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‘Competent, but not allowed to blossom’: Midwifery-trained registered nurses’ perceptions of their service: A qualitative study in Sri Lanka.

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Abstract

Objective: To explore midwifery-trained registered nurses’ perceptions of their own profession as maternity care providers and how they identify their role, tasks, and responsibilities within a multi-professional team.

Design: An exploratory qualitative study using focus group discussions and qualitative content analysis.

Setting: Three selected tertiary care hospitals in the Capital Province in Sri Lanka.

Participants: Twenty-two midwifery-trained RNs working in intra-partum and postpartum units.

Findings: The overriding theme of the analysis was identified as ‘competent but not allowed to blossom fully in their practice’, based on two main categories: ‘provision of competent care’ and ‘working with disappointments’. Each main category had four subcategories: ‘acting with compassion’, ‘cooperation in emergencies’, ‘exceeding one’s boundaries’, ‘taking full responsibility’ and ‘deprived of utilizing special knowledge and skills’, ‘role confusion with other professional groups’, ‘lack of professional identity’, and ‘not being appreciated by others’, respectively.

Conclusion: Midwifery-trained RNs conveyed a deep sense of disappointment regarding their profession as maternity care providers in Sri Lanka. Midwifery-trained RNs’ perceptions of their high proficiency are incongruent with their low sense of identity and belongingness within the multi-professional hospital-based maternity care team. This

phenomenon warrants further study, considering its implications for team work and patient safety.

Key words: *Maternity care; South Asia; team work; midwifery practice, role confusion*

Introduction

In different settings across the world, maternity care is provided by a range of healthcare professionals.¹ However, the construction of healthcare professionals' roles and titles, what is denoted by each, and the way they are used, tends to vary in different countries. Such variations in job titles and what they denote is a common source of uncertainty, particularly with regard to nurse-midwives.² This is because midwifery is often offered as an additional qualification for registered nurses.³ For example, in the USA, the title "nurse-midwife" is used to denote a certified nurse-midwife, while in countries such as the UK, Australia, and Sweden, certified nurse-midwives or direct-entry midwives are referred to as 'midwives.'⁴ Across South Asia, including Nepal, India, and Bangladesh, there is variation in who is referred to as a midwife⁵, because in addition to the 'nurse-midwives' there are 'auxiliary nurse-midwives,' 'direct entry midwives'⁶ and nurses with both registered nurse (RN) and registered midwife (RM) titles.^{5,6}

In Sri Lanka, too, there are two pathways to midwifery: direct entry into midwifery (referred to as midwives) and post-registration midwifery training for registered nurses (referred to as midwifery-trained RNs in this paper). Direct-entry midwives have one-and-a-half years' training in midwifery alone. Midwifery-trained RNs have had a three-year training in general nursing and an additional year of specialized training in midwifery. After successful completion of post-registration midwifery training, RNs are eligible to become RMs. In Sri Lanka, RNs who have obtained such post-registration midwifery training are referred to as nurses.

Both these groups (midwives and midwifery-trained RNs) work in intra-partum and postpartum units in hospitals across Sri Lanka. However, unlike the midwifery-trained RNs, who only work in hospitals, midwives could also work in public healthcare settings as 'field' (or community) midwives. In addition to these two groups, RNs (i.e. those without post-registration midwifery training) are also involved in care provision in antepartum and postpartum units, although they are usually not involved in labour room work. Therefore, in hospital-based maternity care units in Sri Lanka, all three groups of professionals, i.e. RMs, midwifery-trained RNs, and RNs, need to come together and work with each other.^{7,8}

The provision of maternity care is a critical and complex task that requires effective inter-professional collaboration.^{9, 10} Some of the barriers to inter-professional collaboration, identified across settings include: professional identities, hierarchies, and a lack of clear roles/tasks among the different professional groups within such teams.¹¹ Although most developed countries have written guidelines that provide a framework for assigning tasks or delegating roles to each member of the health team in order to facilitate collaborative practices among professionals,^{8, 12, 13} this is not the case in less developed regions. For example, in Sri Lanka, only midwives are provided with guidelines outlining their scope of practice, and Midwifery-trained RNs have neither a defined role nor a unique professional title. As such, many of the conflicts and hostilities that have arisen between the midwives and midwifery-trained RNs in Sri Lanka could be related to lack of clarity in roles and responsibilities.¹⁴ However, to date, there have not been any empirical studies on this issue in Sri Lanka.

The aim of this study was to explore (a) midwifery-trained RNs' perceptions of their own profession as maternity care providers; and (b) how they identify their role, tasks, and responsibilities within the multi-professional team.

Methods

This study used an explorative qualitative approach. Focus group discussions (FGDs) were used as the method of data collection to allow in-depth exploration of new topics, while providing insights into the attitudes, perceptions, and opinions of participants¹⁵.

The study setting was tertiary care hospitals in the Capital (Western) Province of Sri Lanka. The study was approved by the Ethics Review Committee of the Faculty of Medical Sciences and the University of Sri Jayewardenepura. Permission to conduct the study was obtained from the Ministry of Health and the relevant hospital authorities. Twenty-two midwifery-trained RNs, working in the intra-partum and postpartum units of the three selected tertiary care hospitals participated. The participants were purposefully selected. The eligibility criteria specified that participants should have at least four years of work experience in the intra-partum or postpartum units.

The participants were informed about the study and what their participation would entail, their right to withdraw from the study at any time, and the measures to ensure confidentiality of the information shared, both verbally and via the consent form.

Data was collected during a five-month period, between August 2013 and January 2014. Three FGDs, with six to eight midwifery-trained RNs in each, were conducted by the first author using a semi-structured discussion guide. The first draft of the guide was developed in consultation with two local experts and was modified based on the findings from the first few interviews. Each FGD was conducted in the local language, Sinhalese, and audio-recorded with the permission of the participants. Each discussion lasted approximately one and half hours, and notes were taken by an observer.

All of the FGDs were recorded, and transcribed verbatim from Sinhalese into English by the first author, who is fluent in both the languages. The data analysis was performed using the qualitative content analysis method¹⁶. First, the authors became familiarized themselves with the content by reading the transcripts several times. Thereafter, meaning-bearing units were identified, condensed, and coded. Similar codes were pooled into subcategories. Similarly, the subcategories were pooled into main categories by differentiating them according to their similarities and differences. Two authors worked independently to code and sort the data, followed by discussion about areas of consensus and disagreement, within the developed subcategories and categories. After several rounds of discussion, the categories and subcategories were modified until an overriding theme emerged that illuminated the latent content of the data.

Findings

The midwifery-trained RNs in the study were between 29 and 55 years of age, with an average of 17 years of nursing experience and 10 years of midwifery experience. Out of 22 participating midwifery-trained RNs, only two held bachelor's degrees in nursing, the others had nursing diplomas.

One overriding theme, two categories of description and four subcategories that illustrated how midwifery-trained RNs perceive their midwifery services were identified (Table 1). The findings are illustrated using direct quotes from the participants. The numbers within brackets refer to a particular midwifery-trained RN's statement during the specified FGD.

Table 1: Overview of theme, categories and sub categories

Overriding theme	Categories	Subcategories
Competent but not allowed to blossom fully in their practice	Provision of competent care	<ol style="list-style-type: none"> 1. Acting with compassion 2. Cooperation in emergencies 3. Exceeding one's boundaries 4. Taking full responsibility
	Working with disappointments	<ol style="list-style-type: none"> 1. Deprived of utilizing special knowledge and skills 2. Role confusion with other professional groups 3. Lack of professional identity 4. Not being appreciated by others

The overriding theme “competent but not allowed to blossom fully in their practice” illustrates how the participants perceived themselves as capable of delivering all facets of maternity care. They were confident of their competency in delivering holistic care because they were capable of identifying all aspects of the mothers’ needs. Nevertheless, they felt disappointed because they were not allowed to utilize their specialized knowledge and skills for providing maternity care.

Provision of competent care

This category describes how the participants perceived themselves as competent care givers because they performed their duties with confidence and aptitude. This category is further clarified by four subcategories: acting with compassion, cooperation in emergencies, exceeding one’s boundaries, and taking full responsibility. Each subcategory is outlined in turn:

1. Acting with compassion

The participants described themselves acting with compassion while providing maternity care, as they stated that they performed their tasks kindly and lovingly; from the time the expectant mother arrived and was taken to the labour unit to the time she was sent to the postpartum unit after giving birth. They welcomed the mother and spoke to her in a friendly manner; they also helped her in meeting her basic needs

by helping her urinate and defecate, changing her sanitary pads, and offering her drinking water. Moreover, the participants were concerned about alleviating the mothers' fears, ensuring their safety, and providing comfort 'like a mother'.

“From the time a mother comes to the labour room (LR) onwards, we look after her like a mother, reducing her fear. The reason is that most [women] come to the LR with a lot of fear” (FGD-01:P6).

2. Cooperation in emergencies

The midwifery-trained RNs collaborated with other maternity care providers, especially in emergency situations to save the lives of the mother and her baby.

Actually, we got a lot of support from them [other professionals]. The midwife also helped us. The Doctors supported, the minor staff supported. Actually, we were very happy. Anyhow, the bleeding was settled. The baby was resuscitated and sent to the PBU (Premature Baby Care Unit). At that time, from the VOG (Visiting Obstetrician and Gynaecologist) level to the minor staff, we all worked together (FGD-02:P7).

3. Exceeding one's boundaries

The midwifery-trained RNs sometimes exceeded their professional boundaries to meet the needs and to ensure the safety of the mother and her baby. In such instances, the midwifery-trained RNs worked without considering the rules and regulations because they had to make decisions about what was required without waiting for the doctor to arrive. The participants were aware that they had violated 'rules' but they felt compelled to do so to save the mother's life.

“The correct thing is we should administer medicine only after it has been prescribed by the doctor. However, sometimes we do things without considering rules, to save a patient's life” (FGD-01:P4).

4. Taking full responsibility

The midwifery-trained RNs participated at every stage of the maternity care process and took full responsibility for the mother and the baby until they left the hospital. They performed all tasks and assumed responsibilities to ensure the safety of the mother and the baby, even if they were not sure who was responsible for the tasks.

I think because the thing called responsibility is in our head, we as nurses (midwifery-trained RNs) never allow mistakes to happen. We jump immediately and cover it (FGD-03:P6).

Working with disappointments

This descriptive category illustrates participants' frustrations and disappointment in their role. This is further clarified by four descriptive subcategories: deprived of utilizing special knowledge and skills, role confusion with other professional groups, lack of professional identity, and not being appreciated by others, each category is introduced in detail.

1. Deprived of utilizing special knowledge and skills

According to the participants, they were limited in their ability to use their skills for certain aspects of delivery of care because of the negative attitudes and responses of other healthcare professionals. In particular, midwives tried to prevent the midwifery-trained RNs from providing the primary care to women at the time of birth; as a result they felt that their specialized training in midwifery was of no use.

We have come here after one year of training in midwifery to help mothers give birth. However, we have been deprived of that opportunity. Obtaining midwifery training has become a tragedy. This is because we do not have the opportunity to perform a delivery (FGD-01:P8).

2. Role confusion with other professional groups

Role confusion amongst maternity professionals prevailed, and the participants expressed concern about lack of clear boundaries regarding their tasks and responsibilities. Tasks overlapped amongst the different categories of professionals, which resulted in role confusion and consequent conflicts among these professionals.

One day, I went for a delivery. When I was getting ready to perform the delivery, the midwife was doing another delivery. At that moment, I was holding the skin to give the epis (episiotomy), a midwife came from the antenatal side, pushed me away, blaming me aggressively and performed the delivery (FGD-01: P6).

Doctors ask us sometimes "Why did you put the CTG (Cardiotocograph)?" and at other times, they ask "Why didn't you put the CTG for this mother?" They ask us "Why did

you do this?” and when we don’t do it (those tasks), then they ask why we didn’t. Then, we do not know what to do because we do not have a defined role. They [doctors] also do not have a defined role. I think, actually, there is a lot of confusion (FGD-02:P5).

3. *Lack of professional identity*

The participants perceived that midwifery-trained RNs lacked a professional identity as they were not officially recognized as nurse-midwives or certified nurse-midwives. They had neither an official title nor clearly demarcated professional and legal boundaries. Hence, the midwifery-trained RNs did not have clear professional recognition. The midwifery-trained RNs referred to themselves as “midwifery qualified nurses” and felt that they were perceived by the public as nurses rather than as midwives.

“Although we call ourselves as midwifery qualified nurses, we do not have an official name. There is no nurse midwife title for us. We have created a name and call ourselves midwifery qualified nurses” (FGD-01:P6).

4. *Not being appreciated by others*

The participants felt that midwifery-trained RNs were not appreciated by other professionals for their contributions and services; in particular, they felt that their superiors only paid attention to them when a mistake occurred. Although midwifery-trained RNs rendered valuable services, they perceived their service as “masked” because they were excluded from the main highlight of maternity care, the delivery of the baby, which was usually performed by midwives. Although the midwifery-trained RNs were responsible for care before the delivery, during the delivery, and after the delivery, it was the midwife who was credited with the delivery of the baby. The midwifery-trained RNs, therefore, felt that their efforts to safeguard the delivery of the baby and the health of the mother and her baby were not visible, appreciated, or valued.

Although we work hard, our role is always hidden. We do half of the doctor’s duties, do the nurse’s part completely, do more than half of the midwife’s duties. However, including their [midwives’] name on the

delivery register implies that the most important part was done by them and we have done nothing (FGD-02:P7).

One of the participants was very emotional and expressed her feelings with eyes full of tears.

“Nobody talks about the contribution of midwifery-trained RNs in reducing maternal and neonatal deaths. God only knows. If the walls in the labour room could talk, they would tell how much service midwifery-trained RNs render” (FGD-01:P6).

The participants talked about how other health professionals tried to devalue their service. According to one participant, who had foreign work experience, this was because doctors feared they may gain the high status that midwifery-trained RNs held in other countries if they allowed them to ‘blossom.’

I have overseas experience. There, patients respect us. They are close to us. I think doctors in our country are scared a similar situation will dawn in Sri Lanka. That is why all the obstacles have been put in front of us (FGD-03:P4).

The midwifery-trained RNs believed that they were belittled by other professionals; to an extent that they regretted getting post registration midwifery training and becoming midwifery-trained RNs.

We feel very sorry thinking of why we came to this field. We thought we would be able to do a lot of work and help another category (referring to the midwives on the health care team) to support a mother. Actually, the work is done by us. But nobody talks about our contribution as midwifery-trained RNs. Why are Sri Lankan midwifery-trained RNs demeaned like this? (FGD-01:P3).

Discussion

The midwifery-trained RNs who participated in this study perceived themselves as maternity care providers who are ‘competent but not allowed to blossom fully in their practice.’ The participants felt that they were qualified to hold this position after completing their training in both nursing and midwifery and strongly believed that they had the necessary

knowledge, skills, and experience to meet the demands of their role: providing services for the mother and the baby. However, the midwifery-trained RNs felt that they were not allowed to utilize their knowledge and skills to perform optimally, particularly because they were prevented from conducting the birth.

This finding is consistent with findings in four other South Asian countries - Bangladesh, India, Nepal, and Pakistan - where nurses and auxiliary nurse midwives felt that their knowledge and skills were not fully utilized in maternity services because doctors prevented them from conducting the birth.^{11, 17, 18} Sleutel and colleagues reported similar results in a study of intra-partum registered nurses; where doctors intervened and obstructed nurses from providing intra-partum care and labour support.¹⁹

In addition to the underutilization of their skills, several additional reasons contributed to the frustration and disappointment felt by the midwifery-trained RNs in this study, including lack of appreciation for their contribution to the maternity service, on-going conflicts with other professionals in the healthcare team, and the lack of a professional identity. Out of these concerns, the most important was not being appreciated by other team members. Almost every midwifery-trained RN appeared to be concerned about this. This finding is supported by other studies that showed lack of appreciation to be one of the most important factors associated with poor work satisfaction, frustration, and work-related psychological stress among midwifery-trained RNs in similar settings.^{20, 21}

The most common cause for disagreement between midwifery-trained RNs and other professionals in the maternity care team was the overlap in their responsibilities. These overlaps occurred more often between midwives and the midwifery-trained RNs, particularly when conducting the birth. This is because midwives prevented midwifery-trained RNs from conducting the birth, resulting in role confusion in the labour and birth units. Sharma et al.¹¹ showed that role confusion is most prominent during childbirth because there is considerable overlap in the scope of practice of doctors and nurses; a similar situation has been observed in many other parts in the world. Midwives, certified nurse midwives, and obstetricians in the United States are known to compete for professional space during deliveries.¹¹ Such an overlap in roles and tasks is known to create tensions among professional groups,^{22, 23, 24} which can be best addressed by outlining clear roles and responsibilities for all the health care professionals of the maternity care team.²⁴

Studies have reported a significant relationship between job ambiguity and less-effective job performance.^{25, 26, 27} In addition, conflicts are known to lead to poor performance, lack of cooperation, wasting of resources, and loss of productivity.²⁸ Lack of clear job descriptions results in ineffective working and creates confusion, while clear job descriptions bring a feeling of clarity and security to the employees²⁹ resulting in optimal work performance.³⁰

The findings of this study point to role confusion among professional groups, leading to conflicts as a result from lack of job descriptions, clear roles, and professional boundaries. Although this may not be a phenomenon unique to this setting, the possible root causes may relate to the large power gaps between professional groups within the hierarchical organization of the health system in Sri Lanka. For example, doctors are seen as the leaders and decision makers, and RNs, midwifery-trained RNs, and midwives are regarded as holding a subordinate position relative to them. Midwives perceive their 18-months specialized training as being superior to the 12-months training received by the midwifery-trained RNs. However, according to the International Confederation of Midwives (ICM), achieving the core professional competencies is not determined by the length of their training alone, and as such their roles should not be determined by the training but on whether they have achieved the required level of professional competence.³¹

Another possible source of conflict, especially between midwives and midwifery-trained RNs, may relate to the elevated position previously held by community midwives as prominent community workers and leaders. They held an esteemed position as those who attended births in domiciliary contexts, and although this position is diminishing with more births taking place in hospitals, this attitude could still prevail among the public and among the midwives themselves with regard to their role in childbirth. Most of the conflicts around the conduct of the delivery could be related to the midwives' own beliefs about the exclusivity of their role in this aspect of maternity care and their resistance to change.

The roles and responsibilities of the health care professionals who provide maternity care require clarification to minimize inter-professional conflicts.²⁴ Hence, the creation of job descriptions for each member of the health care team is a high priority, particularly for maternity care settings, as frustrations and dissatisfaction could threaten the safety of the patient.^{32, 33} However, greater mutual respect and a change in attitudes is necessary to remove

the root sources of conflicts to promote better inter-professional collaboration among health care professionals and to improve the quality of maternity care services in Sri Lanka.

There are strengths as well as limitations of this study. As the first study to explore midwifery-trained RNs' perceptions of their service in the Sri Lankan context, it provides valuable insight into midwifery-trained RNs' professional practice, and their contribution to maternity care services. Because of the lack of prior research in this area, the first author drew from her own prior experiences as a midwifery-trained RN. Although this may have been helpful in engaging with the participants for data collection, it may also have been a source of bias. To ensure the trustworthiness and credibility of the findings, the data analysis involved prolonged data discussions with co-researchers who did not have any professional experience in midwifery. To establish confirmability, the findings were illustrated using quotations from the interviews. As the participants were drawn from three out of the five main hospitals in the research setting, the transferability of the study's findings may be limited. Although there was similarity in the experiences described, and the nature of the work arrangements across hospital settings tend to be similar, these results are relevant only for these and other very closely related settings.

Conclusion

Midwifery-trained RNs in three hospitals in Sri Lanka conveyed a deep sense of disappointment regarding their profession as maternity care providers in hospitals. Midwifery-trained RNs' own perceptions of high proficiency are incongruent with their low sense of identity and belongingness within the professional sphere. The study findings call for clearly defined, well-demarcated professional boundaries for Midwifery-trained RNs' to develop confidence in their work and to scale up inter-professional collaboration, in order to provide safer quality maternity care to the clients. In addition, addressing the hierarchical organization and work culture may be necessary, to enhance mutual respect for each other's professions within the maternity care team, in order to facilitate safe maternity care.

Conflict of Interest

None.

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