THE ROLE OF THE REGISTERED MIDWIFE

C F VAN NIEKERK

Senior Lecturer, Department of Nursing, MEDUNSA

OPSOMMING

Die vroedvrou lewer deur die eeue heen haar diens aan die gemeenskap en haar rol het saam met die mediese wetenskap ontwikkel.

Navorsing is gedoen oor die hedendaagse rol van die vroedvrou in Suid-Afrika. Daar is bevind dat sy in die lewering van omvattende gesondheidsorg die geneesheer aanvul. Sy het voorkomende, koördinerende, terapeutiese, versorgings, opvoedings, besluitnemings en *locum tenens* rolle waarin sy tradisionele en nie-tradisionele funksies verrig. Omstandighede bepaal of hierdie funksies afhanklik of onafhanklik uitgevoer word, en dikwels het die vroedvrou nie wetlike dekking vir dit wat sy in belang van haar pasiënt moet doen nie. Weens die omvattendheid van die vroedvrou se take is daar 'n behoefte aan voortgesette onderwys ten opsigte van baie van haar funksies.

INTRODUCTION

SOCIAL ROLES:

may be defined as prescriptions for interpersonal behaviour. Persons who share common attitudes and beliefs and assume responsibilities for certain tasks are performing a social role[2]

What **is** specific about the role of the registered midwife, is that it is **not** specific.

How could it be specific when

- every mother is unique
- every labour is unparalleled
- every baby is different
- every situation is singular?

Role descriptions differ because

- practitioner views do not coincide
- authors disagree
- time moves on
- needs, statistics and values change.

Roles are dynamic because

- technology demands increased intellectual and psychomotor development
- humaneness demands affective and effective co-ordination of care
- mortality and morbidity rates demand reduction
- money, status and power demand quality.

And yet the midwife has always played a role delivering a 24-hour service every day of every year for as long as man has recorded occurrences. She still serves every class of mother in every corner of the Republic of South Africa and the world. Her services are normally rendered in hospitals, clinics and homes but she functions as effectively in a caravan!

When a doctor is available she attends both to him and the patient. When he is not available she manages well in the interests of the mother and the infant and according to her experience and knowledge she does not only anticipate problems but recognises the need to obtain medical aid. She adheres to the regulations of the South African Nursing Council which enable her to deliver a comprehensive service by independently executing those diagnostic and therapeutic activities the profession permits or by performing diagnostic and therapeutic activities under the direct or indirect supervision of a medical practitioner or on his direction or written or verbal prescription.

DEPENDENT FUNCTIONS:

those functions carried out as a result of the diagnostic or therapeutic prescriptions of a doctor (or dentist, in the case of dental care only).

In the case of dependent functions the doctor accepts full responsibility for prescribing or assigning any diagnostic or therapeutic acts the nurse may be requested to carry out.[4]

ROLE DEVELOPMENT

Since the beginning of time the midwife has been concerned with *women's business:* pregnancy, labour, motherhood, childcare. This basic midwifery role, acknowledged in ancient religious documents, remains to this day. A role is, however, flexible. The flexibility is evident from adaptations, modifications and changes occurring in the role of the midwife from the time of physicians and barber-surgeons onwards. Advances in the obstetrical and educational fields, the cognisance taken of human rights and increased legal prosecutions for negligence are but some factors which influenced and still influence the role of the midwife.

ROLE:

. . . a position in a social structure, a set of expectations associated with a position in a social structure, or a set of behaviours associated with a position.[1]

The present role of the midwife also bears witness of role adjustments related to current human philosophy and needs, technoscientific development and expanding knowledge and skills. The midwife's responsibility, for instance, has become more than a moral issue — it is now also a legal issue. Thus her preparation must be more than

TABLE 1 THE PREVENTIVE ROLE OF THE REGISTERED MIDWIFE

Activities	Number of respondents undertaking the activity	% of 294 respondents	% respondents determining function independent
Health Surveillance activities			
Abdominal palpation	128	44	79.8
Auscultation of fetal heart	128	44	80.3
Determining blood pressure	143	49	80.6
Assessing involution of uterus	102	35	81.2
Inspecting for healing of episiotomy	112	38	81.2
Inspecting the condition of lactating breasts	120	41	82.2
Inspecting the general physical condition of the baby	130	44	81.8
Health maintenance activities			
Prescribing a diet in antenatal period	109	37	81.9
Immunising (for example against polio)	69	24	71.6
Swabbing	107	36	81.0
Avoiding overdistension, retention-bladder	97	33	79.1
Diagnosing progress in labour	105	36	75.4
Administering B.C.G. vaccination — baby	84	29	68.6
Ensuring rest and sleep	109	37	83.3
Early detection activities			
Drawing blood: Rh-grouping, haemoglobin, WR, etc	133	45	70.7
Examination of urine	127	43	77.9
Obtaining cervical smear	80	27	68.8
Undertaking vaginal examination	107	36	80.0
Assessing haemoglobin	75	26	74.7
Undertaking ultrasonic screening tests	2	1	50.0
Obtaining high vaginal swab for bacteriology	29	10	58.8
Screening for carcinoma cervix, breasts	30	10	71.4

training — it demands education as well as training. To determine the present role, that is the position of the registered midwife and registered nurse in a particular social structure and her utilisation in providing comprehensive health services the author and a colleague investigated the situation.

THE RESEARCH

The objectives of the investigation were to determine

— what functions the registered midwife presently undertakes
— the position of the various functions on a responsibility continuum
— the extent and nature of the preparation received for each function
— the need for further education with regard to each function.

Interviews

Personal interviews and group discussions with doctors and matrons of twenty-three government services were conducted. Purposive sampling using four criteria, was used to select the services.

The services represented

— all population groups
— western, south-eastern and eastern Cape, Natal, Transvaal and Orange Free State
— various services at state, provincial and local authority level comprising a comprehensive approach to health care.

The unstructured interviews and group discussions provided information regarding

— the role, responsibilities and preparation of the registered nurse/midwife
— problems related to the provision of comprehensive health services
— possible solutions to the above-mentioned problems including the increased utilisation of the registered midwife
— overlap in medical/nursing functions and views on the concept *expanded* or *extended* role.

During interviews a number of doctors and matrons stated that, due to existing shortages of doctors which they expected to continue for many years, the registered midwife is currently the obvious category of worker to complement the available medical manpower in order to provide comprehensive care.

Activities such as taking a full history, performing a complete physical assessment, managing unexpected complications such as twin and breech deliveries, transverse lie, resuscitating the infant (utilising various techniques), controlling haemorrhage, treating conditions such as venereal disease, anaemia, kwashiorkor, tuberculosis, thrush, obtaining specimens, interpreting laboratory findings, checking developmental stages, prescribing and dispensing medicines up to schedules III, IV and even V, are already undertaken by many registered midwives.

Some interviewees believe that functions such as vacuum extraction and low forceps deliveries are but two of a number of therapeutic activities which the midwife should be able to undertake if and when necessary.

A number of doctors expressed concern about activities in which circumstances forced the midwife to act independently without legal coverage.

INDEPENDENT FUNCTIONS:

are those for which . . . the nurse takes full legal responsibility.[4]

Independent fuctions involve actions which the nurse initiate herself[3]

Such activities include *inter alia,* prescribing and administering analgesics in outlying clinics. Circumstances often placed the midwife in the unenviable position of deciding between withholding an analgesic (with implications for the mother and the baby) or giving it (with implications for herself). The problem is further compounded by the fact that standing orders are not valid with regard to schedule VI drugs. Communication with the doctor is also difficult due to a number of reasons such as the midwife being the only person in the clinic and having to cope with more than one delivery at the same time, as well as with unreliable telephone services.

Further activities they are concerned about include treatment for example of convulsions, eclampsia, oedema and hypertension. The doctors prepare written instructions to guide the midwife when prescribing but some doctors felt that the midwife needs legal protection on a national level. This is especially true for cases where intramuscular and inhalational analgesics are administered in good faith based on a protocol mutually accepted for the benefit of the patient.

Another important issue, which became evident during the interviews, was the lack of knowledge amongst doctors about the depth and extent of the midwife's preparation as well as about her role, legal obligations and responsibilities. This might be a contributory factor to both role overload and underutilisation — two factors closely related to motivation and job satisfaction and thus personnel turnover.

Questionnaires

Questionnares were distributed to 400 persons in the twenty-three services. A matron of each service selected the respondents in her particular service according to the criteria of registration as a nurse and/or midwife and employment in a situation in which a wide range of nursing functions were undertaken.

The data, returned by 294 respondents, was processed into frequency tables and interrelated percentages. These provided the basis for analysis and subsequent findings.

Findings based on data obtained from questionnaires

Findings about role

The data indicated that 469 of 474 activities listed in the questionnaire were undertaken by one or more registered midwives. The number of activities undertaken illustrated the scope of the midwifery role. The number of respondents undertaking a specific activity (ranging between one and 233 per activity), supports the assumption that the role of the midwife is flexible and comprises traditional functions (undertaken by most midwives), non-traditional functions (undertaken by the select few only) and non-nursing functions (in the absence of the appropriate category of health worker).

Various roles comprising the comprehensive midwifery role,

TABLE 2 THE CO-ORDINATING ROLE OF THE REGISTERED MIDWIFE

Activities	Number of respondents undertaking activity	% of 294 re-the spondents	% respondents determining function independent
Health assessment activities			
Determining previous health status	208	71	80,3
Determining present health status	210	71	81,7
Determining general physical condition	214	73	79,8
Determining cognitive status	206	70	81,2
Determining psychological status	203	69	79,5
Determining economic status	210	71	81,5
Determining occupational background	195	66	83,9
Referral Activities			
Referring mother to support services such as clinics, social welfare	123	42	83,4
Referring selected patients to doctor	93	32	76,0
Referring to medical or supplementary health service personnel	94	32	66,7
Referral to clinic (229 respondents)	110	48	78,9
Referral to hospital (229 respondents)	115	50	83,0
Referral to dentist (229 respondents)	120	52	82,9
Referral to child guidance (229 respondents)	77	34	75,9
Referral to social worker (229 respondents)	132	58	76,5
Referral to physiotherapist (229 respondents)	80	35	69,2

TABLE 3 THE **THERAPEUTIC ROLE** OF THE REGISTERED MIDWIFE

Activities	Number of respondents undertaking the activity	% of 294 respondents	% respondents determining function independent
Therapeutic activities			
Infusing fluids and electrolytes	89	30	56,4
Doing episiotomy	89	30	69,7
Infiltrating local anaesthesia	75	26	60,5
Removing placenta: Brandt Andrews method	88	30	82,4
Suturing episiotomy	71	24	67,1
External bimanual compression of uterus	37	13	57,9
Intubation (endotracheal)	35	12	63,6
Performing circumcision	5	2	42,9
Medicine related activities			
Administering pethilorfan	32	11	34,2
Administering potassium bromide 1,20g	33	11	48,5
Administering chloral hydrate 2 g	33	11	48,7
Administering nitrous oxide and oxygen analgesia	29	10	60,0
Administering general aneasthetic	2	1	50,0
Administering oygen per mask	90	31	64,5
Administering oxytotic medications (intra-venous)	58	20	36,8
Prescribing sedatives	37	13	59,4
Prescribing diuretics	20	7	54,2
Prescribing vasodilators	12	4	47,1
Prescribing vitamins	86	29	68,0
Treatment activities			
Treating sore buttocks	129	44	71,4
Treating skin rashes	122	41	60,3
Treating kwashiorkor, marasmus	108	38	57,5
Treating conditions such as colds, influenza	76	26	58,5
Suppressing lactation	74	25	70,3
Emergency treatment activities			
Treating shock	99	34	72,1
Resuscitation with positive pressure	42	14	73,3
Performing external rotation: shoulder presentation	14	5	86,0
Commencing artificial respiration (intermit-tent positive pressure respirator)	46	16	43,8
Infusing blood	50	17	32,1
Family planning activities			
Administering oral contraceptives	101	34	73,6
Issuing oral contraceptives	95	32	72,2
Placing intra-uterine device in situ	30	10	63,8
Administering intramuscu-lar contraceptives	91	31	58,2
Examining for presence of intra-uterine device	65	22	70,3

emerge from a classification of the 469 activities into related groups. The roles are as follows

Preventive role reflected by health surveillance, health maintenance and screening activities

Co-ordinating role reflected by health assessment activities on a biopsycho-social level, recording and reporting and referral activities

Therapeutic role reflected by prescription and administration of medication, prescribing and altering treatment, emergency treatment and family planning activities

Nurturative role reflected by helping and supportive activities

Education role reflected by teaching nursing personnel and other categories of health workers and teaching health care consumers

Decision Making role including decision making about appropriate nursing care and decision making about the need for medical intervention

Locum Tenens or **Deputising Role.**

The above roles are substantiated in Tables 1 to 7 in which selected activities pertaining to each role are listed. The number and percentage of 294 respondents who undertook each activity as well as the percentage responses brought out in favour of the action being an independent function are indicated.

Unfortunately the data not only reflected the true role of the registered midwife but also the malutilisation of her services in non-nursing activities which ought to be performed by another category of worker. The malutilisation is clearly illustrated in table 8.

Findings about responsibility

An interesting finding with regard to the responsibility for various activities is that no activity is totally (100%) dependent or independent. Responsibility for specific activities ranges between 85% dependent and 85% independent. The variation in the percentage responses with regard to the dependent/independent nature of an activity is to some extent reflected in the last column of Tables 1 to 7 which contain selected examples of activities in-

cluded in the complete research project.

This leads to the conclusion that midwifery activities are interdependent rather than dependent or independent. The dependent/independent classification varies according to different situations and attitudes, the number of doctors available and the protocol accepted with regard to *medical* and *nursing* activities in a particular situation. For professional practice it is conducive to realise that the registered midwife is accountable for her every action, whether self-assigned or accepted by prescription, as well as for omission to act.

Findings about preparation

Findings regarding the preparation of the registered midwife indicate that the midwifery course is the main preparation for the midwife's role. Post-basic (for registration) education and inservice training for specific activities were however received by as many as 40% of respondents.

A need for further education of more than one type was indicated by the respondents for 98% of the items. Midwives indicated a need for **post-basic courses** for registration in order to perform placentography, to suture the cervix, treat missed abortion, determine maternal cardiac function, apply forceps and vacuum extractor, do an episiotomy, anaesthetise and suture the perineum, diagnose abnormalities in labour, resuscitate, expel the placenta using Brandt Andrews method, increase flexion and manual rotation in occipito posterior positions, perform versions, take high vaginal swabs, manually remove placenta, control haemorrhage, treat infections and haemorrhoids and undertake blood analysis with Astrup micro-apparatus.

The total need for further education of midwives was expressed as follows: post-basic (for registration) courses were required for 8% of the activities, post-basic (non-registration) courses for 45% and inservice training for 34% of the activities.

TABLE 4 THE **NURTURATIVE ROLE** OF THE REGISTERED MIDWIFE

Activities	Number of respondents undertaking the activity	% of 294 respondents	% respondents determining function independent
Supportive activities			
Arranging financial benefits for mother	73	25	80
Supporting unmarried mothers	73	25	81,6
Accompany patient to hospital	81	28	79,8
Supporting mother in puerperium	106	36	87
Providing psychological support in the antenatal period	101	34	85,4
Assisting mother with care of baby	127	43	86,9
Encouraging mother to cope with new situation	123	42	85,7
Promoting relationships: mother-baby-father	90	31	87,7

TABLE 5 THE **EDUCATIONAL ROLE** OF THE REGISTERED MIDWIFE

Activities	Number of respondents undertaking the activity	% of 294 respondents	% respondents determining function independent
Educational and counselling activities			
Instructing patient regarding diet, clothes, lesser complications in antenatal period, etc.	128	44	84,2
Instructing parents regarding management of siblings	93	32	92,8
Instructing husband regarding support of wife	63	21	91,1
Health education: mother and baby, during postnatal visit	128	44	85,6
Inservice education: all categories personnel	86	29	84,8
Instructing mother: own care, care of family and neonate during puerperium	119	40	86,4
Providing genetic advice	52	18	69,1
Informing mother/parents of abnormalities or other conditions of neonate	97	33	82,5

TABLE 6 THE DECISION MAKING ROLE OF THE REGISTERED MIDWIFE

Activities	Number of respondents undertaking the activity	% of 294 respondents	% respondents determining function independent
Basic nursing care activities			
Providing basic care in the antenatal period	117	40	82,2
Providing basic care in the labour period	109	37	83,1
Providing basic care in the puerperium period	109	37	84,6
Providing basic care during postnatal visit	92	31	83,5
Providing basic care to neonate	128	44	89,2
Providing care to premature in incubator	79	27	72,2
Providing care to premature without incubator	88	30	74,5
Determining need for medical intervention			
Baseline assessment in emergencies	191	65	72
Measuring pelvic capacity (pelvimeter)	55	19	77,2
Diagnosing disproportion (Chassar Moir method)	30	10	72,4
Diagnosing abnormalities such as tumors, fetal death, dysmature fetus	103	35	77,9
Auscultating fetal heart with ultrasonic aid	56	19	60,7
Auscultating maternal cardiac function	51	17	77,4
Diagnosing abnormalities in labour such as prolongation and haemorrhage	92	31	83,2

TABLE 7 THE LOCUM TENENS or DEPUTY ROLE OF THE REGISTERED MIDWIFE

Activities	Number of respondents undertaking the activity	% of 294 respondents	% respondents determining function independent
Locum tenens activities			
Giving exercises	97	33	86.4
Interpretation of Röntgenograms	15	5	52,4
Undertaking X-ray pelvimetry	1	0.3	100
Directing breathing and relaxation exercises	90	31	87.8
Undertaking chest radiography	3	1	75.0
Undertaking electrocardiography	4	1	50.0
Taking ultrasonogram	9	3	16.7
Taking X-rays	7	2	50.0
Arranging adoption	33	11	69.1

TABLE 8 ACTIVITIES ILLUSTRATING THE UTILISATION OF THE REGISTERED MIDWIFE FOR NON-NURSING ACTIVITIES AND THE NUMBER AND PERCENTAGE OF 294 RESPONDENTS UNDERTAKING THE ACTIVITIES

Non-nursing activities	Respondents undertaking the activity	% of 294 respondents
Completing admission forms	142	48
Obtaining a deposit for treatment	44	15
Providing receipts	66	22
Returning items from safe	112	38
Dispensing prescribed medicine from unit stock	97	33

A logical deduction from these findings seems to be that continuing education of a non-registerable nature, offered by the employer and/or on private initiative, is needed by registered midwives in order to undertake their present activities.

The role of the registered midwife is broad and dynamic. Care should thus be taken to clarify specific role limitations and role expectations when new midwifery personnel are appointed in specific situations. Written protocol should indicate which functions are considered *dependent*. This will minimise feelings of uncertainty amongst new employees and persons circulating between units. Postbasic midwifery education — which is now available — should concentrate on preparing the practising registered midwife for non-traditional nursing activities. Through personnel development programmes and private initiative continuing education (non-registration) should strive to promote expertise in specialised areas of practice. Midwifery education should aim at in-depth knowledge of responsibilities, role overlap and collaborative activities, skills in communication and interpersonal relationships as well as internalised affective skills.

Through quality in education the mother and child will become the focal point, the team spirit will grow, roles will be adapted to needs and collaborative comprehensive care will become a reality.

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