Personal Values Required for Ethical Best Practice during Intrapartum Care

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Abstract

Women bring into the birthing unit values which include preferences, concerns and expectations that are involved in decision-making during intrapartum care. When midwives fail to meet the women's values, they experience such care as being inhumane and degrading, thus affecting the childbirth outcomes. The inhumane and degrading care includes a lack of sympathy and empathy, as well as a lack of attention to privacy and confidentiality. Midwives' possession of the required personal values and the ability to integrate women's values are vital to enhance ethical best practice during intrapartum care. The aim of the study was to explore and to describe the midwives' personal values that are required for ethical best practice during intrapartum care. The birthing unit at a public hospital in the Gauteng province of South Africa formed the context of the study. A qualitative research design that was explorative, descriptive and contextual in nature was used. The following personal values emerged: (1) respect, trust and dignity; (2) justice, equality and fairness; (3) freedom of choice and autonomy; (4) integrity, honesty and consistency; (5) good character and personality; (6) self-control and rapport; and (7) open-mindedness and flexibility. The midwives' personal values form a strong precursor that is crucial for ethical best practice during intrapartum care. The individual midwives, nursing education institutions and health facilities can use the study findings in areas such as reflective midwifery practice, the midwifery curriculum, recruitment and selection processes, and as part of key performance areas and indicators in performance reviews.

Keywords: best practice, ethics, intrapartum care, midwives, personal values, perspective

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Introduction and Background Information

Midwives' personal values are precursors of ethical best practice during intrapartum care. Personal values, which are the starting point for morality and ethics, mean ideals and beliefs that individuals uphold, and that lie at the core of human behaviour and attitudes (Kaya et al. 2017, 717). Individual personal values relate to the principles, morals and ideals that are considered by an individual to be important. They direct a person to prefer specific values in the professional field and define a person's character. Personal values underpin the development of professional values (Shahriari et al. 2013, 2). Rapid changes in technology and rising conflicts between midwives and women's personal values further compound the ever-increasing complex ethical dilemmas in midwifery practice. Disconnection with personal values causes a person to behave inappropriately and to make impulsive decisions (Özcan, Akpinar, and Ergin 2012, 400). Childbearing women and midwives may not share the same values. If not well-integrated, this may lead to a chaotic birthing unit environment characterised by lashes, disrespect and mistrust.

The World Health Organization (WHO 2008, 6) defines the term best practice as a technique or methodology that, through experience and research, has proven reliably to lead to a desired result. It affords one the opportunity to acquire knowledge about lessons learned and to continue learning about how to improve and adapt strategies and activities through feedback, reflection and analysis in order to implement larger-scale, sustained interventions that are more effective. The concept ethics, on the other hand, includes determining what is good, right and fair (Aderemi 2016).

The WHO (2015) states that globally women experience disrespectful and abusive treatment during childbirth. A study conducted by Mukamurigo et al. (2017, 4, 13) revealed that, during childbirth, women were cared for in an undignified way, including offending, disgracing, shouting, threatening and condemning remarks, as well as midwives not responding to their calls for help. Moreover, treatment of this nature does not only violate women's rights to respectful care but also threatens their rights to life, health, bodily integrity and freedom from discrimination. In the same vein, improper provider values, attitudes and behaviours have a significant impact on healthcare-seeking behaviour, as well as the physical, psychological and emotional health of women and their newborn infants.

The Human Rights Watch (2011) report states that midwives in South Africa are inhumane and render degrading care to women during labour. Hence, there is an urgent global call to implement respectful, evidence-based care for all (International Federation of Gynaecology and Obstetrics et al. 2015, 96). National and international initiatives and guidelines exist to reduce the global outbreak of maternal disrespect by healthcare providers (Human Rights Watch 2011; WHO 2015). Despite the availability of initiatives to reduce disrespect and abusive treatment, midwives are unable to demonstrate appropriate caring personal values during intrapartum care. Midwives'

failure to demonstrate values and ethical practice during intrapartum care is equivalent to the increasing disrespect and abuse.

Lothian (2009, 2) asserts that the values and ethical responsibilities to women, employers, the profession and society provide a direction for midwives, clarifying who and what midwives stand for. Women in labour find themselves in a vulnerable situation that may be complicated by unexpected emergencies; therefore, knowledge of midwives' personal values is crucial to implement ethical best practices for intrapartum care in such situations. The survival of women during childbirth is linked to value-based care that includes women-centred human rights and ethical practice. Ethical practice is concerned with making judgements, which may be good or bad. Midwives are obliged to be professionally competent and provide ethical and value-based intrapartum care in whatever environmental circumstances prevail. However, Pohling et al. (2016, 449) proclaim that personal values are associated with ethical competence, and a suggestion is to consider such values in the selection of employees.

International and national midwifery education and training programmes, such as the WHO (2009) global standards for the initial education of professional nurses and midwives and the South African Nursing Council nursing education and training standards in terms of the Nursing Act (South Africa 2005), entrench ethical values as well as the code of conduct. The ethical codes ensure that midwives are not only well grounded in knowledge and skills, but also in attitudes (SANC 2013). The ethical values embedded in nursing education and training programmes as well as the professional code of conduct will enable midwifery students upon qualification to distinguish between good and bad practices and/or role models.

Statement of the Research Problem

Midwives' portrayal of inappropriate personal values during intrapartum care translates into inhuman and degrading care as reported by the Human Rights Watch (2011). Inhumane and degrading care by midwives leads to acts or omissions that constitute misconduct that is liable for professional conduct inquiry. The cases of alleged unprofessional conduct and cases of malpractice against nurses and midwives continue to rise. However, according to a statistical report by the SANC (2015), only about 12 maternity care-related professional conduct cases were reported in the period March 2015 to November 2015. Most serious adverse events occurring in birthing units are from unethical behaviour of midwives, as described in the Human Rights Watch (2011) report.

Appropriate personal values of midwives enable them to provide the safest and best intrapartum care that is sensitive to the preferences, concerns and expectations of women. Such sensitivity demands their insight, intuition, moral knowing and ability to recognise the salient moral cues in any given situation where a moral issue exists. Additionally, it requires the ability of a midwife to interpret an individual's verbal and non-verbal behaviour, to identify individual wishes or needs, and to make applicable

responses to promote sensitive intrapartum care. If midwives as students joined the profession with their own appropriate values, it would enhance their ability to integrate the values inherent in the midwifery practice. Kaya et al. (2017, 717) support this notion. It is vital for midwives to be mindful of their values, which guide their personal and professional behaviours. When midwives demonstrate the required personal values during intrapartum care, they will uphold ethical practice and foster the development of relationships of mutual respect and trust with women, as well as zero tolerance to colleagues who are arrogant and inhumane, and who degrade women during the intrapartum period.

Previous studies focused on factors influencing choice in birth place and the meaning of a poor childbirth experience; however, none of those studies dealt with midwives' personal values influencing their behaviour towards women during childbirth (Houghton et al. 2008; Mukamurigo et al. 2017). This brings to the fore the need to interrogate midwives' point of view regarding the personal values that are required for ethical best practice during intrapartum care.

Research Question

What are midwives' perceptions regarding the personal values that are required for ethical best practice during intrapartum care?

Purpose of the Study

The objectives were to explore and to describe the midwives' perspectives regarding the personal values required for ethical best practice during intrapartum care in a birthing unit at a hospital in Gauteng, South Africa.

Definition of Key Concepts

Best practice involves the gathering and application of knowledge about what is working, and what is not working in different situations and contexts through feedback-learning reflection (WHO 2008, 7).

Ethics includes determining what is good, right and fair (Aderemi 2016).

Intrapartum care refers to the care of women and their unborn babies throughout the first, second, third and fourth stages of labour, during the period from the beginning of true labour until one to two hours after delivery of the placenta (Lowdermilk 2012, 379).

A **midwife** is a person registered as such in terms of section 31 of the Nursing Act (South Africa 2005) and who supports and assists the mother and the baby to achieve and maintain optimum health during all stages of pregnancy, labour and puerperium.

Personal values are the principles, morals and ideals considered by an individual to be important. They direct a person to prefer specific values in the professional field and define a person's character (Özcan, Akpinar, and Ergin 2012, 400).

Perspective refers to a particular point of view centred around or arising from a person's own individual existence (Stevenson and Waite 2011, 458).

Research Design and Method

Research Design

The researcher used a qualitative research design that was explorative, descriptive and contextual in nature (Burns and Grove 2011, 20, 536, 549).

Research Methodology

Setting

The study was conducted in the birthing unit at a mother-and-child public hospital in the Gauteng province, South Africa. The services provided by the hospital are emergency, preventive and curative care. The location of the hospital is the city of Johannesburg in South Africa. It serves the City of Johannesburg clinics that include regions A, B, C and F, and also one hospital in the West Rand. The hospital provides a clinical teaching and learning environment for nurses and other healthcare professionals and students for affiliated higher education institutions, including the university where the researcher was employed at the time of the study. The population served by the hospital was estimated to be 1 000 000. The total number of beds was 340 and only 329 beds were used then. The hospital comprises seven outpatient clinics, one emergency department, eight paediatric, and three gynaecology and six maternity wards. The birthing unit consists of two adjacent wards. The first is a nine-bedded ward and four comfortable one-seater sofas for intermittent use by women in the latent phase of labour. The ward serves as a triage and an admission ward. The second ward is a birthing section consisting of 10 birth rooms. However, the first birth room that is near the admission ward is reserved for women who are in the transitional phase of the second stage of childbirth on admission. The three-month birthing unit statistics at the time of the study (October to December 2014) indicated about 995 to 1 019 vaginal births and 499 to 563 caesarean sections.

Population and Sampling

The population consisted of 46 permanently employed female registered midwives allocated to the admission and birthing unit for day and night shifts at the time of the study. Recruitment of the potential participants occurred during the unit conference meetings held in the birthing unit on 27 and 28 October 2014 for both day and night staff of different shifts. The inclusion criteria required midwives who were currently registered with the SANC as midwives, had five or more years of experience working in the birthing unit, and were willing to sign the consent form indicating their

willingness to participate in the study. A non-probability purposive sampling method was used to select midwives who met the inclusion criteria. The sample size was determined by data saturation, which was reached during the third session of the focus group interviews (18 participants).

Data Collection Method

The researcher used semi-structured focus group interviews to collect data. A pilot focus group interview was conducted with five midwives who met the criteria for participation in the study, using the same research question as the main study to give the researcher an opportunity to refine interview skills such as listening, paraphrasing, probing and summarising. The midwives who participated in the pilot study were not included in the selected sample. The participants were afforded the opportunity to choose the date, venue and time for the interviews. The venue chosen by the participants was a hospital boardroom that had a large oval table surrounded by comfortable chairs. The seating arrangement enabled face-to-face eye contact between the participants and the interviewer. The boardroom environment was non-threatening, clean, air-conditioned, easily accessible and removed from any distractions (De Vos et al. 2013, 350). The author, who was then a lecturer at a university in Gauteng, conducted the focus group interviews. The relationship among the midwives working in the birthing units of the hospital under study and the interviewer was a mutual and collegial relationship that developed during clinical accompaniment of midwifery students and service-university collaboration meetings over time.

At the beginning of each focus group interview session, the interviewer welcomed the participants, introduced herself and requested the participants to introduce themselves. Icebreakers such as humour were used to allow the participants to settle, and to feel free and relaxed during the interviews. The participants were informed that there were no right or wrong answers and were urged to feel free to share their points of view even if they varied from what their colleagues said. An overview of the study was explained, and the participants were informed about the purpose of audio recording of the interview session and making of field notes during the interactive conversation.

The participants' names were replaced with numbers to ensure anonymity and confidentiality, for example, PA1 meaning participant A session one of the focus group interviews. The participants were informed that they were free to terminate their participation in the study without giving a reason and that they would not be sanctioned for non-participation. The interviewer gave the participants some time to reflect before signing the consent forms. The participants signed a consent form for the focus group interviews and the use of the audio recorder during the interview sessions for accurate data collection. The question posed was: "Tell me your perceptions about personal values required for ethical best practice during intrapartum care." The focus group interviews were conducted in English. Communication techniques such as probing, active listening and silence were used, and the interviewer encouraged the participants to give more information about the phenomenon by paraphrasing, reflecting and

summarising their contributions (Murphy and Dillon 2011, 161–170). Three interactive focus group interviews (for group A, B and C sessions) that consisted of six participants in each group were conducted over a period of three weeks for about 45 to 60 minutes per session. The focus group interviews took place on 28 November, 1 December and 5 December 2014. Saturation of data occurred during the third group when no new information was forthcoming from the participants.

Data Analysis

Data analysis occurred after each interview session. The researcher listened repeatedly to recorded interviews, followed by verbatim transcriptions. The researcher read and reread the verbatim transcripts to get a global understanding of the interviews. Tesch's open-coding qualitative data analysis protocol was used to analyse the data (Creswell 2014, 183–213). Statements were extracted and categorised into thematic clusters for use as citations in the description of the findings. A list of emerging categories was then developed. The findings were integrated into a thick, exhaustive description, which also included the field notes, to cover most possibilities of midwives' perspectives. The purposefully selected co-coder was given the interview transcripts and a copy of Tesch's open-coding protocol of qualitative data analysis to analyse the data independently. A consensus meeting was held with the independent co-coder to discuss the findings. A follow-up focus group interview was done with five of the participants who were involved in the study to verify the identified categories.

Trustworthiness

Trustworthiness was ensured by using the four criteria of credibility, dependability, confirmability and transferability. Credibility was attained through prolonged engagement, triangulation, member-checking, semi-structured interviews, and the authority of the researcher and supervisors. Transferability was attained by using a purposive, non-probability sampling method and reaching saturation of the data. Dependability was attained through a thick and dense description of the methodology of the study. Confirmability was attained by conducting a confirmability audit (Lincoln and Guba 1985, 316–319).

Ethical Considerations

The research proposal was approved by the Nursing Department Science Committee, the Academic Ethics Committee (AEC1701-2011), the Higher Degree Committee (HDC1302-2011) of the University of Johannesburg, and the public hospital in Gauteng where the research was conducted. Ethical considerations in terms of the quality of research, informed consent, the right to confidentiality and anonymity, and privacy and benefit or risk ratio were adhered to in accordance with the Democratic Nursing Organisation of South Africa (2005) position paper.

The researcher conducted the study with the utmost honesty to ensure quality of research. The participants were informed about the purpose, objectives, methods and

duration of the study, and the researcher's identity and qualifications. The participants were made aware of their right to withdraw their consent at any time during the study if they wished to do so. Permission was obtained from the participants to use an audio tape recorder during the data collection. The participants were requested to sign the consent forms to indicate their agreement to participate in the study.

The participants were requested not to mention their names and the name of the institution during the focus group interviews, but to refer to each other as colleague number one or two and so forth. The audio recordings were kept safely under lock and key and will be destroyed three years after the completion of the study. Only the researcher, supervisors and co-coder had access to the information collected. The participants were informed that the research results would be made available to them upon their request. The participants' dignity and self-worth were maintained throughout. The focus group interviews were directed by the research questions and probing was done in accordance with the participants' responses. The participants were assured that there were no risks associated with the research; rather, the patients and hospital management will benefit from the description of the recommendations to promote midwives' ability to portray appropriate personal values required for ethical best practice during intrapartum care.

Findings

The description of the findings on midwives' perceptions regarding the personal values that are required for ethical best practice during intrapartum care is presented in accordance with Table 1.

Table 1: Midwives' perceptions regarding the personal values required for ethical best practice during intrapartum care

Interview question	*Categories*
What are your perspectives regarding the personal values that are required for ethical best practice during intrapartum care?	Respect, trust and dignity Justice, equality and fairness Freedom of choice and autonomy Integrity, honesty and consistency Good character and personality Self-control and rapport Open-mindedness and flexibility

Respect, Trust and Dignity

Personal values of respect, trust and dignity are required during intrapartum care as indicated in Table 1. Midwives who lack such personal values are often mean towards women during labour.

> I heard a woman screaming and the midwife in attendance told her in a very loud voice shut up! When you were having fun with your husband, did you not know that it would be painful at the end? I could not believe what I heard is still happening in this era. (PA1)

> Similarly, the other one in that birth room was saying to a woman I am not the one who told you to get that pregnant. So do me a favour and push! Shouting Puush! Remember it is your problem, if you kill your child. Just push! (PC3)

> As a midwife, you tell the woman you are taking care of about the need to eat and drink during the first stage of labour. Suddenly, the other midwife based on her views about childbirth, entered the room and without greeting the woman, she literally snatch the food away from the woman's hand and told the woman that she is not supposed to eat anything in case she needed to go for caesarean section because she will choke and die. The message does not only instil fear but also cause woman to be confused and information given by midwives cannot be trusted. (PE1)

> Colleagues! What I have observed is that some of us apart from being ill-mannered, we have no regard for the decency of patients during labour by leaving them exposed to answer a cell phone without asking for excuse from the patients. (PB2)

Justice, equality and fairness

Midwives put great emphasis on the values of justice, equality and fairness during intrapartum care. They gave the impression that they were observant of their colleagues' behaviours and actions as depicting or not depicting the personal values of justice, equality and fairness during their interactions.

> In my opinion, I think as midwives we should always be ethical, unbiased and reasonable in dealing with women and their families. People should be treated in the same way no matter what. (PF2)

> One of the women who was 40 years old told me in my face that we tend to give more attention and best care to younger women than older women and we shout at them and leave them to give birth alone unassisted. In delegating intrapartum care responsibilities among midwives, the unit manager should also always strive to achieve impartiality, objectivity and likeness. (PB1)

> Women and their families often experience our intrapartum care as unreasonable, imbalanced and favouring others more. (PE2)

Freedom of Choice and Autonomy

According to midwives, freedom of choice and autonomy are the core values that characterise best intrapartum care as depicted in Table 1. They realised the importance of allowing women to exercise their freedom of choice, thereby promoting their autonomy during the intrapartum period.

Women during labour are in a state of vulnerability due to physical and emotional exertions of labour hence they tend to change the previous choices they made regarding pain management during the early stages of labour. (PE3)

To facilitate women's liberty to choose during intrapartum period I would say it means giving the woman as much information as possible for example on pain management during labour and letting her make the decision about whether she would want to have something or not. (PA3)

... like for instance in giving them information about foetal monitoring during labour and the positions to be adopted during the second stage of labour. We often stress on the positive aspects of continuous electronic foetal monitoring and supine lithotomy position at the expense of other method and alternative positions proven beneficial such as squatting position as preferred by some cultures. (PC1)

True, at one time we as midwives are more or less dictating choices to women by informing them that this is the way to go I am putting you on continuous electronic foetal monitoring and you have to adopt supine position to give birth for the sake of you and your baby's well-being. (PC4)

Integrity, Honesty and Consistency

Midwives' perception was that integrity, honesty and consistency as personal values sustain ethical practice, as well as becoming a prerequisite for ethical best practice during intrapartum care.

Midwife's competence and faithfulness is significant for women during intrapartum care. Being competent, truthful and honest in whatever you are doing irrespective of whether someone is watching over you or not. (PF3)

Midwives should make the woman aware that she is taking care of two women at the same time in order to gain their cooperation. Midwives tend to find ways to bend the rules and make things happen. For example completion of the labour records of two women retrospectively whilst sitting at the nurses' station. A retrospective recording of care given does not hold the truth thereby threatening not only the standard of care but also the faithfulness and reputation of midwives. (PC2)

Delayed recording of findings and interventions is a dangerous unethical practice indeed! Something could happen during immediate postpartum period that need those records to be retrieved to check and ascertain something like the amount of blood loss that occurred during intrapartum period only to find inconsistencies due to mix up of information. (PE1)

Yaa neh! I am thinking that putting the woman first and being in such a relationship with woman and her companion as midwife one has to be genuinely truthful and stable in her approach to intrapartum care. (PD3)

Good Character and Personality

Although the midwives acknowledged their differences in character, personality and approach to intrapartum care, they considered that being empathetic and upfront with women in a compassionate manner is central to best intrapartum care.

> Midwife should be able to do good without being watched and adapt to any situation, any social class and what the woman wants, informing her of her choice and actions, but in a humble way. (PA2)

> Colleagues we should take a stance of being approachable and responsive to individual women's needs. Our reputation and charisma as well as seeing women as unique individuals who have different needs are crucial during intrapartum care. (PC1)

> What is worrying is that the majority of us tend to act in a pretentious manner in the presence of senior colleagues but once they leave our sight we revert to implement methods that produces untoward results such as the use of Valsalva manoeuvre and fundal pressure to hasten the second stage of childbirth process. (PF1)

Self-control and Rapport

It became evident from the midwives that they took cognisance of their own personal values that promote positive interpersonal relationships with women during labour, for example their ability to exercise self-control and to create rapport (Table 1) with women during intrapartum care, notwithstanding the situation that prevails.

> ... a midwife whilst assisting a student midwife to manage the second stage of childbirth complicated by shoulder dystocia. She was so passionate, remained calm and being confident while at the same time managed to portray a good relationship and compassionate care to the woman. That midwife is talented indeed. (PD1)

> I can be like that under normal circumstances but once an emergency sets in I tend to panic, lose it and even raise my voice not only to my colleagues but also to the woman as well. (PE1)

> You have not seen and heard about the worst incident. One day a midwife was helping a teenage primigravid to give birth. When the midwife put her hand poised on the perineum, the teenager thought that the midwife was occluding the vulval opening, thereby preventing the foetal head from advancing, she then kicked the midwife on the chest. The midwife retaliated and hit back. (PF2)

> The right thing is that if you admit a woman who is in labour you become responsible for that woman throughout the childbirth process until she is ready to be transferred to the lying in ward to improve woman-midwife rapport. Interconnection with women and their companion/families brings about mutual composure and respect as well for both the midwife and the woman. (PB3)

Open-mindedness and Flexibility

Midwives perceived open-mindedness and flexibility (Table 1) as important personal values when assisting women during the intrapartum period.

> Women in labour are in control of their care. What midwives can do best for them is to be open-minded, receptive and rely on their ability to make sound decision in the process of giving birth. (PD2)

> A woman requested a midwife to rub her back with herbal ointment believed to hasten the progress of labour. The midwife refused claiming the ointment is useless. Instead of making such a comment, a midwife could have been responsive and adaptable enough and engaged the woman to talk about the ointment and see how best she can help. (PA1)

> When I assisted a woman in labour from one of the neighbouring country, I asked her open-ended questions about childbirth-related practices in her family to help establish open communication and a friendly and trusting therapeutic relationship. I became a bit unsettled when she indicated to me that her genital is different because of the customary rituals performed to her at a young age but she wanted to give birth vaginally and asked that her genitals should be stitched back otherwise her husband would leave her. I had to think fast, reassured her and informed her about midwife so and so who is experienced in assisting women with the similar situation and with her permission I would invite the midwife to come an assist her to give birth and I will remain to observe as part of learning. Midwives should be wary and be receptive of knowledge women brings along to the birthing unit as it may directly point towards women's urgent need for other professional assistance. (PE2)

Discussion

Respectful intrapartum care requires midwives to involve the women and their families in the basic care, through continuous communication, information sharing and decision-making. Taking women and their needs into consideration as individuals during intrapartum care implies the midwives' ability to espouse their personal values of respect and dignity. According to Edlund et al. (2013, 852), dignity is concerned with how people feel, think and behave in relation to their worth or value to themselves and others. Respect for human dignity forms the core of midwifery philosophy of the International Confederation of Midwives (2014) and the SANC (2013) code of ethics for nursing and midwifery practitioners. Nonetheless, issues have been raised which illuminate that, too often, women receive care that falls below this standard. The implication is that midwives who lack the respect for their own self-worth will be unable to respect the dignity of women in labour.

The WHO (2015, 3) recommends the development of policy initiatives on the importance of respectful maternal care, an inclusive process, constant identification and reporting of disrespect, and the implementation of preventive and therapeutic measures to promote respect during intrapartum care. Midwives must be competent and trustworthy to meet their obligations to women during the intrapartum period. Trust is

an attitude that allows one to rely confidently on someone and is a fundamental basis of ethical best practice during intrapartum care (Dinc and Gastmans 2013, 501). To build a trusting relationship with women, midwives should possess other personal values such as justice, equality and fairness.

Justice in caring is described as care that is ethically, morally and legally correct, and that is equally and fairly distributed based on the need for best patient care outcomes. Women are morally obliged to seek justice, equality and fairness during the intrapartum period (Juujärvi, Myyry, and Pesso 2010, 469). Despite the fact that it is within their human rights, women may not demand just, fair and equal intrapartum care because midwives might perceive them to be difficult. Midwives' failure to exhibit such values impedes women from demanding what is due to them during intrapartum care. Simmonds et al. (2013, 149) claim that the staffing levels, physical environment and leadership within the birthing unit affect just, equal and fair intrapartum care.

Houghton et al. (2008, 61) assert that midwives' attitudes and beliefs may have a significant impact on women's choices. Another factor that affects women's freedom of choice is the insufficient information provided to obtain informed consent (Sakala, Yang, and Corry 2013, e25; Torres and De Vries 2009, 15). In most cases, labouring women are unaware of the limited information given, and that tends to determine their choices, thus affecting their autonomy during intrapartum care. According to Halfdansdottir et al. (2015, 593), autonomy in the place of birth is about women's informed understanding of available choices, and their mental capacity for evaluating and making decisions regarding the choices. It tends to focus on situations in which decisions need to be made about healthcare interventions, and in discussions about matters of confidentiality, fidelity, privacy and truth-telling (Entwistle et al. 2010, 741). When midwives deny women the opportunity to exercise their freedom of choice and autonomy, the women end up feeling isolated, uncertain and powerless (Hadjigeorgiou et al. 2012, 381). Consequently, women may become arrogant and uncooperative with midwives during intrapartum care, predisposing themselves to unnecessary interventions such as labour augmentation and instrument-assisted birth.

Integrity, honesty and consistency as value ethics are socially valued character traits which, if midwives possess them, uphold their standing. According to Pairman et al. (2015, 365), the three values of integrity, honesty and consistency are interrelated, with integrity referring to consistency between spoken words and actions, including honesty as the capacity for truthfulness, while leaving room for women and their families to express the truth from their own perspective. Investigation into childbirth malpractice claims by women and their families revealed that communication problems, perceived deception and lack of honesty by midwives motivated them to file the claims to seek revenge. In such cases, midwives' open and honest expression of empathy and apology will enable them to learn from the experience, and offer timely support to women and their families (Sakala, Yang, and Corry 2013, e31).

Midwives are held accountable for the type of intrapartum care they deliver; hence, empathy, apology and redress are entrenched within the Batho Pele (People First) principles (Department of Health 2008). Midwives who are loyal and dependable will portray caring behaviours and the ability to implement ethical best practice during intrapartum care. Eley and Eley (2011, 385) assert that midwives' good character and personality are crucial to intrapartum care. Personality is composed of temperament and character. Character reflects personal goals and values that tend to develop in response to life experience, and temperament refers to automatic emotional responses to experience that are moderately developmentally stable. Midwives' good character and personality are characterised by being competent, caring, safe, ethical and women-centred practitioners that are self-directed, cooperative, compassionate, novel, modest risk-takers, confident and objective (Eley and Eley 2011, 385). Often, women experience midwives without appropriate character and personality as being bad because they usually portray rigid, non-cooperative, inhumane attitudes and lack people skills, thus impeding ethical best practice during intrapartum care (Traynor 2014, 548). Such midwives lack self-control and are unable to establish good rapport with women during intrapartum care.

Self-control is a skill that entails a repertoire of goal-directed actions that enable a person to take firm charge of his/her own choices about life, deciding on what to change, what to hold onto, and what to let go (Scheick 2011, 115). Poor communication, lack of cooperation and coercion are evidence of lack of self-control and rapport. For example, midwives who lose self-control will forcefully pin a woman down to the recumbent position when the woman tries to adopt an upright position during the second stage of labour. Consequently, aggression and violent behaviour occur, whereby a woman and a midwife could start to fight and swear at each other. The development of self-control skills such as cognitive restructuring, self-instruction and problem-solving strategies is necessary in this instance to enable midwives to de-stress in order to manage stressful situations (Orkibi and Ronen 2015, 285). Good self-control enhances the care of women in labour, as well as the midwives' ability to adapt and adjust their interactions during intrapartum care to maintain good rapport with the women. Midwives' self-control and their ability to create rapport with women will enable them to unleash their professional wisdom, including the expertise to apply their wisdom to create a safe intrapartum care environment.

Midwives confronted with uncertainties during intrapartum care should be able to make quick, accurate decisions to respond effectively to unforeseen circumstances, which can be attributed to them being open-minded and flexible as part of the critical thinking disposition. Open-mindedness is about reflecting an open and impartial attitude when confronted with different behaviour or value systems, whereas flexibility involves the ability to interpret unique situations as a positive challenge and adapting to these situations accordingly (Van der Zee and Van Oudenhoven 2013, 929, 930). The suggestion is that midwives who are open-minded and flexible are able to postpone their judgement when confronted with different beliefs or value systems, think about possible

options, and choose the one that is safe and best to accommodate a woman's cultural beliefs. Walton (2011, 22) asserts that healthcare professionals must be open-minded and flexible when building relationships with patients and seeking to understand the individual patient's beliefs as well as being culturally congruent.

Within the context of the birthing unit, open-mindedness and flexibility call for midwives to integrate current intrapartum care practices and values with women's varied opinions and needs, and to solve problems in a flexible and creative way that demonstrates individualised care and concern for women during intrapartum care (Zori, Nosek, and Musil 2010, 307). Culture care accommodation occurs when nursing actions help people of a particular culture to negotiate with others in the healthcare community in an effort to attain the shared goal of an optimal health outcome for clients of a designated culture (Sitzman and Eichelberger 2011, 93–99). Midwives turn away from reasoned arguments, refuse to admit their mistakes, and resist change on the basis that their intrapartum care practices have served them well in the past and will continue to do so. Having a personal value of open-mindedness and flexibility will enable them to render woman-centred intrapartum care that is characterised by a culture-sensitive, supportive environment where women are encouraged and receive frequent feedback.

Limitations

The contextual nature of the study limits the generalisation of the study findings to other similar settings.

Recommendations

The recommendations emanating from the study with regard to research, midwifery practice and education are set out below.

Research

Further national or provincial research should be conducted on the topic using mixed methods on a larger scale. Additionally, a survey to evaluate how midwives actualise their personal values in practice and action research to facilitate the integration of personal values to enhance value-, human rights- and evidence-based intrapartum care should be conducted.

Midwifery Practice

There is a need for continuous education programmes for midwives based on emerging ethical challenges.

Personal values should form part of the recruitment and selection process, as well as key performance indicators used during performance reviews.

Midwives should demonstrate appropriate personal values and the ability to incorporate women's values to render culturally sensitive intrapartum care.

Women should be engaged in conversations regarding their preferences, concerns and needs to gain insight and explanations and to allow them to participate in shared decision-making during intrapartum care.

Midwives' demonstration of appropriate personal values and their sensitivity to women's values promote ethical best practice during intrapartum care.

Midwifery Education

Integration of indigenous knowledge in the curriculum is essential to prepare midwives who can practice in diverse situations (in the African and Western context).

Midwifery students' learning should be facilitated using methods and assessment tools that help to build on their personal values to enhance their development of professional values and ethical practice.

Conclusion

Midwives' personal values influence their approach to intrapartum care. Ethical best practice during intrapartum care will prevail if midwives, who have the appropriate skills and humanity, including personal values such as justice, integrity, respect and consistency, attend to women in labour. Such midwives will go beyond their intrapartum care-related technical interventions and be able to touch women's spirits to impart love and compassionate care, leading to positive childbirth outcomes. The findings of the study will enhance midwives' mindfulness of their values and the effect thereof on their behaviour to render ethical best intrapartum care in collaboration with other professions. The midwives' employers can integrate the values in the performance management and evaluation system. Midwifery educators should implement strategies for integrating and teaching values to ensure the strengthening of the legacy of caring behaviour embodied by the future midwifery workforce.

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