“The Meat in the Sandwich”: Midwives’ Experiences Supporting Women’s Safety and Autonomy.

Shannon Morris
Clinical Midwifery Consultant
Governance and Risk
Northern NSW LHD
shannon.morris@health.nsw.gov.au

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Abstract

Aim

A foundational aspect of midwifery is partnering with birthing women to provide safe and compassionate care that enables informed decision-making. The aim of this study was to explore how midwives communicate concern to support women's autonomy and safety during labour and birth.

Methods

A mixed-method study design consisting of quantitative and qualitative studies was used. This consisted of a self-administered questionnaire, followed by focus-group discussions with registered midwives.

Findings

Data from the questionnaire was used to determine how often midwives encountered safety concerns and ethical issues in their practice and explore whether and how they were voiced. Of 240 potential study participants 65 (27%) completed the questionnaire. A failure to provide informed consent was the most frequently witnessed breach in professional and ethical standards. Seventy percent of midwives surveyed who witnessed concerns for safe care did speak to someone. However, only 12% spoke explicitly to the person they deemed most responsible for the breach and fully expressed their concerns.

Three intertwining themes of woman-centred care; inter-professional relationships and advocacy emerged from the qualitative data which encompass the core phenomenon of 'the meat in the sandwich'. This core incorporates the complexities faced by midwives when navigating conversations and concerns about women's safety and autonomy.

Conclusion

A fundamental principle of health-service governance is to foster a culture in which staff feel safe to raise concerns. However, the failure to communicate concerns is a well-recognised safety problem in maternity care. Knowing the right thing to do is necessary, but not sufficient, for actually doing it. This report provides insights into interconnecting factors that influence midwives' preparedness to communicate ethical and practice concerns and explores enablers to improving communication and shared decision making.

Keywords:

Safety; consent; advocacy; midwifery; birth.

Executive Summary

The study aim was to explore how midwives communicate concern which supports women's safety and autonomous decision-making during labour and birth. Results indicated midwives often encountered safety concerns and professional breaches, and provide insight into whether and how concerns were voiced.

These findings will benefit clinicians, managers and executives with an interest in strengthening person-centred care, safety culture and organisational leadership. They will be better informed about personal and systemic obstacles and enablers that may influence processes to establishing improved clinical, psychological and emotional outcomes in both the short and long term.

Summary of Findings

The research was conducted across five regional maternity-service facilities in Northern NSW. A mixed-method study design consisting of quantitative and qualitative studies was used. This consisted of a self-administered questionnaire, followed by focus-group discussions with registered midwives. Of the 240 potential study participants 65 (27%) completed the questionnaire. Thirteen registered midwives participated in focus groups.

Data from the questionnaire was used to determine how often midwives encountered safety concerns and ethical issues in their practice. A failure to provide informed consent was the most frequently witnessed breach in professional and ethical standards. Ninety-six percent of respondents indicated that they had witnessed maternity care providers engaging in procedures without giving the woman sufficient time or the option to consider the procedures. However, only 12% of midwives spoke explicitly to the person they deemed most responsible for the breach, to fully expressed their concerns. Thus the majority of breaches were left unaddressed.

The practice of supporting women's autonomy of decision-making and gaining consent during labour and birth is complex. Health policies and guidelines that restrict or limit choice, and system fragmentation with a dominant medical model of care, are barriers to woman-centred midwifery care. Simultaneously, midwives can face professional risk when they advocate for women. Midwives identified barriers when addressing the rights, choices, or welfare of women in their care and articulated that they practise under the knowledge that there is always the possibility that attempts to support a woman's autonomous decisions may fail.

Three intertwining themes of woman-centred care, inter-professional relationships and advocacy emerged from the qualitative data which encompass the core phenomenon of "the meat in the sandwich". This core phenomenon incorporates the complexities faced by midwives when navigating conversations, and concerns about women's safety and autonomy in the provision of their consent or rejection of an intervention.

Midwives described a feeling of being in the middle; constrained because of opposing needs to maintain a status quo between their workplace policies, cultural norms, professional relationships and the need to advocate for women they are caring for. These fundamental,

circumstantial and restrictive factors intertwine to form the key barriers described by midwives when navigating conversations, and concerns about safety, consent, interventions and poor clinical practice during labour and birth.

Key conclusions and recommendations

The study results confirm existing international research which identifies that the majority of encountered safety concerns in maternity care are left unaddressed[5]. This study adds to the narrative and provides a regional maternity service context to failures of the consent process and the complexities midwives can face in meeting the professional standard to uphold a woman's right to self-determination[6]. Results identified pressures on midwives' autonomy and the consequential impact on women's safety and autonomy. Further research exploring maternity workplace culture – effects on professional practice; perceptions of leadership; morale; workplace behaviour and management responses to concerns, is required. This may be best achieved utilising a quantitative tool designed to address unique aspects of maternity care that are not addressed in general measures of workforce culture[33].

Implications for policy and practice include the need for specific guidance for clinicians providing care in situations of maternal refusal; support for formal feedback and reflective practice among clinicians; tools to encourage shared decision-making with women and; graded assertiveness training.

Recommendations

- NNSW Local Health District Maternity Services Committee lead a consumer co-creation project for a feedback tool designed to understand what matters most to women. These patient reported measures should examine the extent to which women experience shared decision-making during their pregnancy, labour, birth and postnatal periods. Results should be utilised to inform practice and drive quality improvement initiatives.
- The Executive of NNSWLHD consider the approval of funding to extend the NNSWLHD Maternity Services licence to continue embedding graded assertiveness training through the Cognitive Institute seminar: 'Speaking up for Patient Safety'. The training program must be multidisciplinary and championed at executive/senior management level to achieve support as a cultural change agent, crucial to improving safety and women's experiences.
- NNSWLHD Maternity Services Committee provide governance in the development of a District clinical guideline for: Shared Decision-Making in Maternity – Partnering with women, to provide specific guidance for clinicians providing care in situations of maternal refusal[34].
- The Executive of NNSWLHD support the redesign of maternity models of care to allow increased capacity for continuity of care relationship-based models such as Midwifery Antenatal Postnatal Service (MAPS). A shift to midwife-led care for low-risk pregnancies could be cost saving. The model also affords clinicians and women the opportunity to develop trusting relationships and for clinician's to understand

the woman's whole context, including meaningful communication about risk, the woman's goals and all alternative options for care.

Background

"The woman is the primary decision-maker in her care and she has the right to information that enhances her decision-making abilities."[7]

In any health interaction, a woman has the autonomy, or right, to determine what treatment she accepts or chooses not to accept[2]. The Northern NSW Local Health District (NNSWLHD) Clinical Governance Framework includes structures and systems designed to ensure person-centred health care. This framework specifies treating a person receiving health care with dignity and respect; involving them in all decisions about their health; and supporting clinicians to improve the safety and quality of their care[3].

An overarching principle of NSW Health service policy is to foster a culture of safety and learning where all staff feel safe to raise a concern. However, the failure to escalate and communicate concern is a well-recognised safety problem in maternity care. Safe care is not just the care provided to women, it's also about how clinicians act and what they say when with them. Safety in this context includes better clinical outcomes, psychological outcomes and emotional outcomes in both the short and long term – for both mothers and babies[1].

Annual, aggregated clinical incident management reports[4] consistently identify care planning, workforce and communication as the most frequent system factors affecting maternity care provision. Care planning encompasses issues where there may have been gaps or failures in collaborative planning to meet clinical-care needs, as well as suboptimal continuity and coordination of care. Communication incorporates communication between clinicians, as well as with women and their families and includes informed consent[4]. In response to the prevalence of these system factors, NNSWLHD Maternity services invested in graded assertiveness training for all maternity clinicians across its five services. Between mid-2016 and mid-2019, 85 percent of multidisciplinary maternity clinicians attended targeted patient safety focused, team communication training.

The failure to escalate and/or communicate concern is a well-recognised safety problem in maternity care[12,13]. Results of collaborative research studies indicate that even though many clinicians hypothetically agree that they would take action if they witnessed unethical practice[14], when faced with a real-life problem, evidence indicates that many make the decision not to say anything [5,15,16,17].

A 2013 study by Maxfield[5] surveyed 3282 clinicians from labour and birth teams and documented how commonly respondents witnessed shortcuts, poor competency, performance issues and/or disrespectful care in the preceding year. While the vast majority (90%) indicated they had concerns about safety and performance, few respondents reported fully discussing their concerns with the person involved, thus the majority of concerns were left unaddressed. Lyndon[16] explored maternity clinicians' perspectives on whether they experienced difficultly resolving patient-related concerns or observed problems with performance or behaviour of colleagues during labour and birth. Just under half (47%) of those surveyed reported experiencing situations where patients were put at risk due to failure of a team member to listen or respond to a concern; 37% reported unresolved concern. Results from a Cross-National Maternity Support Survey in the United States and Canada[17] indicated that it was relatively common for maternity- care providers to

engage in procedures without giving a woman a choice or time to consider it (61.9% witnessing it occasionally or often).

Midwives have a key role to play in maintaining practice standards and are guided about these responsibilities by professional bodies. The Nursing and Midwifery Board of Australia (NMBA) provides core national codes and standards which include a professional obligation to report unacceptable care. Midwives, who register to practice each year, agree to meet these professional standards regardless of the care model and/or setting in which they work[6,11].

Consent is a key professional standard in maternity care but is poorly understood. A 2013 study by Kruske[8] found that maternity-care professionals held conflicting beliefs about women's choices in childbirth. On the one hand they stated that "women were the ultimate decision makers", but also simultaneously agreed that "the needs of the woman may be overridden for the safety of the foetus". This contradiction was further complicated in the minds of clinicians by the belief that they themselves were ultimately legally accountable for outcomes. This belief is despite the clear legal position that health-care professionals are only liable for adverse outcomes caused by their own negligence.[8,9]

The word consent comes from the Latin "to agree". A woman has a right to receive full, accurate and unbiased information about her options and the likely outcomes of her decisions[10]. The term "informed consent" is commonly used in health-care settings to describe a clinician's obligations to inform patients about the risks and benefits of proposed treatment options. However, the adequacy of information given to a woman is related to negligence and the clinician's duty to warn her of the material risks involved in the proposed treatment. Whereas consent is the mechanism which transforms what would otherwise be criminal assault into permission to treat[9]. To be valid, consent must be freely given. Given the obligation to obtain consent, women can also withhold consent, declining recommended treatment. Consent, then, is an agreement between parties that requires sufficient time and information for a woman to autonomously decide on what is in her own best interests and give her permission, or decline.

The current literature highlights the frequency in which maternity workers encounter ethical issues in their practice. However, there is little research exploring the interplay between the attitudes, experiences and practice of midwives and how they respond in these situations. There are a number of studies focusing on undergraduate students' encounters with poor clinical practice and the factors which facilitate or inhibit their willingness to report[18,19]. Again, poor clinical practices were frequently witnessed, yet the majority of students did not intervene or speak up, despite feeling a moral obligation to do so. This literature identified that students experience ongoing distress when they do not have the courage to confront clinicians' poor practice.

Maxfield[5] surmised that to make a difference in the quality of patient care and staff morale, maternity professionals need to acquire the skills to voice their concerns directly in a timely and respectful fashion and to be supported by their health-care organisations when they do. They pointed to organisational commitment and executive leadership as essential to creating an environment that proactively supports safety and quality.

To meet NSW Health core objectives and professional obligations, there is a need to better understand the barriers and enablers experienced by maternity clinicians when they encounter safety and poor professional practice issues.

Study Aim

The study aim was to explore how midwives communicate concern to support women's safety and autonomous decision-making during labour and birth, in regional hospitals in Northern NSW.

Primary Outcome

Improved understanding of barriers and enablers for midwives in communicating concern about safety and consent which supports autonomy and woman-centred care.

Secondary Outcome

Explore midwives' views of their professional role and responsibilities and underlying values, attitudes and behaviours that impact on safety during labour and birth.

Methods

Location

The research was conducted across five regional maternity-service facilities in Northern NSW. Northern NSW Local Health District is geographically large with centralised regional areas and vast surrounding rural area, extending from Tweed Heads in the north to Tabulum and Urbenville in the west and Nymboidia and Grafton in the south.

Study Design

The approach adopted for this research study was phenomenology, underpinned by feminist methodology; seeking to describe experiences as they are lived. This was achieved using a mixed-method design, consisting of sequential, quantitative and qualitative studies. The study design was formulated from the Safety Culture Assessment in Health Care review[20], which recommended a mixed-method approach combining a quantitative measure of safety culture with a qualitative component, such as a focus group to provide greater detail on key areas of the survey findings. Thematic analysis of the qualitative data was informed with a feminist lens; insights were gained through viewing participants' broader comments of power and authority from within the maternity system.

Phase One

– Data collection

All registered midwives working in NNSW were invited to participate in phase one. The study was advertised by email, posted on news boards in strategic areas and presented at staff meeting and in-services. Being a midwife employed by Northern NSW Health was the only criterion for inclusion in phase one of the study.

An anonymous self-administered questionnaire (Appendix 1), adapted from two previous studies: Roth[17] and Maxfield[5], was utilised. Midwives had the option to complete the questionnaire either as a hard copy or electronically. Informed consent was implied if

participants read the information statement and chose to return a completed questionnaire.
Topics covered in the survey included: demographic characteristics; safety and performance in clinical practice (shortcuts, missing competencies and performance problems); and informed consent and experience of ethical challenges. Shortcuts were defined by practices that could be harmful to a woman (not washing hands, not following an agreed protocol); missing competency was defined as a clinician not being as skilled as they should be (not up to date on procedure, policy or protocol or practice was lacking skill); and performance problems were defined as problems which undermined teamwork, safety, a woman's experience or quality of care. Respondents were asked to rate how common each problem was within their teams and who they spoke with about the problem. Some questions enabled the participants to give multiple responses.

The primary researcher entered the data from completed hard copy questionnaires into the electronic survey tool, which also held the participant completed electronic versions. The collated data was then extracted as an Excel spreadsheet for analysis. The results of the questionnaire were analysed before phase two focus groups were held.

Phase Two

– Recruitment and consent

Participants were selected using purposive sampling. Registered midwives who were regularly rostered and worked clinically within a birthing environment were eligible for inclusion. Midwives were excluded from focus-group participation if they were employed in a management or supervisor role, e.g., executive; clinical-midwifery consultant; midwifery-unit manager, clinical-midwifery educators or clinical-midwifery specialists. This purposive sampling aimed to avoid potential hierarchal barriers to midwives fully participating in group discussion.

Focus groups continued to be recruited to and conducted until data saturation was achieved. Transcripts were checked between each focus group by the researcher and facilitator to reach consensus on achievement of data saturation.

– Data collection

Phase two comprised focus-group discussions. These discussions elaborated on the quantitative data by exploring midwives' views of their professional role, and responsibilities and their behaviours. The focus groups were conducted by a midwife experienced in facilitation and a woman's story was used to elicit a narrative of the issues central to the topic. Data was recorded, transcribed, coded and analysed using an inductive process.

Analysis

Phase 1 quantitative data analysis was undertaken using Microsoft Excel and presented as simple descriptive summaries of the results using percentages from the number of respondents.

For the phase 2 qualitative data, audio recordings were listened to in full soon after each focus group by the primary researcher, notes were made about ideas for analysis. Each recording was then professionally transcribed verbatim and deidentified. Data accuracy was supported by listening again to the recordings after transcription to check for errors. Each transcript was read several times in its entirety to get a sense of the data as a whole. Re-readings then followed to identify data chunks related to the research aim. Each relevant statement (data chunk) was copied into a Microsoft Excel spreadsheet with a corresponding focus group reference. Data chunks were coded, with adaptations made to the coding to accommodate new ideas. This process allowed for the identification, segregation and consolidation of concepts that described what was emerging from the data. The data was reviewed within each theme and the rigor of interpretations was upheld by the process of inter-subjective checking by three research team members (SM, CH and KD). Finally, the essential structure of the phenomenon was formulated and written into the reported findings used to inform practice recommendations.

Ethical Considerations

This research was approved by North Coast NSW Human Research Ethics Committee, Approval No. LNR207 - LNR/18/NCC/105 in November, 2018.

To mitigate distress encountered during the research process, safety cards with contact details for the free, confidential NSW Health Employee Assistance Program (EAP) and Nurse Midwife Support Service counselling services were provided to all participants, the researcher, facilitator and the supervisor (Appendix 2).

Reflexivity

> *"Midwifery is a feminist profession – it has to be if we are to keep women protected and in control of their experiences at such a vulnerable time in their life"* [22].

In feminist research, objectivity does not come from the absence of bias, but from reflexivity[9]. By examining my own situational relationship through reflexivity and clinical supervision, I was able to identify how my personal values and assumptions had the potential to influence every stage of the research process[23]. I designed and conducted my research with an awareness of my values and my leadership position within the organisation where the research was undertaken. I was guided in this process by exploring my responses to the following questions suggested by Etherington[24]:

- How has my personal history led to an interest in this topic?
- What are my presuppositions about knowledge in this field?
- How am I positioned in relation to this knowledge?
- How does my subject-position influence my positioning in relation to this topic/ the participants?

Throughout the study, I was mindful of how my own experiences led me to choose safety and autonomy as the focus for this research. Seeking to understand why some midwives are able to actively advocate for women through informed decision-making, while others appear to acquiesce to the cultural norms of their workplace. My viewpoints have been formed from experience, through reflection, questioning, and from my deep belief in social

justice, in equity and in fairness. Decades of working with women inside and outside hospital systems, and with midwives and doctors working within them, has permitted me to bear witness to both excellent communication and to conformity and silence.

I spent more than ten years self-employed as a privately practising midwife, attending women birthing at home and on occasion, accompanying them into hospital. Overlapping, and on either side of those years, I worked in midwifery group practices, in small country hospitals, big cities and in tertiary centres where 10,000 women a year birthed their babies. I chose to birth my own daughters at home, with the care of privately practising midwives, because within that partnership I was afforded the greatest degree of autonomy. My experience, from working within hospital settings, had made me more afraid of what might happen to me because I was in hospital, than what might happen to me outside it.

Through the research process I strived to maintain reflexivity through clinical supervision, diary notes and discussions with my mentor and clinical expert. Additionally, I presented early findings to midwifery peers to explore their responses to the emerging themes. My own birth choices and ways of working attest to the value I place on autonomy. My midwifery work has exposed me to some of the barriers to practising woman-centred care and the constraints on women's birth choices. Therefore, I came to this study with a presupposition that strategies to better support midwives' confidence and skill to facilitate informed decision making are key building blocks for the safety and autonomy of women.

Results

– phase one

Sixty-five midwives completed the questionnaire, which represented 27%. Demographically, midwives who participated were employed in a variety of clinical environments within the three health service networks. Maternity models of care included: pregnancy and intrapartum care under the supervision of medical staff; midwifery antenatal clinics with birth attended by birth suite midwives who have no prior relationship with the woman; and midwifery group practices – ongoing care with small teams of midwives throughout a woman's pregnancy, labour and birth and postnatal care. The Tweed Byron Health Network contains three maternity services across three public hospitals, 48% of the cohort was drawn from this network; Richmond Health Network contains one public hospital maternity service, and represented 40% of the cohort; the remaining 12% was drawn from the Clarence Health Network which has one public hospital maternity service.

Thirty-eight percent of midwives were employed full time, 21% part-time and 10% in either casual or contract positions. Seventy-four percent of respondents described themselves as clinical midwives not in leadership positions. Years of clinical practice was distributed across the respondent group: 28% had less than five years' practice as a midwife; 30% 6-10 years, 20% 11-15 years, 12% 16-20 years and 10% had more than 20 years' clinical practice.

Data extracted from the questionnaire was used to determine how often midwives encountered clinical safety concerns and ethical practice issues, and whether these concerns were voiced. Midwives were asked specifically: if care providers in their hospital explained the risks and benefits of every procedure; and if informed consent requires an on-going decision-making process. Table 1 below, demonstrates responses. Overall, 50% of

midwives agreed that care providers in their hospital explain the risks and benefits of every procedure, while 37.5% disagreed or strongly disagreed with this statement. When defining what constitutes informed consent, the vast majority (97.8%) of midwives agreed that informed consent requires an ongoing decision-making process.

Table 1. Midwives' views of informed consent (%) N.65

Care providers in my hospital explain the risks and benefits of every procedure	
Strongly agree	6.25
Agree	43.75
Neither agree/disagree	12.5
Disagree	29.2
Strongly disagree	8.3
Informed consent requires an on-going decision-making process	
Strongly agree	67.4
Agree	30.4
Neither agree/disagree	-
Disagree	-
Strongly disagree	2.2

Survey participants were asked if they had ever, at any time in their career, witnessed breaches in professional and ethical standards. A failure to provide informed consent was the most frequently witnessed breach. These results are shown in Table 2.

Table 2.
Frequency (%) that midwives reported witnessing experiences with ethical challenges N.65

Have you ever witnessed a care provider engage in a procedure(s) without giving the woman a choice or time to consider the procedure	
Yes	95.7
No	4.3
Have you ever witnessed a care provider engage in procedures explicitly against the consent of the woman	
Yes	56
No	44
Have you ever witnessed a care provider tell a woman that her baby might die if she doesn't agree to a proposed procedure	
Yes	85.7
No	14.3

Midwives who responded to the survey were asked to identify the top three reasons they did not speak up when they had witnessed ethical breaches or had concerns about poor performance. The core reasons midwives identified were:

1. That the person would be harder to work with if confronted (72.5%)
2. They thought the person would retaliate if they confronted them (47.6%)
3. There was not time or opportunity to confront them (36.8%)

Table 3. Depicts how common observations of concern were and who midwives spoke to when raising their concern. The majority of midwives surveyed who witnessed concerns for safe care did speak to someone. However, only 12 percent spoke explicitly to the person

they deemed most responsible for the breach in professional and/or ethical standards and fully expressed their concerns. Around two thirds of midwives shared their concerns with their co-workers. On average, 14 percent of midwives did not raise their concern with anyone.

Table 3. Midwives reporting of concern in past year, by type of concern (%) N.65

Type of Concern	Reported observing in the past year	Spoke with no one	Spoke with person involved	Spoke with co-workers	Spoke with manager
Shortcuts	78	14.5	20	68.75	41.6
Missing Competency	78	12.5	14	58	54
Poor Performance	86	16	12	60	46

Findings

– phase two

Thirteen midwives were recruited as participants in three focus groups for phase two. Participants of the groups described everyday practice situations, relating to consent and professional practice issues, and discussed how they approached or navigated the circumstances, as well as the impact it had on them.

Midwives described the practise of supporting women's autonomy of decision-making and gaining her informed consent, especially during labour and birth, as complex. Three main, intertwining themes that emerged from the qualitative data were:

- Woman-centred care
- Inter-professional relationships and,
- Advocacy.

Midwives described a feeling of being sandwiched between the need to advocate for the women they were caring for and the opposing needs to maintain a status quo between their workplace policies, cultural norms and professional relationships. These fundamental, circumstantial and restrictive factors intertwined to form the key barriers and enablers described by midwives when navigating conversations about consent and safe, respectful clinical care.

These three contributing components encompass the core phenomenon described by one participant as "the meat in the sandwich." This phenomenon incorporates many of the difficulties described by midwives when navigating conversations, and concerns about women's safety, autonomy and the provision or refusal of their consent.

> *"The fear comes from above you, … the organisation and colleagues, but also the woman – you're the meat in the sandwich."*

Woman-Centred Care – "A woman chooses"

Woman-centred care is an essential concept in midwifery that is fundamental to practice. Midwifery care must be focused on the woman's individual and unique needs, expectations and aspirations, rather than the needs of the institution, cultural norms, colleagues or personal ideals[11,25].

> *"The woman is the primary decision-maker in her care and she has the right to information that enhances her decision-making abilities."*[7]

Midwives in this study described how establishing an effective emotional, trusting partnership involved being able to treat each woman individually, and that the more preparation that could be done with them during their pregnancy, the better. Providing this kind of care, however, commands a different model of maternity care to that which is currently available to most women (and midwives). Most midwives who participated in this research were working in medically managed team environments. Midwives can and do partner with women during the hours of their labour and birth. However, most do not have the opportunity to develop trusting relationships with women through their pregnancy.

The provision of information and preparation for women about what to expect during labour and birth was described as a key enabler to informed decision-making during labour and birth. But where maternity systems of care are based around short, task-oriented appointments, a reactive, hurried approach was described as compelling midwives to control the agenda and limit discussion time to ensure that appointments did not overrun.

> *"Our system is so fragmented… there's just no continuity, no opportunity for women to even feel like they can connect with anyone to have these discussions, and certainly a system that's set up to tick boxes. Even if you ask the questions, you're not there to listen to the answer, you're just there to tick the box to say that you've asked that question. …that's how I feel that the time schedule on our antenatal care is set up…it's just not enough time.*

Continuity of midwifery care is the model of care most likely to provide women with both safety and experience[26]. While continuity of care is usually midwifery-led, it is also collaborative with medical colleagues. The model enables women to build a relationship with their midwife (or midwives) over their pregnancy and fosters individualised care, trust and respect.

When providing care for women, midwives reported feeling conflicted to both meet the needs of the institutions they work for and feeling responsible for decisions women make. Participants had mixed responses when describing the use of guidelines and policies. On the one hand midwives pointed out their obligation to follow hospital protocols.

> *"I often feel I'm caught in the middle because the woman said, "I really don't want to be induced," and I say, "Well, you have no obligation because we offer monitoring and we do this and this, and it is your choice," and then they'll (medical staff) come in and you can just see the woman fold. And I feel like I can't say it in front of the consultant and the registrar, so when they go out of the room, I'll say to the woman,*

"Are you sure? Do you want more discussion? Do you want more questions? You do not have to agree to this." But I feel like, who am I betraying here? NSW policy?"

Midwives also expressed a feeling of pressure to demonstrate compliance with guidelines.

"Even when a woman has had what we think is all the information, they have made what we think is an informed decision but that choice is outside our guidelines and those people (doctors/managers) are going to come and what are they going to say to me? and about me? Am I going to be in trouble because I stood up for that woman?"

Conversely, some midwives described utilising those same policies and guidelines to safeguard their clinical decisions about care provision and women's choices.

"I like policies because it takes the person out of it. I like when you have a disagreement with someone and then you can go "Here's the policy, it's not me telling you. It's the policy. The evidence says that you can't continue when they say stop or the evidence says you can't give that now or whatever else."

Additionally, some midwives discussed feeling "*caught in the middle*" when guidelines were used to restrict women's rights to decline treatment or limit her choice. These limitations are part of an allowed/not allowed birth culture; where care choices can be conditional on compliance[27].

"Women are excluded from our program if they haven't had some diagnostic tests which probably does feel like coercion. They still make the choice as to whether they have that test, but the bottom line is if they don't have it, they're not eligible any more".

Midwives also described how the manner in which women were given information and offered evidence was sometimes presented in a biased way, which they felt manipulated women into making choices that were in keeping with recommendations and clinician preferences, rather than being in the woman's best interest. Participants reported that the medical model often dominated discussion and that women were not always given options or both sides of the story.

"She was booked for induction at 40 plus five, and she came in because she just wanted to talk about it… she didn't really want to be induced because she was frightened… The doctor came in and spoke to her (about having the induction that day), "really we recommend that you're induced at 40 plus seven, but that's Friday and we've already got three (inductions on Friday). So, then we'd have to leave you to Monday and then your risk of stillbirth has increased."

Hill[27] states that health professionals usually have safety uppermost in their minds. For some clinicians, mitigating risk is their highest priority and can sometimes be used as the justification for over-medicalisation or coercive practises. Participants repeatedly reported

these practises, giving examples of women being told their baby might die if they did not accept the recommended management plan.

> *"How would you feel if your baby died?"*

Midwives also discussed a culture of expected compliance from women which led to a general assumption that women would just go along with routine care. It is well documented that within the hospital setting women accept what is done to them without challenging midwives or doctors, and in turn the health professionals accept this as consent to proceed[28]. In keeping with previous research[34], consent was often referred to in this study as presumed or collective. It was common for clinicians to obtain consent initially (e.g. for a vaginal examination) but then return later to do another without getting consent the second time. Thus, when a woman gives her permission, some clinicians can assume this gives them the right to undertake all related procedures[28]. The language used to present examinations and interventions was simply as being part of standard care, with no indication that women had any option to say no.

> *"So, I just need to do an examination, are you all right with that?" And it's done."*

Some staff behave differently to the manner represented above. Examples of colleagues' role modeling shared decision-making with the woman were also depicted. Midwives portrayed these interactions as respectful and as inviting women to engage.

> *"…Registrar today who saw the woman, sits down, tells her all the pros and cons, just delivers it so beautifully, "What do you want to do? Before you even start, what's your idea? How do you feel about this at the moment?" Before you even give the stats or whatever, just getting that understanding of what she already knows".*

Midwives in this study stressed the need to begin these conversations in the antenatal period, providing time and opportunity to clarify questions, discuss expectations and for women to practice communication strategies to use during labour. They felt it was important that women be provided with information about the possibility or likelihood of interventions occurring during birth and what each involves. During pregnancy women are likely to be feeling less vulnerable, than when they are in labour. If interventions are offered or recommended during labour, women will be more aware and able to make a more informed choice.

> *"I had this idea …at around the 28-week mark or it could even be 36-weeks, a consultation education session added in, it's not just your normal antenatal clinic appointment, but it might be a 40-minute appointment where you can revisit a lot of those consents, room for a discussion, education, room for questions and answering when you're not going "I can't believe I'm 40 minutes late and you're asking me these questions."*

However, in general the time available during antenatal clinics for women to ask questions and for staff to provide information and discuss options was clearly identified as a contributor to poor practice around consent. Having enough time was described as

paramount to the provision of information for women. Without adequate time for discussion, midwives felt that the process of consent was often reduced to a form.

> *"A lot of booking-in is consent and it is the consent form. Like consent for your baby's Hep B, Vitamin K. The language of consent comes out as – sign this. Can you give us consent for this, this and this? We've got 20 minutes".*

Participants shared ideas for steps they would like to take toward actively engaging women in decision-making. These ideas included explicitly inviting the woman's concerns and questions, inviting their input in determining how they like to make decisions, providing adequate information and time for those decisions to be made.

> *"A really good place to sit and gain informed consent would be say a meeting where somebody's coming along and they're discussing induction of labour. "Well, look you are 40 weeks, you're 40 years old and it's your first baby. NSW Health position is this – however, here are your options… How do you feel? What do you think?"*

Inter-Professional Relationships – Midwifery verses Medical Approach

Midwives cited the imbalance of information and power in relationships; between clinicians, and between clinicians and women. Relationships were described as being hierarchical, with doctors, midwifery-managers and team leaders in more influential positions. This hierarchical nature of the maternity services represented a clear barrier for the midwives to achieve the professional collaboration they desired.

> *"It's just authority, really. The most senior practitioner in the room generally is in charge."*

Participants also described poor teamwork, lack of trust, differences of opinion about clinical assessments, goals of care, and the pathway to optimal outcomes, as barriers to respectful professional relationships.

> *"She (the woman) was caught in the middle at a really vulnerable time in labour, so the doctor wants to intervene, the midwife doesn't see the need for intervening. But the woman was left out of the picture like she was caught in an argument."*

This lack of cooperation and trust between obstetricians and midwives appeared in part to be influenced by organisational structure, leadership and differing philosophies of care and midwives gave examples of where it could lead to poor communication and workplace tension.

> *"…there's a bit of animosity sometimes between some of the midwives and some of the doctors, because some of them (doctors) will say, "I bet so and so was looking after that woman, if she's querying me on this." Because somebody (a midwife) has stood up and said to the woman, "You don't have to do that." … it causes a little friction in the corridors."*

Downe[1] asserts that to improve maternity care, and outcomes for women and their babies, professional relationships need to move to a "both-and" message where neither the obstetric nor midwifery profession is considered superior, but both learn from each other. This is about *both* safety *and* positive experience; *both* mother *and* baby; *both* clinical *and* psychological outcomes; *both* short- *and* long-term benefits.

> *"(A woman was pregnant with) twins and I wanted to do the second twin. I went and spoke to the doctors, can we arrange this? You guys can do the ultrasound (to) see if the head is down. Anyway, we did it and we all knew our roles, and it was fantastic, and the woman actually noticed it. Afterwards she said, "Oh, that was beautiful, there was hardly anyone here." They just sat back, we went in, baby came out, and the doctor said, "Oh, that was fantastic, that was best birth that we saw, and twins!"*

Instability in the medical workforce was raised in the focus groups as an additional barrier to building respectful inter-disciplinary relationships when providing maternity care in regional settings. Metropolitan-based obstetric registrars are placed for short-term regional or rural rotations. In two of the study sites long-term specialist vacancies exist with an acknowledged difficulty in the ability to recruit to those positions. The result is a high rotation of medical staff and regular back-filling with locum medical officers. This instability can make trusting working relationships difficult to establish and adds hurdles to team communication.

> *"By the time we've got the (registrar) rotation to the end we're working well with them. It's difficult, the disjointedness of them coming and going and locums, that aren't familiar with us."*

In contrast to these barriers, participants spoke of the positive role collegiality can play in keeping women at the centre of care when reviewing plans, concerns, and discussing potential contingencies, all of which improved team communication and understanding.

> *"When it works well, it's so good, when doctors trust the midwife, when you trust each other, it's just such a relief when you come on, and there's a doctor there and you're like, oh, thank God you're on, you know, because you know their approach is great, and you know that you can be collaborative."*

Another enabler to building respectful inter-professional relationships was the importance for clinicians to have time for reflection on their experiences. Time allocated to learn more effective approaches and to enhance their practice and teamwork. Participants suggested a number of strategies that could give them opportunities to speak up about their concerns that included a range of times, places and formats. One strategy was identifying people who could act as role models to reinforce good practice and ask reflective question of the multidisciplinary team. Feedback is one of the most powerful influences on learning[30]. Midwives in the study believed that formal feedback is essential for team learning, without it poor and unsafe practice can continue without the person ever knowing their impact.

> *"Are we doing this well? If not, why?"*

Midwives in the study also emphasised the power of hearing women's experience through feedback. Practice change needs to come from within the system itself, but it can be accelerated by women sharing their stories.

> *"Giving them a voice too … you know, they need to participate in this, it's not just midwives and doctors, they need to be involved in it."*

Advocacy – "Who are the guardians of consent?"

The notion of advocacy is complex. Midwives shared many and varied experiences of attempting to address the rights, choices, or welfare of women in their care. Despite having attended graded assertiveness training and having an understanding of the basic principles; to elevate concern with a stepwise approach (balancing respect with the appropriate level of concern[30]). Most midwives still did not feel confident to speak out when witnessing breaches in professional conduct. When midwives advocated for women, they described facing certain risks and obstacles associated with the systems within which they work. They described themselves as intermediaries between the woman and the system and practised with an understanding that there was always the possibility that attempts to advocate for a woman may fail.

> *"When you're with the woman as a midwife and then a doctor comes into the room, straight away you are kind of torn because, oh, I've got a role here now to be there for the doctor as well and depending on how well you get on with that person and your confidence level and how you can speak up and your relationship with the woman, it can depend on which way you're going to go."*

Midwives in the study recognised the importance of their lived experiences as an enabler which helped them to develop skill and confidence to role-model and be able to confidently advocate in the moment. As a group they strongly identified with their professional role as women's advocates and described this as their compelling motivation, or bravery, to intervene when witnessing disrespectful or unethical behaviour.

> *"She consented to the procedure and then she said "stop" because she was in pain. The doctor continued because they needed to do what they had to do.... I've actually put my hand down on the woman and the doctor looked at me in the face and I said "you just stop here now" because in that moment it was all I could do."*

Midwives expressed the difficulty they experienced attempting conversations when a woman is in labour and a complication arises, declaring that there is sometimes very little time to discuss options with her. Sometimes they used urgency as justification for treatment lacking empathy or compassion: "there simply wasn't time." Coupled with this, many participants described professional collusion or protection, in an attempt to gain consent from the woman, when they had no control of the situation.

> *"You're feeling like you kind of want to get that consent because if it happens without consent, it's more traumatising. But for a woman, obviously even giving consent in a rushed moment isn't giving consent… because I know that they trust me*

and I know that sounds bad and in a way that's worse. But, just trying to get that consent out of them while you know that moment's about to happen to protect their (medical) decision, to reinforce their decision and you're trying to justify, to protect."

Midwives identified that in response to these encounters their support system usually involved debriefing with their work colleagues as opposed to reporting conduct breaches to their managers or the person him/herself. This finding – peers first, manager second – is in line with Geraghty's[31] recent research which suggests that there are two divergent points relating to debriefing: being able to unburden and receive empathy and support, and receiving validation regarding decision-making and acknowledging ongoing learning opportunities.

"talk to each other first; clinical supervision; manager."

The findings reveal that midwives can also be subjected to psychological conflict as they observe the way that some women are treated by clinical colleagues during childbirth. The participants described, through examples experienced in the clinical environment, a loss of integrity while trying to advocate for women which caused them moral distress.

"there's a lot of stress when you experience watching somebody doing something disrespectful or against consent, you are sort of like, "Oh God, now I'm going to have to, I know I really need to deal with this," but it's like, you're like, "Oh, far out, what is going to happen if I speak up for this women and create stress?"

The responses in this study related to specific incidents where the participants thought that a woman was being disrespected and poor decisions were made. Many participants made comments regarding the necessary or unnecessary interventions witnessed as being traumatic and stressful to not only the women but to them as well. Geraghty[31] examined the nature of midwives' work-related stress and identified that midwives experience moral distress when they witness poor treatment of women which includes unnecessary and unconsented interventions.

"you think of how much happens in a birth suite that anywhere else would be abuse. Like, anywhere else is so unacceptable, and yet we accept it, and women accept it. I don't know. I don't know why we accept it; I don't know why. Maybe it's just because we're around it all the time and you're just desensitised … and women accept it because it has to be done."

Findings

Midwives described a feeling of being in the middle; constrained because of opposing needs to maintain a status quo between their workplace policies, cultural norms and professional relationships and the need to advocate for women they are caring for. These fundamental, circumstantial and restrictive factors intertwined to form the key barriers described by midwives when navigating conversations, and concerns about safety and autonomy, interventions and poor clinical practice during labour and birth. These themes, defined as: woman-centred care; inter-professional relationships; and advocacy, encompass the core phenomenon labelled "the meat in the sandwich". This core phenomenon incorporates the

complexities faced by midwives when navigating their response to concerns about women's autonomy and the provision or rejection of their consent.

Midwives often appeared to adopt a model of interaction which was in discord between their ideals, often feeling stuck in the middle between the woman and the system. Lack of sufficient time to discuss care options with women, and the dominant medical model of care were barriers to the provision of woman-centered care. Findings highlight that inter-professional collaboration between midwives and other maternity-care professionals is crucial to improving access and women's understanding and choices for their maternity care.

While the findings do not identify the actual frequency of unprofessional and unethical behaviours or those who engage in it, they do provide insights into the barriers that influence midwives' reporting. It is often difficult for midwives to guide and guard the woman's voice and choice when they themselves (midwives) do not feel safe to have a voice within the care environment. The results indicate a clear problem; midwives' responses in this study strongly reflected that many did not feel safe to engage women in decision-making processes, or have a voice to raise their own concern. As a result, midwives can be subjected to psychological conflict and a loss of professional integrity.

Implications for policy and practise include: the need for specific guidance for clinicians providing care in situations of maternal refusal; support for formal feedback and reflective practice among clinicians; tools to encourage shared decision-making with women and; graded assertiveness training. This training must be embedded at an executive/senior management level to encourage a shift in the safety culture to one that positions the woman at the centre of care. This leadership endorsement will demonstrate that collaborative relationships between women, midwives and obstetricians is crucial to improving both safety and women's experiences of maternity care.

Conclusions

It is every midwife's responsibility to support a culture of safety in their workplace, to actively apply the standards and to call out substandard behaviour[6]. Providing information and preparing women for what to expect during labour are key to informed choice, particularly where the risks and benefits are not easily quantifiable[32]. This study provided firsthand opportunities for exploring the complexities in meeting the professional standards of the provision of safe care and informed consent.

The vast majority of maternity clinicians do not perpetuate disrespectful care to women. The disrespect described in this study is 'systemic' not personal. The culture of compliance with the institutionalised system of maternity care is accepted as normal and, in the main, has been allowed to go unchallenged. Midwives in this study are aware, to some extent, how this culture is experienced by themselves and by women.

> *"Every single denial of a woman's autonomy and power in the birth room, great or small, is part of the same problem. Call it out."*[27]

Limitations of the Study

As a regional study, the findings may not be readily generalisable to other local health districts within NSW. The research sample for phase one of the study was 27 percent and drawn from a regional cohort. Survey respondents chose whether to participate, and their responses present a snapshot of their current practice. It is likely that the midwives who participated in the focus groups had an existing interest in the issue of safe care, autonomy and consent; they may have different experiences from those who did not choose to participate. However, quantitative data was reiterated in the qualitative findings and within each theme there were opposing experiences and opinions represented. Due to limitations of the focus groups, midwives' underlying values and attitudes that may impact on women's safety and autonomy during labour and birth were not explored. Further research assessing maternity workplace culture and its effects on: professional practice; perceptions of leadership; morale; workplace behaviour and management responses to concerns, is required. This may be best achieved utilising a quantitative tool designed to address unique aspects of maternity care that are not addressed in general measures of workforce culture[33].

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Appendices:

Appendix 1: Survey tool

Appendix 2: Safety card

Appendix 1. Survey tool

PART 1. Safety and Clinical Practice

1. **<u>In the last year</u> how often have you seen staff who were attending/assisting during labour and birth take shortcuts that have negatively impacted a woman or baby? (for example, not washing hands, not changing gloves when appropriate, failing to check armbands, forgetting to perform a safety check, or not following an agreed-upon protocol).**

◯ a. Not at all during the last year
◯ b. 1-2 times
◯ c. 3-6 times
◯ d. Monthly
◯ e. Weekly
◯ f. Daily

2. **Think of a time when shortcuts negatively impacted a patient. Who have you spoken with about the problem? (Check each that applies)**

◯ a. Have not spoken with anyone.
◯ b. Have spoken with friends and family.
◯ c. Have spoken with some of my co-workers.
◯ d. Have spoken with my manager.
◯ e. Have spoken with Human Resources or another relevant department.
◯ f. Have spoken to the person but probably didn't completely express my concerns.
◯ g. Have spoken to the person and completely expressed my concerns.

3. **Describe the impacts shortcuts have had on the women and babies under your team's care. (Check each that applies)**

◯ a. No actual error, but potential for error.
◯ b. An error, but caught before any harm came to a patient.
◯ c. A patient was affected–but no harm.
◯ d. A patient was harmed / was at greater risk; had to spend more time in the hospital; required more attention from staff or physicians; or required a test / but no medication or treatment was required to counter the harm.
◯ e. A patient was harmed, and either medication or treatment was required to counter the harm.
◯ f. A patient nearly died.
◯ g. A patient died.
◯ h. I would feel uncomfortable having a family member under this person's care.

4. **<u>In the last year</u> how often have you worked with someone clinically who was not as skilled as they should have been for their employed role? (for example, not up-to-date on a procedure, policy, protocol, medication, or practice or was lacking basic skills).**

◯ a. Not at all during the last year
◯ b. 1-2 times
◯ c. 3-6 times
◯ d. Monthly
◯ e. Weekly
◯ f. Daily

5. **Think of the person whose missing competencies created the most negative impact for patients. Who have you spoken with about the problem? (Check each that applies).**

◯ a. Have not spoken with anyone.
◯ b. Have spoken with friends and family.
◯ c. Have spoken with some of my co-workers.
◯ d. Have spoken with my manager.
◯ e. Have spoken with Human Resources or another relevant department.
◯ f. Have spoken to the person but probably didn't completely express my concerns.
◯ g. Have spoken to the person and completely expressed my concerns.

6. **Describe the negative impacts missing competencies have had (Check each that applies):**

◯ a. No actual error, but potential for error.
◯ b. An error, but caught before any harm came to a patient.
◯ c. A patient was affected, but no harm.
◯ d. A patient was harmed/was at greater risk/had to spend more time in the hospital/required increased care/or required a test; but no medication or treatment was required to counter the harm.
◯ e. A patient was harmed, and either medication or treatment was required to counter the harm.
◯ f. A patient nearly died
◯ g. A patient died
◯ h. I would feel uncomfortable having a family member under this person's care.

7. <u>In the last year</u> how often have you worked with someone clinically who exhibited a performance problem (poor attention to detail, poor initiative, uncooperative, lazy, etc) that undermined teamwork, productivity, safety, patient experience, or quality of care?

◯ a. Not at all during the last year
◯ b. 1-2 times
◯ c. 3-6 times
◯ d. Monthly
◯ e. Weekly
◯ f. Daily

8. **Think of the person whose performance problems have the greatest negative impact. Who have you spoken with about the problem? (Check each that applies).**

◯ a. Have not spoken with anyone.
◯ b. Have spoken with friends and family.
◯ c. Have spoken with some of my co-workers.
◯ d. Have spoken with my manager.
◯ e. Have spoken with Human Resources or another relevant department.
◯ f. Have spoken to the person but probably didn't completely express my concerns.
◯ g. Have spoken to the person and completely expressed my concerns.

9. Describe the negative impacts these performance problems have. (Check each that applies):

◯ a. Undermined teamwork.
◯ b. Undermined morale.
◯ c. Undermined productivity.
◯ d. Undermined patient safety.
◯ e. Undermined patient experience.
◯ f. Undermined quality of care.

10. Think of the times when you have had one of the concerns described in this survey (concerns with shortcuts, competence, disrespect, or performance), but did not speak to the person and express your concerns. What got in the way? Please select the top 3 barriers.

◯ a. I thought they would become harder to work with if I confronted them.
◯ b. I thought they would retaliate against me if I confronted them.
◯ c. I was concerned they might get angry if I confronted them.
◯ d. It's not my role to confront them.
◯ e. There wasn't a time or opportunity to confront them.
◯ f. I didn't want to create a conflict in front of our patient.

PART 2. Informed Consent and Ethical Challenges

1. **Care providers in my hospital explain the risks and benefits of every procedure.**
   - ◯ Strongly disagree
   - ◯ disagree
   - ◯ Neither
   - ◯ agree
   - ◯ Strongly agree

2. **When a woman comes to the hospital to birth, she has given informed consent**
   - ◯ Strongly disagree
   - ◯ Disagree
   - ◯ Neither
   - ◯ Agree
   - ◯ Strongly agree

3. **Informed consent requires an on-going decision-making process?**
   - ◯ Strongly disagree
   - ◯ Disagree
   - ◯ Neither
   - ◯ Agree
   - ◯ Strongly agree

4. **Have you ever witnessed a care provider engage in a procedure(s) without giving the woman a choice, or time to consider the procedure?**
   - ◯ Yes
   - ◯ No

5. **Have you ever witnessed a care provider engage in procedures explicitly against the wishes/consent of the woman?**
   - ◯ Yes
   - ◯ No

6. **Have you ever witnessed a care provider tell a woman that her baby might die if she doesn't agree to a proposed procedure?**
   - ◯ Yes
   - ◯ No

Appendix 2. Safety Card

Safety Card

Your wellbeing and safety is of paramount importance to us.

If you want to talk to someone confidentially, you can call the NSW Health Employee Assistance Program (EAP) or the Nurse Midwife Support Service.

Employee Assistance Program (EAP) **1300 361 008**

Nurse Midwife Support Service **1800 667 877**

Both these free services operate 24/7 and offer confidential counselling to assist you to resolve any psychological or emotional distress you may feel.

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