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Factors influencing intra-partum midwifery malpractices at tertiary hospitals in Tshwane, Gauteng Province, South Africa

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Abstract: *Midwifery malpractices occurring during intra-partum care are on the rise. Of all the cases reported to the South African Nursing Council (SANC) in 2013, 47% were midwifery-related and this percentage increased to more than 50% in 2014. The consequences of such misconduct are devastating to the affected women if they live, and to their families as well as the health system. Almost all investigated cases of misconduct would have been avoided if acceptable standards of care had been applied. Disciplinary measures imposed on midwives because of errors, include suspension from practice or being struck off the register or sent for retraining. The aim of this study was to explore and describe the factors influencing midwifery malpractice during intra-partum care at two tertiary hospitals. Thirteen participants were purposively selected and were interviewed up to data saturation point. Thematic data analysis was employed. Factors contributing to midwifery malpractice were categorised according to three themes: external factors, personal factors and administrative factors. Findings revealed a fair share of transgressions amongst midwives, but vicarious liability in respect of the hospital administration exists. Error identification through continuous auditing of maternal files and the implementation of corrective measures is urgently required. Patient interviews could also shed more light on this phenomenon.*

Keywords*: Intra-partum Care, Malpractice, Midwifery, Tertiary Hospitals*

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I. Introduction

Midwives are key pillars in maternal and new-born care because these professionals are the fundamental role players in the provision of care throughout ante-partum, intra-partum and post-partum periods. The frequency of intra-partum malpractice is higher for midwives than for any other nursing professionals. Over a period of two years in South Africa, in 2013 and in 2014, the cases of intra-partum malpractices ranged from 47% to more than 50%, respectively of all cases reported to the SANC [6].

Malpractice occurs when midwives practice in contravention of the midwifery standard of practice. To a considerable extent, such negative incidences are avoidable if compliance with typical guidelines, such as the persistent adequate use of the partograph for all women in the active phase of labour and plotted assessment findings, is correctly interpreted by all midwives. The consequences of malpractice are distressing to women, if they survive, and to their families because of lifetime morbidities and mortalities. In South Africa in 2014, an estimated 9% of maternal deaths resulted from midwives' inadequate adherence to standardised rules during intra-partum care whereas 25.7% of maternal deaths were the result of negligence by other professionals, such as nurses and doctors [19]. Malpractices contributed to South Africa's failure to meet the millennium developmental goals numbers four and five in 2015. Health facilities are expected to be safe places for care, but mismanagement in the hands of those perceived to be skilled care providers remain a challenge.

According to the Iranian Medical Council, up to 46% of errors in health malpractices that occur in Iran could be attributed to midwifery practice in both private and public sectors in that country [3]. The health worker-related factors affecting intra-partum care was reported to be avoidable and included poor intra-partum foetal monitoring, a prolonged second stage of labour without intervention and failure to refer a woman when the need arose [2]. The malpractices occurring in Iran are comparable to malpractices occurring in South Africa reported in the annual Saving mothers' report [19].

Malpractices in maternal care resulting from deviations from standard practice also occur in countries with advanced healthcare systems, such as the United States of America. In an incident reported against a midwife in Virginia, investigations revealed mismanagement, such as sole care offered to a woman whose pregnancy had gone beyond full term (44 weeks) who also exhibited prolonged ruptured membranes with meconium-stained liquor, foetal distress and a prolonged (12 hours) second stage of labour [20]. In South

Africa, any pregnant woman exhibiting elements of risk status, such as postdates, **is** sent to a higher level of care facility where specialists' services to address pregnancy-related complications and emergencies all the time are available. Midwives offering low-risk intra-partum care have guiding protocols regarding the relevant treatment for any labour-related problems that could arise during the intra-partum period. However, malpractices continue to happen under their care.

In instances where a woman, or her family, or the hospital present a complaint to the regulating authority, such as the SANC, and investigations reveal malpractice, punishments are imposed. These include, suspended sentences, removal from the roll or being sent for retraining or a punishment in a court of law in the form of a fine. Such punishments cause those newly qualified nurses who have midwifery as an added qualification to refuse to work in the labour ward. These refusals lead to an increase in the shortage of midwives and this perpetuates more malpractice. This study explored factors contributing to midwifery-related malpractices during intra-partum care at tertiary hospitals in Tshwane, Gauteng Province, South Africa.

II. Methods

2.1 Study design

This was a qualitative descriptive study conducted among 13 midwives providing intra-partum care in tertiary hospitals. Purposive sampling was employed to select knowledgeable [4] study participants who were available and willing to share their views regarding intra-partum care practices. In-depth individual interviews were conducted between November and December 2016 at the workplaces of all participants. Communication during interviews was by means of the English language and an audio recorder was used to capture inputs up to saturation point. Field notes were also jotted down.

2.2 Data analysis

Data from the voice tape recorder was transcribed verbatim. Field notes and transcripts were carefully checked and used during data analysis. Six stages of thematic analysis according to Braun and Clark [5] were employed to analyse data.

2.3 Ethical considerations

Permission to conduct the study was obtained from the university where the study was conducted (SMUREC/H/218/2016: PG). Further permission to conduct the study was also obtained from the Gauteng Department of Health, the research committees from the two tertiary hospitals, and the nursing managers also gave verbal permission. Consent was obtained from participants after they had been informed about the study purpose. Participation was voluntary and anonymity and confidentiality was ensured. Participants were informed that they were free to withdraw from participation at any stage without repercussions.

2.4 Trustworthiness

Trustworthiness refers to the degree of confidence qualitative researchers have in their data [14]. It was enforced by using the criteria of credibility, transferability, dependability, confirmability and authenticity [4]. Credibility was achieved through the prolonged communication of the researcher with the participants about the phenomenon [4]. Transferability was achieved by collecting detailed information from knowledgeable participants [4]. Dependability was ensured using verbatim information and field notes, and audio recordings were kept safe for an audit trail to determine acceptability and to attest the study findings [4]. Confirmability was achieved using an independent coder considered an expert in qualitative research [4]. Authenticity in this study was ensured by reporting with accuracy the lived experiences of study participants [18].

III. Results

Themes and sub-themes that emerged from the collected data from 13 participants are presented in table **one.** The intra-partum practices of midwives are compiled according to three (3) themes under which subthemes were identified.

Table 1: Factors for midwifery malpractice

Themes	Sub-themes
1. External factors	1.1 Shortage of midwives 1.2 Shortage of resources 1.3 Increased patient load 1.4 Delayed decision-making
2. Personal factors	2.1 Negative attitudes 2.2 Poor communication
3. Administrative factors	3.1 Intake of low-risk patients 3.2 Poor managerial support

Midwives revealed that their intra-partum care practices are affected by numerous factors as these influences the way in which midwifery care is provided.

3.1 Theme 1: External factors

3.1.1 Shortage of midwives

Participants emphasised a significant disparity in the ratio between patients and staff as there are always more patients with few midwives. Such disparities compromise the quality of intra-partum care provision, thus, perpetuating malpractice. To illustrate this disparity a participant said: *"The shortage of midwives affects the quality of care because, obviously some women give birth on their own without any assistance in the ward. We are blamed for not being there when the baby is born. But I cannot be everywhere. We are few".*

3.1.2 Shortage of resources

Participants indicated that the shortage of material resources negatively affects the quality of intra-partum care, thus predisposing midwifery care to malpractice. The shortage of resources was expressed as follows: *"With shortage of equipment such as CTG you must verify the foetal heart but sometimes you postpone till there is one available. This way your assessment work is incomplete then you have given the sub-standard care because foetal heart was not done on time because of shortage of CTG machine".*

3.1.3 Increased patient load

Participants acknowledged that their role is to provide intra-partum care to patients, but because of the high number of patients it becomes impossible to do everything on time according to prescribed standards. They further note that the prescribed standard of care in the intra-partum period is jeopardised by extra work because of the increased patient load. This was expressed as follows: *"The problem is the influx of patients. Sometimes there are too many patients at a time. You find that most midwives are busy with childbirth, on the other hand the doctor asks you to prepare an emergency caesarean section. That caesarean section can only be prepared when there are available midwives. You find that a midwife leaves the patient hastily to attend emergency but the patient that you have left becomes unhappy. Secondly that patient's records are not yet completed but you must attend to emergency. This is a problem if records are incomplete".*

3.1.4 Delayed decision-making

Participants stated that patient assessment and interventions are sometimes delayed by both midwives and doctors during intra-partum care. The increased work load affects planned assessment times, leading to the late identification of challenges with ultimate delayed intervention on the part of midwives. A participant said: "*Delay in assessing patients result from more workload. Admission time differs with the time the midwife first assesses the patient. The record will show that a patient arrived at a certain time but she was only seen late by a midwife. If the ward is busy, those in dire need are prioritised but the rest are attended when time allows. This is a problem because you only write the time of assessment when you check that patient even if it is after few hours of arrival in the ward. During auditing of files, the gap of time delay shows, but we do not have record in the patient's file to report that the ward was busy".*

Participants further explained that sometimes a doctor delays in deciding on an urgent problem with the patient. This leads to sub-standard care because the patient may end up with negative fetal and maternal outcomes. A participant said: *"Midwives cannot force doctors to take action except to write their own assessment findings. Time of identification of a problem and informing the doctor differs with time the action was taken. Remember you have informed the patient about the problem and she already knows that there is a problem. But the doctor takes his time to act. When the file is later checked, then the delay on the part of the doctor is a problem".*

3.2 Theme 2: personal factors

3.2.1 Negative attitudes

During interviews participants reported that the behaviour of some of the midwives towards patients is unfriendly. This upsets the relationship of trust between patients and midwives and it affects the women's response and receptivity to the intra-partum care provided. A participant said: *"If I am rude to a patient, or I am in hurry and do not offer proper explanations on assessment findings and give no feedback to these women, things like that are wrong. Sometimes women are afraid to ask or report problems because they fear us. They tell their families who then complain about us that we did not provide safe care to them".*

3.2.2 Poor communication

Study findings revealed insufficient communication between midwives and patients because of a language barrier. Some women from neighbouring African countries do not understand South African languages, including English. This results in a communication breakdown between the sender and the receiver (midwife and patient). Midwives often talk to patients who do not understand the messages. This is seen in the

failure of some foreign women to follow instructions. One participant said: *"We expect a woman to cooperate with us during labour particularly during childbirth. The language barrier poses a huge challenge. Some women from other parts of Africa do not understand instructions and are uncooperative. We end up not able to tell such women about valuable information and or instructions. They do as they see fit and end up with problems amounting to mismanagement on us as midwives"*.

3.3 Theme 3: Administrative factors

3.3.1 Intake of low-risk patients

The findings illustrate a situation in which every patient can walk into a tertiary hospital and be assisted in childbirth regardless of their risk status. This happens despite a policy requirement that low-risk pregnant women should be cared for in a level one health care facility in the country. This practice increases the volume of patients with limited staff resulting in midwives prioritising high-risk over low-risk patients. In the eyes of low-risk patients, midwives practice discrimination which amounts to negligence. On the other hand, such disparities amount to compromised care provided mostly to low-risk patients although the deserving high-risk patients are also affected. These views were expressed as follows: *"The problem is that low-risk patients walk in and are not turned away. They come to labour ward already in advanced stage of labour. You find that some are 6cm cervical dilation and you cannot down refer such a patient. We end up focusing more on normal childbirth among low-risk patients rather than providing quality care to our deserving high-risk patients".*

3.3.2 Poor managerial support

Findings have shown a general lack of support from the hospital executive in addressing challenges experienced in intra-partum care. According to the current study participants, the lack of support reduces the work efficiency of midwives and ultimately leads to inadequate productivity on their part. A participant said *"In my workplace, there is no support from the hospital management at all. We are just a working force. The workload is high but appreciations are lacking. You come to work you go home, there is no form of support. When you see some senior executive member in the ward, you know one of us is in trouble"*.

IV. Discussion

The objective of the study was to investigate the factors that influence midwifery practice resulting in intra-partum malpractice at tertiary hospitals in the Tshwane region in Gauteng Province, South Africa. Midwives provide comprehensive care as illustrated in the shared standards of practice, but several factors affect appropriate delivery of that care. This study provides insights into administrative failures in matching needs and resources. These factors exert a negative influence on midwifery practice and the women in labour in their care. Some midwives display poor caring behaviour that could be attributed to an unacceptable work environment that creates a situation in which malpractice in intra-partum care could occur.

4.1 Theme 1: External factors

4.1.1 Shortage of midwives

The shortage of midwives has serious implications for tertiary hospitals which should provide optimum care to high-risk intra-partum patients. The inadequate staffing in maternity units, particularly in the labour ward, often results in inferior care [17, 22] since some women in labour give birth unattended despite being in the health facility. This exposes the women in labour to mishandling by midwives which is punishable by the SANC if reported. Participants in this study asserted that the workforce shortage compromises the quality of care they provide. The unfavourable patient-staff ratios [8, 22] often lead to undesirable intra-partum outcomes, thus constituting malpractice. The maternal death reviews in South Africa have highlighted the health system's constraints as one of the factors that contribute to inappropriate care [19].

4.1.2 Shortage of material

Among the key findings is a lack of material resources to ensure optimum intervention in the running of intra-partum care. The report on confidential enquiries into maternal deaths in South Africa recommended to meet staff and equipment norms. However, the rigidity in the ideal implementation of the equipment norms policy remains a systemic problem that affects midwifery practice because interventions are often interrupted, delayed or postponed at the expense of women in labour, thus constituting malpractice. Similarly, a study conducted in Swaziland found that midwives often delay application of basic care during labour due to a shortage of resources [16]. In that study, a scarcity of equipment, such as a CTG, was common. Such equipment is important for the user to ascertain key features, such as foetal wellbeing, but its shortage increases inadequate foetal heart monitoring. The challenge of a lack of the required equipment results in substandard care because the inadequate monitoring of patients extends to include incomplete care which is viewed as negligence, particularly if labour outcomes are negative.

4.1.3 Increased patient load

Participants in this study reported an increase in the number of low-risk patients who walk into the facility with little or no intervention by the hospital authorities to curb the problem. By allowing low-risk patients to walk into the hospital and by not increasing the staff means that midwives are destined for failure. High patient volumes coupled with staff shortages, lead to patients having to wait longer for their turn to receive care from midwives. Those patients who wait for a long time to receive care become dissatisfied with that care even if it is good [23]. Furthermore, long waiting times without care put patients at the risk of being exposed to intra-partum complications [9] that often amount to malpractice. On the other hand, providing more midwives may be impossible given the human resource constraints in South Africa. However, it is clear from this study that action is necessary to address the admission of low-risk 'walk-in' patients into tertiary hospitals to reduce poor care that often results in malpractice.

4.1.4 Delayed decision-making

Participants indicated that doctors would at times delay assessing the patient, or in deciding on definitive care, and at times, would simply allow the patient to progress beyond the point at which action should have been taken. Inaction or misguided action on the part of doctors results in incidents in which midwives struggle to get prompt adequate responses. This finding concurs with findings in [10] where at times a doctor would waste time in coming to review the patient when called by the midwife. Such practices result in delays in diagnosing problems and consequently sub-minimum care is provided resulting in missed opportunities for optimal care [19]. The recipients of care are often victims of inappropriate decisions with ultimate complications. Midwives further report having clinical judgements that seem correct to the analysis but are often ignored by doctors [10]. Doctors who lack current information often display elements of resistance to innovations [25] during intra-partum care, thus negatively affecting the care given by midwives. Midwives, therefore, are exposed to the risks of malpractice in managing women in labour due to doctors' inaction.

4.2 Theme 2: Personal factors

4.2.1 Negative attitudes

Midwives are fundamental to the care of women in the process of childbirth [13]. Participants, however, reported that some of their colleagues bully patients in labour, particularly during the second stage of labour. Amongst some of the conditions for adequate care is the will to provide safe service, the right attitude among midwives and effective communication skills [13]. Despite the notion that all people have rights including the right to information [21], negative attitudes among midwives could instil fear in labouring women. Thus, these women fail to report problems, such as the spontaneous rupture of membranes with prolapsed cord. This is an obstetric emergency that requires urgent attention from healthcare providers, but if not reported swiftly, an opportunity for intervention will be missed with a foetal death or a fresh stillborn as a consequence which is categorised as malpractice on the part of the midwife. This implies that patients are unsafe under midwifery care in the hospital.

4.2.2 Poor communication

The study revealed that differences in language pose a challenge in ensuring quality care because messages between the parties may be misunderstood. This has a significant bearing on the interaction amongst midwives and their patients resulting in misunderstanding and an inability to follow instructions. It has been established that language difficulties hinder effective communication and understanding [14].

4.3 Theme 3: Administrative factors

4.3.1 Admission of low-risk patients in the high-risk ward

Participants reported that low-risk patients walk into tertiary hospitals but are not controlled. An aim of tertiary hospitals in South Africa is to deliver care to high-risk patients and emergency cases with intra-partum complications referred from lower level facilities. The patients who walk in unannounced are often low-risk cases, and this causes overcrowding in tertiary hospitals, thus, compromising the care provided in these facilities. This situation leaves room for malpractice. Pregnant women often avoid using the lower risk health facilities because of their mistrust in the ability of the facilities to manage complications there [11]. The uncalled-for admissions [26] of low-risk patients increases the burden of overcrowding at tertiary hospitals creating a situation in which substandard care to the deserving high-risk as well as low-risk patients occurs.

Other studies show that the distance to a health facility is not a barrier affecting the patient's choice of a place for childbirth [24]. Participants in this study reported that the proximity of the hospital to patients' homes motivated them to attempt to gain easy access despite their low-risk status. To reduce negligence by ensuring better functioning tertiary hospitals, the system must put in place strict measures to stop low-risk 'walk-in' patients into the labour wards of those hospitals.

4.3.2 Poor managerial support

A significant percentage of participants in this study reported poor support from the hospital management. This behaviour often frustrates midwives as they feel that they are just an unappreciated workforce. Employees who are unhappy are likely to be more dissatisfied with their jobs and are unintentionally tempted to engage in malpractice. Supportive managers increase employees' 'satisfaction, and ultimately health system efficiency' [26]. Poor managerial support has a negative influence on midwives who are often unhappy leading to an inability to concentrate, and ultimately, to poor work performance and malpractices.

V. Conclusion

Despite the punishments imposed on midwives by the SANC in cases of negligence, malpractices during the intra-partum period in South African hospitals are on the rise. This study revealed the problematic conditions under which midwives are functioning and the resistance of hospital authorities to address negative factors to improve efficiency. Although midwives often provide optimal care, the violation of norms and standards in intra-partum care as a result of administrative problems as well as personal problems affects their practice resulting in malpractice. This manuscript established that most midwives are concerned about the insufficient number of practitioners attending to women during labour, the general shortage of equipment, the delays in patient assessment and the negative attitudes of midwives during intra-partum care.

These multifaceted factors affect midwifery intra-partum care and require collective involvement from the hospital management, midwives as well as the community to address shortcomings such walk ins by low-risk pregnant women. This is despite the need for active midwifery support and implementations of policies that address the day-to-day challenges faced by midwives in the work place.

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