

PERCEPTIONS OF PRIVATE SECTOR MIDWIVES AND OBSTETRICIANS REGARDING COLLABORATIVE MATERNITY CARE IN THE EASTERN CAPE, SOUTH AFRICA

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ABSTRACT

The World Health Organization states that no region in the world is justified in having a caesarean section rate greater than 10 to 15% of the total number of live births. However, there has been an international increase in the rate of caesarean section deliveries and this is a concern to midwives globally. The increase is evident in South Africa and especially in the private sector and where it has been shown to be as high as 70% of the total number of live births per year. As a result, the South African public often perceives giving birth surgically as 'normal' and 'safer' than vaginal delivery. The lack of direct involvement of midwives in the care of pregnant women in the private sector is noted as one of the reasons related to the high caesarean section delivery rates. Hence, the objectives of the study were to explore and describe the perceptions of private sector midwives and obstetricians regarding the feasibility of collaboration in maternity care. The study followed a qualitative, exploratory, descriptive, contextual design. The research population included midwives and obstetricians in the private sector in the Eastern Cape. Non-probability, purposive sampling was employed using semi-structured one-to-one interviews for data collection. The study showed that midwives and obstetricians perceived a collaborative working relationship as being beneficial to maternity care. However, there

are critical impediments that need to be addressed in order to achieve such a partnership. In conclusion, participants saw it possible for collaboration in midwifery care services with positive benefits to the women being attended to.

Keywords: collaborative maternity care, midwife, obstetrician, partnership, perceptions, private sector

INTRODUCTION AND BACKGROUND INFORMATION

The increase in the rate of caesarean section deliveries is a concern to midwives internationally. In South Korea, the national caesarean section rate rose from 4.4% in 1982 to 37% in 2003. This is an increase that was argued and related to either litigation or modern technology use. In Norway, a more moderate increase has been observed: from 2.0% in 1968 to 15.4% in 2004 (Tollanes, Thompson, Daltveit & Irgens, 2007:840). The increase in Canada on the other hand rose steadily from 17.5% of deliveries in 1995 to 28% in 2009 (Harris, Janssen, Saxell, Carty, MacRae & Petersen, 2012:1885). A significant rise in caesarean section rates was reported in Egypt from 4.6% in 1992 to 10.3% in 2000 (Khawaja, Jurdi & Kabakian-Khasholian, 2004:12). The increases indicated above are occurring despite the recommendation by the World Health Organization (WHO) that no region in the world is justified in having a caesarean section rate greater than between 10 and 15%, which is the number of caesarean deliveries over the total number of live births (Betran, Merialdi, Lauer, Bing-Shun, Thomas, Van Look & Wagner, 2007:98; Chaillet & Dumont, 2007:54; Gunnervik, Sydsjo, Sydsjo, Selling & Josephson, 2008:438).

However, some of the high incidences of caesarean section rates reported are from poor and developing countries with limited resources such as family planning, antenatal care clinics and emergency skilful care (Chu, Cortier, Maldonado, Mashant, Ford & Trelles, 2012:3). These authors, in their study on indications of caesarean section rates in sub-Saharan Africa, indicated that as much as the incidence of caesarean section rate was increased in sub-Saharan countries, most of the indications were of an emergency nature such as obstructed labour, bleeding, cord prolapse malpresentations and positions. The findings also revealed that the caesarean section rate became less with the provision of the necessary skill, though one of every seven neonates born from those deliveries died (Chu et al, 2012:4)

In South Africa, the caesarean section delivery rate has increased primarily in the private sector and is currently among the highest in the world (Willie, 2012:87). The South African rate of caesarean section deliveries in the private health care sector has been shown to be as high as 70% per total number of live births per year (James, Wibbelink & Muthige, 2012:406; Keeton, 2010:13). As a result, giving birth surgically in South Africa is often perceived by the public as 'normal' and 'safer' than vaginal delivery, even for low-risk pregnancies (Schlosberg & Templer, 2010:37). Some of the reasons for the high incidence of caesarean section deliveries in South

Africa are related to wealth and membership of a medical aid scheme (Keeton, 2010:21) and the lack of involvement of midwives during the care of pregnant women (James et al, 2012:408). The latter mentioned reason was a finding in a study that investigated the role of midwives in the choice of delivery mode by women in the private health care sector. The study found that should midwives be given an opportunity to make an input, fewer babies would be delivered by caesarean section.

In addition, the study by James et al (2012:408) on the factors that influence pregnant women's choice of delivery mode in the private sector also recommended greater collaboration between midwives and obstetricians in the private health care sector in South Africa for the care of pregnant and delivering women. Various other studies reported reduced rates of caesarean delivery, shorter hospital stays on average and increased likelihood to breastfeed exclusively as associated with collaborative care models (Harris et al, 2012:1891). Waldman and Kennedy (2011:503) state that collaborative practice will benefit the future of maternity care as it will provide obstetricians and midwives with access to a system of care that fosters collaboration among licensed, independent providers. The International Federation of Gynaecology and Obstetrics (FIGO) believe that there are good reasons for obstetricians to collaborate closely with midwives to help strengthen midwifery. Partnerships between obstetricians and midwives can help produce effective professional results (FIGO 2011).

To explore the different forms of partnerships between a midwife and an obstetrician, one needs to understand what a midwife is and what is expected of her. The International Confederation of Midwives (ICM) recognises the midwife as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period. The care includes preventative measures, the promotion of normal birth, the detection of complications in mother and baby, the access to medical care and any other appropriate or emergency help (ICM, 2013:2).

In South Africa midwives could either be employed in public or private hospital settings or they could practise independently. In the public sector, midwives are in a position to provide holistic care to the mother and new-born by managing the prenatal care, delivering the baby, providing postnatal care for the mother as well as providing neonatal care to the new-born, especially in the low-risk midwife-obstetric units. In these units the obstetrician or paediatrician will be consulted whenever necessary or called out in an emergency (James et al, 2012:404). However, midwives employed in the private sector have limited opportunities to provide prenatal care as the women are attended to by their private doctors or obstetricians, and midwives generally do not deliver the baby unless it is a rapid delivery and the doctor has not yet arrived, which is rare. Under these circumstances, the relationship between the mother and the midwife is shortened and, at times, strained as these two people are usually not familiar with each other, hence it might be difficult for the midwife to provide any advice.

Independent midwives, who practise according to the prescriptions of the South African Nursing Council (*Regulation R.2488*, 1990), have no affiliation to a specific medical institution and are therefore employed by the expectant couple. They offer prenatal care and assist mothers with home and hospital births (James et al, 2012:404). Their care also extends to the postnatal period where they are able to do home visits to assist with the demands of being a new mother and help with breastfeeding. This group of midwives is in a position to make a positive input in terms of limiting the rate of caesarean section deliveries, but there are only a few independent midwives in the country used by a very small percentage of the women.

Partnerships or collaborative practice between midwives and obstetricians is not a new phenomenon, hence the recommendation for South African obstetricians and midwives to consider these. There are many different collaborative models of care that work well. The different models of care are only possible with good midwife-obstetrician collaboration. It is also noted that there are similarities in the way midwifery is practised in different developed nations in the world, which make international midwifery care comparisons important (Skinner & Foureur, 2010:28). Waldman and Kennedy (2011:503) state that collaborative practice will benefit the future of maternity care as it will provide obstetricians and midwives with access to a system of care that fosters collaboration among licensed, independent providers. This article seeks to report findings of a study that explored and described the perceptions of private sector midwives and obstetricians regarding collaborative maternity care.

STATEMENT OF THE RESEARCH PROBLEM

The researcher conducted a quantitative research study in 2011 on the factors that influence pregnant women's choice of delivery mode in the private sector. The results indicated that 50% of women opt for a vaginal delivery antenatally but up to 30% of those women end up with a caesarean section delivery and increased hospital accounts to pay (James et al, 2012:406). The findings portrayed a trend, which indicated that private institutions do not fully utilise the expertise of the midwives with regard to maternal care. Currently, as noted in practice in South Africa, private doctors work independently from the midwives whether private or in the public sector. The midwives in the labour wards monitor the progress of labour in the absence of the doctor and depend on the doctors' prescriptions on what next to be done, including the delivery or decisions about the mode of delivery are strictly those of the doctor. The study recommended a system of collaborative midwifery care between the doctors and midwives.

RESEARCH QUESTIONS OF THE STUDY

The research probing questions were:

- What could facilitate such a partnership?

- What could hinder such a partnership?
- What could be the benefits/advantages of such a partnership?

PURPOSE AND OBJECTIVES OF RESEARCH

The purpose of the article is to report the findings of a study that aimed at exploring and describing the perceptions of private sector midwives and obstetricians regarding the possibility of a professional collaboration relating to maternity care. The objectives of the study were:

- To explore and describe the perceptions of midwives and obstetricians in the private sector regarding collaborative maternity care; and
- To use the results of the study to make recommendations to facilitate the implementation of midwife-obstetrician collaboration in maternity care for women in the private sector.

DEFINITIONS OF CONCEPTS

The following concepts were clarified so as to provide the study with meaning.

Collaborative maternity care in this study refers to a dynamic process of facilitating communication, trust and pathways that enable the private practice midwife and obstetrician to provide safe, woman-centred care.

The *Nursing Act, No.33 of 2005* describes a **midwife** as ‘a person who, having been regularly admitted to midwifery education programmes, is legally licensed to give the necessary supervision, care and advice to women during pregnancy, labour and the postnatal period’.

An obstetrician is a physician or surgeon qualified to practise in obstetrics. Obstetrics is defined as relating to childbirth and the processes associated with it (Soanes & Stevenson, 2008:987).

Partnership refers to an undertaking to work with another or others with shared risks and profits (Soanes & Stevenson, 2008:1045).

A **perception** is a way of regarding; intuitive understanding and insight (Soanes & Stevenson, 2008:1063).

Private sector in this study refers to the private healthcare system that is not controlled by the state but run for private profit.

RESEARCH METHODOLOGY

The research design for the study was qualitative, with an exploratory, descriptive and contextual approach. The research population was the private sector midwives

and obstetricians in the Cacadu and Buffalo municipal districts of the Eastern Cape Province. Non-probability, purposive sampling was used to select the sample, which met the inclusion criteria. Furthermore, sampling was done after obtaining the necessary permission to conduct the study and enter the research sites.

Data collection

A pilot study was conducted in order to test the feasibility of the proposed study and the necessary minor shortcomings related to the interview technique were discussed with the research supervisor and corrected. The main data collection was done from June to August 2013 using semi-structured one-to-one audiotaped interviews.

The interviews took place either at the hospital, doctors' rooms, coffee shops or the participants' homes as preferred by the participant. Field notes were used during data collection sessions. The same main question was posed to all the participants and an interview schedule was kept and used to guide the interviews. The main question was:

Tell me, how do you perceive a collaborative maternity care partnership between midwives and obstetricians?

Seven midwives and five obstetricians were interviewed; this included the two interviews that formed the pilot study. Of the seven midwives interviewed, three were hospital-based midwives in the maternity sections of different private hospitals in the Eastern Cape, while the remaining four were independent midwives with their own registered private practices. The five obstetricians interviewed were all based in Nelson Mandela Bay and had established their own private practices for more than a year.

Data saturation determined the completion of data collection and data analysis continued following Creswell's (2007:118) data analysis spiral. The analysis involved the researcher familiarising herself with the data, organising the data and then coding it into themes, sub-themes and categories. An independent coder and the researcher's supervisor assisted with the coding process.

Trustworthiness was ensured throughout the study by maintaining credibility, transferability, dependability and conformability. Permission to conduct the research study was sought from the Nelson Mandela Metropolitan University's Department of Nursing Science and the Faculty Research, Technology and Innovation Committee (FRTI) of the Faculty of Health Sciences. The fundamental ethical principles that guided the study were autonomy (informed consent), non-maleficence (confidentiality), beneficence and justice. Participants were informed of the objectives, the use of an audio-tape recorder and their right to privacy and confidentiality. They were also assured of their right to withdraw from the study at any stage without any penalties.

Data analysis

The researcher transcribed each interview verbatim within twenty-four hours of conducting the interview. The analysis involved the researcher familiarising herself with the data, organising the data and coding it into themes, sub-themes and categories. An independent coder was used and together with the researcher and the researcher's supervisor, the findings were finalised.

DISCUSSION OF RESEARCH RESULTS

Two themes emerged from the data analysis namely: (1) participants perceived a collaborative working relationship as being beneficial to maternity care and (2) critical impediments that need to be addressed in order to realise collaborative maternity care. These themes are discussed below.

Theme 1: Participants perceived a collaborative working relationship as being beneficial to maternity care.

Theme one stated that the participants perceived a collaborative working relationship as being beneficial to maternity care. Collaboration will improve maternity care. Currently in South Africa, midwifery and obstetrical care are practised as two separate entities. Midwifery is mainly the responsibility of midwives while obstetrics is for the doctors. At times, women use a gynaecologist as their doctor of choice for their midwifery and obstetric care, hence seeing them at their private rooms. There are few private midwives, but it is difficult for them to find obstetricians who are willing to collaborate with them. They cannot work without a doctor partner and are therefore limited and become overwhelmed by the number of women coming to them for assistance. Most midwives work as employees at the hospitals, and have little say regarding midwifery and obstetric care, especially in the labour wards of the private health care sector. Participants in this study felt that a collaborative partnership is long overdue and would actually benefit both the general public and the health care professions. In this regard, three participants stated the following:

[W]e have gone the wrong way. We are not benefiting women, we not benefiting the pregnant people, we not doing them a good service in the end. (Obstetrician)

If I was working hand in hand with a midwife, or midwife team, where I am not trying to do everything for all my patients, where if I am freed up to concentrate on the problems, I would probably do better from an obstetric point of view. (Obstetrician)

There would definitely be a drop in Caesar rate and inductions of labour before 41 weeks. We would see far less booked primigravida Caesars for CPD's and 2,8kg babies, we would see happier and safer moms because they have been getting that prenatal reassurance and

health education which is definitely lacking in the private sector because doctors don't have the time to sit with the mother and tell her (Hospital-based midwife)

The quotations are evidence of the possibility of collaboration. Participants above agree that the collaboration between midwives and doctors in the private sector will mainly benefit the women who are being attended to and optimise the positive pregnancy outcome while limiting the risk of caesarean sections.

Findings of the study by James et al (2012:405) indicate that obstetricians are seen as monopolising the care of pregnant women. In order to change the current situation, the aforementioned authors recommended more involvement of midwives in the private health care sector and that these midwives should be empowered to work independently or in collaboration with obstetricians. The collaboration will benefit a close monitoring of the pregnancy of the women and the necessary interventions being initiated as soon as possible. Waldman and Kennedy (2011:503) state that collaborative practice will benefit the future of maternity care as it will provide obstetricians and midwives access to a system of care that fosters collaboration among licensed, independent providers. The introduction of a Midwife Obstetrics Unit (MOU) in the private sector was indicated as a way to implement collaboration. Both obstetricians and midwives expressed such thoughts:

Collaboration would be brilliant To be able to cover for more patients, to be able to give more patients your time or your expertise, it would be almost ideal to have a midwife setup and you just get called in when there are problems. (Obstetrician)

To start what they call a midwifery unit ... where the midwife would see the patients or they have a choice, whether they go to the gynae or to the midwife for prenatal check-ups with referral for high-risk cases and during delivery as well (Hospital-based midwife)

Everybody doesn't have to go through the high risk obstetric unit. Most pregnancies can happily work through a Midwife Obstetrics Unit. (Obstetrician)

It would be the ideal thing for all women to have a midwife to look after them. Especially in the low risk pregnancies, which are the majority ... we should be able to look after people that have complications to deliver. (Obstetrician)

With a low risk situation where the doctors are not involved, there is no doubt that the risk of intervention is less. Less risks of operative deliveries and so forth. (Obstetrician)

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The benefits of a collaborative partnership as indicated by the participants would not only enhance the maternity care, but also promote positive communication between the doctors and midwives. However, the partnership should be guided. One can look for success stories in other countries where a collaborative care model has

been practised such as in the Netherlands, Canada, Australia and New Zealand. In the Netherlands, for example, the maternity care is known for a high percentage of home births (22%) and for the independent position of midwives (Wiegers & Hukkelhoven, 2010:80). Because of this model of care, the caesarean section rate is kept low namely 15% (Centraal Bureau voor de Statistiek, 2007:166). Another example is New Zealand where the maternity service is known for continuity of care, which is established in legislation and where midwives have full autonomy of practice with prescribing rights, use of laboratories facilities, access to hospitals and equal remuneration with doctors (Sinner & Foureur, 2010:28).

Theme 2: Critical impediments that need to be addressed in order to realise collaborative maternity care

Theme two stated that in order for collaborative maternity care to be successful, the different parties should have knowledge of their respective roles. Fulfilment of all these factors will enable the possibility of increased respect of the parties in the partnership. To this perception, participants reported as follows:

It all comes down to ... everybody knows everybody's role, exactly to the point, that there is nothing that can happen that nobody knows, now what now? (Independent Midwife)

I think if midwives start not being afraid to be a professional and stand up to be the patient advocate for what is right and start seeing themselves as not as the assistant but part of the multidisciplinary team, I think that is what hinder our process as well. It is our perception of ourselves, of the midwives. (Independent Midwife)

Obstetrics should be for high risk We sometimes forget that 95% of the people are low risk, there are no problems. (Obstetrician)

Even though it is evident that both midwives and obstetricians should practise according to their scope in order for collaboration to be successful, midwives in this study perceive themselves having limited scope and often do not feel recognised as professionals. The hospital-based midwives all felt that they are seen more as the 'sister' who performs doctor's orders rather than the midwife who is an expert in her field. Evidence of such feelings is noted from responses such as:

Our gynae still feel they are doctors and we are nurses and very much that we are here to carry out doctors orders. We are still there as the nurse, the sister and not as the midwife with the experience We have become obstetric nurses (Hospital-based Midwife)

Even the doctor sometimes think that the midwives are the people working in the labour wards, taking their orders. So they don't specifically understand exactly what the midwife can do. (Independent Midwife)

We have become obstetric nurses. If you look at the state midwife, she is the boss. When she stands up against wrong management of a woman and speak up to a doctor ... in the private

sector if you going to say no to the doctor, they are going to say, he is the doctor, he brings the client, he brings the business ... so what the doctor says goes. You are just the nurse in private care. (Hospital-based midwife)

Midwives need to stand up and take their rightful roles in maternity care in order for collaboration to be successful. The findings of the study showed however that the legal and financial matters might be the biggest hindrance to the feasibility of collaboration. Regarding this perception, the participants had the following thoughts:

Obstetrics and midwifery should be a mostly risk-free area but because litigation has been put into it, it become very complex and a lot of us are in a difficult place. (Obstetrician)

I think unfortunately medico-legal is going to give us the biggest problems. I mean so much so that a gynaecologist in Johannesburg told me that if an anaesthetist is not readily available you should do elective Caesars all the time. MPS told the gynaecologist that. So I think medico legal is the biggest issue we have. Once that is not changed and the stress around medical aspects, it's going to be difficult to change perceptions and then change the system. (Obstetrician)

Currently there is no legal framework for collaboration. This puts too much of a burden on obstetricians who think they are responsible for almost everything. A legal framework that makes clear who is responsible for what is necessary for successful collaborative maternity care (Kruske, Young, Jenkinson & Catchlove, 2013:4; Lane, 2012:33). Collaborative maternity care requires approved regulations and each registration body must give recognition to such collaboration in order for it to be supported. These observations were taken from responses such as:

A legal framework in which we identify what the obstetrician would do, what the midwife should do. We need a legal framework in which we understand that there will unfortunately always be some mishaps that will happen We put together a new framework, in which we care for the women in a way which is humane, which makes the life of both the obstetrician and the midwife easy It will only happen when you have group practices in which midwives and obstetricians will be working together. (Obstetrician)

It has to be endorsed by our health professions council; it has to actually be set up by them for that to be a little bit more reassuring ... that the health professions council will actually have some say or protocol that they set up. (Obstetrician)

Obstetricians in South Africa have to pay a substantial amount to the Medical Protection Society (MPS) for insurance purposes. The MPS is a provider of comprehensive professional indemnity and is an advisory organ for health professionals around the world. The obstetricians find themselves in a predicament. To be able to pay the insurance, they are forced to charge high consultation fees (McIntyre et al 2012:303) and are obliged to treat 'low-risk' pregnant women in order to increase their income. Some of the obstetricians expressed this thought:

Because in terms of cost, a lot of what we do can certainly be done by midwives. Mainly if they run into trouble the obstetricians can come into play. But this is not what gets done because the obstetricians need to pay such a huge insurance to practice as obstetricians, so they want to do the work to be able to justify the R25 000 they have to pay per month So for an obstetrician to refer their patient to a midwife, what's going to happen then, you not going to be able to do obstetrics like I did (Obstetrician)

Lastly, the private health care sector as a business has to look after pricing while making sure of the quality service, but not to jeopardise the aims of the collaboration as well. For that reason, the concept of managed care was mentioned in this study. In a study conducted by Shaw-Battista, Fineberg, Boehler, Skubic, Woolley and Tilton (2011:664), which was to evaluate maternal and neonatal outcomes of collaborative maternity care for a socioeconomically diverse patient population in California, they warned against cost watching. Currently in South Africa, private practice service is seen as being expensive and yet, at times, it is considered as the place of service provided being not worth it, hence managed care is the focus (Hatting & Jooste, 2009:379). Collaborative maternity care will benefit the medical expenditure, as demonstrated by the different participant responses, such as:

Often we over treat and over charge and oversee and over do all of that. Whereas if we downgrade a little bit and the routine non-high risk situations could be dealt with in a more cost effective manner. Everybody doesn't have to go through the high risk obstetric unit. Most pregnancies can happily work through a midwife obstetric unit. (Obstetrician)

We have to get to the primary healthcare cost. Can you imagine, if your thesis proves correct, if collaboration could happen, can you imagine the millions of rands that will be saved in this country. (Obstetrician)

Literature confirms the above statements. McIntyre et al (2011:1) state that the connection between obstetric practices and increased resource utilisation in the absence of clinical need has been used to challenge the routine presence of obstetrics in the contested boundary of 'normal birth'. Collaborative care models are useful cost saving agents as resources are shared while clinical patient outcomes are improved (Granger, Prvu-Bettger, Aucoin, Fuchs, Mitchell, Holditch-Davis, Roth, Califf & Gilliss, 2012:71).

CONCLUSIONS

Participants showed a willingness to a collaborative partnership but insisted on a structure that will protect income and against legal matters. It is conclusive from the findings that such collaboration will not only benefit the partners but the level of service being rendered.

RECOMMENDATIONS

The researcher makes the following recommendations based on the findings of this study:

- The maternity health care providers should pursue new ways of improving collaborative maternity care. Collaborative maternity care models that consider the well-being of women and babies and optimal maternity care should be developed.
- Professional guidelines or protocols should be formulated to promote consistency of practice, team policies and standards.
- A legal framework should be formulated that states the roles of the obstetricians and midwives and this should be enforced by the different registration bodies.

LIMITATIONS OF THE STUDY

Specific limitations that were acknowledged are:

- The study was limited to the private sector only, thus depriving the researcher with insight into perceptions regarding collaborative maternity care in the government setting.
- Although the participants were willing to share their perceptions, they might have concealed information due to their own privacy and to protect themselves. One obstetrician, for example, provided very short and politically correct answers and was not willing to share very much.
- The researcher, being an insider as a practising midwife with her own ideas on collaborative maternity care, had to be careful to remain neutral and not overuse probing questions, which was at times difficult to achieve.

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