satisfaction is mostly high, due to immediate dissemination of results and sharing with the group (Potter *et al.* 2004:127; Harvey & Holmes 2012:190). It was interesting to see the change in the attitude during group sessions. At the beginning of the sessions participants seemed to be a bit reluctant, but by the end of the sessions they were very excited and glad that they could contribute to the research.
- There is minimal researcher bias, due to involvement of participants in data collection and analysis during a highly structured process (Potter *et al.* 2004:127). During group sessions the researcher was allowed to welcome participants, share the question and a bit of background, but was not allowed to share any thoughts or interfere in any way as the sessions progressed.

However, there are several disadvantages that had to be taken into consideration during the study:

- This method may be expensive considering that an appropriate venue must be found, food and drink to entertain experts must be provided, and costs related to equipment (e.g. white boards and stationary), travel arrangements and communication (Waggoner *et al.* 2016:664). However, this method can be organised in such a way that cost can be minimal (Harvey & Holmes 2012:190). To select participants from the same geographical area may be one way of reducing cost (Allen *et al.* 2004:111). These aspects were considered during the planning of the nominal group sessions. Venues were selected considering cost, accessibility as well as comfort and security.
- It may be problematic to organise a nominal group (Waggoner *et al.* 2016:664). To find a time that is suitable for each participant may be a challenge (McMillan *et al.* 2016:655). Indeed, it proved to be a challenge. Several invitations were sent out by email with no responses. It proved more effective to invite midwives known to the researcher who met the criteria. Only four attended the first and second sessions and five participants attended the third session. This may be a limitation to the study.
- Standing among a panel of experts may pose a challenge (Waggoner *et al.* 2016:644). This aspect proved not to be a challenge during the sessions. Participants were only introduced by first name and seemed to feel at ease very quickly.

- Beliefs and cultural practices may be exposed during the discussion session and may hinder collaboration between members of the group (Waggoner *et al.* 2016:644). Due to the skilful way the sessions were managed by the moderator, this aspect was not a challenge. There was a general feeling of respect for each other and sensitive topics were discussed with understanding.

3.3.1 POPULATION AND SAMPLING

A population refers to “the entire set of individuals or objects having some common characteristic” (Polit & Beck 2017:739). In qualitative research the question will be asked: “Who will contribute the most to find a solution to the research question?” In this research a group of experts had been chosen whose knowledge, practise and insights directly link to the research problem. The group selected to participate in the process had a direct influence on the acceptability, validity and credibility of the study. Therefore participants were carefully selected to ensure that they met the required criteria already discussed in the guidelines for the nominal group technique.

In this study experts in the field of midwifery practice were invited to participate. In this study an expert had to meet the following requirements:

- The expert had to be a midwife registered with the South African Nursing Council, irrespective of gender.
- She/he had to be actively involved in rendering midwifery service currently, paid or unpaid, irrespective of whether the service was rendered in the private or public sector and whether the registered person was working in a private practice.
- A midwife fulfilling a managerial role could have been selected for the purpose of adding an additional view point during discussions.
- She/he had to be knowledgeable and strongly task-orientated. This criterion was verified through educational level and position of employment.
- She/he should have had at least five years of experience in the midwifery field. The title of the midwife is not important, as long as other criteria have been met.
- She/he had to be deemed as a role model in the place of employment.
- Participation in a professional organisation would be considered as proof of active involvement in professional development.

Heterogenic groups may bring comprehensive insights from different perspectives to the discussion. Purposive sampling was used to ensure focused and most informative input in order to find solutions to the question and create a better understanding of the challenges related to the research question (Waggoner *et al.* 2016:665).

As the focus was not a particular facility, and the research problem was seen as a generic and even global issue, participants were recruited through their membership at professional midwifery organisations and known by the researcher due to active participation in professional activities in their personal capacity. Experts were identified and invitations were sent out to include midwives from all sectors to ensure rich and comprehensive data.

Waggoner recommends a group size of between five and ten participants (Waggoner *et al.* 2016:665). Invitations were sent out to SOMSA (Society of Midwives of South Africa), Childbirth educational professional forum and PPMA (Private Practising Midwife Alliance). Several invitations were also sent out to midwives known by the researcher and who qualified to participate in the nominal sessions. Two sessions were scheduled (one in Pretoria and one in Johannesburg) and participants could choose which group was the most appropriate for them to attend. A third session was scheduled to ensure more comprehensive data. Midwives from the public sector attended the third session at the University of Pretoria where they are currently enrolled as students and added valuable input. The demographic data of the experts will be addressed in Chapter 4.

3.3.2 DATA COLLECTION AND ANALYSIS DURING NOMINAL GROUP TECHNIQUE

Conducting a nominal group technique requires a well-structured process to ensure the inclusion of each participant's input to make sure that the information gathered are trustworthy. A skilled and knowledgeable moderator must follow the process and ensure the following criteria are adhered to:

- The question set before the panel of experts should be clear and concise (Waggoner *et al.* 2016:665; Potter *et al.* 2004:127). The question must be unrestricted and open to avoid partiality in participants. (Humphrey-Murto *et al.* 2017:17). Pilot testing of the question with a small group of participants is advised (Humphrey-Murto *et al.* 2017:17), although this process was not done during this study due to time constraints and cost. The question that was put to the group during the sessions was: How can professional conduct in midwifery be promoted in the South African context?
- The process must be driven by a moderator who is skilled to lead the process and may or may not be an expert with regards to the question at hand. This person must be unbiased and objective (Potter *et al.* 2004:127). In this study, two different moderators were used. One moderator was a person with a master's degree and an expert in the midwifery field. She also has experience in facilitation of the nominal group technique sessions. The other moderator has a doctorate degree with expertise in neonatal intensive care nursing. She also has extensive experience in the nominal group technique.

- A group of experts are brought together to find solutions and create new ideas to a specific question (Waggoner *et al.* 2016:664; Van de Ven & Delbecq 1972:338). It is important to determine the criteria of what is considered as an expert as has already been discussed under population and sampling.
- Soundness and efficacy of the study should be enhanced considering the level of expertise of participants (Harvey & Holmes 2012:190) and that expertise must be the only reason for selecting participants (Potter *et al.* 2004:127).
- Groups may be diverse and the suggestion is that these diverse groups will have more creative solutions to the research question. Humphrey-Murto refers to possible participants in health research as the nine "Ps": providers, professors, patients, payers, policy makers, private sector, public sector, purchasers and press (Humphrey-Murto *et al.* 2017:17). However, these diverse groups may also lead to difficult communication due to personal differences and perspectives on the question and have a negative influence on the outcomes (Waggoner *et al.* 2016:665; Humphrey-Murto *et al.* 2017:17).

In this study the focus was mainly to gather experts in the midwifery field with clinical experience and those directly involved with management. The first group included midwives currently working in the private sector. One is a nurse educator with a B Cur degree who is currently busy with a Master's degree. Two are clinical training specialists, both with a Diploma in Midwifery and one an advanced midwife. The fourth participant is currently a unit manager with a B Cur degree.

The participants in the second group are all private midwives with independent practices. Three of these midwives did the integrated four-year course and one has a B Cur degree and also is an advanced midwife. Two of these midwives are International Board Certified Lactation consultants and are also South African Certified Perinatal Educators.

The third group consisted of younger midwives more recently qualified. All five of the attendees have degrees in nursing and wrote their final examination in the Higher Diploma in Advanced Midwifery and Neonatology Course.

In this study, two groups were initially scheduled. However, a decision was made to schedule a third group due to poor response rates. The first two groups were only attended by four people each and were mostly from the private sector and independent midwives. A third group was scheduled and five midwives attended. The third group included also more recently qualified midwives, and participants were from both the private and public sector. Although literature indicates that a group smaller than five might lead to limited input, the first

group generated 33 ideas and the second group 34. The third group generated 26 ideas. Nineteen themes were created during analysis and will be discussed in Chapter 4.

3.3.3 NOMINAL GROUP TECHNIQUE PROCESS

The nominal group process is a highly structured face-to-face discussion group in which participants have the opportunity to share their opinions. The process consists of four steps that need to be followed to ensure that clear and concise data can be collected:

3.3.3.1 Introduction

- A brief introduction was made to ensure that everybody felt welcome and comfortable.
- An explanation of the purpose of the research was given (Van de Ven & Delbecq 1972:338).
- The role of the participants was clarified. It was explained that they needed to contribute their perceptions, experiences and expertise to define the problem and find solutions. The importance to consider the subjective as well as objective components of the subject at hand was also explained (Van de Ven & Delbecq 1972:338).
- Consent forms were signed after thorough explanation of the process (Harvey & Holmes 2012:191).
- Ground rules on confidentiality, respect and protection of participant's identity were laid down and clarified (Harvey & Holmes 2012:191).

3.3.3.2 Generating ideas

- Participants were provided with pens and paper.
- Participants were instructed to spend five minutes generating ideas on the main question: How can professional conduct of midwives be improved in the South African context?
- Ideas were privately formed and no discussions were allowed at this stage. This was the first phase of the process (Waggoner *et al.* 2016:664).

3.3.3.3 Round robin

- During the second phase, solutions or ideas were shared with the moderator and also with the rest of the group, but still no discussion was allowed (Waggoner *et al.* 2016:664; Humphrey-Murto *et al.* 2017:15).
- Ideas were recorded on a flip chart in the exact words used by the participant.
- All group members had a chance to share their ideas (Harvey & Holmes 2012:191; McMillan *et al.* 2016:656).

3.3.3.4 Clarification of items

- During the third phase a discussion was led by the moderator and ideas were clarified and reasons behind ideas shared (Waggoner *et al.* 2016:664). The moderator was careful not to interfere in the discussion. During this process related items were grouped together with the permission of the group and ideas could also be altered or excluded. All ideas were debated and clarified to ensure that informed decisions could be made when coming to the voting process. The moderator made it clear that participants did not necessarily need to agree and that it was important to have a personal input when voting on the importance of different aspects (McMillan *et al.* 2016:657).
- It was ensured that all members participated, and no member was allowed to dominate discussions (Harvey & Holmes 2012:192; Perry & Linsley 2006:348).
- The moderator was sensitive towards aspects such as discrimination or disapproval and discussions were constantly steered back to objective and professional input from the group members (Harvey & Holmes 2012:192).

3.3.3.5 Voting and ranking

- During the final phase a method of voting and ranking was used to determine priorities (Potter *et al.* 2004:128; McMillan *et al.* 2016:656).
- During the first stage the participants voted privately to determine the five most important topics (McMillan *et al.* 2016:657). A number was allocated to each topic, for example a 5 to the topic of greatest importance. The method used during this research was an allocation of the number 1 to the topic with highest priority and therefore the lowest scoring topic would have the highest priority. The outcomes were shared with the group and members were allowed to negotiate the reasons why they thought a point was important (McMillan *et al.* 2016:657).
- Consensus methods were mostly of an investigative character and results need to be tested further with qualitative or quantitative methods (Potter *et al.* 2004). A literature search was done to confirm or disconfirm results and is discussed in Chapter 4.

3.4 TRUSTWORTHINESS

It is important that researchers have confidence in the data they generate. To ensure that the process is sound and trustworthy, the study was measured against the following criteria: credibility, transferability, dependability, conformability and authenticity. These criteria were discussed in Chapter 1.

3.5 ETHICAL CONSIDERATIONS

It is very important to understand the ethical principles any study needs to adhere to in order to be deemed as ethical. Research participants must be protected and the benefit must always outweigh the risk (Brink, Van der Walt & Van Rensburg 2018:29).

The ethical principles adhered to during the study were as follows: Beneficence, justice and respect. These principles were discussed in Chapter 1.

3.6 CONCLUSIONS

Research methodology is the method selected by the researcher to find an answer to the research question (Gray, Grove & Sutherland 2013:683). The following aspects of the research methodology were addressed in this chapter: research design, research method which is the nominal group technique, population, sampling technique, data collection and analysis, trustworthiness of the study and ethical considerations.

Chapter 4 will be a discussion on the presentation and analysis of the research data.

CHAPTER 4: PRESENTATION AND ANALYSIS OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

Chapter 4 focuses on the presentation and analysis of the research findings. Analysis of data includes logical grouping and organisation of data gathered. In the nominal group technique method, data on analysis of results are limited. In McMillan *et al.* 2016:10 on how to analyse data from multiple groups, the following processes are described: analysis of raw data, thematic analysis of raw data, analysis of secondary raw data and qualitative analysis. These processes were followed and will be discussed.

4.2 ANALYSIS OF RAW DATA

It is important to review raw data generated in groups to identify abnormalities or discrepancies (McMillan *et al.* 2016:10). Due to the small size of the groups it was easy to clarify ideas and group them together. The groups were different in terms of experience and perspective. They also had a different perspective on priorities. During silent generation, 93 ideas were produced. These ideas were displayed on a whiteboard during the round robin phase. The clarification phase gave opportunity to explain what was meant by each idea and themes were created by grouping similar ideas together. No ideas were discarded, and wording was used as suggested by participants. A list of themes was then written on the board, continually giving an opportunity to clarify and explain.

4.3 THEMATIC ANALYSIS OF RAW DATA

In order to enable cross-group comparison of data, themes were developed (McMillan *et al.* 2016:11). Nineteen themes emerged from the groups. In the ranking and voting phase, the opportunity was given to rank the priorities in each group. A 1 was allocated to the theme of highest priority, meaning that the lowest score (=1) was given to the theme which was deemed the most important.

Different wording had been used by the groups, different ideas were generated and they were differently grouped together. A summary of the participants' details is presented in Table 4.1, followed by a summary of the themes. Each session is then discussed separately and a summary of the ideas is included. The integration of the themes will be discussed last.

Table 4.1: Summary of participant details

	Group 1	Group 2	Group 3
Participants	4	4	5
Average age (years)	45	53	35
Years of experience on average	25	30	12
Sector experience on average	All 4 midwives trained in public sector but working in private sector currently	All 4 midwives trained in public sector and worked in both public and private sectors for some years before starting private practices. One midwife only started a private practice recently and is now in an independent private practice	One midwife is from an African country, trained in the public sector. She is not currently working but is a student. The other four midwives trained in the public sector in SA. Two are currently working in the public sector and three are working in the private sector
Responses in each group	34	33	26
Themes generated in each group	8	6	5

4.4 ANALYSIS OF SECONDARY CODED DATA

Secondary coding may be necessary when themes are scored the same (McMillan *et al.* 2016:11). During all three sessions themes were scored differently and therefore priorities were clear and no secondary scoring was necessary.

4.5 ANALYSIS OF THEMES GENERATED BY THE GROUPS

All themes generated by the groups were considered and scored. The score was calculated by the number value given to each theme, i.e. 1 for the most important and 5 for the least important. The total score for each theme was then calculated, with the lowest score allocated to the most important theme. Table 4.2 is a summary of priority themes of all three groups.

Table 4.2: Summary of priority themes in all three groups

Theme	Session 1 (Group1)	Session 2 (Group 2)	Session 3 (Group 3)
1	Compassion	Basic education and training	Training
2	Passion	Evaluation	Work environment
3	Professionalism	Communication	Interpersonal relationships
4	Communication	Implementation and evaluation of policies	Social media/public opinion
5	Accountability	Basic ethics	Incentives
6	Ethical behaviour	Debriefing	
7	Assertiveness		
8	Leadership		

The following section will discuss the results of the respective sessions

4.6 RESULTS SESSION 1

In the first session, four participants generated 34 responses to the question. These 34 aspects were grouped together in eight main themes. It was very difficult for the group to reach consensus on the order of importance of the themes. All aspects were important and participants felt very strongly about their respective views. Consensus was reached and themes were placed in order of importance as indicated in Table 4.3, which will be followed by a description.

Table 4.3: Results of Session 1

Themes	Aspects considered
Compassion	Touch with care Sympathy Family centred care Care for the caregiver Comfortable environment
Passion	Passion in what you do
Professionalism	Training on professionalism: Positive first impressions Language Professional conduct Professional appearance Reflection to improve professional conduct
Communication	Consent for procedures Explain all procedures Listening skills training Postnatal contact session to evaluate patient experience Understanding mother's concerns
Accountability	Keep midwives accountable for behaviour Employer accountability for work environment e.g. staff ratio
Ethical behaviour	Training on ethics Staff opinions on ethical codes Reward ethical behaviour Mortality & Morbidity meetings to reflect on behaviour Attend SANC disciplinary hearings as part of teaching strategies
Assertiveness	Level of knowledge and skill to improve uncertainty Patient advocacy Talk your knowledge
Leadership	Including staff in company goals Lead by example Incentives and awards Mentorship programmes Remodelling Trust

4.6.1 COMPASSION

It was very difficult for the group to come to consensus on the order of importance of these themes. All aspects were considered important and participants felt very strongly about their views. Three of the four participants rated compassion as highest importance when it comes to professional conduct. They described it as “touch with care”. They argued that midwives should be driven by compassion for mother and babies. Sympathy for the patient was

mentioned as an important aspect, considering their personal experiences, expectations, fears and anxiety. Midwives should be driven by an inner motivation to meet the physical and emotional needs of patients. The patient is also part of a family and therefore family-centred care is very important and should be considered during all aspects of midwifery care.

Emphasis was also placed on compassion for the caregiver, which is the midwife. The group felt that, in order for the midwife to have compassion for her patients, she needs to be cared for as a professional. A well-equipped, clean and hazard-free environment with sufficient, well-trained staffing will allow the midwife to fulfil her professional duty without constraints. Therefore it is important to ensure a professional, emotional and physical safe environment where the midwife can fulfil her professional role.

4.6.2 PASSION

Passion was seen as the second most important aspect of midwifery care. The word “passion”, was used in the sense that related directly to the enthusiasm and commitment midwives need to have for the midwifery profession. They argued that passionate and dedicated midwives would conduct themselves in a professional manner ensuring evidence-based care grounded on ethical principles. They make it their purpose to ensure holistic care for every patient, ensuring the best outcome possible. During discussions reference was made to the negative perception of midwives being uncaring with a lack of clinical skills and knowledge. Although they considered the influence of the work environment, they still felt strongly that if a midwife was passionate about the profession, she or he would accept responsibility to be skilful and knowledgeable rendering evidence-based care within ethical and professional guidelines and ensuring the best care irrespective of the circumstances to ensure a positive and safe outcome for mother and baby.

4.6.3 PROFESSIONALISM

The third aspect discussed by participants during Session 1 was professionalism. Although it is clear from definitions discussed in the literature review that professionalism refers to a specific skill or ability to perform required interventions, the group felt that it is much more than only skills and knowledge. The group argued that, for compassionate and passionate midwives, professionalism will develop and will be grounded in ethical behaviour; the well-known “do no harm” implying “doing the best for your patient”. This will include a positive attitude and communication in an acceptable and professional manner by well-kept and neat professional midwives. These aspects of professionalism, as well as ethical training in the curriculum, were mentioned as very important. Continuous professional development is very important and may also consist of professional-ethical modules taught in workshops.

Considering the work environment of the participants, the manner in which care is rendered has a significant impact on the outcomes. In the private sector patients are well aware of their rights, and great emphasis is given on the environment. The physical neatness and pleasantness of the labour wards, combined with well-dressed, well-spoken and friendly staff drew a lot of attention. Patient satisfactory surveys do not only focus on competence, but also on interpersonal and environmental factors. It is therefore important to train students in all aspects of professionalism. A neatly dressed, well-kept midwife, displaying a positive attitude, communicating in a professional manner is essential.

Another aspect that can improve professional conduct is reflective exercises to evaluate not only practice-based decisions and actions, but also evaluate how situations were managed in a professional and ethical manner. Reflection needs to be taught and can be of value to the student and professional midwife. This process can enhance the learning process and teach them to improve on standards of care. It can increase self-awareness and motivate students to correct behaviour and work towards excellence.

4.6.4 COMMUNICATION

Communication to the patient was seen as the fourth most important theme. According to the group, professional conduct is communicated to patients in a verbal and non-verbal manner. Language is often the barrier in nursing. South Africa has eleven official languages and it is impossible for nurses to be able to be fluent in all official languages. This often creates a barrier when patients are not able to communicate their needs and problems in English, and midwives may get frustrated due to an inability to explain processes and procedures to patients. Irrespective of these challenges, it is important that the midwife communicates in a professional manner and ensures that the patient for example understands procedures before she will be able to facilitate consent.

Part of communication is to listen to the patient, and this was also mentioned as important. The group also claimed that the use of proper medical terms as well as professional language will instil trust and convey professionalism to the patients. It is important that patients understand what is being said. However, communication also includes aspects of professional conduct through non-verbal messages, for example respect with a positive attitude, empathy, compassion, listening and ensuring that choices will be respected. Ensuring privacy and confidentiality conveys a message of care and consideration. The suggestion was made that communications skills must be part of the curriculum and must be included as part of continuous professional development. A process of feedback from patients, with a specific focus on communication issues may help midwives to improve on

their verbal and non-verbal communication skills and ensure that they understand patients' needs and concerns.

4.6.5 ACCOUNTABILITY

The fifth most important theme that emerged was accountability. Accountability was described as a joint responsibility of the employee and the employer. It is important that the employer creates an environment which enables employees to be professional and accountable. During this discussion staff ratios, work environment and lack of support were mentioned as aspects that influence employees' ability to perform their professional duties. If the work environment does not allow midwives to fulfil their professional duties, they cannot be held accountable. But it is equally true that employees must understand that they are accountable for their actions and cannot always find excuses for poor professional conduct. It is interesting that aspects involving management were only later discussed and were not seen by the members of this group as the most important aspect.

Accountability is one of the aspects of professionalism that needs to be addressed during training. During discussion it was argued that it is very important to understand the responsibilities and implications of accountability. Accountability is often only seen as punitive measures when things go wrong. However, it should be part of a culture to ensure the best care of patients.

4.6.6 ETHICAL BEHAVIOUR

Although ethical behaviour is the foundation of professionalism, the group felt that, due to the importance of ethical values in midwifery care it needs to be addressed separately. They felt very strongly that ethical principles are not addressed adequately during training. The Code of Ethics for nursing in South Africa includes aspects that need to be addressed in the curriculum for midwives, such as human rights, the right to life, dignity irrespective of age, race, politics, gender or sexual orientation. The well-known ethical principles of justice, non-maleficence, beneficence, veracity and dignity were mentioned. One such aspect highlighted was respect for patients, which is implied in all ethical principles. However, the group argued that respect for patients is not possible if midwives do not respect themselves and the colleagues working with them. Therefore it is important to ensure a work environment that adheres to the same ethical principles required of a midwife in caring for his or her patients. For example, caring programmes for midwives will communicate respect and compassion, debriefing sessions will communicate the ethical principle to "do good" and in doing so, a culture of caring can be instilled. The same principle will apply to students during training. This aspect was addressed during the discussion on compassion in 4.5.1. Furthermore, it is important to reiterate ethical principles during professional development.

Staff opinion on ethical issues must be tested and opportunities must be used to improve understanding. In the same way that staff should be rewarded for excellent skills and knowledge, ethical behaviour should also be considered when rewarding staff. New staff is often evaluated on skills and knowledge, but rarely on their understanding of ethical conduct.

Often during the discussion of practice-related aspects a lot of focus is put on knowledge and skill, but rarely there will be reference to how certain events were managed from an ethical perspective. Suggestions for professional development included professional-ethical modules been taught in workshops, discussion of ethical aspects during mortality and morbidity meetings in the hospital and visiting SANC disciplinary hearings. Evaluation of newly qualified midwives must also include an ethical component.

4.6.7 ASSERTIVENESS

The aspect of assertiveness evoked strong feelings and a vigorous discussion followed. The understanding of the group about assertiveness is a midwife that has a solid theoretical and skill base. One participant felt particularly strong about putting assertiveness as highest priority. She felt that if a midwife is assertive, she will prevent a lot of harm. Assertiveness is based on adequate knowledge and skills to identify risks, advocating for the patient, teaching, guiding to ensure the best outcome for the mother and baby. She argued that an assertive midwife is also a caring and compassionate person with a passion for her profession. The midwife understands her role as advocate and is not afraid to intervene on behalf of her patient. Professional conduct will be improved by including necessary knowledge and skills into basic training, and also assertiveness training to ensure advocacy for patients.

4.6.8 LEADERSHIP

It is interesting to note that this group placed leadership as the lowest priority. Considering that the participants are well qualified and well established in their professional development, they felt strongly that inherent factors such as passion, compassion and motivation are the determining factors for excellent professional conduct. However they recognise the importance of management to role model professional behaviour. It is important to include staff members in developing company values and goals to ensure that there is a mutual understanding of professional and ethical principles. Mentorship was also seen as a means to develop midwives in their professional behaviour. Rather than always have a punitive method of changing behaviour it was suggested that mentoring of midwives would have better outcomes. Mentoring will also increase trust between staff members and management with a higher possibility of improving professional conduct. Incentives and awards were mentioned as ways in which management can recognise and reward excellent behaviour.

The group was often more focused on what professional conduct entails as on how it can be improved, but it was implied throughout the session that education and continuous professional development on these aspects were very important. The table below indicates the themes developed during discussions and explains how participants voted on the importance of each theme:

Table 4.4: Summarised research priorities, ranked in order of importance Session 1

Themes	Participant 1	Participant 2	Participant 3	Participant 4	Total
Compassion	1	1	2	4	8
Passion	2	3	3	5	13
Professionalism	1	7	4	3	15
Communication	2	4	5	7	18
Accountability	5	7	6	2	20
Ethical behaviour	3	6	8	4	21
Assertiveness	1	8	8	6	23
Leadership	6	5	7	8	24

4.7 RESULTS SESSION 2

Due to the challenge of doing group sessions on a Saturday, other methods of gathering participants for group sessions were explored. A notice received of a meeting for the breastfeeding forum lead to the idea of using this platform to collect data. The chairperson of the Gauteng Breastfeeding Forum gave permission to do a nominal group session directly after the close of the meeting. The members of the forum were informed and invited ahead of time. The criteria for participation were made clear. Consent forms were distributed and signed. Four midwives indicated their interest to participate and consent was signed.

In the second session, four participants generated 35 responses to the question. These 35 aspects were grouped together in six main themes as indicated in Table 4.5 below. Discussions led the group to realise that for all of them the first priority is training on aspects mentioned in the table, moving to the necessity of evaluation of that training and an in-service reiteration of the basic training on a constant basis. Aspects of organisational responsibility, e.g. policies and work procedures and audits were seen as of less importance.

There was no reference made to the importance of leadership. This may be due to the fact that these midwives work independently and are totally self-driven in their practices. Looking at their credentials, they are well trained and form part of the leadership group in the midwifery profession.

Table 4.5: Results of Session 2

Themes	Aspects considered
Basic education and training	Professional and ethical development: ethical principles, advocacy, collegial respect; Cultural sensitivity: religion and culture; Self-development/interpersonal skills: self-esteem; Teaching methods: workshops, seminars, case presentations, ward rounds, peer review, debate groups, technology to improve learning experiences; and Consideration of patient experiences.
Evaluation of staff	Patient feedback system: email, text message, whatsapp, call (anonymous or not); Patient complaint feedback: review of complaints and follow-up; Peer review of staff conduct; Staff assessments and appraisals; Incentives for professional conduct; Guide and mentor staff, not always necessary to be punitive; Non-judgemental mentoring; Continuous professional development on aspects related to staff performance, ethos of nursing; Continuous professional development and peer review must be written into job contract.
Communication skills	Interpersonal skills; Team building events to improve communication and team work.
Implementation and evaluation of policies	Continuous updating; Align with SANC regulations; Auditing on implementation of policies.
Ethical principles	Correlation between self-respect and respect; Advocacy;

	Morals and values; Culture and religion; Informed consent; Professional conduct of midwives; Do no harm.
Debriefing after adverse events	Support to patients, staff and families; Part of teaching and mentoring; Support groups.

4.7.1 BASIC EDUCATION AND TRAINING

The first theme that emerged from the group was basic education and training. Fifty percent of the group voted education and training as the most important aspect in addressing the improvement of professional conduct. Fifty percent of participants voted on aspects of basic ethics, and during discussions realised that basic ethical principles form part of the fundamental aspects taught during basic training. Verbal and non-verbal communication is the means of translating ethical principles to the patient, the family and the multi-disciplinary team, and therefore communication skills are critical in midwifery care. Due to the importance of communication, it will be discussed separately. During discussions several components other than the obvious skills and knowledge components of training were discussed, such as professional and ethical development, cultural sensitivity, self-development and interpersonal skills.

Professional and ethical development

Professional and ethical training received high priority during discussions. It was seen as the foundation of each midwife and need to be instilled during basic training. Professional aspects such as responsibility and accountability and legal guidelines were emphasised. Ethical aspects focused on basic ethical principles of beneficence, non-maleficence, respect and dignity. Respect is very important, not only for the patient, but also for the multi-disciplinary team. If colleagues do not treat each other with respect, why would they treat their patients with respect? Without teamwork which requires respect, the best outcome for the patient cannot be ensured. Although teamwork is an aspect taught as part of communication skills, it is also mentioned in the sense of professional and ethical development. Aspects of teamwork must be taught during basic education and reiterated constantly during professional development. Furthermore, respect must be the basis of the midwife-patient relationship. Respect is an aspect often mentioned as part of human rights, but it is not always taught how to convey respect. Considering the complexity of society with

different cultural practices and religious viewpoints, respect for people is the only way to manage complex situations. A suggestion was made that feedback from patients must include aspects of ethical care, for example to indicate if they were always treated with respect or that they felt their basic human rights were protected.

Another aspect discussed was the importance of advocacy. Apart from being a legal responsibility of the midwife to advocate for her patient, it forms part of the midwife-patient relationship based on the trust that the midwife would inform, guide and care for the patient in order to ensure the best outcomes for mother and baby. Part of this process of advocating for the patient is making sure that the multi-disciplinary team provides the best care for the patient. Advocacy must be taught.

Cultural sensitivity

The health care setting has become increasingly challenging due to several different reasons. One of these reasons is the cultural diversity of patients that need to be dealt with on a daily basis. This may become a source of frustration for both health care worker and patient and may lead to poor health outcomes. It is therefore very important to include aspects of sociology in the curriculum of midwives, for example information on different cultures with each their own health-related practices, religion, family structures, gender roles and child-raising methods.

Apart from the fact that knowledge will improve ethical conduct, patient-centred care is the cornerstone of midwifery care, but is not possible without cultural sensitivity. A midwife who is well-trained in cultural differences will understand the role and influence of culture in health care and will be able to detect barriers to communication, will be able to respond appropriately to the different needs of different cultures, and will be more effective in her care of patients. Cultural competence must be of high priority in midwifery training.

Self-development/Interpersonal skills development

Both these terms were used. One participant argued on the importance of self-development. Aspects of self-development mentioned were self-esteem, confidence and the ability to understand who you are. She felt strongly that if a person/midwife's self-esteem is low with a low level of confidence, she will not be able to manage patients with respect. She will also not have the ability to advocate and put another person's needs above one's own needs. It is therefore important to help students to discover who they are and develop the necessary characteristic required to be a "good midwife". Considering the need for a relationship between a midwife and her patient, and a midwife and the team, interpersonal skills are very important. Examples of these skills are communication, listening skills, etiquette and attitude,

team work, stress management and compassion. Participants agreed on the need for training on these skills during basic training of midwives.

Teaching methods

Methods of teaching were deemed important in order to ensure understanding of what is needed in a diverse world of different cultures and increasingly complex health care systems. Workshops, seminars, case presentations, ward rounds, peer reviews and debate groups were suggested to ensure the integration of theory and practice. It was also suggested that technology must be included to interest students and to make teaching interesting and stimulating.

4.7.2 EVALUATION OF STAFF

The second theme focused on the evaluation of what is happening in practice. This aspect consisted of two parts; namely evaluation of what is the experience of the patient and secondly, the evaluation of the performance of the midwife.

The group felt strongly that a system of patient feedback was required. This system could be to call the patient, send a text or WhatsApp message or ask a patient to fill in an on-line questionnaire to rate the quality of the service rendered or problems experienced. The problems indicated would then be evaluated and discussed with staff members involved. Staff assessment and appraisals could be directly linked with the complaint system and could form the basis of continuous professional development. Peer review could form an important part of the process where staff members evaluate each other's practices and professional conduct and assist and help each other. Aspects of professional ethos must also be included in professional development to reiterate the importance of professional and ethical conduct. The challenges were acknowledged by the group. Evaluation of performance must be seen as mentoring and professional guidance in a non-judgemental way and not always as punitive measures. The purpose of the process must be understood as a method to improve care, ensure standards are met and that patients are treated with respect and dignity. In addition, it is also a way to develop and strengthen staff members and helps them to improve their skills and knowledge to build confidence, enhances self-esteem and improve job satisfaction and motivation. Evaluation and performance measurement should be communicated to new staff members as a method to explain the culture of excellence. Incentives for professional conduct and excellent patient care could be part of the culture of the work place.

4.7.3 COMMUNICATION SKILLS

The third theme focused on communication. This group did not focus on the challenges in language barriers, the reason being that they are working as private midwives and mostly see well educated patients speaking either Afrikaans or English. They saw communication as part of an interpersonal skills set that needs to be developed referring to emotional intelligence. Communication is seen as one of the most important aspects of care, not only focussing on language but on attitude, listening, including a patient into decisions of care and compassion. It entails a relationship of trust and sensitivity to the patient's needs. Another aspect of communication discussed in the group focused on communication in the multidisciplinary team. The relationship with other members of the multi-disciplinary team is as important and needs to be strengthened in order to ensure the best care for the patient. A suggestion was made to organise regular team building events that could help in development of communication and other interpersonal skills.

4.7.4 POLICIES AND WORK PROCEDURES

The fourth theme on the list focused on the need for updated policies and work procedures aligned to SANC regulations and available guidelines on care of patients during antenatal, intrapartum and postnatal periods. Policies and work procedure will ensure that care is standardised and that patients receive the best care based on the most current evidence. These documents can also be used as training tools for new staff members, ensuring competence of all staff. More experienced staff members may use it as a point of reference in more complex situations. During discussions of adverse events, reference was often made to policies and work procedures to establish the reasons for the adverse events. These documents need to be available to staff members and should be discussed during training sessions. An audit system should be in place to ensure that the policies and procedures are actually implemented.

4.7.5 ETHICAL PRINCIPLES

The fifth theme focused on basic ethical principles. Although this theme had been discussed as part of basic training in 4.6.1, the group wanted to re-emphasise the importance of ethical values. The discussion revolved around the important need of morals and values when caring for patients. "Do no harm" is the basis of all decisions made. However, more emphasis was put on the challenge created by caring for people from different cultures and religions. Basic training should include a curriculum on sociology to ensure that midwives are culturally competent. The issue of the correlation between self-respect and respect for patients was discussed at length and related back to the discussion of interpersonal skills during the basic training of midwives in 4.6.1.

4.7.6 DEBRIEFING AFTER ADVERSE EVENTS

The final theme was on debriefing of staff members when an adverse event had occurred. Compassionate care with excellent outcomes for mother and baby is the cornerstone of midwifery care. However, when outcomes are negative it may have a severe impact not only on the patient, but also on the midwife. The midwife needs to be taught and mentored on how to support parents and family members. But she should also be supported. She may feel that she failed the patient and the profession. Fear and guilt may render her unable to fulfil her duties. Advocacy and assertiveness are often compromised due to loss of confidence and fear, and midwives tend to also compromise on ethical values. Job satisfaction may suffer from fear of recurrence of adverse events and it is therefore important that midwives should be supported by management through employment wellness programmes. Debriefing is essential to help her work through the emotional turmoil and to resume her duties with confidence. Support groups can be one such method to help the midwife cope with the challenges she faces during this period. The following table indicates the themes that emerged from group discussions and how they voted on the importance of each theme:

Table 4.6: Summarised research priorities, ranked in order of importance Session 2

Themes	Participant 1	Participant 2	Participant 3	Participant 4	Total
Basic education and training	1	1	3	3	8
Evaluation of staff	3	4	1	1	9
Communication	3	3	2	4	13
Implementation and evaluation of policies	2	6	4	2	14
Ethical principles	4	2	5	5	16
Debriefing after adverse events	6	5	6	6	23

4.8 RESULTS SESSION 3

In the third session, five participants generated 26 responses to the question. These 26 aspects were grouped together in five main themes (see Table 4.7). This group had three very young participants and it was interesting to see the shift in perspective on how the conduct of midwives can be improved. Training of midwives was still seen as a high priority, but much more emphasis was placed on the work environment and what the organisation can do to ensure professional conduct from the midwives. They also focused on the role the social media can play to establish a more positive attitude towards midwives. They mentioned concerns on how to protect midwives in the current health care system because they felt that patients were not always fair and could be very aggressive from time to time.

Table 4.7: Results of Session 3

Themes	Aspects considered
Training	Professional conduct; Cultural sensitivity; Confidentiality; Interpersonal skills training; Empathy;

	Care programmes for students.
Work environment	<p>Management to treat midwives with respect;</p> <p>Support from management when midwives are treated with disrespect from doctors;</p> <p>Appropriate role modelling;</p> <p>Focus on responsibilities/work outcomes;</p> <p>Awareness of negative behaviour and consequences;</p> <p>Excessive work load;</p> <p>Maintaining of confidentiality;</p> <p>Culture of positivity in wards, safe place to share experiences and learn, fairness;</p> <p>Clearly displayed moral and ethical principles;</p> <p>Regular meetings to discuss concerns, work place issues, etc.;</p> <p>Counselling and debriefing;</p> <p>Positive attitude towards colleagues/ cultural sensitivity;</p> <p>Projects to enhance care of patients.</p>
Interpersonal relationships	<p>Self- development;</p> <p>Relationships based on respect;</p> <p>Discussions on cultural issues;</p> <p>Address disrespect;</p> <p>Open conversations;</p> <p>Mutual respect among health care professionals;</p> <p>Treat patients the way you want to be treated.</p>
Social media/public opinion	<p>Use media to teach public;</p> <p>Positive stories on midwifery care;</p> <p>Maintain confidentiality/exposure.</p>
Incentives	<p>Patient rating;</p> <p>Performance development;</p> <p>Appreciation (carer of the month awards).</p>

4.8.1 BASIC TRAINING

The first theme that was discussed focused mainly on the basic training of midwives. Apart from the obvious necessity of skills and knowledge, more emphasis should be placed on aspects such as professional conduct and what it means. It is important to teach students on what is expected of a professional person and how it is communicated in the clinical environment. Cultural sensitivity was specifically mentioned as very important, and training to ensure cultural competence was deemed essential.

They argued for the need in developing interpersonal skills in order to ensure professional conduct. The discussion revolved around aspects such as respect, confidentiality and privacy. More time must be allocated to these aspects to understand how patients and colleagues must be treated.

Empathy towards patients was mentioned as a difficult characteristic to develop. The group felt that the way people are raised in families have a significant impact on how they treat other people, but also believe that behaviour can be changed by teaching interpersonal skills and through observation of expected behaviour in role models. All these aspects have been previously addressed.

The concept of “care for the caregiver” was introduced in Session 1 and repeated by this group. They felt that through care programmes for students showing empathy and acknowledgement for their challenges on personal matters, respect and dignity are being demonstrated to students. A similar theme was touched on during discussions in Session 2 on debriefing in 4.6.6.

4.8.2 WORK ENVIRONMENT

The second theme focused on the work environment. This group focused strongly on the effect of the work environment on the professional conduct of midwives. It may be because they are still young and in junior positions where they do not have the influence or ability to change their work environment and feel that the management is responsible to make the needed changes. Aspects mentioned were excessive workload that is often experienced in labour wards in the public sector. Staff shortages lead to the inability to render the necessary care, leading to frustration, guilt and anxiety that may be the underlying cause for unprofessional conduct.

Another aspect that was addressed is the disrespect that midwives undergo from doctors, leading to poor relationships and poor communication. Midwives are often treated unfairly by management by only considering the complaints from the doctors and patients and not listening to the midwives’ side of the story. This is also applicable in the private sector.

Management needs to support and protect midwives. Midwives often experience anxiety and stress when they cannot fulfil their professional duty due to practice constraints. In hospital settings the practice is task-orientated and doctor-centred, moving away from professionalism that is autonomous and allows midwives to make decisions on needs and care of patients. Often company values differ from the midwife's focus on patient-centred, individualised care to a bigger focus on productivity and financial efficiency. This may impact on work satisfaction and motivation, with a negative impact on professional conduct.

Role modelling was also perceived as an important aspect and part of the responsibility of management. The process of socialisation during formal studies is very important, but if values taught during this phase are not developed in the work environment, it may be abandoned during the first years of practice. Midwives learn a lot from the role models they see in practice, and those examples of professionalism will teach them the ability to develop the necessary skills to influence their work environment. Management need to ensure that positions are filled by knowledgeable and skilled midwives who also display professional behaviour at all times. It is important to create a positive culture in the hospitals.

In cases of adverse or traumatic events, management is responsible to protect and support staff through counselling and debriefing sessions. This aspect was discussed in 4.6.6.

Emphasis was placed on training on cultural sensitivity. A policy of open dialogue on cultural issues may create an understanding for different cultural practices. This related not only to colleagues, but also to patients and can be done as part of projects to enhance patient care. This aspect was discussed in 4.6.1.

The group also recognised the importance of how the midwife understands her professional role and the accountability she has towards the employer and patient. They feel that management often allow midwives to get away with unprofessional conduct such as not keeping patient information confidential. Systems of accountability must be put in place to ensure behaviour changes through consequence management. The lack of accountability systems is seen as a major contributing factor in the occurrence of disrespectful and abusive care.

They also discussed the need for a positive culture in the hospital wards. Such a culture can be created by a safe environment where midwives can practise and learn, be mentored by knowledgeable rolemodels and management, be treated fairly, but also with a clear system of accountability and an expectation of moral and ethical principles. Regular meetings to discuss concerns, work place issues and adverse events will allow midwives to grow

professionally. This meeting will create an opportunity to build strong collegial relationships built on respect.

4.8.3 INTERPERSONAL RELATIONSHIPS

The third theme was interpersonal relationships. This aspect was also discussed in the other two groups, not necessarily as an aspect on its own, but as part of training and professional development. All participants agreed on the importance of and the need for interpersonal or “soft skills” training during the basic training of midwives. Aspects of interpersonal skills that were discussed were empathy, cultural sensitivity attitude and respect. The group argued that respect is essential in the relationship with the patient, but also with the members of the multi-disciplinary team. They suggested that a culture of open conversation should be created in order to understand the different members of the team and to develop an understanding of the stressors and challenges that each faces. Disrespect should be addressed and should not be allowed to fester.

Self-development was also mentioned as important. The argument for self-development related directly to patient experience and need to be discussed during basic training. The group felt the negative perception of midwives related to their conduct can be traced back to personal development.

One participant argued on the importance of self-esteem and confidence. She felt strongly that, if a midwife’s self-esteem is low with a low level of confidence, she will not be able to manage patients with respect, will not be able to make critical decisions and advocate, ensuring the best possible outcome for her patient. Their understanding of professional conduct has been described in terms of “to treat patient as you want to be treated”. This may even contribute to increased mortality rates.

The understanding of cultural differences was repeated and in need of constant reminding and training.

4.8.4 PUBLIC OPINION/SOCIAL MEDIA

The fourth theme relates to social media and public opinion. This topic is no surprise, considering the age of this group’s participants. The group argued the positive aspects of social media, for example, social media can be used very effectively to convey positive messages regarding midwifery care to the world. It can also be used for development purposes, for example, discussions of current research, online reading and training, and support for professionals.

Unfortunately social media is often used as a platform to complain and can create a very negative picture of nursing and midwifery care. Not all midwives are unprofessional and disrespectful and often render excellent care. If positive stories can be shared, obviously with the necessary permission, it can create a more positive attitude towards midwifery care. It is therefore very important to follow the rules when using social media. Keep the posting person and patient free to protect the basic human right of privacy and confidentiality. It is also important to consider your own privacy and remain professional at all times.

4.8.5 INCENTIVES

The fifth theme discussed concentrated on the use of incentives to create a culture of excellence among staff. It is interesting to note that the idea of incentives comes from the group with young and recently qualified midwives. The issue of incentives relates to motivation.

Several methods to motivate staff have been suggested during group discussions. Patient ratings can be used as a tool to measure staff performance and so implied that incentives should be based on performance. This aspect is a repetition of a suggestion made during Session 2 and was discussed in 4.7.2. Appreciation notes can be very rewarding and can be linked to a system of awards, for example “carer of the month” rewards.

Performance development can be used in a positive way to help midwives build on good skills and to work on aspects that need development. The following table indicate the different themes that emerged from the group discussion and how the participants voted the importance of each theme:

Table 4.8: Summarised research priorities, ranked in order of importance Session 3

Themes	Participant1	Participant 2	Participant 3	Participant 4	Total
Training	1	3	1	1	6
Work environment	2	2	3	2	9
Interpersonal relationships	1	3	2	4	10
Social media/public opinion	5	4	5	3	17
Incentives	4	5	5	4	18

4.9 SUMMARY

During the final analysis of the collected data, the themes that emerged were discussed with the moderators and it became clear that all discussed themes related to the question on how to improve professional conduct. These themes can be grouped in two categories: basic education and training and the practice environment. A strong foundation of knowledge, skills and ethical values must be built. Other aspects that became clear during discussions and that need to be added to the curriculum are cultural sensitivity training, interpersonal skills development and communication, and assertiveness training. However, education should be built on in the work place through on-going professional development. Furthermore, management should understand that the work environment has a significant impact on the conduct of midwives and it is therefore important to create a work environment where risks to the midwife and patient are limited and where quality patient care can be rendered.

Evidence of the positive impact described in all the themes was found during a literature review. The aspects of the two main themes that emerged in the final analysis, namely basic education and training and work culture and continuous professional development, are discussed with supporting literature in Table 4.9.

Table 4.9: Themes generated during group sessions and the literature that confirm or disconfirm

4.9.1 BASIC EDUCATION AND TRAINING
<p>4.9.1.1 Professionalism Several aspects can be grouped under the heading of professionalism. This theme was very prominent during discussions on professional conduct, and according to the groups, a very important aspect in the curriculum to train midwives. The following aspects were highlighted and evidence in the literature reiterated the importance of these aspects:</p> <p>4.9.1.2 Accountability Competency 1, described in the Essential Competencies for Basic Midwifery Practice of ICM, the first mentioned requirement for a midwife is knowledge, followed by a detailed description of the needed professional behaviour. The first sentence reads as follows. “The midwife is responsible and accountable for clinical decisions and actions made” (International Confederation of Midwives 2010:4).</p> <p>In the Nursing Act no 33 of 2005, the scope of practice of midwives described in Regulation 786, clearly states that the midwife assumes full responsibility and accountability for certain stipulated tasks, for example promoting, restoring and maintaining the health of a mother and baby (Department of Health 2013b:14). Regulation 254 of the South African Nursing Council indicates that the training of midwifery students needs to include the principles of professional practice (South African Nursing Council 1975:4). Professional practice includes aspects such as responsibility and accountability.</p> <p>4.9.1.3 Ethics Regulation 254 of the South African Nursing Act of 1978 stipulates very clearly the guidelines for the training of midwives in South Africa. Apart from the obvious inclusion of scientific knowledge and emphasis of necessary midwifery skills, midwifery should be practised in a professional and ethical manner (South African Nursing Council 1975).</p> <p>The well-known ethical principles of justice, non-maleficence, beneficences, veracity, fidelity and altruism should form the foundation of midwifery care in South Africa (South African Nursing Council 2013a:4). Patient advocacy is a responsibility of the midwife and needs to be taught during training. However, it is also an ethical aspect grounded in compassion and respect (Department of Health 2013:16). Considering the</p>

evidence of abuse and disrespect in midwifery care, it is important to ensure that the curriculum for midwives includes a comprehensive module on professional and ethical aspects. This point is proven in the literature, with several documents listing the rights of child-bearing women (Manning & Schaaf 2016; White Ribbon Alliance 2011).

In a systematic review on the mistreatment of women during labour, almost all aspects relate to ethical aspects of care, e.g. verbal and physical abuse, stigma and discrimination, refusal of pain relief, lack of informed consent, breaches of confidentiality, lack of support and substandard care, to mention but a few (Bohren *et al.* 2015:10). Training of students socialise them in the way they think and behave (Halldorsdottir & Karlsdottir 2011:807). Although ethical issues are included in the midwifery curriculum, several articles argued the lack of training time and poor quality of educators. Specifically in South Africa it was found that short courses do not allow for adequate training on decision-making and responsibilities (Filby *et al.* 2016:9). The four year integrated course is criticised for producing midwives of substandard quality, partly due to time constraints; and because staff are forced to do midwifery training, they also lack motivation and interest and therefore delivery poor and disinterested care (Schoon & Motlolometsi 2012:784). Educators are often removed from clinical practice and lack competence and skill to demonstrate basic ethical principles.

Role-modelling was repeated during discussions as an important aspect of training (Filby *et al.* 2016:9). Paired learning has been proven to be effective in training midwives. This process can be successful when students are led by qualified midwives who are trained and function as preceptors or by students at different levels. The advantages are numerous, but specifically aligned to the discussion on professionalism, it creates a platform to teach and demonstrate professionalism and ethical values (Cohen, Thomas & Gerard 2015:691). More time should be allocated to these aspects to observe how patients and colleagues are treated.

Empathy towards patients was mentioned as a difficult characteristic to develop. How people are raised in families have a significant impact on how they treat other people; however, it is also believed that behaviour can be changed by teaching interpersonal skills and through observation of expected behaviour in role models. For this purpose, students should be exposed to practical settings where they can be taught while working with patients (Mosadeghrad 2014:84).

4.9.1.4 Reflection

Reflection needs to be taught and can be of value to the student and professional midwife. This process can enhance the learning process and teach them to improve on standards of care. It can increase self-awareness and motivate students to correct behaviour and work towards excellence (Kolyva 2015:16). Reflection can also be valuable as part of the debriefing process after adverse events.

4.9.1.5 Advocacy

Another aspects discussed was the importance of advocacy. Apart from that it is a legal responsibility of the midwife to advocate for her patient (South African Nursing Council 2013:2), it forms part of the clinical responsibilities of a midwife to “initiate and maintain a therapeutic relationship” (Department of Health 2013:14). The midwife-patient relationship is based on the trust that the midwife will inform, guide and care for the patient in order to ensure the best outcomes for mother and baby. Part of this process is to advocate for the patient, making sure that the multi-disciplinary team provides the best care for the patient (Nursing and Midwifery Council 2015a:5). It also means that the midwife needs to question poor practices and protect and speak up when attitudes or actions are discriminatory (Nursing and Midwifery Council, 2015, p. 5) (Nursing and Midwifery Council 2015a:5).

Advocacy is taught. Included in the curriculum for training of midwives it clearly states the inclusion of: “the law governing the practice of midwifery, including the regulations regarding the conduct of registered midwives which shall constitute improper or disgraceful conduct and the conditions under which they may carry on their profession, shall be taught at an applied level throughout the course” (South African Nursing Council 1975:2). However, from literature it is clear that several barriers to advocacy exist and that it is a difficult and complex responsibility. Barriers mentioned are inability or weakness, lack of support, poor ethical conduct and motivation, physician-led practices, risks involved and not enough time spent with patients. Another factor to consider is the lack of knowledge and insight that enables one to advocate effectively (Negarondeh, R; Oskouie, F; Ahmadi, F; Hallberg, I.R 2006:4). It is therefore critical to ensure a comprehensive curriculum with an extended theoretic component as well as professional practice components such as advocacy.

4.9.1.6 Cultural sensitivity

The ethical guidelines for midwives are very clear in terms of how to deal with patients from different cultures (South African Nursing Council 2013a:2). Cultural sensitivity

training is therefore essential to ensure cultural competent midwives. Patient-centred care is the cornerstone of midwifery care, but is not possible without cultural sensitivity. A midwife who is well trained in cultural differences will understand the role and influence of culture in health care and will be able to detect barriers to communication, will respond appropriately to the different needs of different cultures and will be more effective in her care of patients (Lehman, Fenza & Hollinger-Smith n.d.).

4.9.1.7 Assertiveness

Assertiveness is not a word found in the Nursing Act or even in the regulation giving guidelines of what needs to be included in the training of midwives. In the Essential Competencies for Midwives, reference is made to knowledge and skills, respect, dignity, responsibility, accountability, effective communication and many more attributes needed in order to be able to care for patients (International Confederation of Midwives 2010). By implication one can assume that the ability to be assertive should be part of the skills set of an effective midwife.

Assertiveness is the ability to communicate clearly while considering a patient's rights. This is done calmly without fear and anxiety, considering the goals and taking full responsibility of the message you are relating to the patient. The goal should always be to benefit the patient. Confidence in what you are communicating to the patient or the multi-disciplinary team will be visible in direct eye-contact and a positive body posture (Deltsidou 2009:323). Studies done indicated that nurses are mostly more assertive outside of the clinical setting, indicating that their training has a negative impact on their assertiveness ability (Deltsidou 2009:323). It is therefore important to have tutorial support to assist students in the development of assertiveness and help them deal with stress in the clinical field.

Another aspect to consider is the culture of subjugation in nursing. Students are trained in a culture of defeat and powerlessness, adding to their inability to be assertive. This aspect related directly to self-esteem discussed as part of interpersonal skills. It was found that students with low self-esteem do not display the needed professional conduct and lack the ability to communicate with assertiveness (Deltsidou 2009:324).

4.9.1.8 Communication

Communication forms the foundation of all midwifery care considering the importance of a bond between the midwife and her patient (International Confederation of

Midwives 2010:4). Good communication allows for treatment and cares according to the individual needs of the patient and so improve the possibility of the outcomes (Nielsen, Tørring & Hansen 2014:3). Again it can be said that no specifications are made concerning the need for training in communication skill, but it can be assumed as part of professional practice training (South African Nursing Council 1975:2). It has been found that health care workers lack the necessary communication skills due to a lack of training. Communication skills training in general are often overseen or lack depth when it comes to nursing curricula (Steckler 2012:1; Nielsen *et al.* 2014:3). The challenge of communication in South Africa has been recognised as one of the contributing factors for poor patient outcomes (Benjamin *et al.* 2016:74) and needs to be addressed during the basic training of students. It has been proven in research that communications skills can be improved by theoretical introduction, reflection on own communication ability and structured skills training (Nielsen *et al.* 2014:3). At university colleges in Denmark, a communication skills laboratory was established and proven to be very effective in improving communication skills in health care workers (Nielsen *et al.* 2014:3).

Considering the discussion on assertiveness, it is clear that communication skills are necessary in the development of assertiveness.

4.9.1.9 Leadership

Nurses and midwives are primary care givers with the responsibility to manage and lead the care environment and taking leadership in their relations with patients, family and the multi-disciplinary team. It has also been proven that leadership development increases work satisfaction and improves patient care (Curtis, Sheerin & De Vries 2011:2).

The lack of leadership in nursing has been recognised and concerns rose. The question is whether primary education deems leadership skills development important enough to be included in the curriculum (Curtis *et al.* 2011:2). In addition, another question needs to be answered: Is leadership an inborn ability or can it be cultivated through programmes? Both of these questions were addressed in a systematic review. The study concluded that older nurses are better leaders through experience and personal development, but clearly states the fact that leadership can also be taught through programmes. It is important to include leadership skills training in the curriculum of basic training to develop skills early in the nursing career (Curtis *et al.* 2011:3).

4.9.1.10 Interpersonal relationships

The first aspect mentioned in the International Code for Midwives developed by the ICM, is midwifery relationships (International Confederation of Midwives 2014:1). In a study done by Halldorsdottir and Karlsdottir in 2011 of what constitutes a “good midwife”, they concluded that caring, professional competence and wisdom is core, together with interpersonal competence, personal and professional development (Halldorsdottir & Karlsdottir 2011:807). If that is the core of our responsibility, interpersonal skills must be one of the most important requirements to be a midwife. Interpersonal skills, or “soft skills” as some refer to it, is the essential skills one needs to have to deal with patients (Barakat 2007:152). Communication has already been discussed separately, but is also part of interpersonal skills. Other aspects of interpersonal skills are described as listening skills, establishing a relationship of trust, a caring and supportive attitude, verbal communication and the ability to understand non-verbal communication (Halldorsdottir & Karlsdottir 2011:807). Several ways can be used to develop these skills. Interpersonal skills training, as well as the assessment of these skills as part of the assessment of other skills, should be included in the curriculum for medical professionals (Barakat 2007:153).

4.9.2 WORK CULTURE/CONTINUOUS PROFESSIONALISM

4.9.2.1 Accountability

“See it, own it, solve it and do it” is the attitude that is needed to overcome difficult and challenging circumstances. This is a statement made by the Human Rights Watch investigating allegations of abuse and substandard care of women in maternity facilities in the Eastern Cape (Human Rights Watch 2011b:1). One of the possible reasons for poor outcomes for mothers and babies is directly related to the poor professional conduct of midwives, and the lack of accountability systems is seen as a major contributing factor in the occurrence of disrespectful and abusive care (Human Rights Watch 2011a:54; Bohren *et al.* 2015:13).

However, in successful organisations it was found that when accountability is clarified before something goes wrong and is seen as “an obligation, a willingness to except responsibility”, there is a mind shift to prevention rather than using punitive measures to rectify a situation (Manojlovich & Ketefian 2002:18). When there is openness and a willingness to learn from mistakes, students and staff will feel free to report and take responsibility. A change in focus is needed from mistakes and consequences to a culture of learning and effective management of choices made by employees (Boysen

2013:400). However, can accountability be expected from employee if responsibility is not clarified or the work place condition is not optimal?

4.9.2.2 Policies and procedures

There is a very strong link between organisational culture and professionalism (Manojlovich & Ketefian 2002:28). Therefore, professional conduct of midwives will be influenced by professional aspects such as the environment where midwives practice, retention of staff and collaboration among the multi-disciplinary team and more. However, part of the culture also includes clear guidelines when it comes to aspects such as responsibility and accountability. Several documents exist, i.e. Guidelines for Maternity Care in South Africa (Department of Health 2015) and Essential Competencies for Basic Midwifery Practice (International Confederation of Midwives 2010). They are frequently updated on the most current research, suggesting the evidence on the best practices to follow in caring for a pregnant patient. Furthermore, each health care institution is required by law to have updated policies and procedures stipulating the management of patients during their treatment in that institution. The purpose of the policies mostly focuses on risk management and is necessary to ensure that set standards are followed making use of the latest evidence and best practice guidelines to ensure the safest and best care for the patients. Due to the complexity of care one can also not rely on the memory of staff members and it serves as a reference for new staff members and a constant refreshing of more experienced staff members. It is also a reliable method to ensure compliance to legal regulations and laws (Irving 2014).

4.9.2.3 Ethics

Although it can be assumed that all midwives will be trained on ethical aspects of midwifery practice, one cannot assume that a newly registered midwife will understand and be able to practise in an ethical manner once she is confronted with a real-life situation in practice. There is often a difference between what has been taught and what is expected in practice (Manojlovich & Ketefian 2002:19), and therefore it is important that guidance should be given during professional development.

4.9.2.4 Assertiveness

The definition of assertiveness is to be bold and confident in what you do and what you perceive as your duty as a professional person (Merriam-Webster Dictionary, 2018) (Merriam-Webster Dictionary 2018). However, assertiveness is not possible if a professional person is not skilled and knowledgeable (Timmins & Mc Cabe 2014:4).

Assertiveness is based on adequate knowledge and skills to identify risks, advocating for the patient, teaching, guiding to ensure the best outcome for the mother and baby. Furthermore, the environment where midwives work has a definite influence on their ability to be assertive. Due to complicated risk management and the fear of litigation, midwives are increasingly fearful (Timmins & Mc Cabe 2014:2).

Another factor is that midwives need to work in a team with medical doctors who do not share the same philosophy and focus of what is important to the patient. Midwives often become the doctors' assistants and need to follow orders very different from what they believe is right. This may lead to conflict and fear and often disempower midwives. It also sets a poor example to students in training (Halldorsdottir & Karlsdottir 2011:807). A study done in the United Kingdom found that an important reason for lack of assertiveness was poor managerial support describing assertiveness as "brave" instead of encouraging the skill (Timmins & Mc Cabe 2014:9). Another factor may be the old stereotypical believe that women should be submissive and caring and therefore assertiveness is been frowned upon (Timmins & Mc Cabe 2014:11).

Even though assertiveness is being included in most curriculums for midwifery training, it remains a challenge in practice. Every situation is unique and continuous professional development is needed (Timmins & Mc Cabe 2014:11). Whatever the reasons for poor assertiveness skills, it forms the foundation of advocacy, which is a legal requirement according to Regulation 786 of the Nursing Act 33 of 2005 (Department of Health 2013b).

The protection of the human rights of individuals making use of the health care system in South Africa is part of the ethical practice of a midwife and cannot be accomplished if a midwife does not have the skill to be assertive and advocate for the rights of the patient (South African Nursing Council 2006:14).

4.9.2.5 Communication

"Communication is not an "add-on"; it is at the heart of patient care." This is a statement made by an enquiry into the question on the role of poor communication in stillbirths and infant deaths (Rowe *et al.* 2001:23). Communication is needed between health care professionals, between patients and professionals and includes adequate record keeping. In 24%–29% of cases evaluated during this enquiry, communication failure played a significant role in stillbirths and infant deaths (Rowe *et al.* 2001:23). It is therefore important to ensure positive interprofessional relationships based on

partnership and team work, clear lines of accountability, and opportunities to learn together in the work place (Nursing and Midwifery Council, n.d.b:3). This is only possible with effective communication. Patient communication is also very important. In a literature review conducted on what makes a good midwife, the final conclusion was that communication with the patient is the most important factor in midwifery care (Halldorsdottir & Karlsdottir 2011:808).

Considering the International Code of Ethics as described by the ICM which states that midwifery care is based on a relationship of trust between the midwife and her patient, the role of communication cannot be overemphasised (International Confederation of Midwives 2014). Due to communication challenges, midwives may get frustrated if they are unable to explain processes and procedures to patients (Bohren *et al.* 2015:12). Systems need to be put in place to ensure communication, e.g. translators (Benjamin *et al.* 2016:73). However, communication comprises far more than the ability to talk and exchange ideas or information. Professional conduct is communicated to patients in a verbal and non-verbal manner. The WHO made recommendations on effective communication and include obvious criteria such as introduction of the professional to a patient, addressing patients by name, information provided on procedures, options given and supporting and encouraging patients.

Privacy and confidentiality are mentioned as an effective communication method (World Health Library 2018).

Listening is also important to allow the patient into the decision-making process (Halldorsdottir & Karlsdottir 2011:807). Patients feel that they are not listened to, adding to their feeling of despair, and a reason why they perceive their birth experience as traumatic: "Hospital staff did not listen to me, didn't trust that I know my body" (Reed *et al.* 2017:1193).

4.9.2.6 Incentives

Motivation emerges from internal and external factors, and although internal motivational factors have been found to be a strong determinant factor ("sense of calling"), the impact of external motivation factors cannot be ignored (Manojlovich & Ketefian 2002:21). External factors valued mostly by nurses are adequate staffing, flexible scheduling, strong support, visible leadership, opportunities to develop and recognition of excellence (Manojlovich & Ketefian 2002:17).

Literature on this topic is clear that money is not the most important incentive, but

rather recognition of excellence, for example a personal comment, a letter or a post in social media, creating a special occasion, e.g. a party or celebration (Lane 2018). Another way is to recognise the ability or potential by asking for input, suggesting a presentation at a conference or offering leadership development programmes (Lane 2018). Midwives and nurses can be developed professionally by asking their opinion on professional matters and value the input. To share in governance and decisions is not only a way of taking responsibility and shared accountability, but will also be seen as an incentive (Nursing and Midwifery Council, n.d.b:4).

4.9.2.7 Public opinion/ Social media

Social media plays a crucial role in the development of public opinion. Although it is often used in a negative sense, it can also be used for development purposes for professionals, i.e. discussions on most current research, online reading and training and support for professionals (Nursing and Midwifery Board Ireland 2013:6).

It is important to follow the rules in using social media. Consider the following suggestions: act professionally at all time, stay positive, and keep it impersonal and patient-free to protect the basic human right to privacy and confidentiality, protect your own privacy and professionalism and think before you post. Consider the implications and consequences of any message (Nursing and Midwifery Board Ireland 2013:2).

4.9.2.8 Compassion

Compassion is described as a consideration and concern for the pain or suffering of another person (Merriam-Webster Dictionary, 2018) (Merriam-Webster Dictionary 2018). In midwifery it is an understanding of the uniqueness of the experience of birth, but also the expectations, fears and anxiety.

This theme has been emphasised over and over again considering the high prevalence of disrespect and abuse in midwifery care (Reed *et al.* 2017:1187). If mothers do not receive care that they feel is compassionate and considerate, they will most likely not make use of the service, and this may ultimately increase the likelihood of maternal and neonatal mortality (Wassihun & Zeleke 2018). Apart from communication which is seen as the most important criteria for a good midwife, a caring, warm and supportive attitude is crucial (Halldorsdottir & Karlsdottir 2011:808). The mother is part of a family with a unique culture, and therefore family-centred care is important and should be considered during all aspects of midwifery care (International Confederation of Midwives 2014:1).

Several studies on disrespect and abuse found the working conditions for midwives to be very difficult and challenging. Overcrowding of labour wards with limited staff, unsafe environments where midwives can be assaulted, lack of needed equipment and stock, and low salaries are but a few of the barriers to effective midwifery care (Filby *et al.* 2016:8; Bradley *et al.* 2015:1; Miller & Lalonde 2015:550; Bohren *et al.* 2015:19).

4.9.2.9 Passion

Passion is being described as a strong emotional feeling, an enthusiasm for a course (Merriam-Webster Dictionary, 2018) (Merriam-Webster Dictionary 2018). Midwives should be passionate about their profession, passionate to ensure safe, evidence based care for patients. This aspect is often addressed in studies on disrespectful care leading to a poor utilisation of services (Wassihun & Zeleke 2018). Lack of passionate care takes the focus away from patient-centred care and instead midwives rather serve their own purposes.

In a study done by Reed on traumatic birth experiences during labour, aspects identified as “traumatic” to women are that midwives prioritise according to their own needs and not according to the needs of the patients, they lie and threaten to accomplish their own goals, they disregard the patients embodied knowledge of the birthing process and they violate the patients control over the birthing process (Reed *et al.* 2017:1193).

4.9.2.10 Debriefing

Although midwifery care is not always associated with death and is usually a pleasant and happy time for the patient and the midwives working with her, midwives may be exposed to emotional, unpleasant and traumatic events (Dartey & Phetlhu 2017:2). With the high rate of maternal mortality specifically in Africa (World Health Organization 2016), it is possible that midwives may experience the loss of a mother or her baby or both. When adverse events occur, it may lead to fear, stress and guilt, causing midwives to question their abilities and feeling unable to support the patient and the family. It also precipitates the fear of one’s own death, specifically when the midwife herself is still young and can have a similar experience during pregnancy and childbirth. Older midwives may become fearful for the lives of their daughters (Dartey & Phetlhu 2017:5).

Fear of criticism during maternal mortality and morbidity meetings, fear of the reaction of the family, fear of stigma and rejection from colleagues and the fear of law suits resulting in the loss of employment are some other fears that may be experienced by

midwives following an adverse event (Dartey & Phetlhu 2017:5). Due to fear, the midwife who had the experience will not be able to render the same quality patient care. Their thought processes have narrowed and they will have reduced ability to plan, implement and care for each individual patient. Advocacy and assertiveness are often compromised due to loss of confidence and fear and midwives tend to also compromise on ethical values. Job satisfaction may suffer from fear of the recurrence of adverse events and it is therefore of great importance that midwives be supported by management through employment wellness programs (Dartey & Phetlhu 2017:9)

4.9.2.11 Work environment

Literature supports the statement that the work environment has a substantial impact on nursing professionalism (Manojlovich & Ketefian 2002:16). Aspects mentioned were excessive workload that is often experienced in labour wards in the public sector. Staff shortages often lead to the inability to render the necessary care, leading to frustration, guilt and anxiety that may be the underlying cause for unprofessional conduct (Bohren *et al.* 2015:13; Filby *et al.* 2016:9; Dehghani *et al.* 2015:8).

Another aspect that was addressed is the disrespect that midwives undergo from doctors, leading to poor relationships and poor communication (Oyetunde & Nkwonta 2014:44; Dehghani *et al.* 2015:5). Midwives are sometimes treated unfairly by management who only considers the complaints from the doctors and patients and do not listen to the midwives' side of the story. In addition, they may experience confusion and stress due to the fact that they cannot fulfil their professional duty because of practice constraints. In hospital settings the practice is task-orientated and doctor-centred, moving away from a professionalism that is autonomous and will be allowed to make decisions on needs and care of patients. Often company values will differ from the midwife's focus on patient-centred, individualised care to a bigger focus on productivity and financial efficiency (Manojlovich & Ketefian 2002:16; Bradley *et al.* 2015:1; Dehghani *et al.* 2015:8).

The process of socialisation during formal studies is very important, but if values taught during this phase are not developed in the work environment, it may be abandoned during the first years of practice (Manojlovich & Ketefian 2002:19). Midwives learn a lot from the role models they see in practice and those examples of professionalism will teach them the ability to develop the necessary skills to influence their work environment (Manojlovich & Ketefian 2002:16).

4.9.2.12 Interpersonal skills

The seven most important skills specifically for health workers were identified and are vital in midwifery care. They are as follows: active listening, communication, personal stress management, compassion, attitude, team work and problem solving (Diffenderver 2018). Considering that a good relationship between a midwife and patient is so critical (Reed *et al.* 2017:1187; World Health Library 2018; International Confederation of Midwives 2014:2; Halldorsdottir & Karlsdottir 2011:812), it is important to not only include interpersonal training to the curriculum of midwives, but also to have on-going self-development. This aspect related directly to a study done on childbirth trauma. The results indicated that 66,7% of participants relate their birth trauma not to physical factors, but to interpersonal aspects of their care (Reed *et al.* 2017:1187). In a systematic review on the mistreatment of women during labour, evidence suggested the same lack of interpersonal skills such as poor communication, lack of report, poor support and disregard of autonomy (Bohren *et al.* 2015:7). It is therefore important to include methods to evaluate the interpersonal skill of medical professionals, for example, part of an overall evaluation needs to include an evaluation of interpersonal skill or appraisals. Recommendations can be made on grounds of professional conduct. Continued professional development should include development of interpersonal skills (Barakat 2007:153).

Self-esteem or the lack thereof was mentioned several times during discussions and was believed to be part of poor conduct. Literature indicated that 95% of people suffer from a lack of confidence at a certain point in life, with a direct influence on the ability to make decisions often leading to indecision and not moving beyond the limits of one's comfort zone (O'Donovan 2017). Several aspects play a role in the development of self-esteem, for example, the way one grows up, the support from family and the principles one was taught. Experiences also play an important role and will establish a way in which the world is seen.

Another factor that can have a negative effect on the self-esteem of midwives is that they work with doctors that do not share their philosophy on midwifery care (Halldorsdottir & Karlsdottir 2011:807) and often do not respect the role they play in the care of the patient. Instances of abuse and disrespect towards midwives have been reported (Oyetunde & Nkwonta 2014:44; Dehghani *et al.* 2015:5). This may have a detrimental effect on collegial respect and team work. Organisational culture does not always allow midwives to fully develop their professional duties (Manojlovich & Ketefian 2002:16). This leads to poor work performance, loss of motivation and loss of

confidence (Manojlovich & Ketefian 2002:20).

4.10 CONCLUSION

To answer the question on how to promote the professional conduct of midwives, thirteen midwives participated in three sessions. By using a nominal group technique, 93 discussion points emerged and were grouped together in 19 themes. These themes were discussed to ensure that the correct assumptions would be drawn from the discussion groups. Finally, two main themes emerged, namely basic education and training and work environment. A table was created to discuss the literature that supports these two main themes. In Chapter 5 the summary of the findings, conclusions and recommendations will be discussed.

CHAPTER 5: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the previous chapter, the analysis and interpretation of data were discussed. In this chapter, a brief summary of the research design and method and the attainment of the objectives will be presented. The limitations and recommendations will be discussed and conclusions drawn. The research question asked was how to improve the professional conduct of midwives. The aim of the study was to reach consensus on how professional conduct can be improved.

5.2 APPROACH TO THE STUDY

The nominal group technique was used as a method to reach consensus on how to improve the professional conduct of midwives. Three group sessions were held with the main aim to identify methods on how to improve professional conduct. During the three group sessions, 93 topics were discussed and grouped together in 19 themes. Several themes were repeated in the group sessions and data saturation was reached. However, during close evaluation it was found that all themes discussed could be placed under two main themes: basic education and training, and work environment, or both. Considering the level at which both aspects was placed during the voting sessions, basic training and education is seen as the most important aspect to influence the professional conduct of midwives. The second most important aspect is the work environment in which midwives work.

5.3 CONCLUSIONS

The two main themes that emerged from the study were basic education and training and work environment of midwives. These two aspects will be discussed separately in Table 5.1:

Table 5.1: Summary of study findings

5.1.1 BASIC EDUCATION AND TRAINING
From the onset of the study, it was clear that the basic education of midwives plays a crucial role in the professional conduct of midwives. Aspects of professionalism such as accountability and responsibility form the foundation of midwifery care and should be taught. Ethical concepts such as beneficence and non-maleficence are introduced during training. Respect, confidentiality and dignity form the basis of professional conduct. Students are socialised into the profession by teaching in class as described in Regulation

786 and then exposed as described in Regulation 786 d to the clinical practice where they can see and experience how these difficult concepts are demonstrated. During discussions the need for mentors was identified as one of the challenges. The students need to be guided in clinical practice not only by skilled and knowledgeable midwives, but midwives who can demonstrate sound ethical principles, care and compassion in an environment of cultural diversity. They need to be able to display assertive behaviour, take leadership and advocate in a professional manner. Unfortunately the opposite is often true of clinical practice. In the public sector midwives can be very rude and disrespectful. They lack compassion and find excuses in the poor management of health facilities. In the private health care setting students are trained in an environment where midwives are powerless and subservient and do not display any signs of the independent practitioners referred to in documentation such as the Scope of Practice for Midwives by SANC or the competencies developed by ICM. This aspect will be further discussed in the next paragraph on the work environment.

During all three sessions, participants mentioned the importance of character and interpersonal skills that need to be considered in the selection of students and developed during training. It has been referred to as “soft skills” or “emotional intelligence”. Skill and knowledge is of utmost importance for the midwife. However, to be able to build relationships of trust, care and compassion, interpersonal skills are as important and need to be developed during training. Aspects such as communication, leadership, assertiveness, stress management, teamwork and time management should be included in the curriculum. A module on cultural competence can also be included to ensure that students will be able to deal with cultural diversity in the work place.

5.1.2 WORK ENVIRONMENT

Once a midwife enters the profession, it is possible that she will be overwhelmed by the responsibilities of a qualified midwife. The reality of practice is often different of what has been taught in class and described in Regulation 786 and may lead to stress and confusion, it is therefore critical to continue with professional development in the work place. Apart from the necessity to ensure on-going updating on best practices and current research, it is also important to ensure the continuation of the development of interpersonal skills such as communication, team building and leadership. Ethical principles should be displayed in practice, and reflection on different situations can be helpful in changing behaviour.

All these aspects should constantly be evaluated and management should have systems in place to address issues such as disrespect and abuse in the work place. This should also

be the case in instances of disrespect among colleagues or members of the multi-disciplinary team. The effect of poor relationships in the work place has a severe impact on patient care and should be managed effectively. Evaluation of staff members, such as auditing processes ensures that staff members understand that they are accountable for their work, but it should be done in a manner that will enhance practise to ensure the best care for patients.

Furthermore, management needs to assist the new midwife by having a mentorship programme where more experienced midwives can assist and teach or guide the newly qualified midwife in critical thinking and the decision-making process. Policies and work procedures are also helpful in reminding staff members of their responsibilities and must be evidence-based and current. The health care system has increasingly become more challenging during the past few years and midwives need support in the work place. Support must also be given by providing debriefing sessions in case of adverse events.

A culture of excellence in the work place is the responsibility of the institution. However, it cannot be done by management alone. The midwives, who are the experts of patient care, should be included in dialogue on policies, work procedures and decisions regarding patient care, and as a result build confidence, commitment and ownership of responsibilities. Midwives need to be recognised by management as autonomous professionals, allowing them to practise according to ethical and professional values that have been taught during training to prevent demotivation. They need to show the same commitment and support to midwives as they would to the rest of the multi-disciplinary team.

Incentives should be offered to midwives who display caring and compassionate care to patients. Pathways need to be developed in which midwives, who demonstrate passion and commitment to the profession will be allowed to enhance their professional career and also have the satisfaction of recognition as well as being well paid professionals. It is the responsibility of the organisation to ensure adequate staffing, a safe environment, needed equipment and stock.

5.4 STRENGTHS AND LIMITATIONS TO THE STUDY

The following limitations were identified during the study:

- Responses to the invitation to participate in the study were limited. Only 13 midwives attended the three sessions and that may limit the transferability of the results. However, data saturation was reached. Effort was made to include participants from three different

sectors of midwifery care to ensure a broader perspective. On analysis it is also clear that the midwives who participated in the study come from different age groups with work experience of between 5 and 50 years, which may ensure a more comprehensive insight.

- Due to the work load of the midwives, time was very limited and sessions were kept short.

5.5 RECOMMENDATIONS

Research would be of little worth if it does not lead to changes in the clinical practice and education of midwives. It is also important to identify needs for more research and add to the body of existing knowledge. Therefore the following recommendations are made:

5.5.1 RECOMMENDATIONS FOR PRACTICE

- Evidence-based policies and work procedures should be in place in the clinical practice and should be updated on a regular basis.
- Management should support the midwives in implementing evidence-based policies to render the best midwifery care and not allowing doctors to disrespect the midwife as professionals.
- Policies regarding accountability processes should be available and implemented when necessary. However, accountability should be cultivated in a sense of a “willingness” to do the right thing and not only punitive measures to change behaviour. A culture of excellence in patient care must be the focus.
- Collaboration between education and practice is necessary to ensure that an environment is created where responsibility and accountability is clear. The patient should never be compromised for the sake of training.
- Processes should be in place for the active management of communication challenges between multi-disciplinary team members.
- Policies should be implemented to manage incidents of bullying either by doctors or among colleagues.
- Management should support midwives to render patient-centred care following a philosophy that is internationally accepted as the best for the patient, namely that pregnancy and birth are natural processes and the women need to be supported to follow these processes.
- Advocacy by midwives for their patients should be supported by management.
- Management need to create an environment that is safe and comfortable for the patient and the midwife. The environment should be conducive to have a private and dignified

labour allowing the midwife to spend the necessary amount of time to support and care for the patient. This will call for adequate staffing.

- Management needs to allow the maternity ward to be managed differently in terms of visiting hours, allowing family to be present in theatre and considering the needs of the patient in labour.
- The appointment of midwives should be done according to strict criteria in order to select midwives that will not only render safe, but also compassionate care based on strong ethical values. Interpersonal skills should be as strong a criterion as knowledge and skills. If selection is done carefully, these midwives will be effective role models to socialise students into their professional practice.
- Emotional support, such as debriefing sessions should be made available to staff in the event of adverse events.
- Reflective meetings should be part of the culture in the ward. During these meetings events can be discussed, decisions made to enhance practice, but also to evaluate communication, behaviour and decision-making skills.
- Recognition of excellence in the clinical field can be done by the following methods: programmes to develop leadership, publishing positive feedback from patients, and linking feedback from patients to personal performance. For midwives flexible schedules, including them in planning and decision making can be as much an incentive as an increase.
- A system to ensure continuous professional development should be in place, not only focused on skills and knowledge, but also on professional practice including ethical behaviour, rights of the child bearing women and interpersonal skills. Modules on communication skills, cultural diversity, advocacy, assertiveness and leadership will enhance the midwives' ability to render compassionate care.
- Professional translators should be available to assist when communication is not possible between staff members and patients.

5.5.2 RECOMMENDATIONS FOR EDUCATION

Selection process

- The process of selection of students should not only consider matric results, but also psychometric testing measuring personality aspects such as leadership, communication skills and ability to connect to people.
- Numeracy should be tested, ensuring that the student has the ability to do the needed calculations, and literacy testing to ensure the student is fluent in the teaching language.

- An interview should be part of the selection process to evaluate the ability to communicate. During an interview an evaluation of character can also be done and insight into motivation to be a midwife might become clear.
- Evaluation of character is important. Processes need to be in place to ensure that only students of good character are selected, e.g. character references or self-assessment on character. Screening for criminal offences should be done.
- Student needs to be healthy and proof of health should be provided during the selection process. Health screenings can be done by the hospitals prior to appointment.

Midwifery curriculum

- A longer period for training in midwifery should be considered. Interpersonal skills are extremely important and necessary to render care that is patient-centred and built on relationship. Considering the current sociological challenges that is found worldwide, for example, the breakdown of the family, high divorce rates, migration of people, culturally diverse nursing, and language barriers, to mention a few, educational systems need to implement strategies to assist students to develop the interpersonal skills that they need to be effective midwives.
- Curricula should include modules focused on the following aspects: communication skills, leadership training, and development of assertiveness, compassion, ethical behaviour, cultural competence, active listening, personal stress management, attitude, team work and problem solving. The rights of the child-bearing women need to be the focus of all training.
- Reflection should be included as a teaching and learning strategy to develop critical thinking and evaluate behaviour.
- Simulation laboratories should be available to enable students to learn in a safe environment. Interpersonal skills can be evaluated during these sessions.
- Nurse educators should be competent in the class-room and in practice. They need to teach with passion and their behaviour should reflect the ethical principles they teach.
- Support to students should be available to overcome language barriers. Translation services should be available to students, and basic literacy classes can be made available to assist students in language development.

Clinical guidance

- The students need to be guided in the clinical practice, not only by skilled and knowledgeable midwives, but also motivated, compassionate and ethical practitioners. Educational institutions should ensure that there is a system whereby students are guided by mentors or preceptors in the clinical field.

- The educational institution could address issues such as disrespect and abuse in the clinical setting and processes could be developed to make it efficient.
- The nurse educator should guide the students in clinical practice and demonstrate compassionate and caring behaviour. Difficult aspects such as advocacy should be taught on the spot.
- Support or debriefing sessions should be available to students. This will demonstrate an attitude of caring and compassion towards students, helping them cope with the challenges of midwifery care and also teaching them to be caring and compassionate.
- Systems of accountability should be in place. Students should learn to be accountable for their actions to ensure a better understanding once they make the transition to a professional midwife. This process should not only be punitive, but rather an opportunity to learn.

5.5.3 RECOMMENDATIONS FOR RESEARCH

- The same study can be repeated with a larger sample size.
- Patients instead of midwives can be included in a similar study to understand the impact of unprofessional conduct on the birthing experience.
- A research study can be done to evaluate the inclusion of interpersonal skills into the education of midwives or the lack thereof.
- A study to develop strategies to empower midwives to fulfil their professional role in midwifery care could be done.
- A study to determine the effects of communication barriers between doctors and midwives would be of help.
- Methods on how interpersonal skills can be developed in clinical practice should be included.

5.6 CONCLUSION

The findings of this study indicate that two aspects play a critical role in the improvement of the conduct of midwives, namely education and the work environment. According to the ICM, effective care for mothers, babies and their families are based in ethical conduct, informed by formal continuous studies and research to ensure best evidence practises (International Confederation of Midwives, 2014, p. 2). Education plays a pivotal role to ensure trained, skilled, regulated and licenced midwives to render quality care. Training should include theoretical knowledge and practical skills in addition to interpersonal skills such as communication, compassion and attitude. Midwives should build relationships based on ethical principles to advise and support women to make the best choices for themselves and

their families, and in the process ensure a positive birthing experience. However, midwives are often reliant on the health care system to provide facilities where they can train as students and, after qualifying, work as midwives. It is critical that health institutions ensure accessible facilities, well equipped and well managed to ensure that students are trained well. Qualified midwives should work in an environment that allows them to render skilled, knowledgeable and compassionate care for child-bearing women, newborn infants and their families. Only then South Africa may be able to reduce maternal and newborn deaths and reach the Sustainable Development Goals as set out for 2030.

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ANNEXURE A

USING A CONSENSUS METHOD TOWARDS THE PROMOTION OF PROFESSIONAL CONDUCT IN MIDWIFERY IN A SOUTH AFRICA

PARTICIPANT'S INFORMATION & INFORMED CONSENT DOCUMENT

Researcher's name: Naomi Hattingh
Student Number: 83476700
Department of Nursing
University of Pretoria

Dear Participant

You are hereby invited to participate in a research project:

USING A CONSENSUS METHOD TOWARDS THE PROMOTION OF PROFESSIONAL CONDUCT IN MIDWIFERY IN A SOUTH AFRICAN CONTEXT.

I am currently enrolled for a Master's degree in Midwifery in the Department of Nursing at the University of Pretoria. I would like to use this research project to contribute to improving the midwifery practice.

1. Introduction

This information leaflet provides you with information to help you decide whether you would like to participate in this study. Before you agree to participate in this study, you should fully understand what is involved. If you have any questions that are not fully explained in this leaflet, do not hesitate to ask the researcher. You should not agree to take part unless you are completely happy about what we expect of you.

Participation in this research project is entirely voluntary.

2. The nature and purpose of this study

You are invited to take part in a research study of which the purpose is to reach consensus on how to improve professional conduct of midwives in various settings. You are invited in your professional capacity as a midwife who understands midwifery practice, but not as a representative of any institution or association.

3 Procedures that need to be followed

The focus of the nominal group session will be to answer the question:

How can professional conduct be promoted in South African midwifery?

- During the first phase of the group session you will be given time to think about the question. All ideas that come to mind must be written down and at this stage you are not allowed to communicate with the other participants.
- The second phase is a round-robin stage which will allow for each individual to share his or her ideas, and each written concept/idea will be collected by the facilitator. During this stage there is still no discussion, but you will be allowed to add to your previous list of ideas.
- A discussion phase follows where the group members are invited to explain and collaborate on submitted ideas. It is very important to share your ideas and engage in the discussion. Every participant will have time to ask questions and/or clarify what other participants have shared. Your input is important to the study. New items can be added to the existing list created during the previous phases.
- The ideas will be grouped in themes and no ideas will be rejected. Themes or clusters of ideas will be named.
- During the final stage of this group session, voting and ranking will take place. You will assist in prioritising the themes.
- The final results are then shared with the group and discussion will be allowed should there be any disagreement among the participants to find consensus.
- The group discussion may take up to two hours of your time. The time and venue will be communicated. An external facilitator will be facilitating the group session.
- I will not participate in the discussion, but will be taking field notes of the discussions that take place.

4 Risk and discomfort involved

Due to the nature of the nominal group technique no risk are foreseen, but it might be time consuming. It may also have a cost implication such as transport.

5 Possible benefits of this study

The possible benefits of the study are related to consensus on how to improve the professional conduct of midwives: a list of priorities can be drawn up and be used by institutions to build strategies to improve professional conduct in the clinical practice. The priorities can be built into the training of midwives to ensure an ethical foundation for clinical practice; and consciousness may be raised on the equal importance of knowledge, skills and ethical values that form the basis of professional conduct.

6 Ethical approval

The Research Ethics Committee of the University of Pretoria, Faculty of Health Sciences, and telephone numbers 012 356 3084/012 356 3085 granted written approval for this study (find the approval letter attached). This study has been structured in accordance with the Declaration of Helsinki (last update: 2013), which deals with the recommendations guiding doctors in biomedical research involving

humans/subjects. A copy of the Declaration may be obtained from the researcher should you wish to review it.

7 Confidentiality

Your participation in this study is entirely voluntary. You can refuse to participate or stop your participation at any time without giving any reason.

The results of this study will be communicated by the researcher with no reference to any participant.

8 Consent to participate

I have read the above information before signing the consent form. The content and meaning of this information have been explained to me. I have been given the opportunity to ask questions and am satisfied that they have been answered satisfactorily. I hereby volunteer to take part in this study.

I have received a signed copy of this informed consent agreement.

Signature of participant

Date

Witness

Date

We sincerely appreciate your help.

Yours truly,

NAOMI HATTINGH

ANNEXURE B

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 03/20/2022.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 03/14/2020.



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

26/07/2018

Approval Certificate New Application

Ethics Reference No: 403/2018

Title: USING A CONSENSUS METHOD TOWARDS THE PROMOTION OF PROFESSIONAL CONDUCT IN MIDWIFERY IN SOUTH AFRICA

Dear Naomi Hattingh

The **New Application** as supported by documents specified in your cover letter dated 17/07/2018 for your research received on the 17/07/2018, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 25/07/2018.

Please note the following about your ethics approval:

- Ethics Approval is valid for 1 year
- Please remember to use your protocol number (**403/2018**) 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); MPharm, PhD
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, Second Edition 2015 (Department of Health).

ANNEXURE C

 *Cliff Smuts Language*
Practitioner/Taalpraktisyn

Member of the Professional Editors' Guild (Western Cape),
the South African Translator's Institute and ProLingua

Professional translation, editing and proofreading services

Professionele vertaal-, redigeer- en proefleesdiens

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Email: csmuts@xsinet.co.za

16 May 2019

STATEMENT OF EDIT

I, Cliff Smuts, hereby declare that I edited the language and referencing style of the MCur thesis by

Naomi Hattingh

titled: USING A CONSENSUS METHOD TO PROMOTE PROFESSIONAL CONDUCT IN
MIDWIFERY IN A SOUTH AFRICAN CONTEXT

The language and references were fine and correct when I returned the work document to the researcher.

Cliff Smuts

ANNEXURE D

Session One

Compassion
(Temp/Comfort)
11/11 moment of care care for the caregiver
Touch with care
Touch with care
Simpatie
Supportive to M&F

Passion
Show passion in work
do

Professionalism
Pleasant smell | Prof conduct
First impression
Prof. ontvangs van
family
- Prof. voer kom
- Staff op
- Reward
- Code of conduct
- Ethical
- Attend SANC classes
- Reflection on behavior
- Concept language

Ethical behavior
Dr behavior neg./pos. behavior
Midwives to attend M&M

Communicate
language
listening skills | Postnatal classes
understanding concerns. contact session.
communication that boots
- Obtain consent to do procedures
- Inform mother re all interventions
- activity

Accountability
attend M&M 1.
- Level of accountability
- employer accountability
- escalation + starting ratio

Leadership
lead by example
Incentive + reward
mentorship
role modeling

Assertiveness
of knowledge and skills to improve uncertainty
- Talk your knowledge
- Pt. advocacy

	1	2	3	4	5	6	7	8
N	Assertive	Comm	Passi	Compass	Acct.	Leader	Profits	Ethical Duh
* R	Prof	Compass	Passion	Comm.	Leadership	Ethical	Acct.	Assertive
* S	Compass	Pass	Ethics Pr.	Profits	Comm	Acct	Leaders	Assertive
* A	Compass	Acct	Prof.	Ethical be	Pass	Assertive	Comm	Leaders
* Saam 3	Compassion ne stei maone	Passion	Professionalism	Ethical behavior	Communication	Accountability	Leadership	Assertive

Session Two

OUT of house education in working doctors

1 -
2 -
3 -

(A) Education & Training

- Topics eg.
 - Ethics / Advocacy - Pt care
 - Respect
 - Religion / Culture
 - Interpersonal
 - "Basic ethics"
- Methods
 - group / seminars
 - case pres / Ward rounds
 - peer review

Use technology to make it fun & interactive

(2B) Evaluation

Feedback

- peer review
- call
- email / WhatsApp
- SMS

Peer reviews allow feedback in units - if peer prod conduct seen it should be made aware of - not

pt. complaint syst. leading to review of competencies follow-up after if name is known

peer review = CPD

CPD

Include in con. Job descript

to educate the paper required histories

for improvement at all departments & make working to standard

Provides incentives

(3) Implementation & evaluation of policies

updating alignment / connect.

audit

updating

audit

Should be included in policies - as part of practice protocols

support

+ staff + family

at group

the opportunity for debriefing after traumatic events

Debriefing of staff after events

Support groups / initiatives

(3) Basic ethics

- Respect
- Advocacy
- Morals / Values
- Cultural / Religious
- Do no harm
- Prof. conduct among

Interpersonal

Communication

Conduct best staff - if not correct in practice - should be discussed with patient

Advocacy

Debriefing of staff

Communication

Participant	Priorities					
	1	2	3	4	5	6
①	^{Topics} A	C	D	E	B	F
②	A	D	B	C	F	E
③	C	A	E	B	D	F
④	C	A	E	B D	B	F
Σ						

	1	2	3	4	5	6	Total
① Items 1-7	1	1	1	1	1	1	7
② Promote	1	1	1	1	1	1	7
③ Increase sales	1	1	1	1	1	1	7
④ Improve quality	1	1	1	1	1	1	7
⑤ Reduce cost	1	1	1	1	1	1	7
⑥ Increase productivity	1	1	1	1	1	1	7
⑦ Reduce risk	1	1	1	1	1	1	7
⑧ Increase customer loyalty	1	1	1	1	1	1	7
⑨ Increase employee satisfaction	1	1	1	1	1	1	7
⑩ Increase market share	1	1	1	1	1	1	7
⑪ Increase brand awareness	1	1	1	1	1	1	7
⑫ Increase social media presence	1	1	1	1	1	1	7
⑬ Increase website traffic	1	1	1	1	1	1	7
⑭ Increase email list	1	1	1	1	1	1	7
⑮ Increase customer retention	1	1	1	1	1	1	7
⑯ Increase repeat purchases	1	1	1	1	1	1	7
⑰ Increase customer lifetime value	1	1	1	1	1	1	7
⑱ Increase customer referrals	1	1	1	1	1	1	7
⑲ Increase customer reviews	1	1	1	1	1	1	7
⑳ Increase customer testimonials	1	1	1	1	1	1	7
㉑ Increase customer loyalty programs	1	1	1	1	1	1	7
㉒ Increase customer loyalty rewards	1	1	1	1	1	1	7
㉓ Increase customer loyalty benefits	1	1	1	1	1	1	7
㉔ Increase customer loyalty perks	1	1	1	1	1	1	7
㉕ Increase customer loyalty exclusives	1	1	1	1	1	1	7
㉖ Increase customer loyalty VIP status	1	1	1	1	1	1	7
㉗ Increase customer loyalty elite status	1	1	1	1	1	1	7
㉘ Increase customer loyalty platinum status	1	1	1	1	1	1	7
㉙ Increase customer loyalty diamond status	1	1	1	1	1	1	7
㉚ Increase customer loyalty black card status	1	1	1	1	1	1	7
㉛ Increase customer loyalty private jet status	1	1	1	1	1	1	7
㉜ Increase customer loyalty yacht status	1	1	1	1	1	1	7
㉝ Increase customer loyalty helicopter status	1	1	1	1	1	1	7
㉞ Increase customer loyalty private island status	1	1	1	1	1	1	7
㉟ Increase customer loyalty penthouse status	1	1	1	1	1	1	7
㊱ Increase customer loyalty mansion status	1	1	1	1	1	1	7
㊲ Increase customer loyalty villa status	1	1	1	1	1	1	7
㊳ Increase customer loyalty estate status	1	1	1	1	1	1	7
㊴ Increase customer loyalty castle status	1	1	1	1	1	1	7
㊵ Increase customer loyalty palace status	1	1	1	1	1	1	7
㊶ Increase customer loyalty kingdom status	1	1	1	1	1	1	7
㊷ Increase customer loyalty empire status	1	1	1	1	1	1	7
㊸ Increase customer loyalty civilization status	1	1	1	1	1	1	7
㊹ Increase customer loyalty culture status	1	1	1	1	1	1	7
㊺ Increase customer loyalty society status	1	1	1	1	1	1	7
㊻ Increase customer loyalty community status	1	1	1	1	1	1	7
㊼ Increase customer loyalty nation status	1	1	1	1	1	1	7
㊽ Increase customer loyalty kingdom status	1	1	1	1	1	1	7
㊾ Increase customer loyalty empire status	1	1	1	1	1	1	7
㊿ Increase customer loyalty civilization status	1	1	1	1	1	1	7

Session Three

Training

- informal
- formal

prof. conduct
cultural sensitivity
confidentiality
interpersonal skills
(incl. in basic training)

use knowledgeable + skillful

Social media/public opinion

Maintain

- > Confidentiality/exposure.
- > Use media to teach public
- > Add positive stories

Interpersonal relations

- Discussions on show cultural issues
- Respect + kindly address disrespect
- Open conversations
- Staff's background! -> discussions on what is right
- Self-discipline

Use double groups

Case presents close - intensity level where clients experience are highlighted

Review

Build relationships in day to day working context

Support clients to bring out their best

Build trust between staff and clients (through shared events) to protect

Network Family that offers support and advice

Teach interpersonal skills are part of basic training

Empower staff to bring out their best

Build trust between staff and clients (through shared events) to protect

Network Family that offers support and advice

Teach interpersonal skills are part of basic training

of importance of behavior

Ranking of behavior is influenced

by

→ Pt. Profission / Knowledge / Background

→ Education level of staff member

→ Personal experience

→ Personality of staff member.

Kultur → Staf
Pt