Independent midwifery practice: Opportunities and challenges

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Abstract

Despite changes in politics, policies and emerging technologies, many women have little autonomy over the birthing process. Over the last decade, a gradual shift towards independent midwifery care services has emerged and needs to be researched. The aim of this study was to describe the opportunities and challenges that independent practicing midwives face, and to present guidelines for inter-disciplinary collaboration. A qualitative approach was used and midwives, who work in solo (independent) practice, were identified on the internet and via Facebook and invited to participate. Interviews and narrative reports were used for data gathering. Although passionate about their jobs, the most challenging aspect for the midwives, was inter- and multidisciplinary collaboration. Despite the view of the midwife as the primary caregiver for normal births, it is evident that private health care services have not yet recognised the value of and need for independent midwifery services for women with uncomplicated pregnancies.

Keywords: Midwifery practice, private practice, independent midwives.

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Introduction

“Before birth belonged to medicine, it belonged to women” by Walsh (cited in Downe, 2008:117).

For many years, childbirth was seen as a normal event. Babies were born at home under the care of another woman – often the local midwife – in the comfort of the family home. Changes in policies, politics and technology have had a profound effect on childbirth. The aim was to improve maternal and child outcomes and the hospital appeared to be the safest place to achieve that. The change to hospitalisation of low-risk mothers inevitably led to a rise in surgical interventions and caesarean sections (Fahy, Foureur & Hastie, 2008)

There are different models of maternity care, ranging from government supported to private health care services, where maternity care is delivered by a general practitioner, an obstetrician or midwife. In South Africa, for instance,
private health services are delivered during pregnancy mainly to women who have membership to medical aid schemes and/or have medical insurance cover. These women usually choose a gynaecologist as their primary health caregiver and, if she delivers vaginally, it would be in a hospital where high-technical equipment is available. Women sometimes choose a gynaecologist, despite the absence of proof in scientific literature that obstetricians are safer than midwives, for low risk or normal pregnancy and birth (Wagner, 2014).

For a long time private health care seemed to be dominated by a curative approach to pregnancy, with a relatively low priority given to normal vaginal births. Women were given little choice over the type of birth, birth setting or attendants (Segeel & Du Plessis, 2006). Mothers were under the care of the medical practitioner during the antenatal period and they would “deliver” in a hospital of their doctor’s choice; usually by means of a caesarean section.

However, during the last decade, there has been a gradual shift in the pattern, with an increasing number of women seeking care from independent midwives. This could be ascribed to the influence of the internet, where a prolific number of pro-natural birth websites are found. Regents’s Independent Midwifery in London (2014) and the Australian Society of Independent Midwifery (2014) are examples of websites and organisations advertising for finding an independent midwife. The escalating health costs, high caesarean section rates and clients' desire to have a more personal birthing experience, without being exposed to unnecessary interventions, have also contributed to more and more women seeking midwifery services. Many women do not want the homebirth experience, but seek to have an alternative where priority is given to their wishes and needs within the safety of a hospital. According to the Alliance of African Midwives (2012), there is also a growing demand for a less technological medicalised birthing experience in South Africa.

Within the private health care context in South Africa, hospital managers are reluctant to grant private midwives “birthing rights”, due to perceived risks and private medical practitioners’ reluctance to be positive (Du Plessis, 2011). Shared care, where a healthy mother with an uncomplicated pregnancy is cared for by both a medical practitioner and a midwife, is not common and very few medical practitioners share the philosophy of low-technology, woman-centred care (Fraser, Cooper & Nolte, 2006).

Women under the care of an independent midwife usually deliver either at home or in a hospital or maternity obstetric unit, where the midwife has birthing rights. Each midwife has to apply for these “birthing rights” at a private institution and must provide proof of obstetric back-up in cases of emergencies. These independent midwives may practise as self-employed practitioners, in a fee-for-service, or in a partnership, where partners share responsibility, skills and liability. There is nothing contained in the policies of any of the regulatory
bodies around the globe that prohibits independent midwives from setting themselves up in private practice, provided they practise within their scope of practice and do not contravene the rules set out in the acts and omissions, which could lead to disciplinary action by the applicable council or regulatory body (Lubbe & Roets, 2014; International Confederation of Midwives, 2014). Although numerous studies reported on the effectiveness of birth centres regarding clinical, psychosocial and economic outcomes (Walsh, 2007), minimal research was found on the opportunities or challenges that independent midwives face and encounter in private clinical practice (Jansen, Etches, Klein & Reime, 2007).

Within the context of this study the following concepts are described:

**Experiences** refer to all the sensations, feelings and behavioural responses and physical perceptions experienced. Experience is defined as an emotion through the senses or the mind (The Free Dictionary, 2014).

A **midwife** is a person who has successfully completed a midwifery education programme that is recognised by the regulatory authorities in that country and that is based on the *ICM Essential Competencies for Basic Midwifery Practice* and the framework of the *ICM Global Standards for Midwifery Education*; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title "midwife"; and who demonstrates competency in the practice of midwifery. A midwife may practise in any setting including the home, community, hospitals, clinics or health units (International Confederation of Midwives, 2014).

An **independent midwife** is a self-employed, qualified nursing professional, who provide midwifery services in private hospital settings, health care units or at the home of the client.

**Midwife Obstetric Unit (MOU),** in the context of this study, refers to a privately owned obstetric unit that practises women-centred care. This may be a free-standing unit or a unit within a private hospital.

The objectives of this study were to (1) explore and describe independent midwives’ lived experiences of facilitating normal births within the context of private health care settings and (2) compile guidelines that can assist the independent midwife in clinical practice.

**Methodology**

**Research design**

A qualitative descriptive approach was used. As the purpose was to provide a picture of the situation as it naturally occurs and which enabled the researcher to
describe the opportunities and the challenges that midwives are confronted with in private clinical practice.

**Sampling and sampling procedures**

The population included all independent midwives working, in solo or group practice in South Africa, whose contact details were available on the internet. Independent practicing midwives, who were accessible via the internet, facilitated normal births in private hospital settings and were willing to participate in this research, were recruited.

Purposeful convenient sampling was done. Since there is no official register for midwives working as private practitioners in South Africa, the researcher identified prospective participants on the internet and from the *Expectant Mother’s Guide*, a publication by the Childbirth Educators Professional Forum, the internet and the Alliance of African Midwives web-page. They were invited via “WhatsApp”, Facebook, e-mail and SMS to participate in the study. Sixteen private midwives agreed to participate in the study. The sample size depended on saturation and not size, as generalisation was not the intention, but transferability to similar context was (Botma, Greeff, Mulaudzi & Wright, 2010).

**Interview**

Individual interviews and narratives were used to collect the data from independent midwives, working as primary caregivers for mothers-to-be with a normal, uncomplicated pregnancy during the pregnancy, labour, birth and the postpartum period. Volunteers met with the researcher in a place/space of their choice where the research objectives were explained, informed consent obtained and appointments for interviews booked. Some requested to participate via electronic media, namely, a Skype interview, due to the financial implications of travelling. Following the interview, the participants were also asked to provide a narrative, for triangulation of the data.

One central request was made to the participants: “Please tell me about your experiences and the challenges that you face in private clinical midwifery practice.”

Some interviews were tape recorded and, in other instances, due to the preference of the participant, field notes were taken. The researchers observed the midwives’ non-verbal responses, which could indicate discomfort, irritability or stress (hesitation, laughing or other non-verbal cues) and kept personal notes, which included her own reflections and experiences during the course of the interviews. Field notes were written as soon as possible after the interviews. The transcribed interviews were made available to the participants, if they were unwilling to be audio-taped, to ensure the trustworthiness of data.
The participants were requested to provide a narrative, three days after the interview, by e-mail, if she felt the need to add more information. Four narratives were received and one midwife phoned to clarify some of the statements she made.

Trustworthiness

The researchers ensured trustworthiness by using the model proposed by Lincoln and Guba (in Krefting, 1991). Credibility, transferability, dependability and confirmability were ensured.

Ethical considerations

Permission was obtained from the participants in the form of written or verbal consent. The researcher ensured that the participants had assimilated essential points regarding the purpose, content and process of the study, before they consented to it. Ethical standards regarding research and research participants, as indicated in the Declaration of Helsinki (2013), were met. Participants could withdraw from the project at any time as they were under no obligation to participate. There were unintended benefits for the midwives, as they were able to ventilate their feelings and obtain emotional comfort. They expressed their feelings openly, because they did not associate the researchers with the private health sector

Data analysis

This study employed the eight steps, provided by Tesch (cited in Creswell, 2014), to analyse the data systematically. The interviews were transcribed verbatim and organised into themes and sub-themes. The results of the open coding were verified by an independent coder. Grammar and repetition were left unchanged, thereby prohibiting the possibility of losing any information. The narratives were similarly left unchanged and were analysed in conjunction with the transcribed interviews. A consensus discussion was held with the independent coder to discuss the results. The analysed data was used to formulate guidelines for midwives practicing in the context of independent midwifery practice, within a private healthcare facility. The results and the literature control will be presented in an integrated way in the discussion.

Results and Discussion

The age of the participants varied from 30 to 63 years. Midwives from four out of the nine provinces in South Africa volunteered to participate in the research. They had an average of 12 years’ experience in independent practice. All the different race groups were presented. All the themes and sub-themes that emerged are interrelated and illustrated in Table 1.
Table 1: Summary of themes and sub-themes

<table>
<thead>
<tr>
<th>Major Themes</th>
<th>Sub-Themes</th>
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<tr>
<td>Independent midwives are passionate about midwifery</td>
<td>Independent midwives embrace family-centred care</td>
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<tr>
<td>Independent midwifery practice stimulates personal growth and development</td>
<td>• feel that they are a part of an elite group of midwives and health professionals</td>
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<td></td>
<td>• appreciated the autonomy and self-responsibility of private practice</td>
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<td></td>
<td>• appreciated the financial independence</td>
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<tr>
<td>Independent midwives have experienced a breakdown in their relationships with private hospital staff</td>
<td>• Peer hostility</td>
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<tr>
<td>Independent midwifery practice is stressful</td>
<td>• Medical practitioner hostility</td>
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<tr>
<td>Establish and manage independent practice</td>
<td>• A negative birth outcome impacts on the core task of private midwifery practice</td>
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<td></td>
<td>• Personal sacrifices impact negatively on marriages and relationships</td>
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**Independent midwives are passionate about midwifery**

Overall the midwives did not choose private practice because of the financial benefits, but because they are passionate about midwifery. This passion to be in the presence of women giving birth is reflected in the following statement: “I would never be a nurse if I could not have been a midwife.” This was reiterated by the following response: “I became a nurse because that was the only way to become a midwife.”

The participants repeatedly stated that they wished they had gone into independent private practice earlier. They embraced the autonomy and independence and appreciated the fact that they could make their own decisions and take full responsibility for their clients.

Independent midwives embrace family-centred care and the midwives, therefore, believe in the woman’s ability to birth and they want to provide mothers with lasting, positive birth experiences. They do not want to dominate or direct the labouring women; instead they wish to empower them by providing mothers with frank explanations, by exploring options and through genuine sharing. The relationship of trust, fostered during the pregnancy in order to facilitate continuity of care, is extremely important and they do not want to “take over and manage the labour”.

Searle (2000) argues that the midwife made a commitment to the public’s right to safe nursing practice, which includes ethical values such as caring, respect and beneficence. Dietsch, Shackleton, Davies, McLeod and Alston (2010) agree with this and place emphasis on the midwife’s primary responsibility, that is, to
ensure the emotional and cultural safety of the women in her care. The independent midwives felt that these are treasured values with one participant stating: “I walked a road with her; this continuity of care doesn’t happen elsewhere.” Another added: “It was sometimes difficult to put limits, because the clients became attached …. I suppose it’s because she trusted me.” The participants all felt that they were “giving the clients what they wanted”; thus, rendering a service appropriate to low-risk pregnant clients and their families. This is in vast contrast to the technocratic approach to birth. Veith, Christie and Langley (cited in Brooker et al., 2009) agree with this and conclude that nursing needs to develop in response to the changing needs of a society.

**Independent midwifery practice stimulates personal growth and development**

It is the responsibility of all healthcare professionals to play a crucial role in promoting health and preventing illness (Greig & Ricks, cited in Brooker et al., 2009) and the midwife is in the unique position to do just that. The participants all re-iterated the importance (and difficulty) of keeping up to date with new developments in clinical midwifery practice. Very few, however, enrolled for a post-basic specialist course in midwifery. Only two of the participants had an advanced diploma, another two had master's degrees and one participant had a doctoral degree. They blamed the demands of being in private practice for their lack of professional development.

The participants enjoyed working with or sharing ideas with other midwives who had the same philosophy about birth and they felt they were "part of an elite group of midwives and health professionals". They were of the opinion that all women had the ability to make decisions for themselves and that the private midwife was there not to influence, but to support and guide.

Participants felt that they had to prove themselves to the medical practitioners when they started private practice, but none had any hesitation to refer the clients or call medical practitioners for back-up. They felt appreciated and supported by the medical practitioners and they would also defer to these specialists to act as back-up gynaecologists, but would further add that they felt they had earned this respect. The fact that the medical practitioners accepted them as respected colleagues boosted their confidence and self-esteem, as revealed in the following statement: “I am in the most wonderful situation, my doctors support me and it is really easy to get help and assistance.” Kitzinger (2005) is of the opinion that collaboration between the obstetricians and midwives, working as equals, provide the best outcomes.

All the participants enjoyed the fact that they could decide how many clients they want to take, as well the sense of autonomy and self-responsibility
associated with being independent. One participant stated, “I am good at making decisions quickly, under pressure and on my own.”

They confessed that it was difficult to charge clients and to “marry” caring with costing. Veith, et al (in Brooker et al., 2009) agree with this finding and argue that the traditional ethos of caring is currently challenged by the focus on cost effectiveness and value for money.

**Breakdown of the relationships with private hospital staff**

Participants experienced a breakdown in their relationships with some private hospital staff and nurse managers. This was evidenced in situations where hospital midwives, despite being allocated to assist and support the independent midwife, would refuse help and assistance; even when faced with emergencies. Participants experienced victimisation and bullying in various forms. Participants experienced a breakdown in communication, which resulted in blame being apportioned as well as a lack of trust and respect. They felt unappreciated and received minimal feedback about their patient care activities. These experiences were in vast contrast when the deliveries took place in a private MOU.

Workplace violence is a major public concern, receiving growing world-wide attention (Gates, Gorden, Gillespie, & Succop, 2011). This is especially found in health care and although assaults (verbal or physical) are, in general, committed by patients, it is not uncommon for nurses and independent midwives to be bullied by other health professionals and nursing managers. Horizontal violence is prevalent in the nursing profession, causing psychological distress – impacting on patient safety, nurse moral and nurse retention (Walfaran, Krewer, & Mulvenon, 2012).

In the clinical setting, midwives deliver their clients primarily in private hospitals, a private MOU or at home. The complexity of maternity services offered in private hospitals demand effective and specific management (Corkett, & Ribenfors, 2010). The majority of the participants stated that they followed the protocols and guidelines of the particular private hospital and, if it was not in place, they relied heavily on their own Scope of Practice. Despite this, they found it difficult to balance strict hospital policies and protocols with individualised midwifery care. A participant states: “The guidelines by the Department of Health and the strict hospital guidelines do not provide for moms who progress a little slower; I mean, they are not textbook cases… I’m not talking about the ones with problems, these are healthy women.” When midwifery care conforms to mostly medical parameters and is framed by medicalisation, the woman still experience a medically managed labour and birth, regardless of whom she had chosen as the primary caregiver (Downe, 2008).
Participants expressed concern regarding the lack of recognition given to them by their peers. They experienced peer hostility. Their skills and competency were disregarded; they felt ignored or were treated with total disrespect. A participant relates the following: “When I got there, the room was not prepared, and the midwife told me to do it myself; I mean, I have a labouring woman, I cannot spend time on cleaning the room and making the bed?” Some staff members refused to assist the midwife during the labour, despite the fact that the private hospital had a policy for assistance, with one staff member responding that, “You are getting paid for the delivery, do it yourself!”

In the state-funded health care system in South Africa, the medical practitioners provide back-up for women who need caesareans or other interventions during birth. Although not perfect, the relationship between the state practicing midwife and medical practitioner is more relaxed and not overtly hostile. The whole system of state-funded maternity care is based on midwifery care and the numbers of obstetricians are not enough for them to be the primary caregivers in normal, uncomplicated pregnancy and birth.

In private practice the debate over independent midwifery (normal) births versus obstetric births has become a polarising feature. The hostility between the medical practitioner and the midwife appears to escalate when the independent midwife enters the domain of private practice. It is not uncommon to find various blogs on the internet, written by obstetricians and gynaecologists, arguing against homebirths and, especially, midwifery births (Tuteur, 2013). They often present scientific evidence and provide arguments on adverse midwifery delivery outcomes, without making reference to adverse medical practitioner outcomes. Home- and midwifery birth advocates, perhaps in defiance, publish emotional responses and statements (Alliance of African Midwives, 2013; Tuteur, 2013: interactive blog). This seems also to be the case in other countries around the globe (Marchant, 2014).

Some participants recalled teaching medical practitioners, while the latter were still in training, yet when they would meet them later in private practice; they felt that the doctors treated them with disrespect. This made them angry, with one participant saying, “Who trained them? Or did they train themselves? I was there!”

The midwives found themselves torn between the unethical behaviour of some of their peers and medical practitioners, as evidenced by the following statement regarding the act of a medical practitioner. “There she is, shouting and reprimanding me in front of the patient and the other staff …” Some felt that the medical practitioners did not trust them or their decision-making abilities, with a doctor suggest, for example, that: “You should have called me long ago for this c/section”. Another participant confirmed: “There is a lot of mistrust”.
Participants found it “challenging to work with doctors that are focused on pathology and over-react”. Kitzinger, (2005) agree with this finding and argue that doctors learn about normal birth from midwives and that obstetricians are specialists in pathology.

It was obvious that the hostility experienced by these midwives affected their relationship with other health professionals negatively. High-quality care to pregnant women and their babies can only be achieved if there is collaboration between medical practitioners and midwives (Hutchinson et al, 2011). The World Health Organisation (2004, p. 5) contends: “Such collaboration will help to provide access to the full range of care women and their newborns may need, thus ensuring the required continuum of care. [It] must be based on mutual respect and recognition of the specific contribution each type of care provider makes to the continuum of care”.

**Independent midwifery practice is stressful**

Participants felt embarrassed when asked if they considered themselves to be successful. They saw the birth outcomes as the main indicator of success. A negative birth outcome, therefore, impacts on the core of independent midwifery practice. Participants were positive that they were improving society and added aspects of care that were not there before. A participant reasons as that, “I enjoy every day of my life, even if I am exhausted. It is not an easy path …. But I make a change in people’s lives.” Another midwife mentions: “I did not have an unexpected c-section this month, this make me feel good. And the parents were happy too.”

A good outcome also means not having to cut an episiotomy, suturing a tear or when the birth-plan, written by the mother, was fully implemented. None of the participants measured success by “finance”. The participants confirmed that they practised their craft in accordance with their Scope of Practice, despite the observation that it was restrictive in nature, as one suggested: “Our prescribing powers are limited and we really need to be able to give laughing gas (Entonox ®) without a prescription…. I mean, I would rather give that than Pethidine ®.”

Despite the participant’s reassurances that they practise according to prescribed rules and policies, previous research (Du Plessis, & Seekoe, 2012) indicated that this was not always so. Debono, Greenfield, Travaglia, Long, Black, Johnson and Braithwaite (2013) argued that health care professionals demonstrated rule-bending behaviour, despite knowing that the consequences for their actions would be exposed, in the firm belief that it was for the benefit of the client. By practising outside the accepted guidelines, protocols and practice conventions of the unit, the midwife is at risk of being considered negligent, dangerous or deviant. One participant expressed her frustrations as follows: "[I really] find
some hospital protocols, procedures and even aspects of the scope of practice to be restrictive.” All the participants expressed the need for a separate Scope of Practice for independent midwives.

The midwives would not, despite observing inappropriate practice in the clinical setting, report it to management, as they did not want to be seen as an outsider “splitting on staff”. This is not an uncommon phenomenon in nursing and Henderson (2008) found that student midwives were also reluctant to report poor practice.

The hallmark of the nursing profession is caring and this can be regarded as an essential indicator of quality health care. Participants, therefore, expressed sorrow and regret when the birth outcomes were negative. They would all analyse the events in detail to ascertain what happened and all of them re-iterated that they had minimal support, even from other independent midwives, when things went wrong. The birth could be recalled verbatim, by name, and the midwives anguished over each little detail. One midwife recalled an incident in a private hospital: “One bad birth results in a wild-fire – everyone is talking, blaming, [and] pointing fingers …. I heard the doctor in the operating room at L {private hospital} discussing me, analyzing the birth – but he was not there, how can he bad-mouth me and he was not even there? He just heard the story!”

Although fear of litigation featured in all the interviews, it is the attitudes of peers and medical professionals that impacted the most on the midwives when there are negative outcomes, as it impacted on their self-esteem and self-confidence. A few midwives mentioned that occasionally the client, her husband or the family would “not be on the same page”. When client-feedback was negative or when either mom or baby ended up in ICU, it impacted negatively on their self-esteem.

Personal sacrifices impact negatively on marriages and relationships and all the participants stated that their own family-members suffer the most as a result of the demands of private practice. “I gave family-centred care to the clients only and actually felt detached from my family,” states one participant. Many spoke with regret about the various family functions they had to sacrifice or attend while taking separate cars because the midwife may be called to attend t a patient.

Despite the impact on their marriages, most of the midwives felt that the husbands supported them emotionally and physically in their private practice endeavours.
Establishment and management of independent midwifery practice

The huge and growing financial cost associated with private maternity care, where the obstetrician is the primary caregiver, makes midwifery-led births an attractive strategy for nurse entrepreneurs.

It became evident during the interviews that most of the private midwives did not plan to enter into private practice, as one concedes, “I’m not a self-starter – I was kind of bullied into starting the private practice. I suppose I need to be kicked into action sometimes.” Another midwife stated that “this private thing kind of evolved … it took momentum of its own”. No in-depth situation analysis was done before they started and they had entered because of the need to render a service to pregnant mothers and families.

Many participants felt that self-motivation had driven them to make sure that they do not slack off. A participant states, “But I’m not sure that I’m actually successful in the business side of things. M [partner] does the books, I don’t even check it.” Surprisingly, none of the private midwives had a marketing orientation and thought that “word-of-mouth” is sufficient marketing. The private midwives experienced their contact with medical aid companies as daunting – the payment of accounts took a long time and a lot of effort.

In midwifery-led maternity care, a special emphasis must be placed on the collaborative relationship between the independent midwife, midwives employed by the institution and the medical practitioner, in order to care for the vulnerable pregnant mother and her family. Acknowledged as key professionals in the management of uncomplicated pregnancies, midwives can position themselves within collaborative teams, sharing their expertise and insight, whilst facilitating improvements.

It is evident from the data analysed that the professional relationships between the independent midwife, peers and medical practitioners are potentially turbulent and that it requires attention. The strained relationship between health professionals will influence the quality of care given. “It has long been understood that those involved in maternity care do not all share the same ideological viewpoint …” (Wickham, & Robinson, 2010). When none of them make an effort to understand each other or, even worse, if they is aware that they are not communicating with each other, the gap between them simply becomes wider and wider.

Guidelines to improve collaboration

In this study, it was evident that the independent midwife, despite being passionate about the work, experiences a lack of support in the private health
Independent midwifery practice

The experience of workplace violence resulted in apprehension and conflict in the clinical environment. The relationship between independent midwives and management should be improved by establishing effective communication channels. The developed guidelines are divided into three major themes, namely: enhancing the relationship with (1) management, (2) other professional nurses and (3) medical practitioners. These guidelines are illustrated in Table 2.

Table 2: Guidelines to improve collaboration/relationships

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<th>Relationships with</th>
<th>Guidelines to improve relationships</th>
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<tr>
<td>1. Managers</td>
<td>Establish a formal agreement for collaboration between private midwives and medical practitioners. Establish clearly defined communication channels to address concerns. Appoint an independent facilitator to aid discussions. Organise weekly meetings among all the stakeholders. Include independent midwives in the decision-making processes, policies and procedures in maternity units. Establish formal, in-service educational programmes and workshops for professional nurses and independent midwives related to inter-professional teamwork, professionalism and safe midwifery practices. Compile protocols, guidelines and standards as part of the agreement to ensure clear boundaries for safe practice. Arrange an annual audit for quality assurance and availability of protocols, guidelines and standards. Compile and implement a protocol and procedure to manage workplace violence. Make debriefing sessions available, if needed. Appoint a clinical supervisor to assist and assess professional conduct, teamwork, clinical skills and competencies.</td>
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<tr>
<td>2. Professional nurses</td>
<td>Organise monthly meetings between independent midwives and the midwives in the institution. Establish a participatory approach to midwifery care by implementing a mentorship programme to support both independent and other midwives.</td>
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<tr>
<td>3. Medical practitioners</td>
<td>Approach medical schools for placement of medical students in a collaborative practice model with an independent midwife to ensure experiential learning in family-centred care. Communicate and present different philosophies and models of midwifery care at medical conferences to share knowledge and expertise. Publish research results in peer reviewed medical and allied health professional journals to improve the image of midwives. Formulate detailed practice agreements between independent midwives and back-up medical practitioners in case of an emergency.</td>
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Limitations

This was a qualitative study reflecting the experiences and challenges of a sample of independent midwives and the purpose was not to generalise the
findings. Independent midwives in other settings may have different experiences and challenges, however, the literature review indicated similarities in many countries around the globe. Independent midwives, who primarily conduct homebirths, were not included in the study, as the focus was on the private health care context. Their experiences will provide valuable insight on especially the back-up provided by emergency services.

Conclusion

Despite the need for independent midwives few opportunities are available at private health care facilities, as only a few private hospitals in South Africa approve birthing rights for independent midwives. The medical practitioner is seen as the client and his approach to “birthing” appears to be a caesarean section, since the caesarean section delivery rate had escalated in especially private hospitals (Naidoo, & Moodley, 2009).

Despite the view of the midwife as the primary caregiver for normal births, it is evident that private health care services have not yet recognised the value and need for independent midwifery services for uncomplicated pregnant women. The participants in this study indicated the occurrence of horizontal violence, evidenced by a breakdown in the relationship between health professionals (professional nurses and medical practitioners). This impacts negatively, not only on the quality of patient care given, but also on the image of health professionals.

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References


