MIDWIVES' PERCEPTION OF ETHICAL BEHAVIOUR AND PROFESSIONAL MALPRACTICE IN THE LABOUR UNITS OF TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA

by

MANARE MARGARET MASHIGO

submitted in accordance with the requirements

for the degree of

MASTER OF ARTS

in the subject

HEALTH STUDIES

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR JM MATHIBE-NEKE

SEPTEMBER 2016

Student number: 42809762

DECLARATION

I declare that **MIDWIVES' PERCEPTION OF ETHICAL BEHAVIOR AND PROFESSIONAL MALPRACTICE IN THE LABOUR UNITS OF TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

30 November 2016

..... **.....**

SIGNATURE **DATE**

Margaret Manare Mashigo

MIDWIVES' PERCEPTION OF ETHICAL BEHAVIOUR AND PROFESSIONAL MALPRACTICE IN THE LABOUR UNITS OF TSHWANE, GAUTENG PROVINCE, SOUTH AFRICA

STUDENT NUMBER: 42809762
STUDENT: MANARE MARGARET MASHIGO
DEGREE: MASTER OF ARTS
DEPARTMENT: HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA
SUPERVISOR: DR JM MATHIBE-NEKE

ABSTRACT

Aim: The purpose of this study is to establish midwives' perception of ethical and professional malpractices in labour units and to enhance the awareness of ethical behaviour and professional practice by midwives.

Design: A qualitative, exploratory, descriptive and cross sectional design was followed to explore the midwives understanding of and experiences of ethical practice and professional malpractices in Labour Units of Tshwane, Gauteng Province. A non-probability purposive sampling was used to draw a sample from midwives with two or more years of experience working in Labour Units.

Data collection: Individual in-depth interviews using open ended questions were used to collect data. Interviews were recorded using an audio tape recorder, which was later transcribed verbatim. Data collection was continuous until saturation was reached with the eight (n=8) participant.

Findings: the results of the study revealed that midwives do understand the ethical code of conduct. However, due to challenges such as shortage of staff; shortage of material resources; non-compliance of midwives to policies and guidelines; fear of decision-making; and lack of management support, all this makes ethical conduct more challenging. It is hoped that the findings of this research will make contributions to midwifery training and practice.

Key concepts

Ethical behaviour; Labour Unit; midwife perceptions; professional malpractices.

ACKNOWLEDGEMENTS

- I thank the Lord Almighty for the strength provided which enabled me to do this study and there were days I wanted to close the books.
- I want to take this opportunity to thank my supervisor, Dr JM Mathibe-Neke, for the continued support, the love, patience shown throughout my studies, all the memories shared I appreciate every moment.
- I thank the University of South Africa's Health Studies Department for the opportunity to do my research.
- I also like to thank the Tshwane Ethics and Research Committee for approval to conduct my study at their institutions.
- I also want to thank my colleague, Mrs MG Makua, who was there at the inception of my proposal and channelled me to the right direction.
- I also want to thank the midwives of Gauteng who participated in this study.
- I also want to thank my daughters, Nthabiseng, Puseletso and Gontse, for your continuous patience, support and believing in me throughout my studies.

Dedication

I dedicate this dissertation to the following special people:

Nthabiseng, Puseletso and Gontse.

I love and appreciate you more than you will ever know.

PRESENTATION IN SUPPORT OF THE DISSERTATION

2016. STTI (Sigma Theta Tau International Congress). Poster presentation: **Midwives' perception of ethical behaviour and professional malpractice in the labour units of Tshwane, Gauteng Province, South Africa.** Cape Town, South Africa.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANMC	Australian Nursing and Midwifery Council
CPD	Continuous professional development
CTG	Cardiotocograph traces
DENOSA	Democratic Nurses Organisation of South Africa
HIV	Human Immunodeficiency Virus
GG	Government Gazette
IOM	Institute of Medicine
MOUs	Maternal obstetric units
NVD	Normal vertex deliveries
OHSC	Office of Health Standards Compliance
RSA	Republic of South Africa
SANC	South African Nursing Council
TB	Tuberculosis
UNISA	University of South Africa
WHO	World Health Organization

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Chapter 1 presents an orientation to the study with reference to the background information about the research problem, the research problem, the purpose and the objectives of the study, the significance of the study, the definition of concepts, theoretical framework of the study, research design and the methodology and the scope of the study. Chapter divisions are also highlighted.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

Midwives form the backbone of maternal and child health care in South Africa. The care provided by midwives during childbirth is a unique life experience and midwives are therefore expected to comply with policies and legislation governing their profession so that they are able to identify complications and intervene accordingly (Maputle & Hiss 2010:5). As stated by Summer (2001:1), "nursing consists of a unique relationship between a patient and a nurse, which is multifaceted and highly complex". Midwifery practice is governed by skills and knowledge which provides grounding to ethical clinical decision-making. The researcher's interest was driven by observing cases of malpractice presented by the South African Nursing Council (SANC). SANC is the regulating body responsible for setting standards of education and practice for nurses and midwives in South Africa and one of its functions is public protection through the investigation of complaints against those enrolled or registered in terms of the Nursing Act (Act no 33 of 2005) (South Africa 2005b).

Professional midwives and nurses are expected to provide quality care to health-care users who rely on their expertise knowledge and professional skills. However, the findings of a study on exploring nurse's personal dignity, global self-esteem and work satisfaction by Sturm and Dellert (2016:392), led to a finding that professional nurses' satisfaction with their practice environment influences the quality of patient care and outcomes. In circumstances where a malpractice has occurred or the family is not

satisfied about the care, they may also institute legal actions if not attended promptly (McHale & Tingle 2007:53).

As stated by Kulju, Stolt, Suhonen and Leino-Kilpi (2016:401), ethics is seen as a foundational competency in healthcare and that ethical competence can be viewed as part of professional competency, honesty and loyalty to patients. Midwives are required to make frequent decisions in their everyday practice that almost always may compromise an ethical encounter leading to an ethical dilemma. Ethical dilemmas that may be faced by midwives are concerning for example, the right to self-determination versus confidentiality, distributive justice and privacy (Ito & Natsume 2016:439). At each ethical encounter, there are opportunities for "good" or "bad" decision-making which may either benefit or harm the patient (Kinnane 2008:23). The researcher has noted, through her experience at SANC, that malpractices and ethical decision making go hand in glove as adverse events often occurs due to failure by a midwife to make an ethical decision during the care of a woman in labour. Therefore, the aim of this study is to enhance awareness of ethical behaviour and professional malpractices in selected Labour Units of Tshwane, Gauteng Province.

South Africa is recently burdened by serious adverse events occurring in Labour Units which lead to litigations. In 2011, the Minister of Health released the amounts of lawsuits already paid by the various Provincial Departments of health amounting to R1.7 billion in the past seven years related to gynaecology, midwifery and surgical procedures and R100 million was for Gauteng Department of Health. All these lawsuits are related to obstetric malpractices (Maphumulo 2011:13). Furthermore, the SA-News released a statement which revealed that the Gauteng Department of Health has 306 negligence claims totalling R1286 billion of which 155 claims are for damages around childbirth (Child 2014:1).

The researcher has observed the disciplinary hearings conducted by SANC and that, midwives in their mitigating circumstances often bring up the issue of shortage of staff, as well as their working conditions that makes it difficult to continuously assess, monitor and evaluate the condition of pregnant women pre and post-delivery. Midwives often argue, for example, that the task has been carried out but they had difficulty in recording their actions as they have to attend to other emergencies. Selebi and Minaar (2007:53) cited Seshoka (2005:32) stating that public hospitals are hounded by dire shortages of

skilled nurses and midwives. Furthermore, the authors stated that when nurses are overloaded due to shortages and absenteeism the delivery of quality care may be jeopardised. Nyathi and Jooste (2008:28) corroborates the above saying that increased workload leads to low morale which then may lead to low standard of care and that any practice which falls below the required standard of a professional is a malpractice. Arries (2006:62) also conducted a study that led to the formulation of practice standards in ethical decision-making and this was based on the SANC's disciplinary reports on cases of unprofessional conduct observed during 1993-1998. The study indicated that observed disciplinary cases reflected situations where the nurse had made decisions to maintain, restore or promote the health of a patient, and further concluded that, from the observations made, midwives and nurses' clinical decision-making was ineffective as it did not adhere to the framework of clinical, ethical and legal correctness for any nursing action and ethical decision-making. The quality of care often lies within the quality of the decision taken.

1.3 RESEARCH PROBLEM

Midwives working in Labour Units are confronted with ethical decision-making when caring for a woman in labour. There is always fear of the baby not being safely delivered or the mother presenting with complications. Hood, Fenwick and Butt (2010:268) conducted a study on the story of scrutiny and fear about the experiences of Australian midwives. The study revealed that midwives' perception of work environment is driven by fear of litigation and it is increasingly stressful.

According to International Council of Nurses (ICN: 2012:4) code of ethics, one of the crucial elements is about nurses and midwives that they carries responsibility and accountability for nursing practice, and for maintaining competency, also ensuring that the care provided is not compromised. The midwife is therefore, mandated by the Code of Ethics to provide ethically acceptable standards of clinical nursing practice.

As stated by the South African Nursing Council (SANC 2010:2), competencies are a combination of knowledge, skills, judgement, attitude, values, capacity and abilities that underpin effective performance in a profession. These are requirements of a practitioner to be considered competent in a designated role and practice settings. The midwife is considered competent if he or she has the ability to integrate and apply the knowledge,

skill, judgement, attitudes, values and abilities required to practice safely and ethically in a designated role and setting.

The researcher, who has experience with the investigation of malpractices, has observed a variety of emotions displayed by midwives during disciplinary hearings at SANC. Though the policies and maternal guidelines are available to guide the midwives, little is known as to how the midwives perceive or understand the ethical and malpractice issues within the Labour Units. Therefore, this study aimed to explore and describe the midwives' perception of ethical and professional malpractice issues within the selected Labour Units in Tshwane, Gauteng Province.

1.4 AIM OF THE STUDY

1.4.1 Research aim/purpose

The purpose of this study is to establish midwives' perception of ethical and professional malpractices in labour units and to enhance the awareness of ethical behaviour and professional practice by midwives.

1.4.2 Research objectives

- To explore midwives' understanding of ethical behaviour and professional malpractice in Labour Units of Tshwane, Gauteng Province.
- To explore midwives' experiences of unethical behaviour and professional malpractice in Labour Units of Tshwane, Gauteng Province.

- To recommend guidelines to enhance ethical and professional practice by midwives during intrapartum care.

1.5 SIGNIFICANCE OF THE STUDY

The researcher is hoping that the study will make contributions to the midwifery education and practice by assisting in developing guidelines on ethics and

malpractices and thus reduce the rate of litigation cases in obstetric units in Tshwane, Gauteng Province.

1.6 RESEARCH QUESTION (GRAND TOUR)

What are the midwives' perception regarding ethical behaviour and professional practice with regard to intrapartum care?

1.7 DEFINITION OF CONCEPTS

1.7.1 Labour Unit

Labour Unit is defined as a hospital room that is equipped to cater for a woman in labour to remain in that room throughout the period of birthing (www.thefreedictionary.com).

1.7.2 Professional misconduct

Nursing Act (Act no 33 of 2005) defines professional misconduct or unprofessional behaviour as a conduct which, with regard to the profession of a practitioner, is improper, disgraceful, dishonourable or unworthy (SANC 2005:6).

1.7.3 Ethical behaviour

Ethical behaviour is defined as an ideal human conduct, practices or beliefs of a particular group of individuals, for example, Christian ethics, medical ethics or nursing ethics (Pera & Van Tonder 2011:5). Ethics is a branch of philosophy dealing with values relating to human conduct, with respect to the rightness and wrongness of certain actions, and to the goodness and badness of the motives and ends of such actions (Moodley, 2016:10). In the context of this study, ethical behaviour refers to a particular method of inquiry undertaken by midwives to respond to the particular needs of women in labour, with reference to the Code of Ethics.

1.7.4 Perception

Perception is defined as a process by which people translate sensory impressions into coherent and unified view of the world around them and it may be based on incomplete and unverified information. Perception is equated with reality for most practical purposes and guides human behaviour in general (www.businessdictionary.com).

1.7.5 Malpractice

Malpractice refers to failure to provide professional service with the skill usually exhibited by a responsible and a caring member of a profession such as a physician, midwife or nurse, through reprehensible ignorance or negligence or any improper practice which may lead to harm or death of the patient (Moodley 2016:140).

Malpractice is generally regarded as a label for undesirable activities or regarded as negligence by a professional. It is a legal term to describe any situation where a professional service or the results are unsatisfactory to the client. It is also regarded as a conduct towards a client/patient which is considered reprehensible either because it is an unreasonable lack of skill or fidelity, an evil practice, immoral in itself or forbidden by the law (Erasmus 2008:5).

1.7.6 Midwife

A midwife is a person registered under the Nursing Act (Act no 33 of 2005), as a midwife to render nursing care on a woman to achieve and maintain optimum health from pregnancy, through all stages of labour and pueperium (South Africa 2005:4).

Furthermore, a midwife is a person who, having been regularly admitted to a midwifery educational programme duly recognised by the country in which it is located, has successfully completed the prescribed course of studies and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery, and is recognised as 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 (ICM 2005).

1.8 THEORETICAL FOUNDATIONS TO THE STUDY

The study is based on the Theory of Principlism, a framework for biomedical ethics. Beauchamp and Childress are referred to as the most well-known proponents of the four principles, as stated by Clarke (2009:54), who further refers them as middle-level principles that are not ranked in any order of importance.

1.8.1 Principlism

Principlism endows our ordinary moral experience (perceptions, intuition) with justificatory force. Principlism refers to four fundamental ethical principles as applied to this study. The four ethical principles that are applied in this study are, namely: autonomy, beneficence, non-maleficence and justice (Clarke 2009:54; Chervenak & McCullough 2012:2).

- **Principle of autonomy** requires one to acknowledge and carry out the value-based preferences of the adult as a competent patient. The woman in labour also has own perspective on medical care on what is in her best interest. During intrapartum care, midwives should provide the pregnant woman with all information required so that she can make an informed decision regarding her care.
- **Beneficence** requires one to act in a way that is expected to reliably produce the greater balance of benefit over harm in the lives of patients and, in this study, it is the lives of both mother and baby.
- **Non-maleficence** means that midwives should prevent causing any physical, emotional or psychological harm to women in labour.
- **Justice**: all women in labour to be treated fairly by midwives, and this also includes fair distribution of resources.

Chervenak and McCullough (2012:3) further described the professional virtues as follows, which are paramount in ethical practice:

- **Self-effacement**: midwives should not act on the basis of potential differences between themselves and the patient, such as race, religion, nationality, gender, sexual orientation, manners, socioeconomic status or proficiency in English;

- **Self-sacrifice**: this virtue is seen through midwives willingness' to care for women in labour with infectious diseases such as tuberculosis (TB), Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS);
- **Virtue of compassion**: midwives caring for women in labour should be motivated to recognise and seek to alleviate the stress, pain and discomfort of women giving birth; and
- **Integrity**: this virtue imposes an intellectual discipline to the midwives' clinical judgment about the patient's problems during labour and how to solve or address those problems. Midwives to always make sure that while addressing other virtues, they do not compromise the integrity of the patients by divulging sensitive information (Chervenak & McCullough 2012:4). This theory is more applicable in addressing midwives' perceptions of ethical behaviours because if decisions are made with what is in the best interest for the patients, there will be less complains of professional malpractice (www.theor medbioeth2011Dec 32(6) 375-388).

1.9 RESEARCH METHODOLOGY

Research methodology relates to the research process that the researcher followed throughout the entire journey which includes the tools and procedures used with specific reference to individual steps taken. A phenomenological approach following Spielberg (1975) six core steps to explore the midwives understanding with regard to ethical behaviour and professional malpractices issues within the selected Labour Units of Tshwane ,Gauteng Province (Streubert & Carpenter 2011:81).

1.9.1 Research design

A qualitative, exploratory, descriptive and cross-sectional design was followed in this study with the aim to ensure awareness of ethical conduct and professional malpractices in a specific setting using a phenomenological approach. This method enabled the researcher to describe the perceptions of midwives and lived experiences of ethical behaviour and professional malpractices in their work environment (Gu, Zing, & Ding 2009:6). This method is suitable for this study as the researcher used in-depth interviews to collect data from participants. Research was conducted at a familiar setting in the obstetric lecture rooms (Moule & Goodman 2014:175).

A cross-sectional study examines data at some point in time, meaning that data were collected on only one occasion with the participants. The advantage of this method is that it is less time-consuming, less expensive and it is more manageable for the researcher because large amounts of data can be collected at one point (Basavanthappa 2010:187).

1.9.2 Population

For this study, population refers to all midwives working in the Labour Units of Tshwane in Gauteng Province. The population chosen was informed by the professional conduct statistical reports from SANC with Gauteng being the highest, note (SANC 2013:4). The target population was midwives with two or more years' experience working in the selected Labour Units in Tshwane, Gauteng Province.

1.9.3 Sample design

A non-probability purposive sampling was followed. Purposive sampling is used in qualitative research where the aim is to sample a group of people with specific set of experiences or characteristics such as midwives. The researcher makes judgment about composition of the sample and selects participants who are found to meet the criteria, midwives with two or more years' experience working in the selected Labour Units in Tshwane, Gauteng Province at the time of the study.

In non-probability, not every participants has the chance or opportunity to be included in the study (Moule & Goodman 2014:360; Basavanthappa 2010:223).

1.9.4 Data collection

Data collection is the process of selecting subjects and gathering data from the selected subjects. The actual steps in the process are specific to a study and are dependent on the research design. Data were collected by observing and questioning with the researcher being the primary data collection tool (Burns & Grove 2011:24).

1.9.5 Data collection instruments

For the purpose of this study, individual in-depth interviews were conducted as a method of data collection. Open-ended questions using an Interview Guide (Annexure E) were used to give participants an opportunity to relate their experiences or understanding of ethical issues and malpractices. Streubert and Carpenter (2011:45) describe semi-structured interviews as best suited for qualitative researchers, more flexible and that the opportunity for story telling is inherent in format. A central grand-tour question was posed to the participants followed by probing questions as in the Interview Guide. Communication techniques such as reflecting, clarifying, probing and summarising were utilised during interview to explore more about the phenomena under study (Jooste 2010:311).

1.9.6 Trustworthiness

In this study, rigor or trustworthiness were enhanced by applying Lincoln and Cuba (1985) methods as cited by Polit and Beck (2008:539), namely: credibility, dependability, conformability and transferability;

1.9.6.1 Credibility

Based on Lincoln and Cuba (1985), credibility refers to the confidence in the truth of data and interpretation thereof. For this study, the researcher ensured credibility through prolonged engagement with participants and member checking to confirm that data had been captured correctly (Creswell 2003 in Streubert & Carpenter 2011:48).

1.9.6.2 Dependability

Dependability relates to the consistency of findings. Polit and Beck (2008:539) describe dependability of qualitative data as the stability of data over time and over conditions. To ensure dependability, the researcher did an audit trail by collecting all data, transcripts and forward to an external reviewer for scrutiny. In addition, for other strategies, the researcher included dense description of the research methods, taking of field notes and peer review.

1.9.6.3 Confirmability

Polit and Beck (2008:539) refer to conformability as the objectivity in terms of the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning. The researcher ensured that findings reflect the participants' voices and not biases or the researcher's perspective. Streubert and Carpenter (2011:49) stated that the way in which a researcher documents the conformability of the findings is to leave an audit trail. Accordingly, in this study, the researcher illustrates clearly the evidence and thought processes that led to the conclusions.

1.9.6.4 Transferability

Transferability essentially refers to the generalisation of data or the extent to which findings can be transferred to other groups. As the study was conducted only at selected Labour Units, transferability might be a limitation, however, the researcher provided sufficient descriptive data in the report to enable consumers to evaluate possible applicability to other similar settings (Polit & Beck 2008:539).

1.10 DATA ANALYSIS

Data analysis was initiated with data collection, which was integrated continuously with ongoing member checking and verifying of facts. Raw tape-recorded data were transcribed into transcripts with significant phrases identified and grouped into phrases with common thoughts pertaining to ethical conduct and professional malpractice. Identified phrases were then organised and analysed into clusters of themes (Streubert & Carpenter 2011:134).

1.11 ETHICAL CONSIDERATION

For purposes of this study, the ethical principles set out by the ICN (2012) was followed as a guide. The researcher has the responsibility towards the participants to be executing the research in an ethical manner and abide by the set principles, namely: principle of autonomy, beneficence and non-maleficence, anonymity, confidentiality and scientific honesty.

1.11.1 Principle of autonomy

The participants were informed by the researcher about the purpose of the study and benefits, and that they have a right to make a choice to participate in the study freely without duress and can withdraw at any time without penalty. Participants' rights and dignity were respected at all times to ensure a trusting relationship. Participants signed a Consent Form to participate once all explanation about the study had been given by the researcher and because they were all midwives no interpretation services was required (Brink & Wood 2001:206; Moule & Goodman 2014:59). The researcher made sure that all information given by the participants was treated with strict confidentiality. The names of participants were given identification codes in order to protect their identity. The codes were given in sequence as they follow each other as: P1 (01_Mas_Jul 15).

1.11.2 Principle of beneficence and non-maleficence

The researcher ensured that the research benefit both the research subjects, institution and add value to literature of midwifery practice. Private information was not collected and that the participant's thoughts were not misrepresented. The researcher did not envisage any physical, psychological or emotional harm to the participants and institutions as the study is aiming at exploring the understanding that midwives have regarding ethical conduct and professional malpractices. The researcher ensured that the study was conducted in the best interest of participants and the selected Labour Units. The data collection method used was individual in-depth interviews that were conducted in a private room, which was closer to the Labour Ward to ensure privacy (Moule & Goodman 2014:60).

1.11.3 Principle of justice

All participants were treated fairly and with respect, and upon completion of the study the results will be forwarded to institutions where the research was conducted, as well as to the ethics committee in that district (Polit & Beck 2008:147). Mautner (2002 in Tjale & De Villiers 2004:224) states that justice includes all habits and dispositions of a good citizen and, therefore, the researcher made sure that the participants were given a fair chance to participate in the research. This is also supported by the Theory of Principlism applied to this study.

1.11.4 Scientific honesty

The researcher avoided fabrication and forgery of facts and results at all cost. All information recorded from participants were transcribed as such so that the reader is able to understand the live experiences, mood or feelings portrayed. The researcher also ensured that integrity is maintained by providing feedback to participants about emerging interpretations in order to obtain their reactions (Polit & Beck 2008:540). The research design was not manipulated because the purpose of the study is to establish and enhance the awareness of ethical behaviour and professional malpractices by midwives so that guidelines can be developed to assist in reducing malpractices in Labour Units (Moule & Goodman 2014:60).

1.11.5 The rights of the institution

Permission was sought from the selected institutions upon approval by the Ethics Committee of the University of South Africa (UNISA) (Annexure A). The names of participating institutions were protected.

1.12 SCOPE AND LIMITATIONS OF THE STUDY

The study was conducted in the labour units of institutions that reported a higher incidence of litigations in Gauteng Province, therefore, the results are limited to the selected Labour Units.

1.13 OUTLAY OF THE DISSERTATION

The dissertation contains the following five chapters:

- Chapter 1: Orientation of the study
- Chapter 2: Literature review
- Chapter 3: Research methodology
- Chapter 4: Data analysis
- Chapter 5: Findings and recommendations

1.14 CONCLUSION

Chapter 1 presented the orientation of the study. It further outlined the background information about the research problem, the research problem, the aim and the significance of the study, the definition of concepts, theoretical foundations of the study, research design and the methodology and scope of the study. Chapter division was also highlighted. The next chapter outlines the literature reviewed on background to ethical conduct and professional malpractice.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 2 describes a range of activities associated with conducting a literature search on the topic and in this instance, midwives' perception of ethical conduct and professional malpractice in Labour Units. A search for relevant material was undertaken to expand the researcher's understanding from multiple realities and also to establish the experiential descriptions of ethical conduct and professional malpractice (Goodmann & Maule 2014:210). The focus is given to midwifery practice, the responsibilities and duties of a midwife during antenatal, intrapartum, postnatal care and puerperium, midwifery and ethics, professional conduct and malpractices in midwifery care.

2.2 ETHICS IN MIDWIFERY CARE

2.2.1 What is ethics?

As stated by Moodley (2016:3), ethics has been defined in various ways over time and has been referred to as a complex field of study as it deals with all aspects of human behaviour and decision-making. Ethics is a disciplined study of morality, a careful and systematic reflection on and analysis of moral decisions and behaviour. Morality concerns the actual behaviours and beliefs about what standards one's behaviour and character should meet. Morality reflects on concepts like virtues, rights, responsibilities, good and bad, right and wrong, just and unjust. In dealing with women in labour, midwives should as such rely on ethical principles and morality in guiding ethical decision-making (Chervenaic & McCullough 2012:02) as ethics is a matter of knowing what the right thing is to do, while morality is a matter of doing the right thing.

2.2.2 The South African Nursing Council Code of Ethics

A Code of Ethics refer to a set of principles and rules by which a profession is expected to demonstrate an oath to society and regulate the moral behaviour of its members

(McLeod-Sordjan, 2014:475). The South African Nursing Council has put together Code of Ethics (SANC 2013:5) which is a tool that assists nurses and midwives in identifying their ethical responsibilities and serves as a foundation for ethical decision-making. Midwives are required to make frequent decisions in their everyday practice that almost always may compromise an ethical encounter, at each encounter there are opportunities for good or bad decisions to be made which may lead to benefit or harm to the woman (Kinnane 2008:23).

Nursing and midwifery have traditionally drawn their ethical understanding from bioethics, which is based on four principles (autonomy, beneficence, non-maleficence and justice) to guide women in their ethical thought, discussions and decision-making. The following ethical behaviours are embedded in the Code of Ethics, namely: truthfulness and confidentiality; honesty and integrity; caring and compassionate; accountability; advocacy role and justice. The principles guiding professional conduct in midwifery as stated in the SANC Code of Ethics (SANC 2013:5-6) are, namely, ethically based decision-making; accountability for decision and conduct; relevance of care provided based on carefully considered options of care; responsiveness to needs of those requiring of care; equity in distribution of time among all health-care users and fairness in dealing with colleagues and health-care users.

2.3 PROFESSIONAL MALPRACTICES IN MIDWIFERY CARE

2.3.1 What is malpractice?

Malpractice is generally regarded as a label for undesirable activities and more directly speaking as a negligent behaviour displayed by a professional person. It is a legal term to describe any situation where a professional service or results are unsatisfactory to the healthcare user (Erasmus 2008:5). Erasmus further states that malpractice is regarded as a conduct towards a patient which is considered reprehensible, either because it is an unreasonable of skill or fidelity, an evil practice, immoral or it is contrary to the law. It may mean mistreat of a disease, injury of a patient through negligence, or carelessness in one's conduct (Erasmus 2008:5; Klebanov 2013:56). Nursing and midwifery malpractices exist because midwifery practitioners make mistakes and it is human to make mistakes, especially within the stressful conditions under which midwives practice. However, it is important to note that not every mistake or failure in care of a woman in labour justifies a

malpractice as in other instances it is not possible to demonstrate clearly the true nature of the problem and how the midwife's actions or inaction caused the harm to the patient. The Institute of Medicine (IOM) released a report in 1999 entitled **"*To Err is human*: *Building a safer Health System*"**. This report stated that errors caused between 44 000 and 98 000 deaths every year in American hospitals and over one million injuries. This IOM report received tremendous attention from both public and healthcare industry drawing a lot of media attention. Since this report, issues of patient safety have received attention worldwide (http://www.ncbi.nlm.gov/pmc/articles.accessed 2013/11/12). In South Africa, the issue of patient safety has become a thorny issue to government as a lot of funds go into the settlement of litigation cases. The Office of Health Standards Compliance (OHSC) was also established in line with the requirements of the National Health Amendment Act, 2013 (Act 12 of 2013), with the core objective of protecting and promoting the health and safety of the users of health services through monitoring and enforcing compliance with prescribed norms and standards as well as disposing of complaints from health-care users (DoH 2011:16).

The World Health Organization (WHO) launched the World Alliance on Patient Safety which is celebrated on the 9th of December each year to enhance awareness of unsafe health care practices. The Democratic Nurses Organisation of South Africa (DENOSA 2011/2012:61) highlighted the purpose of "patient safety day" and further indicated that patient risks within the health care practice are escalating. Factors such as excessive workloads, reduction of support services, increasing/advancing technology and lack of support services, increasing/advancing technology and lack of material resources were identified as contributing to professional malpractices (DENOSA 2011/12:61). Two hundred and thirty-five (235) cases were handled by the Professional Conduct Committee (PCC) of SANC during 2010-2013 and fifty-nine emanates from obstetric units (SANC 2013). Table 2.2 illustrates the statistics from SANC per province for the period of 2010-2013:

Table.2.2: Unprofessional conduct cases per Province (2010-2013)

Province (South Africa)	Statistics
Eastern Cape	08
Free State	11
Gauteng	28
KZN	04
Limpopo	04
Mpumalanga	01
Northern Cape	02
North West	00
Western Cape	01

(SANC, 2013)

The above table depicts Gauteng Province as having the highest number of malpractices followed by Free State at less than half of the cases dealt with in the Gauteng Province, and this justifies the researcher's choice of Gauteng Province which is also supported by the report stated earlier on litigation costs paid by the Gauteng Department of Health.

From an international perspective, United Kingdom reported 5609 claims of clinical negligence in 2005 and 3766 claims on non-clinical negligence. It was further stated that the statistics continue to rise as the members of the public are more informed of their rights to health care (McHale & Tingle 2007:53). Ho (2009:59) conducted a study in Hong Kong on medico-legal aspects of obstetrics and the role of a midwife as the number of malpractices around childbirth issues continue to rise. The study revealed that most common allegations made in obstetric litigations are, namely: (a) inadequate intrapartum fetal monitoring; (b) inadequate response to signs of fetal compromise; (c) failure to respond to cardiotocograph traces (CTG); (d) proper communication of care and incorrect timing of entries, etc. The major omissions occurring during labour and delivery nurses were identified as failure to monitor maternal and fetal status appropriately; inappropriate use or monitoring of oxytocin, failure to notify doctors timeously, initiation of procedures without adequate client information or consent. Ho (2009:59) further stated that litigations increases because the clients are more educated and have higher expectation and are generally demanding more. Lewis (2012b:310) described the hard and difficult times faced by midwives in the care of a woman in labour where they try to find ways of helping some women and their families to cope with grief, loss and pain of bereavement in its myriad of forms. While doing these, midwives need to also recognise the impact that this

may have on their own emotions and their ability to work safely and effectively with all concerned. Most of the time, midwives can feel alone when dealing with sad and challenging situations, hence the reason why the researcher need to explore their perceptions on ethical behaviours and malpractices in the Labour Unit (Lewis 2012b:311).

2.3.2 Elements of malpractice

Klebanow (2013:56) describes the elements of malpractice as follows:

> The accuser is owed a duty; accused has violated the duty; accused departed from acceptable standards of care that a reasonable peer professional would have provided in the similar situation; accuser had a significant injury as a result of the negligence which resulted in damages. In midwifery practice failure to properly assess, monitor and evaluate both the fetal and maternal conditions; failure to seek for the assistance of an obstetrician when the condition of the mother and her unborn child warranted such interventions, failure to record and report all the actions done on the mother during the intrapartum care; verbal or physical assault of the pregnant woman during labour constitute a malpractice.

However, as per the recommendation stated by Mathibe-Neke (2015:78), malpractice can be minimised by, amongst others, creating a positive practice environment that strengthens and supports the workforce that will lead to a positive impact on patient outcomes and organizational cost-effectiveness that will ensure quality healthcare. Furthermore, by applying collaborative and interdisciplinary approaches to client care.

2.3.3 Myths about malpractices

In the article named the Malpractice of Malpractice by Klebanow (2013:56), the myths about malpractices were depicted as follows:

> Practitioners and their hospitals should look into the real remedy to the problem, willingness of the medical profession to concentrate on reducing errors and improving health care throughout the country.

As stated by Klebanow (2013:56), the problem can be solved by encouraging professionals to admit their mistakes to the patients, offer apologies and work outside the court of law to arrive at an equitable solution. However, in the South African context, health departments and institutions are working very hard to reduce malpractices through quality assurance departments where complaints on adverse events are investigated. On the other hand, Chen and Hsu (2015:791) argue that "a good nurse shows concern for her patients by caring for them efficiently, effectively and attentively, thus fostering their wellbeing and that if one fails to be a good nurse, it is because one does not make an effort or one is unwilling to act, rather than being unable to act".

2.3.4 Perceptions on malpractice

As stated by Vryonides et al. (2015:881), "within the limitations of scarcity, nurses face moral challenges and their decisions may jeorpadize professional values, leading to role conflict, feelings of guilt, distress and difficulty in fulfilling a morally acceptable role", which is perceived as a malpractice in the context of ethical behaviour. Vryonides further highlights that certain difficult circumstances may sometimes limit the nurses' ability to act according their professional or personal values and norms, and as such leading to a gap between the ideal ethical decision and the actual behaviour. Armstrong (2006:120) concurs with the above statement in a publication on "towards a strong virtue ethics for nursing practice" by claiming that nurses are often left without the necessary tools to resolve moral conflicts; a situation that contributes to malpractice.

2.4 THE REGULATION OF MIDWIFERY PRACTICE IN SOUTH AFRICA

In South Africa, the practice of midwifery is controlled and regulated by the South African Nursing Council (SANC) under the Nursing Act (South Africa 2005b). The importance of regulating midwifery practice is about public wellbeing through the improvement of standards of practice and standard of education, and also to make sure that those rendering midwifery care have the training, knowledge and skills in order to be competent in rendering quality care. The researcher has noted, through her experience at SANC, that malpractices and ethical decision-making goes hand in glove as adverse events often occur due to failure by a midwife to make an appropriate ethical decision during the care of a woman in labour.

Midwives practice is according to the scope of practice which is Government Gazette (GG) R2598 (SANC 1984) R2488 (SANC 1990). Government Gazette GG (R2488) is the scope of practice for midwives in South Africa and it states that “the midwife shall diagnose the health needs of the mother and child during pregnancy, labour and puerperium and that all information and records of labour be properly kept” (SANC 1990). Regulation R2488 is the regulation relating to the conditions under which the registered and enrolled midwives may carry out their profession. These regulations stipulate that “a registered midwife shall carry out her profession under the conditions as set out by this regulation”. In the course of her practice, a registered midwife shall “at all times have available the equipment and materials required for the practice of midwifery” (SANC 1990). Furthermore, “a registered midwife shall keep clear and accurate records of the progress of pregnancy, labour and the puerperium and of all acts, including emergency acts which he/she performs in connection with the mother and child” (SANC 1990:par 2.2).

SANC investigates and takes disciplinary steps against any member of the profession for unprofessional conduct in terms of Chapter 3, Section 46 and 47 of the Nursing Act and also takes into account other regulations such as the scope of practice (R2598) (SANC 1984), Government Gazette (GG) R2488 (SANC 1990) which is the scope of practice for registered midwives, and Acts or Omissions (R387) (SANC 1985). Omissions outlined by these regulations are as follows:

- Wilful or negligent omission to carry out such acts in respect of the monitoring, diagnosing, treatment, care, prescribing, collaboration, referral, co-ordination and patient advocacy as the scope of practice permits.
- Wilful or negligent omission to protect the name, person and possessions of a mother and child under her/his care or charge in the course of pregnancy, labour and puerperium through the correct identification of the mother and child, the prevention of accidents, injury or other trauma, the prevention of infection and spread of infections, the checking and monitoring at reasonable intervals of all forms of diagnostic and therapeutic interventions.
- The specific care and treatment of the vulnerable high-risk mother and child, the seriously ill, the disturbed, the confused, the unconscious patient and the mother with communication problems.

- Wilful or negligent omission to keep clear and accurate records of the progress of pregnancy, labour and puerperium and all acts which he performs in connection with a mother and child.
- Failure to summon the doctor timeously when the condition of the mother warranted such interventions. Section 46 deals with the procedure of inquiry by Council into charges of unprofessional conduct and Section 47 outline the types of penalties to be applied when a registered person is found guilty (South Africa 2005:87).
- Failure to comply with the conditions under which he/she may carry on his profession, as promulgated by R2488 of 26 October 1990, as amended (SANC 1990).
- Purporting to perform the acts of a person registered in terms of the Medical , Dental Health Professions Act (Act no 56 of 1974) or the Pharmacy Act (Act no 53 of 1974) , unless the registered midwife is also registered in such capacity, Acts or Omissions (R387) (SANC 1985:9).

Section 46 deals with the procedure of inquiry by the SANC into charges of unprofessional conduct and Section 47 outlines the penalties to be applied when a registered midwife is found guilty (South Africa 2005:87).

Government notices, as amended from time to time, deal with the acts and omission of which SANC may take cognisance. The important principle, irrespective of how many times such regulations are amended, is that those governing the scope of practice should always be read in conjunction with acts and omissions and the conditions of practice. This principle underlines the accountability of the midwife and highlights the fact that the midwife functions as a member of the health team even if she is in private practice. The midwife should take into consideration her independent, interdependence and dependent functions and that she remains accountable for her acts and omissions as stipulated by SANC Regulations and Scope of Practice (SANC, 1984 as amended).

2.5 THE ROLE AND RESPONSIBILITIES OF A MIDWIFE

2.5.1 Who is a midwife?

The definition of a midwife as adopted by the International Confederation of Midwives (ICM, 2005) is a good starting point to show who midwives are. The broad definition has been accepted by midwives and other healthcare professional around the world (Kinnane 2008:22) as follows “a midwife is responsible for assessing, recognising and intervening for and responding to abnormalities when attending to a woman in labour. She is further charged with the responsibility to properly document and communicate her findings to the obstetrician of the maternal and fetal wellbeing” (McDermott, Sharma, Dowell, Greninger, Montagut, Lamb, Archibald, Raudales, Tam Lee & Rothenberg 2007:199231).

In South Africa, a midwife is a person registered as such in terms of section 31(1) b of the Nursing Act 33 of 2005). “The midwife assists and give support to a healthcare user which is the mother and her unborn child through all stages of pregnancy to achieve and maintain optimum health during pregnancy, all stages of labour and puerperium” (South Africa 2005:4). For this study, focus was mainly during stages of labour, because this is the critical phase where midwives ought to make certain decisions in rendering care to women. And it is often during these stages where complications or undesirable outcomes may arise.

2.5.2 The four stages of labour

Labour can be divided into four stages. The first stage of labour starts from commencement of contractions and dilatation of the cervix, lasting until full dilatation of the cervix. It is a progressive process that is divided into three phases as depicted in Table 2.1 (b). The latent phase starts from the onset of labour till the cervix is 3 cm dilated. During this phase, there is more progress in effacement of cervix and minimal descending of the presenting part. The active phase starts from 4cm cervical dilatation until full dilatation which is 10cm and the transition phase is the period between 8cm to 10cm cervical dilatation (De Kock & Van der Walt 2004:14). It is during the first stage of labour that the midwife engages longer with the woman.

The second stage of labour starts from full cervical dilatation to complete birth of the baby. It is also called the expulsion phase. This is a critical phase, the mother experiences excruciating pain with the head crowning and the mother has an urge to bear down. It may last for plus or minus 45 minutes in a primigravida and 30 minutes with a multipara but it may also depend on the condition of the woman. The third stage of labour lasts from the birth of the baby to the delivery of the placenta and membranes, and the fourth stage lasts for an hour after delivery of the placenta, which carries a risk of complications, for example, post-partum bleeding whereby a midwife needs to act promptly and ethically (De Kock & Van der Walt 2004:14-19).

Table 2.1 (a): The four stages of labour

Stages of labour	Characteristics
The first stage of labour	The interval between the onset of labour and full dilatation of the cervix
The second stage of labour	The period from full dilatation of the cervix until the delivery of the infant
The third stage of labour	Comprises the interval between the delivery of the baby and the delivery of the infant
The fourth stage of labour	An hour post-delivery of the placenta, that incudes monitoring of the woman and baby and the examination of the placenta

(Cronjé, Cilliers & Pretorius 2011:79-87)

Table 2.1 (b): The phases of the first stage of labour

Phases of labour	Cervical dilatation
Latent	0-3 cm
Active	4-7 cm
Transition	8-10 cm

(Cronjé et al 2011:79-87)

2.5.3 Duties of a midwife

The midwife carries the responsibility of monitoring the maternal and fetal wellbeing as guided by the Scope of practice, The National and Provincial Policies such as the Maternal Guidelines, The Batho-Pele Principles and Patient's Right Charter. McDermott et al. (2007:199259) highlighted the importance of having the fetal heart rate monitoring

tool which must always be available to be able to observe signs of deviations of the fetal wellbeing. The monitoring of foetal and maternal wellbeing by the midwife is classified under antenatal, intrapartum, postnatal and neonatal care as outlined below.

2.5.3.1 Antenatal care

De Kock and Van der Walt (2004:9) indicated that this is an important phase where the midwife comes into contact with the pregnant woman for the first time. Complete assessment of gestational age and baseline data is made and risk factors are identified. The midwife has to take the full history which includes previous pregnancies, any pregnancy complications that the women had any allergies, use of alcohol or cigarette smoking. Fraser, Cooper and Nolte (2006:237) affirm that the midwife has to assess the woman's level of health by taking a detailed history, offer appropriate screening tests, ascertain baseline recordings of the blood pressure, urinalysis, blood values, abdominal examination, fetal development and fetal heart auscultation, as these parameters will be used as a standard for comparison as the pregnancy progresses. The midwife also has to provide the woman and her family with the opportunity to express and discuss any concerns they may have regarding the pregnancy, previous pregnancy complications if any, labour or puerperium (Fraser et al. 2006:240).

2.5.3.2 Intrapartum care

The midwife has to always maintain a clear and effective communication with the mother and be welcoming to the woman in labour. Fraser et al., (2006:434) stated that the woman need to be given correct and adequate information about the physical process of labour so that she is able to make an informed decision regarding the method of delivery and coping strategies to be used during birth. Emotional support should be given by expressing a caring attitude and the midwife to be the advocate for the child-bearing woman. The partner may also be allowed to be with the woman for support purposes, as guided by the policy of the institution and the woman's willingness or values and beliefs of both parents. The midwife to do bladder care, vital signs monitoring, urinalysis, fluid balance, vaginal examinations and fetal heart rate monitoring. Bennett and Myles (1989:195) affirm further saying that the midwife need to observe for changes in the fetal heart rate patterns, to identify any signs of fetal distress.

2.5.3.3 Postnatal care

The midwife has a role to care, support and monitor the health of a new mother and her baby (De Kock & Van der Walt 2004:14). The midwife is further required to attend to the mother and her child at least once a day and shall not discharge them from her care until such time that the conditions of both are satisfactory (Fraser et al. 2006:613; SANC, 1990 as amended).

2.5.3.4 Immediate care of the newborn

The baby should be identified immediately on both limbs indicating the family name, sex, weight and date of birth. Initial assessment in terms of heart rate, respiratory efforts, muscle tone and skin colour are recorded (De Kock & Van der Walt 2004:16).

2.4.4 Professional development

The midwife has the duty to develop themselves so that they are at par with the latest competencies and evidence-based practice. The rising litigations in obstetric units was a sign that the skills of some of the midwives is outdated. During the National Nursing Summit (2011), the Register of the SANC presented a paper on the Transformation of Qualifications and Standards of Practice. It was pointed out that the Council was working on the New National Qualifications, Advance scopes, Standards for Practice and the introduction of Continuous Professional Development (CPD). The Council indicated that they were looking for a model suitable for South African nurses to enhance CPD (*Mail & Guardian* 2011:3). Conditions relating to continuing professional development will be in terms of section 39 of the Nursing Act. Currently in SA, all nurses and midwives have been advised to begin with portfolio of evidence so that they are ready and comply with SANC's requirements for Continuous Professional Development (CPD) model. Midwives need to develop their portfolio of evidence for all courses attended, with focus to ethics, one's area of practice, leadership and management and teaching and research (South Africa 2005:29; Ho 2009a:58).

2.4.5 Communication

Coordination and delivery of quality obstetrical care requires optimal communication amongst members of the multidisciplinary team. A midwife has the responsibility to communicate any relevant information of her findings to the physician (McDermott et al. 2007:199246). Proper recording is also essential in the communication of care because it assist in continuity of care as in nursing they say "***what is not recorded is not done***". Omissions in recordkeeping can lead to speculation that something is being hidden (Ho 2009a:59). Midwives are supposed to openly communicate with the women during delivery about the care provided, but literature has shown that most of the time there is limited open communication between midwife and a mother (Maputle & Hiss 2010:10). However, in the South African context, language barriers is also a factor that interferes with the interactions of midwives with women during labour because of different racial groups being attended to at the Labour Units. Though there is provision of language interpreters, sometimes they are not readily available, especially during labour, and this may lead to unethical decision being taken as the midwife may fail to understand what the woman is requesting, and she may also fail to give a clear explanation about childbirth process (Ito & Sharts-Hopko 2002:673; Maputle & Hiss 2010:6; Ho 2009a:10).

2.4.6 Midwifery-led care as a preferred model of care

Literature revealed three models of care in midwifery practice namely: midwifery-led model of care, shared model and medically led model. Not all these models make the lives of midwives easy in terms of decision-making. Globally, midwives are the primary carer for women before, during and after childbirth. Different models of care are practised to provide support and assistance to women during intra-partum and postnatal periods (Sandal 2012:324). Literature reviewed revealed that in midwifery led care models, the midwife is the lead professional in the planning, organising and delivery of care throughout pregnancy, birth and postpartum periods and that this models contributes to high quality and safe care in high income countries. Midwifery-led care revealed significant benefits for the mother and baby with no identified adverse effects.

Women who received midwifery-led care, as stated by Sandal (2012:234), Saleem, McIntyre, Rattani and Sylkonder (2015:200), Gu, Zhang and Ding (2011:243), were less likely to experience intended hospitalisation, analgesia, non-instrumental birth, reduced

maternal and neonatal mortality as opposed to medically led care (Sandal 2012:234). A descriptive qualitative study conducted in Pakistan, Karachi in 2015, on midwives' perception about their practice in a midwifery-led care model, revealed that midwives are struggling to be recognised as professionals, encountering barriers to practice as independent practitioners, obstetrician's reliance and trust in midwives expertise, that may have an impact on ethical decision-making (Saleem et al. 2015:200).

However, it should be noted that in some developing countries like South Africa, midwives mostly practice in a medically led model of care whereby even the advanced midwives are not seen as taking decisions in the care of women during labour, especially those working in an obstetrician-led care institutions. However, there are independent midwives who are working in maternal obstetric units (MOUs) whereby they routinely take decisions regarding the management of a woman in labour. Currently, the regulating body SANC, has developed the Advance Scope of Practice for midwives and it is hoped that the voice of advanced midwives will be heard. Sometimes midwives rely on the expertise of obstetricians who may not readily be available to assist during emergencies whereby the mother may end up with complications of which midwives will be accountable for (Saleem et al. 2015:200). However, in this study it is not clear whether the midwives' autonomy role and decision-making in the clinical setting is properly enhanced because of the rise in litigation. In a midwifery-led care models, midwives make their own decisions and it enhances job satisfaction due to autonomy of practice such as promotion of vaginal births (Sandal 2012:323). In other instances, midwives feel overworked, due to staff shortage which impacts them in doing the work, especially in a midwifery-led care model and therefore they feel comfortable in an obstetric led unit where the obstetrician carries the responsibility for decision-making (Saleem et al. 2015:201).

2.5 CONCLUSION

Literature review involves the process of identifying literature relevant to the topic of the research and studying relevant literature. For this study, the literature reviewed provided an overview of the current knowledge regarding ethical conduct and professional malpractice. The literature presented indicated midwifery practice and its relevant legislation, roles and responsibilities of a midwife, midwifery and ethics, Code of Ethics for midwives, professional malpractices in midwifery care and myths about malpractices. The research methodology is discussed in the next chapter.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 3 presents the research methodology that comprises the research method, research design, population, sampling technique, instrument, data collection and data analysis as well as ethical considerations.

3.2 RESEARCH DESIGN

A qualitative, exploratory, descriptive and cross-sectional design was followed in this study to explore the midwives' perception of ethical behaviours and professional malpractice in the Labour Units using a phenomenological approach (Christensen, Johnson & Turner 2015:370). The qualitative approach is chosen because it: investigates personal subjective understanding and attaches personal meaning to people's experiences, focuses mainly on identifying, exploring and describing the experiences of participants and data are collected till saturation occurs (Burnard, Morrison & Gluyas 2011:61; Barbour 2009:12).

This method was found to be suitable for the purpose of the study as it enabled the researcher to access each participant's inner world of subjective experience of ethical behaviour and professional malpractice in their work environment (Gu, Zing & Ding 2009:6). The design is also suitable for this study as the researcher used in-depth interviews to collect data from participants. Research was conducted at a familiar setting, an obstetric lecture room that is part of the Labour Unit structure (Moule & Goodman 2014:175).

A descriptive design aims at obtaining complete and accurate information about the phenomena through observation and discussion that provides an overview of the research situation. It can be used in a natural setting whereby the researcher gathers narrative data, analyses content which is grouped in patterns and themes (Polit & Beck 2008:237).

An exploratory study often explores research questions in which there is little known about the phenomenon. The aim is to determine the extent of involvement in relation to a particular problem (Basavanthappa 2010:182). The aim of this study was to explore and describe the extent of midwives ethical behaviour and professional malpractice issues in the selected Labour Units of Tshwane, Gauteng Province.

A cross-sectional study examines data at some point in time, meaning that data are collected on only one occasion with the subjects. The advantage of this method is that it is less time-consuming, less expensive and is more manageable for the researcher because large amount of data can be collected at one point (Basavanthappa 2010:187). Each participant was interviewed once and large amounts of data were captured because the participants had time to elaborate on their perception of ethical behaviour and professional malpractice.

3.2.1 Research question

Polit and Beck (2008:81) describe research questions as specific queries that the researcher want to answer in addressing the research problem. Brink (2009: 80) affirms to that by stating that "a research question is an interrogative statement which flows from the purpose and narrow the focus of the research". Therefore, the research question that guided this study is, namely: "**What are the midwives' understanding of ethical behaviour and experience of professional malpractices in the Labour Units of Tshwane, Gauteng Province?**

3.3 RESEARCH METHODS

3.3.1 Sampling strategies

3.3.1.1 Population

The term population refers to all suitable or potential subjects, elements with similar characteristics and attributes the researcher is interested in studying (Christensen et al. 2015: 163; Basavanthappa 2010:220). For this study, population refers to all midwives working in the Labour Units of the two institutions in Tshwane, Gauteng Province. The

criteria for inclusion was registered midwives working in the Tshwane District in Gauteng Province and that the midwives should have two or more years' experience working in the selected Labour Units of the Tshwane Gauteng Province. The purpose of the study was clearly explained to participants to enable them in making an informed decision to participate in the study and further that they have the right to withdraw from the study (Basavanthappa 2010:219; Streubert & Carpenter 2011:128).

3.3.1.2 Sampling design

A non-probability purposive sampling was followed. Purposive sampling is used in qualitative research where the aim is to sample a group of people with specific set of experiences or characteristics such as midwives. The researcher made judgment about composition of the sample and selects participants who are found to meet the criteria. The researcher visited the institutions to recruit midwives whom she felt are experienced and met the criteria for inclusion and willing to participate in the study. Polit and Beck (2008:335) and Christensen et al. (2015:171) affirm the above by stating that purposive sampling is when the researcher specifies the characteristics of the population of interest and then locates individuals who match the needed characteristics. For example, in this study, the researcher located those midwives with two or more years of experience working in the labour rooms. In non-probability, not every subject has the chance or opportunity to be included in the study (Moule & Goodman 2014:360).

Advantages of purposive sampling within the context of this study are that it is less costly and that it involves less fieldwork as the study can be conducted at the hospital where participants are working, but it is less efficient for generalisation and it requires considerable knowledge of the researcher (Basavanthappa 2010:223; Polit & Beck 2008:357).

3.3.1.3 Sample

A sample is a set of elements that makes up the population, and an element is the unit where and about which information was collected. Therefore, sampling refers to the process of selecting a portion of the population to represent the entire population in order to obtain information regarding the phenomenon under study (Polit & Beck 2008:358). The qualitative researcher using purposive or judgmental sampling does not know in

advance how many participants may be needed therefore sampling was continuous until saturation occurred. Burns and Grove (2005:358) state that saturation of data occurs when no new information is provided with additional sampling, only redundancy of previously collected information (Brink, Van der Walt & Van Rensburg 2012:141). No new information emerged during the 7th interview and saturation of data occurred with the 8th participant.

3.3.1.4 Ethical considerations

Ethical approval to conduct the study was obtained from the Higher Degree Ethics Committee of the Department of Health Studies, University of South Africa (UNISA) (see Annexure A). Prior to the collection of data at the selected institutions permission was obtained from Tshwane Research and Ethics Committee and permission was sought from the management of the institutions (Annexures B and C). Furthermore, prior to collection of data the participants were given an explanation about the purpose of the study and a written consent to participate in the study was obtained as well as consent that the interview will be recorded using a tape recorder and that information shared will be treated with strict confidentiality (see Annexure D).

The researcher ensured that participant's responses were not linked to them personally. No names of participants or their institutions were divulged. Pseudonyms in the form of identification numbers such as (Participants 1, 2, 3 etc.) were used instead of the names of participants to ensure confidentiality.

Participants were assured of their right to self- determination. This meant that participation in the study was voluntary and that they could withdraw from the study at any time should they wish to do so (Barbour 2009:81).

Participants were reassured that data collected will be stored in accordance with the University regulations and may be destroyed after five (5) years and that only the researcher and the supervisor will have access to the information. No form of remuneration was given to participants. Barbour (2009:80) attests that paying participants is a rather vexed issue and that sometimes what are essentially value judgments may appear as an ethical concern.

3.3.2 Data collection

3.3.2.1 Data collection approach and methods

For the purpose of this study, the researcher followed the semi-structured method using an Interview Guide (see Annexure D). Questions in the Interview Guide were based on the study objectives and were used to guide the individual interviews. The questions in the Interview Guide were developed by the researcher and reviewed by the supervisor. The advantages of this method were that: It gave participants opportunity to expand in their response to questions; uses an Interview Guide which allows order of questioning; allows flexibility and that the researcher had the opportunity to make follow ups on questions for clarity purposes.

However, this method has some disadvantages because it is time-consuming as interviews are conducted on a one on one basis and it may be prone to **bias** from the researcher's influence, language, body language which may be misinterpreted by the participants (Guthrie 2010:123; Barbour 2009:119).

Bias refers to the influence that produces an error or distortion which can affect the quality of the evidence. Bias can occur at any time of the study, but it does not necessarily mean the researcher caused it intentionally (LoBiondo-Wood & Haber 2010:166). The following factors may lead to bias; participant's lack of openness, researcher's subjectivity, researcher's experiences or expectation may cause distorted information and errors in sample selection method used or data collection methods (Polit & Beck 2008:197). To control bias during data collection, the researcher always ensured that the two voices are kept separate, namely, the emic insider participant voice and the etic (outsider or researcher voice) as much as possible. The researcher further kept her personal judgment or interpretations outside the data (Brink et al. 2012:99).

3.3.2.2 Interview as a data collection method

An Interview Guide was used to facilitate the interview process. In the context of this study, individual interviews were conducted as a data collection method. Interviews are versatile, serving as an effective information collection methods in a whole range of qualitative research methodologies (Christensen et al. 2015:340).

Streubert and Carpenter (2011:45) describe semi-structured interviews as best suited for qualitative researchers, more flexible and that the opportunity for story telling is inherent in format. Before commencement of interviews, each participant was assured of privacy and confidentiality, anonymity, right to withdraw at any time and informed consent. Permission to record the interviews was obtained.

Participants were encouraged to feel free to share as much information as they could. A central grand-tour question was posed to the participants, followed by more probing questions as reflected in the Interview Guide. Communication techniques, such as reflecting, clarifying, probing, summarising, were utilised during interview to explore more about the phenomena under study. Each interview lasted between 45-60 minutes and were tape-recorded and then transcribed verbatim. Data collected were verified with participants (Jooste 2010:311). All data and information collected were transcribed and kept under lock and key. The advantages of interview as a form of data collection were that:

- The interviewee had the opportunity to speak and elaborate about the phenomenon under study, in the context of this study, ethical behaviour, professional malpractices and their code of conduct as midwives;
- Researcher was the only instrument for data collection;
- Interviewing, as a data collection method, may yield more results as it allows storytelling, as such, participants had an opportunity to give more information about their lived experiences of ethical conduct and professional malpractices in the Labour Units; and
- Allowed the researcher to seek clarities and verify participant's information provided (Taylor & Francis 2013:207). After every interview, the researcher was able to check with each participant and verify data collected if it represents the thoughts of the participant.

3.3.2.3 Data collection process

Christensen et al. (2015:70) define data collection as how the researcher obtains empirical data to be used to answer the research questions. Data may be gathered through gathering or creating a data set which is obtained from listening to participants,

observation, interviewing, tests, document analysis and questionnaires. In this study, data collection was done through individual in-depth semi-structured interviews. Interviews were conducted over a period of two days. The context for data collection was a private room within the labour units, which was arranged through the assistance of the unit managers. The room was identified with a “Do not disturb” notice A battery-operated digital voice-recorder was used to record the interviews. The researcher also recorded notes in order to verify with participants if data was correctly captured and represents the voice of participants. Emotions and non-verbal responses were captured as well. The interviews were conducted in a private room next to the labour room and interviews were face to face. Participants were also reassured that none of the information shared was linked to the participants or their institutions.

3.3.3 Data analysis

Data analysis was initiated simultaneously with data collection and was verified continuously with ongoing member checking. Raw audio-recorded data were transcribed into transcripts with significant phrases identified and grouped into phrases with common thoughts pertaining to the phenomena under study. Identified phrases are then organised and analysed into clusters of themes (Streubert & Carpenter 2011:134).

Thematic Analysis was done by reference to Cresswell’s 1998 analytic spiral guidelines, as cited by de Vos, Strydom, Fouché and Delport (2009) as follows: data collection and preliminary analysis; managing and organizing data; reading and writing memos; generating categories, themes and patterns; coding the data; testing the emergent understandings; searching for alternative explanations and visualizing data.

3.4 TRUSTWORTHINESS

Trustworthiness in this study was enhanced as follows:

3.4.1 Credibility

Based on Lincoln and Cuba (1985), credibility refers to the confidence in the truth of data and interpretation of them. For this study, credibility was enhanced through prolonged engagement with participants and member checking in ensuring if data have been captured correctly (Creswell 2003 in Streubert & Carpenter 2011:48; McBrien 2008:1286).

3.4.2 Dependability

Dependability relates to the consistency of research findings. Polit and Beck (2008:539) describe dependability of qualitative data as the stability of data over time and over conditions. To ensure dependability, the researcher did an audit trail by collecting all data, transcripts and forward to an external reviewer for scrutiny. In addition, other strategies included dense description of the research methods, notes taken and peer review.

3.4.3 Conformability

Polit and Beck (2008:539) refer to conformability as the objectivity in terms of the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning. The researcher ensured that the findings reflect the participants' voices and not biases or the researcher's perspective. Streubert and Carpenter (2011:49) stated that the way in which a researcher documents the conformability of the findings is to leave an audit trail and, in this study, the researcher illustrated clearly the evidence and thought processes that led to the conclusions.

3.4.4 Transferability

Transferability refers to essentially to the generalisation of data or the extent to which findings can be transferred to other groups. This study was conducted with midwives from two selected Labour Units, hence transferability will be difficult, however, the researcher provides sufficient descriptive data in the report to enable consumers to evaluate possible applicability to other similar settings (Polit & Beck 2008:539).

3.5 CONCLUSION

The research methodologies were described in this chapter. The research project was a qualitative, exploratory, descriptive, cross-sectional and a non-experimental study. Semi-structured individual interviews were conducted. Purposive sampling was followed in selecting the suitable participants with rich information regarding the phenomena under study. Written notes and digital audio recordings were made during the interviews. The findings are discussed in Chapter 4.

CHAPTER 4

PRESENTATION AND ANALYSIS OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

Chapter 4 focuses on the presentation and analysis of the findings of the study from collected data. Six major themes emerged from the data analysis. Some recommendations were also offered by participants. Narratives or stories shared have been depicted to show the midwives 'perceptions and understanding of ethical behaviour and professional malpractices in the labour rooms. Almost all of the participants had experienced a malpractice error and have experienced the challenges brought by litigations. The demographic data of participants have been presented. The findings have been substantiated by literature.

4.2 DATA MANAGEMENT AND ANALYSIS

The analysis was done manually and documentation included transcriptions of recordings obtained from individual interviews and notes taken during the interviews. Information was obtained from the eight individual interviews conducted with registered midwives working in the selected Labour Units of Tshwane, Gauteng Province. Interviews were audio recorded and transcribed verbatim. Data analysis started during interviews and continued throughout the transcription of recorded interviews. According to Burns and Grove (2015:643), data collection and data analysis in qualitative research can be done simultaneously till saturation is reached. Data saturation was reached with the eighth (8) participant. Data are usually in the form of notes, digital files, and audio recordings and through qualitative analysis technique, these data is organised to promote understanding.

Christensen et al (2015:376) affirm that in qualitative research data analysis may be undertaken collectively in meeting with participants through summarised stories, reflections and notes taken by the researcher that will eventually emerge into themes and concepts. Based on Thematic Analysis, six major themes emerged as: participant's understanding of ethical behaviour and malpractices; participant's experiences; ethical decision-making; litigation experiences; the impact of malpractices and litigations and

factors contributing to professional malpractices, as illustrated in Table 4.2 and explained in this chapter. A theme is a recurring regularity emerging from an analysis of qualitative data (Polit & Beck 2008:767).

4.3 SAMPLE CHARACTERISTICS

Table 4.1: Sample characteristics of study participants (N=8)

1. Gender	
Females	08
Males	00
2. Age	
40–45 years	02
46–50 years	04
51–58 years	02
3. Work experience (years)	
2–10 years	02
11–20 years	02
Above 20 years	04

4.3.1 Participants' age

Two of the participants were aged between forty and forty-five years, four were aged between forty-six and fifty years, while two were between fifty-one to fifty-eight years of age.

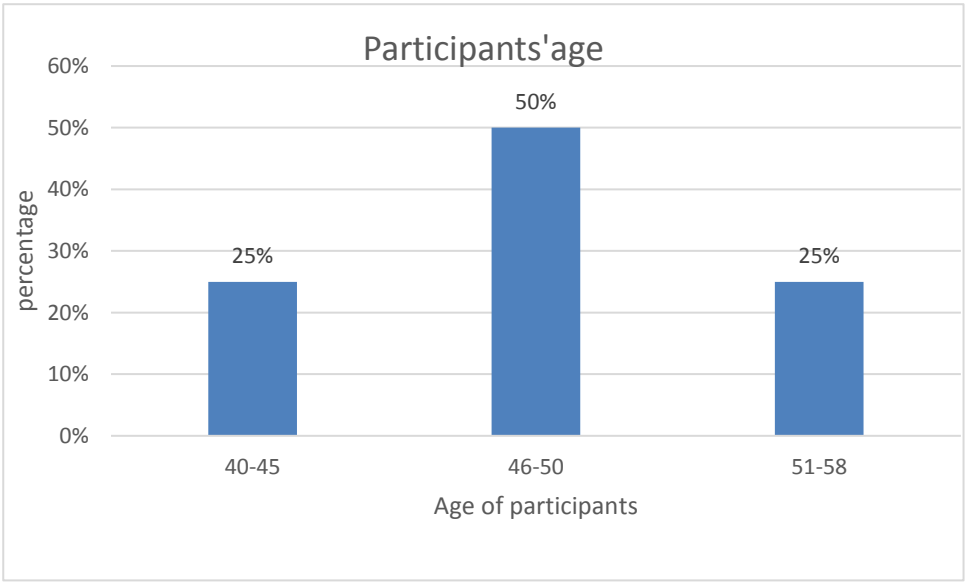

Figure 4.1: Participants' age (N=8)

4.3.2 Participants' level of education

All participants held a Diploma in Nursing (General, Community, Psychiatry) and Midwifery and seven participants (88%) have advanced midwifery training. Advanced midwifery is a qualification designed with a primary purpose to produce competent, independent and critical thinking midwives who provides scientific, safe and comprehensive midwifery care to individuals, families and communities within the legal and ethical framework (SANC 2014:8). These midwives are specialists in midwifery care and they function at a higher level above those with basic midwifery training. This implied that the participants were highly qualified and experienced midwives and, as such, met the criteria for inclusion.

4.3.3 Participants' work experience

Four of the participants had more than twenty years of experience working in the labour rooms, and two (25%) have 11-20 years of experience whereas the remaining two (25%) participants of which one (12, 5%) had eight years and the other one (12, 5%) had 2-3 years of experience working in the Labour Unit. All participants had vast experience of working in the Labour Units.

Figure 4.2: Participants' work experience (N=8)

Table 4.2: Major and subthemes

Major themes	Subthemes
Understanding ethical practice and professional malpractices	• Understanding of ethical practice • Accountability and responsibility • Failure to follow practice standards
The experience of ethics and professional malpractices	• Noble and fulfilling • Challenging and stressful • Need for information
Ethical decision-making	• Dilemma in decision-making • Professional conduct and image • Poor decision-making
Litigation experiences	• Negligence • Giving of evidence • Failure to advocate for the patient
Impact of malpractices and litigations	• Frustration, discouragement and demoralisation • Financial implications • Conflict between colleagues
Contributory factors	• Lack of resources • Delayed referrals • Financial rewards • Patient's Rights versus litigations • Staff attitude • Poor record-keeping

4.4 DISCUSSION OF MAJOR THEMES AND SUBTHEMES

The major and sub-themes stated in Table 4.2 are discussed as follows:

4.4.1 Understanding ethical practice and professional malpractices

The understanding of ethical practice

Participants were asked to explain their own understanding about ethics, and the following statements were mentioned:

> "Ethics are rules and regulations prescribed to us by our institutions, district health and South African Nursing Council and if not followed we end up with an omission." (P4)

> "I can say ethics involves rules and regulations, protocols and it includes professional standards that a midwife must adhere to." (P3)

According to Erasmus (2008:6), ethical practice entails acting from a sense of moral duty, respecting another's rights and honouring one's obligations. Midwives have the duty to do good and to do no harm to their patients. Rich and Butts ([s.a.]:17) state that ethical behaviour is more than just a feeling, a moral code or value. Ethical behaviour entails adhering to ethical norms by professionals, whereby they acquire the information required, and eliminates possible errors and bias while ensuring accountability for accurate reporting on results.

Accountability and responsibility

Griffith (2012b:601) says that the midwife-mother and baby relationship gives rise to a duty to care, therefore midwives have a duty to care and to be careful. There was indication that participants knew what is expected of them by the community and how they should conduct themselves as professional midwives as expressed in the following response:

> "Ethics refers to the accountability and responsibility, things that you are supposed to do as a midwife. There's a certain manner in which a midwife should conduct herself, and there's an image that you must uphold. And you are answerable to the employer and the community that is as a midwife you need to preserve life. You need to conduct yourself in a certain way not to take your profession and the nursing into disrepute, don't take the dignity of the nurses down." (P8).

Kinnane (2008:4) supports the above saying that the terms 'ethics' and 'morals' are often used interchangeably and that ethical theory means thinking, a reflective process − a more philosophical approach to ethics, whereas morality applies to the more every day, socially acceptable ideas of what is right or wrong, or "good and bad" behaviour within a particular community and, in this instance, in midwifery practice. The research is based on the Theory of Principlism, which incorporates the four ethical principles, namely: autonomy, beneficence, non-maleficence and justice.

Autonomy means that the woman is given information and has the freedom to make choices and they advocate for their own health. Based on autonomy, the midwife does not impose decisions on the woman but respects the rights of the woman. Beneficence is acting in the best interest of the woman, whereas non-maleficence is the counter-balance for beneficence. The midwife must always ensure that the benefits of certain actions should be balanced against the amount of harm. And that, in all the care given to patients, avoid unjustifiable actions nor discrimination (www.ministryofethics.co.uk.30 May 2015). Therefore, midwives have to practice in a compassionate and morally accepted manner by the community and patients.

A Code of Ethics is described by SANC as a tool that assists nurses in identifying their ethical responsibilities and serves as a foundation for ethical decision-making (SANC 2013:3). The Australian Nursing and Midwifery Council (ANMC) in their Code of Ethics for midwives affirms that midwives value informed decision-making, value respect and kindness for self and others and quality midwifery care for each woman and her infant (ANMC 2008:28). Smith and Godfrey (2002:2) highlight that women operate differently from men (as stated by Gilligan and others) as women evaluate ethical situation according to the ethic of care, which emphasises relationships and responsibility for the midwife and woman. Furthermore, that the ethic of care is different from the ethic of justice which focuses on autonomy, individualism and rights, however, both are applicable within the context of this study.

Failure to adhere to practice standards

According to Erasmus (2008:5), nursing malpractices exists because it is human to make mistakes under stressful conditions and that midwives work in a highly stressful environment. Professional malpractice is a conduct which is considered reprehensible either due to lack of skill or immoral. The participants showed their understanding of malpractice as shared from the following:

> "Malpractices are the wrong practices that need to be corrected, they are wrong practices like failure to give treatment or omission to give care to a woman in labour. When there is a malpractice, it constitute an adverse event or let me not classify it as serious for now but you can be taken to a disciplinary committee for a hearing." (P7).

Another participant mentioned that malpractice:

> "is doing things not in the way it is supposed to be done, not rendering patient care, and not treating clients correctly." (P2).

The above is supported by Klebanow (2013:56) who refers to malpractice as a label for undesirable activities, and more specifically as negligent behaviour displayed by a professional person and that where the professional service or results are unsatisfactory to the healthcare user.

Most participants agreed that malpractice may be associated with poor decision-making on the part of the nurse and further elaborated that such cases end up with litigation cases, either internally or externally:

> "Malpractice is when as a midwife I don't practice according to the code of conduct, set standards and not rendering quality patient care." (P3).

> "failure to administer magnesium sulphate to a patient with gestational hypertension;) refused to touch the baby as midwife was not wearing glove; delay in referring patient to hospital and mother delivering a fresh still born and failure to advocate for the patient and the woman delivered alone in an ambulance without an escort." (P4)

Omissions mentioned are similar to what is happening in other countries. In the USA, the common types of breaches in the medical profession involve failures to diagnose, misdiagnoses, misreading or ignoring laboratory results, surgical errors, incorrect medication or dosage, premature discharge, failure to respond or recognise symptoms. Erasmus (2008:5) affirms that nursing malpractices exists because it is human to make a mistake under stressful environment in which nurses and midwives function. It must also be noted that health-care professionals have a duty to warn patients about medical risks, known as the duty of informed consent. The patient also has a duty under informed consent to provide pertinent information, such as furnishing a complete health and medical history, and to adhere to the treatment plan (Klebanow 2013:56).

4.4.2 The experience of ethics and professional malpractices

Participants shared both and negative experiences of working in Labour Units with reference to ethical practice and professional malpractices.

Noble and fulfilling

Seven (88,8%) of the participants reported positive experiences when asked about their experiences of working in the Labour Units but all had contrasting opinions. For example:

> "it is a blessing and is fulfilling to be a midwife." (P6).

Participants were all aware of the litigations happening in the Labour Wards and they associated that with shortages of staff, and they also view it as a demoralising factor to those who love midwifery.

One participant expressed this as follows:

> "It is not good or bad, some cases are discouraging and some are positive, it gives me that satisfaction working with the community, although there is shortage of staff and it's a high stress environment". (P1)

Challenging and stressful

Midwifery practice was also referred as a very challenging career and this is what the other participants shared:

> "To be a midwife is a stressful career because you are working with two lives, the mother and the baby, so is two lives that depend on you and you must make sure that you save both lives." (P5)

Participants further highlighted that they sometimes feel frustrated as illustrated in the following response:

> "In midwifery you deal with two lives, and we are not allowed to be human, we are supposed to be God and never say anything even if the woman is not cooperating during delivery some patients come with negative attitude and it's frustrating." (P3).

Both the positive and negative experiences of working in the Labour Units have been voiced by the participants. Lewis (2012b:310) supports the above saying that being a midwife is far from easy, yet on a daily basis one witness tremendous acts of generosity, kindness and care in which midwives support women and their families in often intimate, difficult and demanding situations. Lewis further states that, in some instances, these difficult situations may be because of hospitals centric systems in which the majority of midwives work, which runs counter to and militates against continuity of care. There is also a darker side in midwifery whereby, during those moments, both the mother and the midwife dread, the fear of abnormal blood results, loss of a baby and death of a mother. Other social challenges that the mother is having become part and parcel of a midwife's role and recognising and responding with effective approaches that help and support the woman and her family are essential to good midwifery care (Lewis 2012b:310).

Need for information

However, participants also believed that:

> "The community need to be more educated on their responsibilities not only on their rights because some of the adverse events happen because the mother came to the clinic late already having complications." (P7).

Furthermore:

> "Sometimes antenatal mothers come to the MOU in labour when they were told to go straight to hospital and some end up delivering fresh still birth or other complications." (P5).

A qualitative descriptive study in Pakistan by Saleem et al., (2015:205) explored the midwives' experiences and perceptions about a midwifery-led care model, revealed that midwives struggle to practice independently and autonomously while providing care to women during stages of labour, and that, though midwives provide skilful maternity care,

they are not recognised by society as professionals and that they face lots of frustrations and challenges due to shortage of resources and the shortage of staff which have a serious impact on patient safety and quality care.

4.4.3 Ethical decision-making

Dilemma in decision-making

Participants stated that in their line of duty as midwives they are often faced with difficult situations where they are to make an ethical decision to a woman during intrapartum care to ensure quality care as expressed in the following response:

> "As a midwife I am expected to behave in a professional manner, treat my patients well and not with attitude, regardless of the situation." (P6).

Midwives working in Labour Units are confronted with ethical decision-making when caring for a woman in labour and there is always fear that the baby or the mother may present with serious complications during the intrapartum period. Arries (2006:62) affirms that decision-making is a very critical component of nursing and midwifery practice and that any decision made has an impact on the lives of the patients. The quality of these decisions lies at the heart to deliver quality patient care and it involves the application of the four ethical principles.

In this study, it was revealed that in some cases midwives make ethical decisions relating to the care of a woman in labour but the patient be the one to make that decision impossible, as illustrated in the following response:

> "[A] patient refused to take anti-retroviral therapy stating that her pastor told her that she was healed of HIV and she refused to take treatment and when the baby was delivered she also refused to participate in the PMTCT (Prevention of Mother to Child Transmission) program after the baby was born and Nevirapine was not administer medication to the baby." (P5).

The researcher's view point was that in this type of cases the Children's Act (Act no 38 of 2005) has to be applied in order to cater for the rights of the newborn baby (South Africa

2005a). It was also not clear as to whether the baby will be given the treatment at home since the mother believes otherwise. However, the response was that the mother was then referred to the clinic manager and the case was further referred to the social workers.

Some of the challenges were reported as follows:

> "[A] young girl came to the facility being in labour and after delivery she did not want to breastfeed or touch the baby and then she mentioned that she was raped and didn't report at home that she was raped by a family member it was an ethical dilemma for me and I ended up having to involve the mother and the social workers." (P7).

The researcher believes that the mother of the baby has the right to decide and still not forgetting the right of the innocent child. With reference to autonomy, the mother has the right to make an informed decision and not be forced to breastfeed. The midwife had a duty of confidence but in this case they had to intervene so that the mother to the 19 year old is also informed. Griffith (2008:51) affirms that the duty of confidence is not absolute because there will be occasions where confidential information about a patient will need to be disclosed to others, especially where critical decisions have to be made. Griffith (2008:51) further said that it is essential that midwives understand the scope of the duty of confidence owed to the women in their care.

Professional conduct and image

Erasmus (2008:6) stated that ethical practice entails acting from a sense of moral duty, respecting another's rights and honouring one's obligations. That nurses and midwives have a duty to do good (beneficence) and a duty to not do harm (non-maleficence) towards patients in their care. This principle denotes that midwives have to be careful when making decisions to avoid physical, emotional and social harm to the woman in labour as also expressed by one of the participants:

> "There is an image that you must uphold as a midwife, conduct yourself in a professional way and not take the profession into disrepute and you have to be accountable and responsible to your actions." (P8).

As stated by McLeod-Sordjan (2014:474), professionalism and ethical practice are symbiotic as professionalism is rooted in ethical knowledge and moral reasoning skills framed by nursing's Code of Ethics.

Poor decision-making

Participants mentioned that in most cases they associate malpractice with poor decision-making stating that sometimes midwives at other clinics refer to the MOU instead of sending the patient straight to the hospital:

> "we assess every woman that comes and refer to the doctor, maybe in the clinics it can be said but it might be associated with poor decision-making but not here in the hospital, mainly because in the clinic there are midwives only and if the decision is wrong, there is no one to correct you unless you phone the hospital for an opinion"

Decision-making has been cited by participants as a problem whereby midwives felt that sometimes they are afraid to make decisions due to the high rate of litigation cases in midwifery care.

Poor decision-making was also related to failure to advocate for the woman as stated in the following response:

Participants acknowledged the occurrence of failure to advocate for a patient for example:

> "Sometimes it happens that you make a decision thinking that you are making a good decision but only to find out that you are making a wrong decision. For instance, I had a case where a patient was referred to hospital because of polyhydramnious and preterm labour and then the EMS (emergency medical staff) were called, and when they arrive, the mother was fully dilated, and they refused to take her because they said she was going to deliver on the way, then the mother delivered at the clinic and the baby was so small a preterm and very distressed. It was very distressing and the EMS could not take preterm baby because the ambulance had no facility and the MOU also did not have the facility nor the equipment to cater for the needs of a preterm baby and the said baby died, if I had insisted that the mother be transferred maybe the baby would had survived." (P2).

Arries (2006:62) affirms that clinical decision-making is a critical component of nursing practice and further that nurses and midwives make daily clinical decisions that impact on the lives of their patients whereby these decisions may be good or bad and that the quality of these decisions lies at the heart of the process to render quality care. Lachman (2012:112), in a research paper on "Applying the ethics of care to your nursing practice", refers to Watson's caring model that requires the nurse to acknowledge the uniqueness of the individual patient and make an effort to preserve the patient's dignity by applying the elements of caring as: attentiveness; responsibility; competence and responsive to care that will ultimately enhance ethical practice.

> "Yes sometimes we make wrong decisions as midwives, In our MOU a woman with low HB (Haemoglobin) came in with ruptured membranes, according to the clinic notes she was supposed to deliver in hospital, she was told to go to hospital as she said she has transport. However, the woman did not have transport and went outside whereby she delivered by herself, and this was a poor decision because the patient was not properly assessed." (P8)

A study conducted by Hood et al., (2010:268) in Australia revealed that midwives work in an environment they perceive as driven by fear of litigation and increasingly stressful and therefore some decisions made out of fear may be wrong. Lewis (2012b:310) supports the above statement saying that there is a darker, sadder but equally important side in the role of a midwife. That there those moments that both the mother and midwife dread; the fear of the loss of the baby, the death of the mother or any abnormal condition that may arise post-delivery. And it is during these difficult and challenging situations where midwives often feel alone. These are some of the quotes from the participants:

> "A woman presenting with labour pains and had big abdomen came to the clinic, she was not referred to the hospital, she had shoulder dystocia and after the struggle to deliver the baby, the patient started bleeding profusely and was sent to hospital in a very critical and compromising condition." (P4).

Midwives are regarded as frontline workers providing intrapartum care and therefore skills and knowledge concerning the application and interpretation of the CTG is paramount for them. It has been pointed out that the ability to perform and interpret the CTG independently has become a standard requirement for midwives making fetal

assessments. Failure to adhere to protocols may results in a negative outcome for the mother or her unborn baby and contributes to claims of midwifery negligence. And further more a midwife is legally liable for assessment errors and interpretation of fetal heart rate patterns that result in fetal or maternal injury or death (Ho 2009a:59). Midwives must always know that they have a duty to care, to be careful and not to be careless with mothers and babies (Griffith 2012:601).

> "We did not have CTG before with the feto-scope, it was difficult to detect the fetal heart, especially with women who have a big abdomen so we had a lot of transfers to hospitals which also add more burden to midwives at the hospital level." (P2).

4.4.4 Litigation experiences

Negligence

Most participants mentioned they have never given evidence in a litigation case but have gone through the experience of having been reported for negligence or failure to make an ethical decision, which later were not found wrong by the department.

> "I once found a patient with meconium aspiration waiting for an ambulance which delayed for three hours and patient delivered a fresh stillborn, incident was reported to quality and the investigations concluded that the adverse event was due to transport related issues." (P1)

Giving of evidence

One senior participant who mentioned that as the operational manager she is often requested to give evidence:

> "as an operational manager, I am often requested to give report every time there is a serious incidence".

Other participants also indicated that:

> "most of the time when there is a malpractice error, we are called to write statements and often matters are solved internally".

One participants explained that she was litigated for poor care and said:

> "I was taken to a disciplinary hearing by the Department of Health and also by the regulating body SANC for failure assess the fetal and maternal conditions properly, failure to advocate for the pregnant woman in labour and patient was discharged to go to the hospital but delivered alone outside the clinic premises and I was suspended for six months and I did my sentence." (P8).

Failure to advocate for a patient

> "I was charged with failure to advocate for the patient who was referred to hospital and deliver alone in an ambulance on way to hospital just five minutes away from the clinic." (P1)

Another participant shared her experience as follows:

> "I was working night duty in another clinic, on report taking I found a patient with meconium stained liquor and the patient was to be transferred to hospital, the ambulance was delayed and it was almost three hours when the patient delivered an FSB (fresh still birth)." (P7).

Klebanov (2013:56) affirms the above findings saying that the most common types of breaches in the medical profession involve failures to diagnose, misdiagnose or ignoring laboratory results, incorrect medication or doses, poor follow up care, premature discharge, disregard or not taking appropriate patient history and failure to recognise symptoms. It is further stated that in the USA, that the leading causes of malpractice suits is diagnostic error which accounts for around 40% of cases ,costing insurers an average of $300,-000 per case to settle. However, in RSA the most causes of malpractice suits are around birth injuries and about 155 cases of negligence have been reported by the Gauteng Department during 2012/2013 with an average amount of R5 million per claim (Child 2014:01).

4.4.5 The impact of malpractices and litigations

Frustration, discouragement and demoralisation

> "You can't even work, you feel frustrated, it is demoralising, you feel demoted when there is malpractice in your ward, you are frustrated, afraid of touching a patient because thinking you might repeat the same malpractice, won't take decisions to discharge patients, especially if you facing a litigation involving discharging and referrals, you feel like resigning and there is low staff moral which leads to absenteeism." (P2).

> "But we don't do that anymore, we are afraid to take decisions because of fear of litigations. They always say joo! What if something happen, we are afraid to be that independent practitioner we use to be you always need someone to help, to take decision for you." (P8).

Low morale was also experienced as an outcome of litigations based on participants being discouraged to take ethical decision making.

As stated by the following participants, litigations also to lead to low staff morale.

> "It is very painful, it is demoralising and you will feel that you are not effective and efficient as a midwife, and you become stressed, it can even affect your health." (P1)

> "Fear of touching patients, there is a fear factor and thinking that you will get involved in another adverse event and have another law suit." (P5)

> "Low morale leads to absenteeism which then leads to shortage of staff, and where there is shortage you look at more patients being one and mistakes do happen. Sometimes you become alone and if you deliver a fresh still born, nobody wants to touch the FSB because they afraid to write statements." (P4).

Frustration, discouragement and demoralisation further led to fear to make ethical decision as illustrated below:

Participants were asked on how they are impacted by the litigations of nurses, a number of them expressed that it is discouraging and:

> "There is fear of making decisions as those under litigation are not willing to work because of fear of having another malpractice and this increase the work load on the one who has no litigation case. This leads to midwives who are not involved in the litigation to be also discouraged to work due to fear of having a malpractice." (P8).

Most participants mentioned that:

> "Once there is a malpractice one develop fear of touching patients nor even taking certain decisions." (P1; P4; P6; P8).

Hood et al., (2010:268) conducted a study on the story of scrutiny and fear and the findings of that study revealed that midwives feel unsafe at work, as their work environment is driven by fear of litigation. Midwives cited that they feel exposed and not supported during legal proceedings.

Midwives are independent practitioners but the rise of litigations has made them not to act by refraining from being independent midwives and making decision but to wait for the doctor to make a decision. This is what participants said:

> "It affects us badly because now as I am saying midwives are afraid to take decisions, like when you do a per vaginal examination on a woman and you find that she's 1cm then you sent her home and tell her she'll come back when the pains are stronger, you have got transport you can come back later because our labour ward is too small is 8 bedded ward." (P2).

Lack of confidence was also indicated by one participant who was involved in a litigation case by stating that:

One participants who was involved in a litigation case shared the following:

> "it results in lack of confidence, I feel I let my community down, you think people are looking at you even if they don't know anything about you, you feel like you are

incompetent in decision-making, and it affects you socially you start being grumpy, and neglecting your social responsibilities … .” (P7).

Financial implications

In terms of one being found guilty, participants expressed fear of financial or even job loss as expressed below:

> “It affects midwives emotionally, psychologically and also financially if you are suspended from work, for me it affected me a lot and I even started to leave the work and go and start something new, you end up having to change your social life, at home you become grumpy children you neglect them, sometimes you may get suspended without pay, and it gives financial stress. Financially is bad, you become angry with yourself, psychologically, you become depressed.” (P7).

Conflict between colleagues

Litigations leads to conflict between colleagues that affect interpersonal relationship as reflected in the following response:

> “There becomes conflict between us as colleagues when we write statements, and the problem is to modify the statement to suit everybody because somebody want to know what you write and again you don’t want to put somebody in the hot soup, so writing of statements is wrong sometimes you write lies trying to cover the colleague. Sometimes you ask each other what you have written so I think the statement should be fair and confidential or rather written before your union representative.” (P8).

4.4.6 Contributory factors

Several factors were cited by participants as contributing to unethical behaviour and professional malpractices as follows:

Lack of material and human resources

Shortage of resources with specific reference to a cardiotoco-graph machine (CTG) was a concern, midwives need a CTG machine to continuously monitor the fetal heart rate of the baby during intrapartum care to enable the midwife to observe signs of distress, especially with high-risk patients in order to make a decision regarding further care and to prevent malpractice.

One participant said:

> "Having one machine causes delay on other patients and using fetoscope alone you won't be able to pick up complications, it may give wrong readings and it won't tell if there is bradycardia." (P1).

> "We did not have CTG before with the fetoscope, it was difficult to detect the fetal heart especially with women who have a big abdomen so we had a lot of transfers to hospitals which also add more burden to midwives at the hospital level." (P2).

Recently Pretoria newspaper released an article which revealed that nurses quit in droves because of poor working conditions. In that article nurses voiced that the 2010 Nursing Strategy Report had since promised to address poor working conditions, retention strategies, unsafe working conditions, the lack of resources which threaten the safety and wellbeing of nurses and patients but to date similar conditions are still there (Makhubu 2016:2). The report further indicated that the nurses are performing non-nursing duties such as those of porters and cleaners, and still give care to patients of which it impacts on the quality of care given.

Shortage of staff has been cited as a challenge as participants indicated that when they are short staffed their workload increases. The high workload lead to exhaustion and low morale which adds to absenteeism and poor quality care,

> "if we are short staffed we focus on others and others end up delivering on their own." (P1).

Shortage of staff has been reported in most research findings and poses as an international concern. For example, in America, heavy load on nurses is a major problem for American health-care systems and the reasons for high workload are due to increased demand for nurses; inadequate supply for nurses; reduced staffing and increased overtime (Carayon & Gürses 2005:284). Table 4.2 depicts the relationship between nursing workload and patient safety.

Duffin (2014:10) affirms that higher number of nurses are associated with improved survival rates among patients. And in a study on Safe Staffing and Medical Errors, it was determined that seven (7) additional lives would be saved for every 100 patients if nurse numbers increases and this will be guided by the type of unit and acuity levels of the patients. Wallace (2013:50) supports the above saying that an effective staffing model should take into account resources such as support personnel, equipment and supplies because having adequate resources on hand improves the nurse and midwives workflow and improved patient outcomes.

Working in an environment with proper human and material resources could contribute towards attainment of positive results and less adverse events. From an international perspective a scoping review was done, which explored the relationship between maternity workforce, staffing, skill mix and deployment practices and the safety of maternity care in both middle and high income countries. The review results found evidence of an association between higher obstetrician staffing levels and lower still births rates , and an increase in babies needing resuscitation and in adverse events and near misses" being related to midwifery staffing shortages (Sandall 2012:323).

In a report released by Irinnews in RSA, it was revealed that midwifery shortages impacts on maternal health. It was further stated in that report that for every 100 000 babies born up to 625 mothers die due to childbirth complications and that mortality in children under five (5) years is steadily rising and stubbornly high at 104 death per 1000 live births as per figures from Government (Irinnews 2011:6). The relationship between nursing workload is depicted in Table 4.3.

Table 4.3: The relationship between nursing workloads and patient safety

Mechanism	Description	Example
Time	Nurses with workload may not have sufficient time to perform task safely, apply safe practices, monitor patient and may reduce communication with Doctors and colleagues	More or less time to double check procedures, for example medical
Motivation	Dissatisfied with their jobs, dissatisfaction is affecting their motivation for high quality performance.	No or little motivation and commitment to high level of performance, creating frustrations and contributing to negative attitude
Stress/Burnout	Nurses with high workload experience stress and burnout It results in negative impact on their performance.	Reduced physical and cognitive resources available for nurses to perform adequately
Errors in decision-making	Cognitive workload can contribute to errors, for example slips, lapses or mistakes.	Forgetting to administer medication
Violation of work rounds	Workload conditions make it difficult for nurses to follow rules and guidelines, thus compromising the quality and safety of patient care	Inadequate hand washing in between procedures
Systemic organisational impact	Workload of nurses and managers could affect the safety of care provided by another nurse	A charge nurse may not be available to help other nurses with patients when needed

(Adapted from Carayon & Gurses 2005)

Table 4.3 illustrates how work overload impacts on the quality of care being given. It concurs with the findings of this study that participants said if they are overworked they do not make ethical decision and the quality of care given to their patients become compromised.

> "If we are short staffed we focus on others and others end up delivering on their own." (P1).

Nyathikazi indicated that South Africa has biggest challenges due to shortage of midwives because people are trained as a general nurse first and then be given midwifery skills and that South Africa is not producing enough midwives to provide the best care possible, much as a lot of women are delivered at hospitals (Irinnews 2011:6).

According to the statistics from SANC, the total number of registered nurse and midwives is (n=136854). However, it must be noted that not all of them are rendering obstetric care. It is difficult to determine the number of midwives rendering obstetric care because there is no separate register for midwives in RSA (SANC 2014:1).

The issue of catering high number of patients was cited as the problem by participants in both institutions.

> "I think another CHC or MOU is needed to relieve the influx of patient it will relieve the stress on us because we cater for patient some from Limpopo province? And all over from referring clinics" (P5).

The participants further said:

> "We are a district hospital with 32 clinics referring to us and only 8 (eight) render a 24 hour service (MOU) so a lot of patients are seen by us. We deliver around 350 NVD (normal vertex deliveries) a month and another nearby MOU deliver 60 cases a month." (P6).

Delayed referrals

Delayed referrals of high risk patients from other clinics has been pointed as a contributing factor as some of the cases are referred already complicated. Participants shared the following:

> "Delayed referrals by other clinics to the MOU." (P4)

And that:

> "sometimes patients with high BP are referred late and come to MOU already with complications, and sometimes antenatal mothers come to the MOU in labour when they were told to go straight to hospital and some end up delivering fresh still birth or other complications." (P3).

> "Late bookings by ante-natal mothers also add to the problems because complications may be picked up late." (P4)

The researcher's view is that some of the complications happen because there was a delay in transportation to hospital and also due to lack of responsibility from patients. However, in Gauteng, the issue of transport does not hold because the ambulances are available at clinics to transfer patients to tertiary institution. WHO (1998) highlighted the importance of having maternity waiting homes as a way to reduce maternal and perinatal mortality and other complications. The waiting homes are facilities where the high-risk mothers can be accommodated and cared by skilled workers whilst waiting for delivery. Introduction of waiting homes will reduce some of the complications because the patients would not need any urgent transportation to hospital. High-risk patients will then be monitored at the homes until delivery time.

Financial rewards

The study findings revealed that midwives were not satisfied with their salary packages visa vie the work they do as it is demoralising. Participants indicated further that where overtime was done, there is serious delay of payments, which demoralises them more:

> "we were not paid overtime for maybe 8 months so who will want to work for charity if not being paid that's why midwives are not happy, so let people be paid for overtime." (P8).

Miya (1996:43), in his declaration of "a life shared for the sick and knowledge dispensation as a young doctoral graduate", supports the fact that the salary packages for nurses need to be reviewed and take into account the qualifications one holds. Furthermore, that the hospitals need to create portfolios and acceptable remuneration packages for all nursing qualifications from a diploma to a doctoral level.

The researcher's view is that financial incentive such as overtime payments have been made to inspire employee's loyalty and increase productivity among employees and also to curb shortages.

Patient's rights versus litigations

Most of complaints received with regard to midwifery practice is mainly that patients are more knowledgeable about their rights. The community is more informed through the use of media and can do an internet search to be capacitated about a condition. One of the participants said:

> "People are aware of their rights, they hear the media everywhere and know what is right or wrong." (P?)

McHale and Tingle (2007:53) reported that the claims of non-clinical negligence in the United Kingdom continues to rise as the members of the public are more informed of their rights to health care. However, in the context of this study, the following response was presented as an argument:

> "It is not that the litigations are becoming too high, it is because people know their rights, there is transparency the rights are written everywhere at the clinics and if they are not satisfied they complain." (P8)

Ho (2009:59) supports the above statement by highlighting that though there is improvement in obstetric and neonatal care, clients have also become better educated, have higher expectations and are generally demanding for quality care. London and Baldwin-Ragaven (2008:6) highlight that health professionals have an ethical obligation to place the wellbeing of patients at the forefront of their professional commitments in an attempt to advocate for, protect and promote human rights, and thus furthermore, undertake an ethical commitment to maximize the wellbeing of those in their care.

Staff attitude

Staff attitude was also found to be a contributory factor to professional malpractice as participants expressed that some midwives become irritable when dealing with difficult clients and end up not behaving ethically:

> "Sometimes we give attitude if the patient is not cooperating during delivery and you are thinking of saving the two lives." (P5).

Staff attitude is one of the six key priorities that the Minister of Health came up with in the National Strategic Plan (Department of Health 2011) in order to improve quality care of patients. This is an indication that nurses and midwives' attitudes are a problem and it is affecting service delivery. This is what participants shared:

> "Obviously for him to come up with the six key priorities and attitude being one of them it means there is a problem with our attitude and obviously the attitude impacted on the ethical conduct of nurses and midwives." (P6).

Participants further displayed responsibility regarding midwives attitude, which was also reflected in a study by Mathibe-Neke, Langley and Rothberg (2014: 747) on perceptions of midwives regarding psychosocial care, namely:

> "We need to refine our emotions and to display a positive attitude, pray to God and ask the new mercy for the day." (P5)

Khalil (2009:437) conducted a study on nurses' attitude towards patients in South Africa and the findings were that because of severe shortage of nurses and frustrations encountered nurses tend to reward good patients with tender loving care and difficult clients were ignored or their needed interventions delayed. Khalil and Karani (2005:4) and AbuAlRub (2004:73) argued that nurses' frustrations stem from inadequate support from managers, unfair blaming, eroded morale and general work dissatisfaction. However, grouping patients as "good or bad or difficult should not be condoned, but it was found to be the only strategy that some nurses could utilise to protect themselves from traumatic encounters with difficult patients". The authors further said that covert violence against patients is difficult to validate, but such unprofessional behaviour

constitute negligence (Whyte 2011:18; Khalil 2009:437). On a positive note, Miya (2015:31), in his reflection on "a life shared for the sick and knowledge dispensation" as a young doctoral graduate, argues that:

> "although blamed for negative attitude and laziness, nurses continue to be at the forefront of health services delivery and that babies are born safely, injured and the sick are given support and comfort by the very same so called rude nurses, however, nurses go an extra mile to facilitate quality care with little recognition by the consumers."

Poor record-keeping

Coordination and delivery of quality obstetrical care requires optimal communication amongst members of the multidisciplinary team. A midwife has the responsibility to communicate any relevant information of her findings to the team through recording (McDermott et al 2007:19936).

> "As midwives we have acts and omissions, if I did not record the fetal heart rate at the time it was supposed to be done is regarded not done" (P7).

Proper recording is also essential in the communication of care because it assist in continuity of care as in nursing they say "***what is not recorded is not done***". Gabs in the record can lead to speculation that something is being hidden (Ho 2009a:59). One participant said:

4.5 RECOMMENDATIONS

The following recommendations were made by the participant in order to reduce unethical practice and professional malpractices, as reflected in Table 4.4.

Table 4.4: Recommendations

Themes	Responses
Human and material resources	"Improve clinic structures or build another MOU or a hospital in Tshwane Metsweding region to alleviate the influx of patients at the MOU and the district hospital." (P8). "Increase the frequent visits of obstetricians for the MOU." (P7). "Provide facilities with adequate machinery and clothing." (P2). "That the institutions to improve on their material and human resources so that quality obstetric care can be provided." (P4; P5; P7; P8)
Staff development	"Provide training to midwives; in-service training, seminars and workshops." (P8).
Use of guidelines and protocols	"As midwives it is important to adhere to scope of practice, maternal guidelines, protocols and policies as described by the profession." (P3). "Assess clients correctly following use of BANC and maternal guidelines." (P4). "Strengthen the use of protocol for instance BANC." (P2).
Management support	"Management to support midwives emotionally and have debriefing sessions after SAE (serious adverse events)." (P4; P5; P6; P7). "The management must improve in giving support and encouragement to their staff especially when faced with adverse events incidents." (P1; P2; P3; P7). "Management to appreciate midwives (give praise where due)" and also we need to be encouraged, given support and be appreciated when doing well. May be somebody must say you are doing good, they should not only come when there is a problem." (P2)

Themes	Responses
Accountability and responsibility	"Peer group censoring that is as midwives we need to stand for what is right, be able to correct one another rather than to shield the wrongs" (P1). "Midwives to always strive to portray a positive attitudes and improve on it, through the tone of voice, how we address clients should portray respect at all times." (P7). "Be able to accept our wrong doings because to err is human, patients to be told immediately of any wrong doing and redress accordingly. Encourage to have the debriefing sessions after adverse events experiences." (P8).
Remuneration	"Institutions to pay the staff overtime incentives on time not after six months" (P8).
Recordkeeping	"Proper record keeping and communication of findings amongst staff members." (P7).
Information	"Educate antenatal mothers on their responsibilities to book early; follow the clinic instructions in order to minimise complications." (P1).

Recommendations were made with reference to the midwives behaviour and other factors that are said to contribute to professional malpractices, which includes the following: availability of human and material resources; staff development; the importance of management support; empowering pregnant women by ensuring they are well informed about matters related to pregnancy and childbirth; midwives adhering to the use of maternity guidelines and protocols; accurate recordkeeping and maintaining accountability; and responsibility in managing women during birth. The study revealed that there is non-compliance from pregnant women attending ante-natal care, with regard to early antenatal care booking nor adhering to appointment dates. That training of antenatal mothers of their rights and responsibilities is emphasised at the clinic level.

> "They must be encouraged to book early, adhere to the advice of midwives and report early on any deviations from normal." (P1).

4.6 CONCLUSSION

Chapter 4 presented the findings of the participant's understanding and experiences of ethical behaviour and professional malpractices. Both positive and negative experiences by participants were explained in detail and the way they experienced litigations. Several factors were identified that lead to professional malpractices and recommendations based on those factors were outlined. The next chapter provides the conclusions, limitations and recommendations from the findings.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 5 presents the summary, conclusion, limitations and recommendations of the research study which focused on the midwives' perceptions of ethical behaviours and professional malpractice in the Labour Units. A brief overview is given on the research design and method and the attainment of objectives.

5.2 RESEARCH DESIGN AND METHOD

A qualitative exploratory, descriptive and cross-sectional design was followed. The overall aim of the study was to explore the midwives' perceptions of ethical behaviour and professional malpractices in the selected Labour Units of Tshwane, Gauteng Province. Eight in-depth individual interviews were conducted. Data were collected till saturation was met with the eighth participant. Data collected from individual interviews were recorded, transcribed verbatim and analysed manually into major themes and sub-themes. Several factors that lead to professional malpractices in the Labour Units were identified and various recommendations were mentioned. Guidelines relating to the reduction of malpractices and litigations were also presented.

5.3 ATTAINMENT OF THE RESEARCH OBJECTIVES

The objectives of the study were:

- **To explore the midwives' understanding of unethical behaviour and professional malpractice in Labour Units of Tshwane, Gauteng Province**

Participants displayed the understanding of unethical behaviour and professional malpractices as displayed from their responses and experiences.

- **To explore the midwives' experiences of unethical behaviour and professional malpractice in Labour Units of Tshwane, Gauteng Province**

All participants shared their individual and peer experiences of unethical behaviour, however, only three through the litigation process whereby two served the sentences and one was not found guilty for the offence. The impact of the litigations were also shared.

- **To explore and describe the factors that contributes to unethical behaviour and professional malpractice by midwives in the selected Labour Units of Tshwane, Gauteng Province**

Several factors that contributes to unethical behaviour and professional malpractices were outlined by participants. Recommendations were provided by participants to address the identified factors.

- **To recommend guidelines in reducing professional malpractices and unethical behaviours in the Labour Units**

Recommendations to minimise unethical practice and professional malpractices were shared by each participants. Administrative recommendations, recommendations for midwifery practice, nursing education and further research were made with reference to the midwives behaviour and other factors that are said to contribute to unethical behaviour and professional malpractices.

5.4 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

5.4.1 Understanding and experiences of ethical practice and professional malpractice

The study findings indicated that the participants understand the importance of ethical practice and what could lead to malpractices. Participants stated that in their line of duty as midwives they are often faced with difficult situations where they are to make an ethical decision to a woman during intrapartum care to ensure quality care. Erasmus (2008:6) stated that ethical practice entails acting from a sense of moral duty, respecting another's rights and honouring one's obligations. That nurses and midwives have a duty to do good

(beneficence) and a duty to not do harm (non-maleficence) towards patients in their care, which also implies an obligation based ethics that emanates from theories of utilitarianism, deontology and principlism (Beauchkamp & Childress 2009 as cited by Lachman 2012:112). This principle denotes that midwives have to be careful when making decisions to avoid physical, emotional and social harm to the woman in labour as also stated by Arries (2006:62).

With reference of participants fearing to expose their colleagues, midwives should learn to stand for what is right, if a colleague is doing something wrong, don't protect but address the issue in an attempt to enhance quality and ethical practice in midwifery care. This is justified by a report released by The Institute of Medicine (IOM) in 1999 entitled **"To *Err is human*: *Building a safer health system*"**, because "*to err is* human but forgive is divine", therefore that healthcare professional must not feel bad in accepting their wrongs (http://www.ncbi.nlm.gov/pmc/articles).

Midwifery malpractices exist because of the stressful conditions under which midwives practice. However, it is important to note that not every mistake or failure in care of a woman in labour justifies a malpractice as, in other instances, it is not possible to demonstrate clearly the true nature of the problem and how the midwife's actions or omissions caused the harm to the patient.

5.4.2 Ethical decision-making

Participants acknowledged that they are expected by the profession to behave ethically with responsibility and accountability. To be rational in decision-making when encountering ethical dilemma during their practice, however, there are situations where poor decision-making arises leading to possible failure to advocate for the woman. Fear to make decisions was also highlighted which is compounded by women not cooperating with the process of decisions made by midwives. The researcher assumes that this is a situation where midwives, rather than perceiving women as being non-cooperative, should rather refer to the fundamental ethical principles that will guide the decision-making process. The focus of the decision-making process should be based on the notion of doing good, being good, and also reflecting on the theoretical basis for virtue ethics where a person wants to do good, to be good and to act on the good as stated by Smith and Godfrey (2002:3).

5.4.3 Litigation experiences

Most participants have never experienced litigation process but three have gone through the experience of having been reported for negligence wherein one was not found guilty and two served the sentences. One participant mentioned that as the operational manager she is often requested to give evidence in adverse incidences. The most common practice is that participants are often requested to write statements on incidences that they are involved in and matters are often resolved internally. The three participants who underwent litigation shared the impact of the experience. The shared emotions concurs with Vryonides, Papastavrou, Charalambous, Andreou and Merkouris (2015:881), in a study on thematic synthesis of qualitative studies on ethical dimension of nursing care rationing concluded that "within limitations of scarcity, nurses face moral challenges and their decisions may jeopardise professional values leading to role conflict, feelings of guilt, distress and difficulty in fulfilling a morally acceptable role".

5.4.4 Impact of malpractices and litigations

Participants indicated that the experience of a litigation due to a malpractice affects them badly. There were various emotions shared, for example, anger, guilt, discouraged, frustration, that often lead to fear of making further decisions, loss of confidence, reduced self-esteem and absenteeism due to low staff morale. The possibility of losing income was also a concern. A conclusion of a study by Numminen, Leoni-Kilpi, Isoaho and Meretoya (2015:845) states that: "ethical climate of the work unit is an important element affecting midwives professional and ethical practice, nevertheless, whatever the environmental circumstances, midwives are expected to be professionally competent by providing high-quality care ethically and clinically".

5.4.5 Factors contributing to unethical behaviour and professional malpractice

Several factors that contribute to unethical behaviour and professional malpractices were cited by participants, for example, that most of the time, one midwife attends to about eight women simultaneously, which affects the quality of care given as they become overworked and lose concentration and the ability to undertake rational decision-making. The high workload leads to exhaustion and low morale, which adds to absenteeism.

Research shows that a heavy nursing workload adversely affects patient's safety even on an international basis (Carayon & Gürses 2005:284). Shortage of resources such as cardiotoco-graph machine was a concern as midwives need a CTG machine to continuously monitor the fetal wellbeing during intrapartum care.

The Human Rights Watch (2011) affirms that South Africa's poor maternal outcomes are linked to the lack of midwifery services and that, in order for South Africa to address the country's maternal health care, there is a need to invest more with better trained midwives as it is the midwives who are running the entire service and are as such overworked.

The report further revealed that catering for high numbers of women poses a challenge as it increases workload and that lead to stress and burnout. When a midwife is stressed out, the quality of care is affected and wrong decisions may be taken which may lead to malpractices.

However, the report also stated that some of the problems and complains from women are due to the negative attitude displayed by midwives to clients. If midwives display a positive attitude to clients, then the clients will have less to complain about. A positive attitude allays anxiety and patients feel free to discuss their concerns with midwives. All participants in this study alluded that their attitude towards patients need a serious check and that they should try and separate personal issues to the work environment. Moreover, the participants acknowledged that any form of violence against health-care consumers is wrong and against the ethical conduct of the profession. However, the severe shortage of staff, increased workload and eroding morale had led to the negative attitude towards patients.

Participants needed support from management, and suggested that managers should have a way of creating a positive work environment to midwives, give recognition and praise to good performance and not only come when mistakes occurs. Midwives are rarely taken for counselling after they had an adverse event or even after a disciplinary hearing, as such, participants viewed this as lack of support and that they are always being blamed for incidents. Midwives feel that after an adverse event, management have to arrange for debriefing to all involved so that they become encouraged.

The findings further revealed the importance of team work amongst the members of the multidisciplinary team. The participants cited that due to the rise in litigations they fear to take ethical decisions in their care to mothers during labour and that they always rely on the doctors and those at the MOU's said they just refer cases even those that they can handle.

5.5 RECOMMENDATIONS TO MINIMISE UNETHICAL BEHAVIOUR AND PROFESSIONAL MALPRACTICES

The following recommendations are based on the study findings and the recommendations of each participant. The identified administrative recommendations can assist management of institutions in initiating support structures and programs to assist registered midwives in rendering quality midwifery care and practicing as independent practitioners. This is justified by Numminen et al. (2015:856) when recommending that nursing managers responsible for and having the power to implement changes should understand their contribution in ethical leadership, the nature of the nurses' work and the work related factors in planning developmental measures.

5.5.1 Administrative

- To manage and reduce the rate of adverse events and to effectively manage the adverse events cases in the Labour Units.
- All professional malpractices errors to be reported by the officer in charge of the unit to the manager in charge immediately.
- Debriefing sessions to be arranged for all staff involved and counselling support offered where necessary.
- At the institutional level, managers to ensure that midwives are supported at all times.
- After every incident of serious adverse event, gabs are identified and quality improvement plans developed to avoid similar occurrences.
- Reinforce sound procurement system to ensure that resources are available and machinery are in good working order for the effective and efficient quality midwifery care.

- Appropriate management of staff shortages which include a plan with relief staff, especially when other staff members are on sick, study or maternity leave.
- Utilisation of junior personnel, such as Enrolled or Auxiliary nurses, to assist with non-midwifery activities such as monitoring of vital signs, urine testing and intake and output to offer midwives to focus on midwifery care.
- Availability and accessibility of ethical resources to midwives, for example, developing a workplace Ethics Committee that will assist in addressing the stated recommendations as also recommended by Welsch Jensen, Small, Swanson and Bosanek (2014:1) who stated a crucial role that Ethics committees should act as the liaison between health-care professionals and the patient and family to mediate ethical issues.

5.5.2 Midwifery practice

- Midwives to take responsibility of working on their negative attitude, as a positive attitude or a good response informs the client that the practitioner is concerned of their wellbeing.
- Effective communication among staff members: midwives to make sure that they give one another proper report about patients and document all care given to ensure that there is continuity of care.
- Teamwork: assist one another during decision-making and affirming of findings before caring out the task as this will minimise mistakes.
- Regular in-service education on ethical matters.
- Midwives to conduct and participate in ethics rounds as a form of supporting healthcare personnel in handling ethical dilemma that would lead to better insights concerning ethical issues (Silén, Ramklint, Hansson & Haglund 2016:203).

5.5.3 Nursing education

- Incorporating healthcare ethics education in the undergraduate curriculum to provide students with transformative knowledge that fosters moral resilience (Monteverde 2016:104) to equip midwives better and enable them to always apply the four ethical principles during their care of women from pregnancy to puerperium. As stated by Behrens and Fellingham (2014:144), healthcare

educators are tasked with the responsibility of teaching ethics as applied to the context of their working life.

5.5.4 Further research

- Further research needs to be conducted on a larger sample that also addresses the impact of malpractices on midwives and efforts to reduce unethical practice and professional malpractices.
- Nurse managers' ethical leadership and contribution in creating ethical leadership.

5.6 LIMITATIONS OF THE STUDY

The study was conducted only in two institutions, therefore the findings cannot be generalised to other settings. A similar study need to be conducted in other institutions. Other participants kept on expressing themselves in Setswana even after explanation was given that the medium of instruction is English: the language that needed to be translated, which then carries a risk of losing valuable data in meaning. Some participants had pending cases with their statutory body and they seemed not too comfortable to speak about malpractices and, as such, other vital information could have been omitted.

5.7 CONCLUDING REMARKS

The findings revealed the difficult circumstances under which participants are operating such as system failures, increased workload and inadequate human resources as the key contributors to the gaps in providing quality obstetric care. With these challenges, it is difficult to envisage how participants managed the adverse events they came across, especially from difficult client who did not adhere nor follow clinic instructions and system failures, such as delay in transporting the patient to tertiary care. Much value has to be placed on the importance of community education that women be made aware of their responsibilities and not to dwell only on their rights and also for them to make informed choices. Nevertheless, midwives need to guard against factors that might negatively impact or threaten the women's dignity during the midwife woman interaction, which can be perpetuated by amongst others, verbal abuse, privacy and confidentiality, loss of autonomy, discrimination and ignorance of the woman's preferences (Papastavrou, Efstathiou & Andreou 2016:96). It is clear from the study findings that it is often difficult

for participants to implement the basic ethical principles in their daily encounter with women that is autonomy, beneficence, non-maleficence and justice. This calls for staff development in-service training on ethical matters.

Gumbi (Irinnews 2011:3) supports the above saying that, in one of the biggest labour ward in KwaZulu-Natal, the midwives and doctors have managed to reduce serious adverse events/malpractices through team work. And she further indicated that the midwives received an ongoing training through monthly meetings where they discuss difficult cases and had information-sharing sessions, which ensured that they are up to date with the latest developments, policies and protocols. The content analysis of a qualitative study by Smith and Godfrey (2002:305) led to the emergent of the following themes: personal characteristics, professional characteristics, knowledge base, patient centeredness, advocacy, critical thinking and patient care which are all crucial in enhancing ethical behaviour amongst midwives.

REFERENCES

AbuAlRub, R. 2004. Job stress, job performance, and social support among hospital nurses. *Journal of Nursing Scholarship* 36:73-78.

Armstrong, A. E. 2006. Towards a strong virtue ethics for nursing practice. *Nursing Philosophy* 7(3):110-124.

Arries, E. 2006. Practice standards for quality clinical decision-making in nursing. *Curationis* 29(1):62-72.

Australian Nursing and Midwifery Council (ANMC). 2008. *Code of professional conduct for nurses in Australia*. Australia: Nursing and Midwifery Council.

Barbour, R. 2009. *Introducing qualitative research: A student guide to the craft of doing qualitative research*. Los Angeles: Sage.

Basavanthappa, BT. 2010. *Textbook of nursing research*. 2nd edition. Ameriaca: JP Brothers Medical Publications.

Beauchamp, TL & Childress, JF. 1994. *Principles of bioethics*. 2nd edition. New York, NY: Oxford University Press.

Behrens, KG & Fellingham, R. 2013. Great expectations: Teaching ethics to medical students in South Africa. *Bioethics* 14(3):142-149.

Brink, H, Van der Walt, C & Van Rensburg, G 2012. *Fundamentals of research methodology for health care professionals*. 3rd edition. Cape Town. Juta.

Brink, PJ & Wood, MJ. 2001. *Basic steps in planning nursing research: From question to proposal*. Sudbury MA: Jones & Bartlett Learning.

Brown, SJ. 2011. *Evidence-based nursing. The research practice connection*. 12th edition. Sudbury MA: Jones & Bartlett.

Burnard, P, Morrison, P & Gluyas, H. 2011. *Nursing research in action: Exploring, understanding and developing skills*. 3rd edition. Palgrave: Macmillan.

Burns, N & Grove, SK. 2005. The practice of nursing research: conduct, critique and utilasation. 5th edition. Philadelphia Saunders. Elsevier.

Burns, N & Grove, SK. 2015*. Understanding nursing research*. 6th edition. Saunders Elsevier.

Carayon, P & Gürses, AP. 2005. A human factors engineering conceptual framework of nursing workload and patient safety in intensive care units. *Intensive and Critical Care Nursing* 21(5):284-301.

Chervenak, A & McCullough, LB. 2012. Ethics in obstetrics and gynecology: Global library of women's medicine. *L Glob Libr Women's Med* (accessed 3 May 2014).

Chen, S & Hsu, H. 2015. Nurses' reflection on good nurse traits: Implications for improving care quality. *Nursing Ethics* 22(7):790-802.

Child, K. 2014. *Hospital horrors costing SA plenty*. The Times, 17 January.

Christensen, LB, Johnson, RB & Turner, LA. 2015. *Research methods, design and analysis*. 12th edition. Edinburg Gate: Pearson.

Clarke, DL. 2009. Moral principlism alone is insufficient, and traditional moral theories remain important for practical ethics. *SAJBL* 2(2):54-58.

Cronjé, HS, Cilliers, JBF & Pretorius, MS. 2011. *Clinical obstetrics: A South African perspective*. 3rd edition. Cape Town: Van Schaik.

De Kock, J & Van der Walt, C. 2004. *Maternal and newborn care: A complete guide for midwives and other health professionals*. Pretoria: Juta.

DENOSA. 2011/12. Patient safety day. *Nursing Update* 36(1):60-61.

Department of Health. 2011. *The National Strategic Plan for Nurse Education, Training and Practice 2012/13–2016/17*. Pretoria: Government Printers:1-146.

De Vos, AS, Strydom, H, Fouché, CB & Delport, CSL. 2009. Research at Grass Roots for the Social Sciences and Human Service Professions. 3rd Edition. 471pp.

Erasmus, K. 2008. To err is human, where do negligence, malpractice and professional misconducts fit the puzzle. *Journal of Professional Nursing Today* 12(5):5-8.

Fraser, DM, Cooper, MA & Nolte, AGW. 2006. *Myles textbook for midwives*. African Edition. Churchill Livingstone: Elsevier.

Goodmann, M & Maule, P. 2014. *Nursing research: An introduction*. 2nd edition. Philadelphia: Sage.

Griffith, R. 2008. Midwives and confidentiality. *British Journal of Midwifery* 16(1):51-53.

Griffith, R. 2012. Accountability on midwifery practice: Answerable to mother and baby. *British Journal of Midwifery* 20(8):601-602.

Guthrie, G. 2010. *Basic research methods: An entry to social science research*. India: Sage.

Gu, C, Zhang, Z & Ding, Y. 2011. Chinese midwives experiences of providing continuity of care to laboring women. *Midwifery Journal* 27(2):243-249.

Ho, LF. 2009a. Medico legal aspects of obstetrics: The role of the midwife in Hong Kong. *Hong Kong Journal of Gynecology, Obstetrics and Midwifery* (9):58-62.

Ho, K. 2009b. Insurer-provider networks in the medical care market. *The American Economic Review* 99(1):393-430.

Hood, L, Fenwick, J & Butt, J. 2010. A story of scrutiny and fear: Australian midwives' experiences of an external review of obstetric services, being involved with litigation and the impact on clinical practice. *Midwifery* 26(3):268-285.

Human Rights Watch. 2011. *Stop making excuses. Accountability for maternal health care in South Africa*. South Africa.

Hwang, J & Park, H. 2014. Nurses' perception of ethical climate, medical error experience and intent-to-leave. *Nursing Ethics* 21(1):28-42.

International Confederation of Midwives. 2010. *Standards and guidelines for midwifery education*. Available from: http//www.internationalmidwifery.org (accessed 10 April 2015).

International Council of Nurses. 2012. *The ICN Code of Ethics for Nurses*. Geneva. Swirtzerland:1-10.

Irinnews. 2011. Available from (www.irinnews.org/report)

Ito, C & Natsume, M. 2016. Ethical dilemmas facing nurses in Japan: A pilot study. *Nursing Ethics* 23(4):432-441.

Ito, M & Sharts-Hopko, NC. 2002. Japanese women's experiences of childbirth in the United States. *Healthcare for Women International* 23:666-677.

Jewkes, R, Abrahams, N & Mvo, Z. 1998. Why do nurse's abuse patients? Reflections from South African obstetric services. *Social Science and Medicine* 47:1781–1795.

Jooste, K. 2010. *The principles and practice of nursing and health care ethos and professional practice, management, staff development and research*. 1st edition. Pretoria: Van Schaik.

Khalil, DD. 2009. Nurse's attitude towards 'difficult' and 'good' patients in eight public hospitals. *International Journal of Nursing Practice* 15(5):437-443.

Khalil, DD & Karani, AK. 2005. Are nurse's victims of violence or perpetrators of violence? *Kenyan Nursing Journal* 33(2):4-9.

Kinnane, JH. 2008. Everyday encounters of everyday Midwives: Tribulations and triumph for ethical practitioners. *Australian Journal of Midwives* (accessed 8 July 2014).

Klebanow, D. 2013. The practice of malpractice. *USA Today* (05):56-58.

Kohn, LT, Corrigan, JM & Donaldson, MS. 2000. *To err is human: Building a safer health system*. Institute of Medicine. Washington, DC: National Academy Press.

Kulju, K, Stolt, M, Suhonen, R & Leino-Kilpi, H. 2016. Ethical competence: A concept analysis. *Nursing Ethics* 23(4) 401-412.

Lachman, VD. 2012. Applying the ethics of care to your nursing practice. *Medsurg Nursing* 21(2):112-116.

Lewis, R. 2012a. Inter-professional learning in acute care: developing a theoretical framework. *Nurse Education Today* 32:241-245.

Lewis, P. 2012b. Hard and difficulties times – the provision of good midwifery care. *British Journal of Midwifery* 5:310-311.

LoBiondo-Wood, G & Haber, J. 2010. *Nursing research methods and critical appraisal for evidence-Based practice*. 7th edition. Mosby: Elsevier.

London, L & Baldwin-Ragaven, L. 2008. Human rights and health: Challenges for training nurses in South Africa. *Curationi*s 31(1):5-18.

Mail and Guardian. 2011. *National nursing summit. Ethics take centre stage*. Supplement. 25-31 March.

Makhubu, AMB. 2016. Introduction reckoning with apartheid the conundrum of working through the past. *Comparative Studies of South Asia, Africa and the Middle East* 36(2):256-262.

Maphumulo, Z. 2011. *Various departments of health sued for millions*. City Press, 13 November.

Maputle, SM & Hiss, DC. 2010. Midwives' experiences of managing women in labour in Limpopo Province of South Africa. *Curationis* 9:5-10.

Mathibe-Neke, JM. 2015. The role of the South African Nursing Council in Promoting Ethical Practice in the Nursing Profession: A normative analysis. Unpublished Research Report. University of the Witwatersrand.

Mathibe-Neke, JM, Langley, G & Rothberg, AD. 2014. The perceptions of midwives regarding psychosocial care. *Health SA Gesondheid Journal* 19(1):742-750.

McBrien, B. 2008. Evidence-based care: Enhancing the rigour of a qualitative study. *British Journal of Nursing* 17(20):1286.

McDermott, U, Sharma, SV, Dowell, L, Greninger, P, Montagut, C, Lamb, J, Archibald, H, Raudales, R, Tam, A, Lee, D & Rothenberg, SM. 2007. Identification of genotype-correlated sensitivity to selective kinase inhibitors by using high-throughput tumor cell line profiling. *Proceedings of the National Academy of Sciences* 104(50):19936-19941.

McHale, J & Tingle, J. 2007. *Law and nursing*. St Louis: Elsevier.

McLeod-Sordjan R. 2014. Evaluating moral reasoning in nursing education. *Nursing Ethics* 21(4):473-483.

Miya, PA. 1996. Teen's right to privacy vs. mother's right to know. (*AJN) The American Journal of Nursing* 96(3):43-62.

Miya, RM. 2015 Reflections: A life shared for the sick and knowledge dispensation. *Nursing Update* 40(1):30-31.

Monteverde, S. 2016. Caring for tomorrow's workforce: Moral resilience and healthcare ethics education. *Nursing Ethics* 23(1):104-116.

Moodley, K. 2016. *Medical ethics, law and human rights. A South African perspective*. Pretoria: Van Schaik.

Moule, P & Goodman, M. 2014. *Nursing research: An introduction*. 2nd edition. Pretoria: Sage.

Numminen, O, Leino-Kilpi, H, Isoaho, H & Meretoya, R. 2015. Ethical climate and nurse competency. *Nursing Ethics* 22(8):845-859.

Nyathi, M & Jooste, K. 2008. Working conditions that contribute to absenteeism among nurses in a provincial hospital in the Limpopo Province. *Curationis* 31(1):28-37.

Papastavrou, E, Efstathiou, G & Andreou, C. 2016. Nursing student's perceptions of student dignity. *Nursing Ethics* 23(1):92-103.

Polit, DF & Beck, CT. 2008. *Nursing research: Generating and assessing evidence for nursing practice*. Philadelphia PA: Lippincott Williams & Wilkins.

Rampfumedzi, DP. 2006. Quality control of obstetric nursing records in a selected regional hospital. Unpublished Masters. University of South Africa, Pretoria.

Rich, K & Butts, JB. [s.a.]. *Foundations of ethical nursing practice*. Jones & Barlette:105-123.

Rozmus, C, Carlin, N, Polczynski, A, Spike, J & Buday, R. 2015. The Brewsters: A new resource for inter-professional ethics education. *Nursing Ethics* 22(7):815-826.

Saleem, JR, McIntyre, J, Rattani, SA & Sylkonder, R. 2015. Midwives perception about their practice in a midwifery led care model in Karachi Pakistan. *British Journal of Midwifery* 23(3):200-206.

SANC see South African Nursing Council.

Sandall, J. 2012. Every woman needs a midwife, and some women need a doctor too. *Birth* 39(4):323-326.

Selebi, C & Minaar, A, 2007. Job Satisfaction among nurses in a public hospital in Gauteng. *Curationis* 30(3):53-61.

Silén, M, Ramklint, M, Hansson, MG & Haglund, K. 2016. Ethics rounds: An appreciated form of ethics support. *Nursing Ethics* 23(2):203-213.

Smith, KV & Godfrey, NS. 2002. Being a good nurse and doing the right thing: a qualitative study. *Nursing Ethics 9*(3):301-312.

South Africa. 2005a. *Children's Act (Act No. 38 of 2005)*. Government Gazette, 492(28944). Pretoria: Government Printer.

South Africa. 2005b. *Nursing Act (Act No. 33 of 2005). Regulations relating to the approval of and minimum requirements for the education and training of a learner leading to Registration in the Categories Professional Nurse and Midwife*. Pretoria: Government Printer.

South African Nursing Council. 1984. *Regulations relating to the scope of practice of persons who are registered or enrolled under the Nursing Act, 1978 as amended*. Government Notice No. R2598 of 1984 as amended. Pretoria: SANC.

South African Nursing Council. 1985. *Rules setting out the acts or omissions in respect of which the council may take disciplinary steps*. Government Notice No. R387 of 1985, as amended. Pretoria: SANC.

South African Nursing Council. 1990. *Regulations relating to the conditions under which registered midwives and enrolled midwives may carry on their profession*. Government Notice No. R2488 of 1990.Pretoria: SANC.

South African Nursing Council. 2013. *Code of ethics for nursing practitioners in South Africa*. Pretoria: SANC:1-9.

South African Nursing Council. 2014. *SANC registration and enrolment figures*. Pretoria: SANC.

Streubert, G & Carpenter, J. 2011. *Qualitative research in nursing. Advancing the humanistic imperative*. 5th edition: Lippincott Williams & Wilkins.

Sturm, BA & Dellert, J. 2016. Exploring nurses' personal dignity, global self-esteem and work satisfaction. *Nursing Ethics* 23(4):384-400.

Summer, J. 2001. Caring in nursing: A different interpretation. *Advanced Nursing* 35(6):1-10.

Tjale, A & De Villiers, L. 2004. *Cultural issues in health and health care: A resource book for Southern Africa*. Pretoria: Juta.

The United Nations. *The International Bill of Human Rights*. UN General Assembly Resolution 217A (111) of 10 December 1948.

Vryonides, S, Papastavrou, E, Charalambous, A, Andreou, P & Merkouris, A. 2015. The ethical dimension of nursing care rationing: A thematic synthesis of qualitative studies. *Nursing Ethics* 22(8):881-900.

Wallace, BC. 2013. Nurse staffing and patient safety: What's your perspective? *Nursing Management* 44(6):49-51.

Welsch Jensen, LE, Small, R, Swanson, C & Bosanek, M. 2014. Nurse's perceptions of Ethical Issues in an Academic Hospital Setting. An unpublished paper presented at STTI Conference. Hong Kong:1-6.

Woodward, V. 2000. Caring for women: the potential contribution of formal theory to midwifery practice. *Midwifery* 16:68-75.

World Health Day. 1998. *Safe motherhood: A matter of human rights and social justice*. Geneva: Switzerland.

Whyte, A. 2011. Reputation on the line: Alison Whyte tracks the recent history of care failings that have put nurses' image in the spotlight. *Nursing Standard* 26(12):18-21.

INTERNET SOURCES

http://www.ncbi.nlm.gov/pmc/articles (accessed 12 November 2013)

www.thefreedictionary.com (accessed 12 August 2014).

www.businessdictionary.com (accessed 2 May 2015)

www.markraminc.co.za/ medicals/law (accessed 2 November 2015)

www.theor medbioeth2011Dec 32(6) 375-388 (accessed 14 March 2015).

ANNEXURES

ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE, DEPARTMENT OF HEALTH STUDIES

UNISA university of south africa

UNIVERSITY OF SOUTH AFRICA
Health Studies Higher Degrees Committee
College of Human Sciences
ETHICAL CLEARANCE CERTIFICATE

REC-012714-039

HSHDC/368/2014

Date:	10 December 2014	Student No:	4280-976-2
Project Title:	Midwives' perception of ethical behavior and professional malpractice in the labour unit of Tshwane, Gauteng Province, South Africa.		
Researcher:	Manare Margaret Mashigo		
Degree:	MA in Nursing Science	Code:	MPCHS94
Supervisor:	Dr JM Mathibe-Neke		
Qualification:	PhD		
Joint Supervisor:	-		

DECISION OF COMMITTEE

Approved [√] **Conditionally Approved** [ ]

Prof L Roets
for **CHAIRPERSON: HEALTH STUDIES HIGHER DEGREES COMMITTEE**
L.L. Roets (Prof)

Moleki
Prof MM Moleki
ACADEMIC CHAIRPERSON: DEPARTMENT OF HEALTH STUDIES

PLEASE QUOTE THE PROJECT NUMBER IN ALL ENQUIRES

ANNEXURE B: REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH MIDWIVES IN AN OBSTETRIC UNIT (GAUTENG PROVINCIAL HEALTH)

43 Block BB
Soshanguve
0152
26/08/2014

The Head of Department
Gauteng Provincial Health

REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH MIDWIVES IN AN OBSTETRIC UNIT

Topic: Midwife's perception of ethics and professional malpractices in the Labour Unit of Tshwane Gauteng Province

I am, Margaret Mashigo, an M A (Health Studies) student at the University of South Africa, presently engaged in the above mentioned research project as above under the supervision of Dr. J M Mathibe-Neke. I hereby request permission to conduct a study in the selected obstetric units (indicate those units here) in Tshwane. The proposed obstetric units are Soshanguve Clinic 3, Kalafong and Jubilee Hospitals.

The purpose of the study is to explore and describe the factors that contribute to the professional malpractices in the selected obstetric units in Tshwane Gauteng Province.

In order to complete this study I need to conduct in-depth interviews of approximately 45-60 minutes with individual midwives working in the selected units in Tshwane. Data of the research study will be kept under lock and key for the period of the research.

Informed consent will be obtained from the midwives to participate in the research. The researcher will safeguard the names of the institutions and the participants through confidentiality and anonymity. Voluntary participation will be indicated in the consent letter. All participants reserve the right to withdraw from the study at any time without any obligation.

Confidentiality will be ensured on all data by erasing information on the digital recorder after completion of study. Findings of the study may be shared with participating institutions.

If there is an indication of emotional discomfort, counselling will be offered as arranged within the context of the study. There will be no individual benefits such as remuneration but the findings may benefit and add value to midwifery practice.

Enclosed find a copy of the proposal.

Thank you

Name: Margaret Mashigo
Cell no: 084 207 6619
Work tell: 012 429 3274/3472
Email: mmashigo@sanc.co.za
42809762@ mylife.unisa.ac.za

ANNEXURE C: REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH MIDWIVES IN AN OBSTETRIC UNIT (TSHWANE DISTRICT - GAUTENG PROVINCE)

CONCERNED INSTITUTIONS

The Head of Institution
Tshwane District - Gauteng Province

REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH MIDWIVES IN AN OBSTETRIC UNIT

Topic: Topic: Midwife's perception of ethics and professional malpractices in a

obstetric unit of Tshwane Gauteng Province

I am, Margaret Mashigo, an MA (Health Studies) student at the University of South Africa, presently engaged in the above mentioned research project as above under the supervision of Dr. Mathibe-Neke, I hereby request permission to conduct a study in the following selected obstetric units in Tshwane , namely Soshanguve Clinic 3, Kalafong hospital and Jubilee Hospital.

The purpose of the study is to explore and describe the perception of midwives on ethics and professional malpractices in the selected obstetric units in Tshwane Gauteng Province.
In order to complete this study I need to conduct in-depth interviews for approximately 45- 60 minutes with individual midwives working in the selected units in Tshwane. Data of the research study will be kept under lock and key for the period of the research.

Informed consent will be obtained from the midwives to participate in the research. The researcher will safeguard the names of the institutions and the participants through confidentiality and anonymity. Voluntary participation will be indicated in the consent letter. All participants reserve the right to withdraw from the study at any time without any obligation.

Confidentiality will be ensured on all data by erasing information on the digital recorder after completion of study. Findings of the study may be shared with participating institutions.

The study will not pose any health risks to participants and the name of the institution will not be tarnished.

Enclosed find a copy of the proposal

Thank you

Name: Margaret Mashigo
Cell no: 084 207 6619
Work tell: 012 429 3472
Email: mmashigo@sanc.co.za
42809762. mylife@myunisa.ac.za

ANNEXURE D: PARTICIPANTS' CONSENT FORM

Dear Prospective Participants

REQUEST FOR CONSENT TO PARTICIPATE IN A RESEARCH STUDY

Title of study: Topic: Midwife's perception of ethics and professional malpractices in a obstetric unit of Tshwane Gauteng Province.

I hereby invite you to participate in the above mentioned research study. I am, Margaret Mashigo, an M-A (Health Studies) student at the University of South Africa, presently engaged in a research project as above. The purpose of the study is to explore and describe the factors that contribute to the professional malpractices in the selected obstetric units in Tshwane Gauteng Province.

Individual in-depth interviews will be conducted with you for approximately 45-60 minutes. The interviews will be digitally recorded with your permission to be transcribed later. Data will be kept under lock and key, only the researcher, independent coder; supervisor will have access to them. These will be destroyed after two to five years and will be destroyed after the research study.

The researcher will safeguard your privacy as a person and that you have the right to withdraw from the study at any time without any obligation. Any information shared during the group discussion must remain confidential.

The study will not pose any physical health risks to yourself and where there is a feeling of psychological or emotionally stressed out you will be guided to see a mental health care practitioner. You will not benefit by participating in the study as an individual but results will add value to midwifery practice.

The results of the research will be made available to you on request. A copy of this Consent Form will be given to you to keep.

I …(name of participant)……agree/ not agree to participate in the research project.

Signature of participant……Date……

I herewith confirm that the participant has been fully informed about the nature of the study.

……

Signature of the researcher

NB (The researcher will call participants and also go physical to the units when recruiting participants and an informed consent will be signed by both at that time of the visit.

Thank you

Margaret Mashigo
Cell no: 084 207 6619
Work tell: 012 420 1074
Email: mmashigo@sanc.co.za
42809762. mylife@myunisa.ac.za

ANNEXURE E: INTERVIEW GUIDE

42809762 Mashigo datacollect.doc

TOPIC: MIDWIFE'S PERCEPTION OF ETHICS AND PROFESSIONAL MALPRACTICES IN AN OBSTETRIC UNIT OF TSHWANE GAUTENG PROVINCE

Demographic data

Gender:

Age:

Years of experience:

Opening question

What is your understanding of ethics and professional malpractices in the Labour Unit?

Questioning guide

1. Kindly share your working experience in the Labour Unit.
2. What do you understand by ethics and malpractice?
3. Did you ever experience a malpractice error?
4. If the answer is 'Yes', may you elaborate on your experience?
5. How did you handle the situation?
6. Have you ever been litigated for care, what for and what was the outcome?
7. Were you ever been called to give evidence in a malpractice issue?
8. Have you ever had to make an ethical decision in midwifery care and how often does that happen?
9. Do you associate malpractices with poor decision-making in the care of a woman in labour? Please elaborate on your answer.
10. What impact does malpractices and litigations have on your practice as a midwife
11. From your own perspective as a midwife, what is your view on the rise in litigation cases arising from Labour Unit and what can be done to improve the situation?
12. What strategies can you recommend in trying to reduce malpractices?