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Challenges to midwives' scope of practice in providing women's birthing care in an Australian hospital setting: A grounded theory study

G.B. Kruger*, T.V. McCann

Department of Nursing and Midwifery, Institute of Health and Sport, Victoria University, Australia

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ABSTRACT

Objective: To identify and explore processes midwives use to exercise their scope of practice whilst caring for women during normal birth.

Methods: Strauss and Corbin's (1998) grounded theory approach was used. Data were collected from 17 midwife participants using participant observation of women's labour and birth care followed by semi-structured interviews.

Results: The core category of *promoting normal birthing*: *aspiring to develop a midwife-led scope of practice* conceptualises midwives working to develop their scope of practice to promote and facilitate normal birthing for women. Two interrelated categories, *promoting and maintaining healthy birthing* and *optimising scope of practice* further explicate how midwives provide woman-centred care within their scope of practice.

Conclusions: The theoretical framework generates conceptual knowledge of how midwives aspire to promote healthy, safe and responsive birthing care for women in their scope of practice in a hospital setting. Findings provide greater insights into the competing perspectives of birthing care challenging midwives' capacity to provide woman-centred care, influencing the degree to which midwives are able to exercise their scope of practice in promoting normal birth.

Introduction

Scope of practice underpins what midwives do in providing care to women across pregnancy, labour and birth, and the post-birth periods. The International Confederation of Midwives [ICM] defines scope of practice [1] as providing aspirational standards for midwives' roles in working with women. This informs and influences expectations for practice, with an emphasis on enabling midwives to be the primary caregiver for women during childbearing, promoting normal birth. In Australia, this approach underpins statutes of practice and guides interpretations of midwives' scope of practice in the context of maternity care [2].

Midwives' scope of practice is influenced by several factors including assessing women's and baby's health needs; women's childbearing expectations; and competency levels and practice experience. Their capacity to provide quality maternal and newborn care that meets individual women's and babies' needs [3] is also influenced by the structures and organisation of care. Specifically, this refers to models of maternity care and the medical and midwifery approaches to childbirth: the traditional medical obstetric-led approach, and the emerging midwifery paradigm. The traditional medical approach comprises obstetricians assuming responsibility for women in normal birth and when intervention is required. The model is predicated on the use of a risk-based approach with medical dominance influencing surveillance of women's care and birthing [4]. In contrast, the midwifery approach conceptualises a wellness-based approach which encourages respect for, and facilitation of, healthy individualised childbearing experiences for women and their babies through midwifery care [5]. Both approaches influence the organisational culture, and quality and risk management framework of maternity care, which in turn, impact directly on how midwives are able to make clinical decisions [6]. The intersection of these approaches in practice can create tension and conflict in professional relationships due to unclear practice boundaries [7]. Such understandings influence the boundaries in which midwives are able to utilise their scope of practice with healthy women regarding the organisational hierarchy, and opportunities to fulfil their practice role [3,8].

Midwives practising in a midwife-led approach aim to promote normal birthing through the provision of woman-centred care [9], a central tenet of the approach which prioritises women's holistic and individual needs for their childbearing experiences. For midwives practising within the confines of the dominant obstetric-led model,

* Corresponding author at: St. Alban's Campus, Victoria University, PO Box 14228, Melbourne 8001, Australia.
E-mail address: gina.kruger@vu.edu.au (G.B. Kruger).

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there can be limited opportunities presented for the provision of woman-centred care, impacting on their capacity to promote normal birth.

Women's expectations for childbirth also influence how midwives work to fulfil their scope of practice within the culture of hospital care. Such expectations include choices around receiving individualised care from a midwife and participating in decision-making [10]. Meeting such expectations is an integral part of providing woman-centred care for well women [11], though this can be challenging in hospital settings.

Other important elements of scope of practice relate to levels of knowledge, safety and competence in midwives' practice, and the context in which they practice [12,13]. The World Health Organisation [14] names the midwife as the health professional best educated to provide appropriate and safe care to women and their babies during normal labour and birth. This has implications for role identity and developing practice boundaries for providing midwife-led care to women and babies.

Together, the aforementioned factors contribute to the politics and pragmatics of practice influencing women's individual experiences, and midwives' roles in fulfilling their scope of practice in labour and birth care. Therefore, the aims of this study were to explicate the processes midwives used when exercising their scope of practice during women's normal labour and birth and to develop a substantive theory of midwives' scope of practice.

Methods

Study design and setting

Strauss and Corbin's approach to grounded theory [15] was used to generate knowledge of the processes midwives used in their practice with birthing women in their social world of a hospital birthing suite. The study was conducted in a public hospital in Melbourne, Australia. Within the birthing unit, midwives mainly practised within the predominant model of traditional obstetric-led care whilst providing birthing care to women.

Participant recruitment

Midwife participants were recruited initially using purposive sampling. Inclusion criteria were registered midwives practising in the birthing unit either on a full- or part-time basis. As data collection progressed, theoretical sampling was used to achieve data saturation. The sample comprised 17 midwives. The researcher met potential participants and spent time getting to know them in the maternity unit.

Ethical considerations

Ethical approval was gained from university and the hospital's Human Research Ethics Committees prior to the study being undertaken. Although women were not study participants, formal written permission was obtained for the researcher to be present during care provided by midwife participants.

Data collection

Data collection comprised semi-structured interviews, participant observation, and, accessing women's clinical records. Consistent with the grounded theory approach, data collection and analysis occurred simultaneously. In-depth, semi-structured, audio-recorded interviews were conducted with each of the midwives, with more than 1 interview conducted with key participants on 6 occasions. An aide-memoir was used to guide interview questions (Table 1). As interviews progressed, questions were more focused on exploring specific concepts of the data which emerged in developing the theoretical model.

Table 1
Aide memoire questions.

Routine of care
Midwives have spoken about providing routine care in labour • What do you think routine labour care to be? • Can you tell me about some of the cues you observe in a woman's labour?
Risks in care Midwives have talked about weighing up risks in care • What do you think risk is in a woman's labour? • How does this influence what you do? • What would you consider to be intervention in labour?

Participant observation was conducted where the researcher observed midwives providing labour and birth care to the women. Ten episodes of observation were undertaken over 60 h with an additional 110 h of observation completed in the maternity unit. Clinical records were accessed and the partograph used to capture specific information about observed episodes of care.

Data analysis

Data analysis focused on open, axial and selective coding and use of the constant comparative method as outlined by Strauss and Corbin [15]. Data analysis comprised asking the question of 'What is going on here?' in working to understand what midwives were doing in their care of women while using the constant comparative method to identify individual variations. Analysis generated thematic labels conceptualised into emergent categories which were then linked to an overarching core category to form a theoretical framework.

Study rigour was achieved through the use of Guba and Lincoln's [16] four elements of trustworthiness: credibility, transferability, dependability and confirmability. Measures used to achieve these elements comprised, for example, adhering to the grounded theory approach to achieve integrity through data triangulation and member checking data with key participants.

Results

Findings comprised a core problem, core category, and two interrelated categories (Table 2 – Overview of theoretical framework).

Core problem

The core problem was *Ambiguity in fulfilling their scope of practice*. The problem reflected midwives' uncertainty about the extent to which they were authorised to exercise their scope of practice during women's labour and birth. Such uncertainty arose from competing role expectations in the provision of women's care and resulted in inconsistencies with defining practice boundaries and associated decision-making.

> There are practice boundaries where a woman may become changed from being low risk … it's difficult to think about making decisions about midwifery or medical approaches to care as we don't have midwife-led practice … it's on our shoulders as midwives as in the background is the doctor wanting such and such. (Interviewee No. 15)

Core category

The core category, *Promoting normal birthing: aspiring to develop a midwife-led scope of practice*, conceptualised how midwives dealt with ambiguity in their practice. Within the core category, 3 transitions explicated how midwives responded to the core problem. The first transition, *attempting to shift the focus from obstetrician to woman-focused*