

Caring during clinical practice: Midwives' perspective

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Background: Caring forms the core of nursing and midwifery. Despite caring being an important emotional aspect of midwifery and nursing, there are general public complaints about uncaring behaviour in midwifery. Therefore, there is a need to explore caring from midwives' point of view with the hope of identifying solutions and recommendations for midwifery practice. Furthermore, the study aimed to stimulate debate and discussion about the caring behaviour of midwives.

Objective: To explore caring during clinical practice as perceived and experienced by midwives.

Method: The study was contextual, exploratory and qualitative. The participants were midwives working in state and private hospitals in Tshwane, South Africa where BTech II and III midwifery learners were allocated for work integrated learning (WIL). Data collection was carried out through self-report using a questionnaire and focus group. Questionnaires were distributed to 40 midwives at private and state hospitals in Tshwane. This was followed by two focus group sessions to ensure that data is enriched. The hermeneutic interpretive approach was used to analyse data, and analysis continued until saturation.

Results: Themes of caring and uncaring related to patient care and midwives emerged. The findings illustrated that the midwives had excellent theoretical knowledge of caring, but some of them did not display caring behaviour during clinical practice.

Conclusion: Some of the midwives did not display caring behaviour. Implication for practice was provided based on the research findings. Recommendations included measures of improving caring behaviours during midwifery practice.

Introduction

Caring is a popular concept in nursing and midwifery which forms part of good patient care values – indeed, caring is frequently described as the core business of nursing and midwifery. It involves the relationship in which the carer is committed to the needs of the one cared for (Mason-Whitehead *et al.* 2008:44). It is the inborn human trait and emotion that drives one to care for the other. Midwifery caring is aimed at supporting and assisting the woman during the natural process of childbearing and differs from other health professionals' ways of caring.

Caring in nursing and midwifery was defined as early as the 1900s and still nursing theorists suggest multitudes of concepts in their studies about caring (Dickson 1996:24; Watson 2006). Some of the concepts suggested with regard to the meaning of caring include empathy, presencing, knowing, listening, interacting, sensitivity, giving feedback, teaching and helping. Watson uses ten carative factors of caring to describe Human Caring Science (Jesse 2006:104). According to Watson, caring converts 'cure' to a sacred act and when carried out with a caring consciousness, it honours the person as an embodied spirit (Watson, Jackson & Borbasi 2005:104). Caring is an ethical principle or standard by which curing interventions are measured. Swanson (Mason-Whitehead *et al.* 2008:44) states that caring has a 'doing for', a behavioural aspect, as well as a 'being with', an emotional aspect. Woodward (2000:69) repeats the dual definition and postulates that the instrumental and expressive elements of caring are inseparable and essential to caring. However, the instrumental component is emphasised most, thus threatening the integrity of the whole. The cause for this shift could be attributed to the loss of humanitarian values as observed with globalisation.

A South African study explored health-seeking behaviours of antenatal women. A notable theme emerging from the study was the abuse of antenatal women by midwives, described as an overall deterrent to seeking healthcare services (Abrahams, Jewkes & Mvo 2001:245). Furthermore, most of the nurse disciplinary hearings held by the South African Nursing Council annually

are related to midwifery clinical practice. There is little or no literature available focussing on management of the problem (Abrahams *et al.* 2001:245). The challenge facing midwifery clinical practice is to facilitate the processes through which midwives can be re-socialised to caring as a professional value.

Problem statement

In 2004, the Adelaide Tambo School of Nursing Science of Tshwane University of Technology conducted a pilot study exploring caring behaviours of registered nurses as perceived by learners (Ramukumba, Wright & Chokwe 2005). The results showed that most of the Baccalaureus Technologiae II and III (BTech I and II) learner midwives expressed experiences of uncaring behaviours by registered midwives at different units of healthcare institutions. The BTech I learners described uncaring behaviour as lack of commitment, lack of compassion, incompetence, lack of conscience and lack of confidence in their work. Unexpectedly, the BTech III and IV learners did not perceive and experience uncaring behaviours amongst registered midwives. The question is, were the BTech III and IV already socialised that uncaring behaviours are acceptable, thus becoming complacent with the status quo? This article reports on follow-up research carried out in 2006–2008 and is aimed at creating a dialogue to deliberate about how to rectify, manage and prevent uncaring behaviours in midwifery clinical practice (Chokwe, Wright & Erasmus 2010:4).

The purpose of the study was to explore caring from the perspective of midwives during the clinical practice of midwifery in private and state hospitals in Tshwane, Gauteng, South Africa.

Theoretical foundation of the study

The philosophy of Human Caring Science as described by Watson is the theoretical basis underpinning the study. Watson developed ten carative factors of caring, of which four were used as the basis of this study (Jesse 2006:104).

- To provide caring, faith and hope have to be instilled and the belief system of self and of the one-being-cared-for have to be facilitated. In a caring relationship, the midwife has to be genuinely present, and assist the labouring woman in building self-confidence.
- The systematic use of the scientific problem-solving method for decision-making must be used in caring relationships. Midwives should use therapeutic use of self when creating a caring-healing practice, and use evidence-based information when providing care to their patients.
- The provision of a supportive, protective and corrective mental, physical, socio-cultural and spiritual environment is imperative. In the course of their care, midwives should create a physical and psychological environment conducive to the cultivation of beauty, dignity and peace.
- Caring includes assistance with the gratification of human needs. In a caring relationship, midwives should identify the needs of the woman and assist her to meet the basic

needs which will facilitate balance between mind, body and spirit.

Research methods and design

Design

A qualitative exploratory research design (Creswell 2007:36) was used. In the study, midwives' perspective of caring during midwifery clinical practice in private and state hospitals in Tshwane, Gauteng, South Africa, was explored.

Population

The target population (Burns & Grove 2001:806) was midwives working in the midwifery clinical areas to which the BTech II and III learner midwives were allocated for work-integrated learning. The sampling method was convenient and purposive (Schneider *et al.* 2003) to ensure that the sample chosen contained the most representative characteristics or typical attributes of the population. Three institutions were conveniently and purposively sampled. A census sample of 50 was realised, since each midwife who was approached agreed to participate and signed the informed consent form.

Data collection

Initially it was planned that the data be collected through individual interviews, but the midwives could not verbalise their perspective of caring during midwifery clinical practice although pre-testing was carried out successfully. After several attempts of collecting data with five participants, the researcher decided to gather the data through an open-ended questionnaire, which was followed by focus group sessions to provide rich qualitative data (Chokwe *et al.* 2010:108).

The questionnaire comprised a demographic profile of the participants (Section A), which included age, years spend in midwifery practice, nationality, work location and whether participants enjoyed working as a midwife. Section B was based on the factors that discouraged the midwives in practice, the meaning of caring, the experiences of caring behaviour and the effects of caring and uncaring in practice. Forty questionnaires were received from the participants, and 30 were analysed as saturation was reached.

Focus group sessions comprising eight to ten midwives each was conducted at state and private institutions. The interview schedule used for the focus groups was based on the same aspects as the questionnaire. The focus group discussions were recorded on audiotape with the permission of the participants and the assistance of a moderator. Both the questionnaire and the interview schedule were pre-tested. The questions were rephrased after five questionnaires were analysed, and adjusted to ensure that the instrument measured what was intended.

Data analysis

A hermeneutic interpretive approach, which includes naïve reading, structural analysis and interpretation of the whole

as postulated by Speziale and Carpenter (2007:88), was used to analyse the data.

Results

The findings regarding the midwives' perceptions and experiences of caring in midwifery practice are presented in terms of the demographic profile and findings from the questionnaire and focus group data.

Demographic profile of the participants

The sample size was 40 participants ($n = 40$). More than half (58%; $n = 23$) were between 21 and 40 years old, whilst less than a third (27%; $n = 11$) were in the age range 41–50. A third of the participants (30%; $n = 12$) had five or less years of midwifery experience, followed by a smaller group (28%; $n = 11$) with 11–15 years of experience.

All South African language groups were represented: a quarter (25%; $n = 10$) was Northern Sotho, followed by Afrikaans (22%; $n = 9$). Most of the participants (73%; $n = 29$) worked in state institutions, whilst (27%; $n = 11$) worked in private healthcare institutions. Almost all participants (98%; $n = 39$), enjoyed working in midwifery clinical practice.

Data presentation

Table 1 indicates the themes and categories generated from the analysed data. The themes were:

- patient care related incidents of caring and uncaring
- midwife related incidents of caring and uncaring.

The categories are discussed as caring and uncaring incidents and sub-categories are supported by the direct quotes from the participants.

Patient related incidents of caring and uncaring

Patient related incidents of caring and uncaring expressed by midwives were patients' positive feedback, and lack of commitment.

Compassion and patients' positive feedback

The participants mentioned that when someone displayed a positive attitude, she would be passionate about her work. In turn the patients would trust and have confidence in her, and that constituted caring. They further mentioned that the patients cooperated better when care-givers demonstrated

caring behaviour. According to the participants' perceptions, patients appreciated what was done for them. Some of the participants stated the following:

'Patients comply with their treatments. They become thankful and they learn to trust us as midwives.' (P6, female, 27)

'Caring behaviour is evident when patients came back to the hospital and expressed their gratitude to the personnel. The patients spoke positively about personnel and the institution had a positive image in the community.' (P10, female, 41)

Lack of commitment

According to the participants, ignoring patients' requests and cries for assistance, leaving them unattended during labour and not providing them with pain medication constituted uncaring.

The participants perceived that when they were uncaring, patients would not be content about the care they receive. They stated that patients might be rude, rebellious and uncooperative regarding their treatment, be less concerned about their babies' wellbeing and distrust the advice and care that the midwives provided. Some participants shared the following:

'[Patients say:] Sisters give us this information and advice, because they think they are better people than us. They have no interest in us or our babies, this is just a job.' (P1, female, 31)

'When caring is absent, the patients lose hope; they even say it is better to die.' (P2, female, 33)

Poor communication

The participants said that some of their colleagues influenced others negatively and had been impatient in the way they provided patient care. According to the participants' experience, the patients were sometimes labelled as 'difficult' or 'stubborn', their needs disregarded, with resultant risk for complications. Verbal abuse, rudeness, accusing patients of wrongdoing, shouting at unbooked patients and screaming by some of the midwives were identified as uncaring. Participants mentioned the following:

'The woman was told, "You are too old to have kids, push otherwise you will be held responsible for your baby's death".' (P30, female, 40)

'If you want to kill this baby, you shouldn't have come here; you should have done it outside the hospital.' (P5, female, 35)

'The patients are not respected, they are treated like children.' (P6, female, 27)

Midwife related incidents of caring and uncaring

The sub-categories generated from midwife related incidents of caring included cooperativeness and togetherness, whilst incidents of uncaring included deficient mentoring of and support for newly qualified midwives, lack of appreciation by managers, colleagues and doctors, and lack of unity amongst midwives.

Teamwork

The participants said that when personnel helped each other, teamwork and spirit would be improved. Understanding

TABLE 1: Themes, categories and sub-categories from the questionnaire and focus group.

Theme	Categories	Sub-categories
Patient care related incidents	Caring	Compassion and patients' positive feedback
	Uncaring	Lack of commitment Poor communication
Midwife related incidents	Caring	Cooperativeness and togetherness
	Uncaring	Deficient mentoring and lack of support for newly qualified midwives
		Lack of appreciation Lack of unity amongst midwives

one another as colleagues would result in reduced stress amongst personnel, leading to less shouting at patients and reduced negative emotions by the staff. The participants explained that if midwives cared for one another, standards and quality of patient care would be improved. Some of the participants stated:

'If standards of patient care are high, we feel good about ourselves and self-esteem will be uplifted.' (P22, female, 29)

'If everyone becomes a team-player, work will be less stressful and absenteeism will be minimal.' (P1, female, 31)

Deficient mentoring of and lack of support for newly qualified midwives

A participant stated that newly qualified midwives were not mentored in their new role as professionals. Instead they were judged when uncertainties arose during performance of tasks. A young midwife mentioned that older midwives were unsupportive, seemingly irritated by their lack of experience and competency. According to the young midwife, they were ostracised from the midwifery profession. The participants stated that due to the uncaring they experienced, they moved from one institution to another trying to find a more caring and supportive environment. Participants expressed it as follows:

'Nobody mentors the newly qualified professional or orientates her to ascertain her ability in coping with the new role, I tell you, no one.' (P23, female, 36)

'You will constantly be asked by other colleagues where did you train or who trained you. This will make you feel upset and undermined by your own colleagues.' (P3, female, 27)

'The midwives undermine each other's knowledge and competency, especially when you are newly qualified or when you completed from the institution that is different from theirs. With these comments, we feel incompetent. We lack confidence and you either absent yourself from work or resign.' (P18, female, 31)

Lack of appreciation by managers, colleagues and doctors

A frequently mentioned factor was lack of appreciation and support from the institutions' management and colleagues, which discouraged newly qualified midwives to continue midwifery practice. In the participants' view, lack of support and disregard for staff shortages and their dejected feelings were major consequences of managers' uncaring behaviour. They agreed that there was no appreciation of the work done from colleagues, doctors, immediate supervisors, the patient and the community. Instead, when mistakes happened in the ward, it was always exaggerated by the institutions' managers. Participants elaborated:

'No one appreciate the hard work you put in patient care, even patients do not appreciate our efforts.' (P25, female, 45)

'Nobody appreciates the work I do here, at least where I "moonlight" the environment is warm; people appreciate my role.' (P27, female, 44)

'Personnel are lost through resignations as they move from one institution to another in pursuit of job satisfaction and professional gratitude.' (P13, female, 37)

'Everybody will always remember that [Sister Y] recorded wrong information in the patient's record, and remember [Sister X] gave expired vaccines to eight babies.' (P19, female, 42)

One of the participants explained a doctor ignored her advice that a multiparous woman who had been in prolonged labour for more than six hours be taken for caesarean section due to cephalo-pelvis disproportion. She remarked:

'The doctor undermined my advice and advocacy, consequently the patient died in theatre due to rupture of the uterus.' (P12, female, 51)

Lack of unity amongst midwives

The participants felt that poor teamwork amongst midwives affected the quality of care and the wellbeing of patients. Some of the midwives allowed their personal differences to affect patient care. Patients were sometimes denied assistance and care. The midwives expressed their worry that there was no unity amongst midwives. Sometimes work was not distributed evenly by the unit manager and nobody helped each other. Participants said:

'The patients are told that "You are not my patient, you belong to that team" or sometimes they are told, "I am not responsible for caring for you, I work that side".' (P20, female, 49)

'There is no unity amongst midwives; team spirit is absent and we do not support each other. When you do something good, everybody forgets, but do something wrong and you will see how everybody remembers.' (P4, female, 32)

'Doctors support and protect each other in times of problems. What is wrong with us midwives?' (P11, female, 29)

'We are demotivated; there is a deterioration of the quality of work. As a result of an uncaring environment, the turnover of the midwives is high.' (P14, female, 45)

Ethical considerations

Approval was granted by Research and Ethics Committee of the University (Reference number: 2006/10/025), the Gauteng Department of Health and the managers of the hospitals. Respect for persons, autonomy, beneficence, justice, confidentiality and anonymity principles were adhered to (Brink 2006:30-48). In addition, the participants gave written informed consent to participate in the study.

Trustworthiness

In order to ensure trustworthiness of the study, the principles as proposed by Lincoln and Guba (1985:Chapter 11) were considered.

- *Credibility*. Reflects the accuracy of the participants' experiences in the study and includes activities that increase the probability that credible findings will be produced.
- *Transferability*. Refers to the probability that the findings have meaning to others in similar situations of study.
- *Dependability*. Triangulation of methods has the prospect of enhancing the dependability of the findings (Sharts-Hopko 2002:85).
- *Confirmability*. The process of recording the findings in such a way as to leave an audit trail which can be followed by other researchers (Speziale & Carpenter 2007:49).

Discussion

Patient related incidents reflecting caring and uncaring

Mulaudzi, Mokoena and Troskie (2001:96) explain caring according to five C's: commitment, compassion, competency, conscience and confidence. Compassion as one of the five C's of caring means being considerate and kind. The midwives explained that when they were compassionate in their care, patients responded positively to their guidance, and cooperated better with taking treatments. This notion is also supported by Woodward (2000:69), who states that in a caring environment, positive relationships are formed and maintained.

There were occasions when midwives declined to assist patients because they were not assigned to them according to the delegated duty list. According to Watson, Jackson and Borbasi (2005:115), midwives' caring means encompassing professional knowledge and attentiveness to others. Lack of commitment resulted in failure to promote a respectful and empowering childbirth experience for women, which according to Kennedy (2000) is necessary to strengthen the woman's confidence as a mother. Furthermore, the ethical code of the International Confederation of Midwives (ICM) states that midwives should cooperate with the woman in labour and use their professional ability to meet the individual's needs (International Confederation of Midwives 2010:2). Therefore, not only did the midwives contravene the ethical code of the ICM but went against Watson's theory of human caring in terms of assisting individuals with basic needs and ensuring that a healthy balance between mind, body and spirit is created (Jesse 2006:103).

The present study provides evidence that patients were faced with the same uncaring, unfriendly environment found in a study about the efficacy of role models (Bluff & Holloway 2005:305), which recognises vertical and horizontal conflicts as the cause of an uncaring, hostile environment in midwifery. In addition, though processes for action against uncaring behaviour are in place, the evidence from this study and the study by Bluff and Holloway (2005:305) is that such behaviour was not addressed. In the above mentioned study it was mentioned that no remedy occurred because the managers awaited formal complaints from the patients (Bluff & Holloway 2005:305).

According to Mulaudzi *et al.* (2001:96), communication forms the most important link between the attributes of caring. Caring is described as a web of connection that enables care providers to gather knowledge of the one cared for through trust and faith; it is 'other-regarding' (Kennedy *et al.* 2004). The current study revealed that there was poor communication with patients; midwives failed to explain procedures to patients and responded negatively to patients' requests. Midwives contravened Watson's carative factor of assisting with the gratification of human needs (Jesse 2006:103).

Midwife related incidents reflecting caring and uncaring

The participants were of the opinion that when personnel worked together by helping each other, teamwork and spirit would improve. Understanding one another as colleagues would result in reduced stress, leading to limited shouting at patients and less negative emotions. Based on the participants' experiences, patients cooperate positively by adhering to treatment and advice when they are in a trusting relationship with personnel in a caring environment. The positive collaboration between patients and personnel results in maximised utilisation of the institution. In such a situation, midwives meet the carative factor of Watson's theory of instilling faith and hope and the belief system of self (Jesse 2006:104).

The study also established that midwives undermined each other; more often when an individual trained at an institution which did not have enough credibility according to popular belief in the midwifery community. The participants expressed a lack of support from their own colleagues, saying that they did not care for one another; due to this aspect, the standard and quality of patient care was lowered. The findings of this study match the findings of research carried out on midwives' needs with regard to support (Kirkham & Stapleton 2000:467). This research revealed that midwives experienced lack of mutual support and role models from colleagues and managers. As a result, an uncaring environment with professional pressures to conform to rules and policies produced feelings of blame and guilt (Kirkham & Stapleton 2000:467).

At times, the midwives disregarded decisions taken by newly qualified midwives because they ridiculed the institutions at which they trained or undermined the knowledge they attained, which resulted in in-fighting. Consequently, an unfavourable environment characterised by horizontal violence was created (Kirkham & Stapleton 2000:467). In Kirkham and Stapleton's study, the midwives verbalised that they decided to work as individuals as they constantly had to defend themselves due to lack of confidence and feelings of powerlessness. Due to powerlessness, they were unable to empower their patients since they lacked confidence and could not share what they did not have. The uncaring environment in the current study goes against the carative factor of Human Caring Science of engaging in an authentic learning experience that promotes unity (Watson 2006:383).

The midwives listed several factors that were deterrents in their work environment. They identified a lack of appreciation by their superiors, professional bodies, doctors and colleagues for the hard work they performed. They felt that managers ignored staff shortages and did not assist in cases of absenteeism. The findings of this study are affirmed by the work by Freeney and Tiernan (2009:1561), which revealed that being undervalued by managers as one of the barriers of nursing engagement which produced uncaring

behaviour, contributed to burnout syndrome. The current study indicates that the midwives experienced prolonged anger and frustration which created a hostile, uncaring environment for patients and juniors. Lack of appreciation goes against Watson's carative factor of providing a supportive, protective and corrective mental, physical, socio-cultural and spiritual environment in which beauty, comfort, trust and peace are cultivated (Watson 2006:383).

Lack of teamwork resulted in a low standard of patient care and increased absenteeism. The few midwives remaining on duty became so overworked that they suffered from burnout syndrome, leading to impatience and impolite behaviour directed at patients. In an Irish study (Begley 2001:231) on relationships in midwifery practice, the findings attributed prolonged feelings of stress, frustration and low morale to medicalised childbirth, which is characterised by loss of professional independence, lack of consultation and being undervalued; a situation which is evident in the private sector in the current study. The same opinion is held by Rafii, Oskouie and Nikravesh (2007:304) in a study about caring behaviour of nurses, which found that irrespective of the positive personal attributes of conscience and commitment that individual nurses possessed, long lasting negative problems in the workplace became evident when nurses suffered from burnout syndrome.

Limitations

The data collection method changed from individual interviews to an open-ended questionnaire and focus group sessions because midwives were unable to verbalise the meaning of caring during planned in-depth interview. In addition, individual interviews with midwives could have added rich data to the study.

Recommendations

The following recommendations are related to practice, research and nursing education.

- Managers need to address and maintain staffing norms in the institutions where they work in order to improve the caring aspect of their personnel.
- Regardless of patients' written reports, uncaring behaviour must be investigated and managed as a matter of urgency.
- There is a need to conduct exit interviews with midwives to gain more understanding of the link between support, burnout and staff turnover.
- Midwifery training should include and emphasise the affective aspect of caring in the curriculum and assess caring behaviour before registration with the South African Nursing Council.

Conclusion

The study provides evidence that some of the midwives demonstrated excellence in caring behaviour by showing compassion, cooperativeness and togetherness.

Unfortunately there is evidence of negative behaviour of some of the midwives exhibited by lack of commitment and appreciation, as well as deficient mentoring and support for newly qualified midwives.

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Competing interests

The authors declare that they have no financial or personal relationship(s) which may have inappropriately influenced them in writing this article.

Authors' contributions

M.E.C. (Tshwane University of Technology) was responsible for writing the manuscript, data collection and analysis. S.C.D.W. (Tshwane University of Technology) was responsible for guidance and supervision with regard to the project and interpretation of the findings.

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