

**Behavioural Ethics among Nurses in Midwife Obstetric Units: Patients and their Perceptions in Cape Town, South Africa**

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**Abstract:** A structured questionnaire survey of randomly selected 229 patients in two public hospitals (maternity wards) in Cape Town, South Africa was done to explore post-natal patients' perceptions towards the ethical behaviour of nurses in their wards. 150 questionnaires received were usable for descriptive, correlation, and exploratory factor analysis (principal component analysis). From the results, inadequate nurses' number, negligence on the part of the nurses, and lack of detailed information to patients are the three clear issues that need to be addressed in these public hospitals to increase patient satisfaction and retention, should they wish to give birth again. Patients' concerns with the nurses' ethical behaviour is related to 'empathy' and 'assurance' dimensions. The importance of these two dimensions cannot be overemphasised in medical care, globally, as they are increasingly becoming the driving forces towards patients' satisfaction and retention. Understanding the individual needs of the patients and showing them that the nurses do care through emotive individualised attention, and acts that raise the confidence levels of patients that the nurses and the hospital will deliver safe services, are recommended.

**Keywords:** *Behavioural ethics, nursing ethics, Midwife Obstetrics Units, maternity, sub-Saharan Africa*

## 1. Introduction

It is common knowledge that medical care is quite complex, and that the medical team, the patients and the patients' relatives are getting well informed on how to resolve ethical concerns within the medical practice. This study is focused on maternity care in hospitals. Midwifery practice in South Africa is an integral aspect of the national health care which provides maternal health care (Dippenaar, 2009). Recent authors on maternity ethics (such as Chadwick et al., 2014; Kim & Kim, 2014; Klomp et al., 2014; Suhonen et al., 2015; Zakaria et al., 2015) conducted most of their studies outside the African continent. Chadwick et al (2014) who conducted their qualitative study in South Africa found that one-third of the women interviewed in the study had positive birth experiences and half of the respondents had negative birth experiences that are related to poor interpersonal relationships with caregivers, lack of information, negligence, and absence of a labour companion. This quantitative study conducted also in South Africa (Cape Town) goes further to explore more conclusive dimensions that women who came to hospitals to give birth regard important for their satisfaction. This study will take a social science perspective on nursing / midwifery ethics rather than medical, as it is only focused on women's (patients) perceptions of nurses' behaviour towards them while they are in the maternal care during labour or birthing. The respondents are not expected to have in-depth knowledge of medical procedures and their consequences. This study's significance lies in the importance of medical practitioners to recognize factors that are important to patients during medical care. Medical care is not exempted from the classical marketing principle of service providers identifying customers' needs and trying to satisfy them. Health institutions have high regard for behavioural ethics that are aligned to the needs and care of patients. Hence the importance of this study in the medical care cannot be overemphasised, as health institutions strive to continuously understand the driving forces towards patients' satisfaction and retention.

## 2. Literature Review

South Africa is not performing well regarding maternal health (Chadwick et al., 2014). In as much as South Africa is classified as a middle-income nation with established health care system and infrastructure, the maternity mortality rate (MMR) has been reported to increase from about 150 deaths per 100,000 live births in 1990 to about 625 deaths per 100,000 births in 2010 (Blaauw & Penn-Kekana, 2010). The MMR for the developed world is estimated at 16 deaths per 100,000 births compared to 240 deaths per 100,000 in the developing world (World Health Organisation, 2012). These figures reveal that the MMR for South Africa is

still high compared to developing world estimates. In 2012, it was reported that more than 52% of maternal deaths in the public maternities in South Africa are related to factors that can be avoided (Saving Mothers 2008-2012, 2013). Nzama and Hofmeyr (2005) posit that there is a dearth of research on the quality of medical care in South Africa, with much research focusing on health systems factors and access to medical care. Few studies revealed that poor intra-partum care affects women's use of maternity care negatively and may actually make birthing mothers hesitant to use health care facilities when they are in labour (Dzomeku, 2011; Tlebere et al., 2007). Understanding how women perceive quality health care in maternities is therefore very important (Chadwick et al., 2014).

As stated earlier, there is a dearth of literature in Africa on maternity health care, especially from the women's perspective (Chadwick et al., 2014). Few studies done in South African public sector obstetric units reported some level of verbal abuse of birthing women, negligence, poor maternal care and practices (such as Human Rights Watch, 2011; Kruger & Schoombee, 2010; Silal et al., 2012; Vivian et al., 2011). Barrett and Stark (2010) reported that modern maternity or obstetric care often subjects women to institutional routines that may have negative effects on their labour progression. Hodnett et al. (2013) posit that some women's experience during childbirth can be dehumanising. Fraser et al (2009) state that the reasons for patients' dissatisfaction with maternity services include fragmented and insensitive care, long waiting times, lack of emotional support, lack or inadequate information, inflexibility in hospital routines, poor medical control, the emotional aspects of hospitalisation and the dehumanising aspects of reproductive technologies. However doctors' and nurses' competency will assure patients that they are well-cared for, well-respected and treated with dignity, even if the experience with the prior hospital bureaucracy was unpleasant. Maputle and Hiss (2010) recommend that midwives have courtesy and respect while relating to patients.

Baston and Hall (2009) posit that there is a high likelihood that the women while being admitted in maternal care will be anxious, as they anticipate an uncertain future. If they are greeted with a smile and warm personal welcome, they will feel better, valued and respected. Caring for birthing women is not an exact science as some will not conform to the expected parameters, hence requiring individual needs to be met. Goethals et al. (2010) call on nurses to consider the values and expectations of patients and their relatives, as nurses' acts are acts of good care, oriented towards the betterment of the patients' overall well-being (Levine & Lowe, 2013). Ingvild et al. (2014) posit that a good midwife is readily available to women in labour, showing kindness and compassion to their concerns and pains. She is obliged to render safe and competent care, as her relationship with patients modulates the experiences of pregnancy, labour, birth and postpartum period. As stated by Tebid et al. (2011), the mother needs not only the physical support during labour, but understanding, respect, alliance, trust, care and warmth as well as encouragement from the nurses/midwives. Moreso, the safety of the mother and child (Halldorsdottir & Karlsdottir, 2011) is as important as preserving the mother's sense of dignity before, during and after childbirth (Torres & De Vries, 2009).

Papastavrou et al. (2011) posit that patients seem to value behaviour that reveal competency on how to perform nursing activities more important than nurses do; as nurses perceive their psychological skills and affective caring behaviour as more important than patients do. However, this study argues that an appropriate combination of competency and empathy will do a lot world of good to an anxious birthing mother, who needs care that is both individualised and holistic in nature. A competent midwife plays a general coaching role to women in labour pain and gives them individualised information about the progress of their labour (Klomp et al., 2014). Sengane (2013) posit that women in labour wish for the constant presence of a midwife, and Eliasson et al. (2008) state that women in labour expect nurses to provide support to them, for example rubbing their backs and abdomen, assisting them to stay in a comfortable position, giving them pain-relieving medications, holding their hands, giving them something to drink, assuring them that everything will be fine, and preparing them for delivery. The marketing concept put forward by Bosworth (1995) that focuses on identifying customer needs and finding ways of satisfying them also holds true for health institutions and medical care.

### 3. Methodology

Quantitative research method is applied to this study as this study takes a more conclusive approach, using the prior qualitative studies done as foundation. The variables (15 items) introduced in the questionnaire battery (close-ended, Likert-type scale questions) emanate from previous studies (such as Chadwick et al., 2014; Halldorsdottir & Karlsdottir, 2011; Kim & Kim, 2014; Ingvild et al., 2014; Klomp et al., 2014; Papastavrou et al., 2011; Suhonen, et al., 2015; Tebid et al., 2011; Torres & De Vries, 2009; Zakaria et al., 2015). The questionnaire explored patients' perceptions of the nurses/ midwives' behaviour towards them during their stay in two public hospitals' midwife obstetric units. These two hospitals are situated in Cape Town, South Africa. The survey of patients in two hospitals is acknowledged by this study as a research limitation, as more public hospitals needed to have been included in this study. However getting consent from public hospitals is very difficult. Consent letters were received from the two hospitals involved before the study was conducted. 229 questionnaires were distributed to post-natal patients in the two hospitals, using a simple random technique at different days, over a period of two months. A total of 150 completed questionnaires received were usable for analysis. The first stage of analysis used descriptive analysis to explore the level of responses to individual variables.

An exploratory factor analysis (EFA), known as Principal Component Analysis (PCA) was conducted at the second stage of analysis, to reduce the relatively large number of the variables used in the questionnaire, grouping them into smaller factors. Both stages of data analysis used IBM's statistical software (IBM Corporation, 2016). Factor analysis has the ability of reducing and grouping variables, establishing underlying dimensions among grouped variables, and providing evidence of scale validity (Hair et al., 2010; Pallant, 2007; Williams et al., 2010). During the factor analysis, the Kaiser's criterion technique was used to decide which factors should be retained, depending on the Eigen value rule to retain factors with Eigen value of 1.0 or more, for analysis (Conway & Huffcutt, 2003; Pallant, 2007; Williams et al., 2010). At the initial stage of factor analysis, four components/factors were generated; however two of the factors have only one variable each. These two variables were eventually removed from the analysis due to their having very low correlations with the other variables, namely: *"Nurses did not explain procedural steps"* and *"I will not recommend this hospital"*. The factor analysis was re-run and two components presented in the results and discussion section of this paper, were generated. These two factors scored an Eigen value of above 1.0, with 49.48% and 9.73% of variance explained respectively. This analysis was followed by the reliability tests of these two components using Cronbach's Alpha reliability coefficient, which measures the internal consistency of variables in a factor/component (Gliem & Gliem, 2003). Cronbach's Alpha score ranges between 0 and 1, where scores that are up to 0.7 generally indicate internal consistency. George and Mallery (2003) advocated that Cronbach Alpha scores' cut-off point of between 0.5 - 0.7 be used. A low Alpha score may suggest that a small number of variables appear within a factor or that there is a poor relationship between variables in analysis (Tavakol & Dennick, 2011). This study considered a Cronbach Alpha coefficient of 0.7 and above to be acceptable in measuring internal consistency between variables in a factor. At the third and final stage of data analysis, Spearman's Correlation test was employed to scan for relationships between patients' statements - ordinal variables (Cessford, 2003; Ezeuduji et al., 2016a, b; Veal, 2011; Zondo & Ezeuduji, 2015).

### 4. Results and Discussion

The results of the descriptive and factor analyses conducted on post-natal patients' statements on how they were treated by the nurses in their wards are shown in Table 1. It is noteworthy that some responses made by the patients may be understood as generally positive, but some significantly negative responses need to be pointed out. Patients made positive responses towards the statements: *'nurses received me with dignity and love'* (about 89% agreed); *'nurses consulted me at procedural steps'* (80% agreed); *'nurses gave good care in labour ward'* (80% agreed); *'nurses worked with care during my labour'* (78% agreed); *'I am comfortable to contact nurses for help'* (about 77% agreed); *'nurses cooperated well with me'* (about 81% agreed); and *'nurses helped me change beds'* (about 75% agreed). Respondents however made significantly negative responses to the statements: *'I was informed of my birth route'* (about 43% disagreed); *'nurses went extra mile to assist me'* (about 35% disagreed); *'nurses assured I was not left alone'* (about 33% disagreed); *'I will come back to this hospital for next birth'* (about 33% disagreed); *'I will not recommend this hospital to others'* (about 45% agreed); and *'care received attests to sufficient staff in hospital'* (about 33% disagreed). These study results

have some conflicting responses given by the respondents, for example, 89% and 80% of respondents agreed to nurses receiving them with dignity and love, and nurses giving them good care in the labour ward, respectively; but 35% of them disagreed that nurses went the extra mile to help them, and 45% of them stating they will not recommend the hospitals to others. It is therefore posited by the researchers that patients have some real concerns towards the nurses, which they were not explicit about, but implicit. It should be noted that the respondents for this study are new mothers and mothers with new babies, and the effect that their anxious state (just after childbirth) can have on their psychology and in their responses cannot be overemphasised (see Baston & Hall, 2009). This is one of the major weaknesses of social sciences research, hence researchers always need to 'read between the lines', in interpreting the data collected.

In as much as nurses should always endeavour to go the extra mile in attending to patients and play the companion role for women in labour; however from these results, it seems that inadequate nurses' number, negligence on the part of the nurses, and lack of detailed information to patients are the three clear issues that need to be addressed in these public hospitals, to increase patient satisfaction and retention, should they wish to give birth again. This finding supports Chadwick et al. (2014) finding that lack of information, negligence, and absence of a labour companion are some of the negative experiences of maternity ward patients in South Africa. The 45% of patients who stated they will not recommend the hospitals to friends and relatives raise a strong alarm towards the nurses and the healthcare system in these maternity wards. These results support Chadwick et al. (2014) position that South Africa is not performing well regarding maternal health; and Saving Mothers 2008-2012(2013) report that more than 52% of maternal deaths in the public maternities in South Africa are related to factors that can be avoided. Dzomeku (2011) and Tlebere et al. (2007) therefore posit that poor intra-partum care affects women's use of maternity care negatively and may actually make birthing mothers hesitant to use health care facilities when they are in labour.

As earlier stated in the research design and method section, the factor analysis conducted generated two factors significant for the results of this research, self-named by the authors as 'empathy' and 'assurance', and contain variables relating closely to each other within the particular factor or dimension (Table 1). The 'empathy' dimension contains seven variables and the 'assurance' dimension contains six variables. These dimensions were labelled as such, as the variables in each factor can be explained by these labels. Respondents mostly agreed to these statements (see mean values), depicting that the satisfaction levels are relatively acceptable. The factor analysis however brought to fore, the importance of the 'empathy' and 'assurance' dimensions in the medical care. These dimensions drive patients' level of satisfaction during their medical care and can support their decision of coming back to the hospitals' services or not. The 'empathy' factor has strong focus on understanding the individual needs of the patients and showing them that the medical practitioners do care through affective or emotive individualised attention. The 'assurance' factor focussed on the confidence that patients have not only towards the nurses, but also towards the hospital to deliver safe services.

**Table 1: Descriptive and factor analyses: ethics in nurses' behaviour, items and statistics (n = 150)**

Behavioural dimensions	Items	Agree or strongly agree (%)	Disagree or strongly disagree (%)	Factor Loading	Mean	±SD	Cronbach Alpha	Variance explained (%)
<b>Empathy</b> (7 items)	Nurses gave good care in labour ward	80	20	0.783	1.93	0.757	0.866	49.482
	Nurses received me with dignity and love	88.6	11.4	0.751	1.83	0.689		
	Nurses consulted me at procedural steps	80	20	0.727	1.95	0.797		
	I am comfortable to contact nurses for help	77.4	22.6	0.650	2.00	0.786		
	I was concerned for my child's safety	82.6	17.4	0.635	1.87	0.771		
	Nurses worked with care during	78	22	0.600	1.99	0.768		

	my labour							
	I was informed of my birth route	56.7	43.3	0.600	2.27	0.793		
<b>Assurance items)</b>	(6 Care received attests to sufficient staff	67.4	32.6	0.792	2.14	0.795	0.846	9.728
	Nurses helped me change beds	74.7	25.3	0.777	2.03	0.750		
	I will come back for next birth	66.6	33.4	0.658	2.17	0.862		
	Nurses cooperated well with me	80.7	19.3	0.653	2.03	0.704		
	Nurses went extra mile to assist me	64.6	35.4	0.593	2.23	0.787		
	Nurses assured I was not left alone	67.4	32.6	0.557	2.10	0.825		
Variables removed from factor analysis	Nurses did not explain procedural steps	36.0	64.0	Variable removed from factor analysis				
	I will not recommend this hospital to others	45.4	54.6	Variable removed from factor analysis				

Extraction Method: Principal Component Analysis; Rotation Method: Varimax with Kaiser Normalization; Rotation converged in 3 iterations; Cumulative variance explained: 59.21; Kaiser-Meyer-Olkin Measure of Sampling Adequacy: 0.928; Bartlett's Test of Sphericity: 0.000; Two variables removed from the analysis due to very low correlations with the other variables: "Nurses did not explain procedural steps" and "I will not recommend this hospital"; Items were arranged according to results of factorial analysis (Eigen value > 1) and factorial loadings > 0.43 (Costello & Osborne, 2005); Questionnaire were itemised along a 4-point Likert-type scale: 1, strongly agree; 2, agree; 3, disagree; 4, strongly disagree.

As earlier reported, a competent midwife makes a birthing mother feel safe. She is physically and emotionally there to expertly support the women in labour pain and give them individualised information about the progress of their labour, assure them that they will be fine, and actively be involved in making them fine at the end (Eliasson et al., 2008; Klomp et al., 2014; Sengane, 2013).

The last stage of data analysis tested for cross relationships between 'empathy' and 'assurance' variables (Table 2). Correlation test revealed much positive correlation between variables in the 'empathy' and 'assurance' factors or dimensions, showing that the more patients agree to the variables found in the 'empathy' dimension, the more they agree to the variables explaining the 'assurance' dimension. This result further validates the finding that 'empathy' and 'assurance' related behaviour exhibited by nurses are important in drawing the trust and confidence of the patients during medical care, as nurses and other medical practitioners strive to deliver proper medical services. The correlation test also showed that in as much as there are positive correlations between 'empathy' and 'assurance' dimensions, the variable - 'nurses helped me change beds', found in the 'assurance' factor has no correlation with the 'empathy' variables - 'nurses received me with dignity and love', 'nurses consulted me at procedural steps', and 'I was informed of my birth route'. Patients therefore, do not relate nurses helping them to change beds with 'empathy'. Much of the patients who agreed that 'they were informed of their birth route' ('empathy' variable), did not agree that the 'care they received attests to sufficient staff' ('assurance' variable), showing no bivariate relationship. Generally speaking, the results in Table 2 can still be interpreted thus: there is a strong positive correlation between 'empathy' dimension and 'assurance' dimension in medical care.

**Table 2: Correlation test: ‘empathy’ versus ‘assurance’ factors / dimensions (n = 150)**

<i>Assurance (6 items)</i>	Care received attests to sufficient staff	Nurses helped me change beds	I will come back for next birth	Nurses cooperated well with me	Nurses went extra mile to assist me	Nurses assured I was not left alone
<b>Empathy (7 items)</b>						
Nurses gave good care in labour ward	***	***	**	***	***	***
Nurses received me with dignity and love	***	NS	***	***	***	***
Nurses consulted me at procedural steps	***	NS	***	***	***	***
I am comfortable to contact nurses for help	***	***	***	***	***	***
I was concerned for my child’s safety	***	*	**	***	***	***
Nurses worked with care during my labour	***	***	***	***	***	***
I was informed of my birth route	NS	NS	***	***	***	***

Notes: Spearman’s Correlation test significance. \*,  $p < 0.05$ ; \*\*,  $p < 0.01$ ; \*\*\*,  $p < 0.000$ . NS, no significant results.

These findings are supported by the results put forward by Tebid et al. (2011), that the mother needs not only the physical support during labour, but understanding, respect, alliance, trust, care and warmth as well as encouragement from the nurses/midwives. Halldorsdottir and Karlsdottir (2011), and Torres and De Vries (2009) also posit that the safety of the mother and child is as important as preserving the mother’s sense of dignity before, during and after childbirth. From the findings, this study argues that an appropriate combination of competency and empathy will do a lot world of good to an anxious birthing mother, who needs care that is both individualised and holistic in nature.

## 5. Conclusion

This study shows that post-natal patients surveyed are somewhat satisfied with the treatment they received from the nurses in the maternity ward. However, the 45% of patients who stated they will not recommend the hospitals to friends and relatives raise a strong alarm towards the nurses and the healthcare system in these maternity wards. Nurses should always be encouraged to go the extra mile in attending to the birthing mothers and always be there as companions while the women are in labour and after they have given birth. Lack of detailed information to patients, negligence on the part of the nurses, and inadequate staff number are the three clear issues that need to be addressed in these public hospitals, according to the study results, to increase patient satisfaction and make them come back to the hospital, should they wish to give birth again. The Government of South Africa through its National and Provincial Departments of Health must ensure that there are adequate numbers of midwives/nurses in the public hospitals’ Midwife Obstetric Units, and these nurses/midwives should continue to be actively involved in continuous training and development exercises that are geared towards extensive and personalised medical care and ensuring adequate information are given to patients, whilst avoiding role conflict with the doctors. This research also infers the emphasis that must be placed on ‘empathy’ and ‘assurance’ dimensions of the medical care. These dimensions are increasingly driving patients’ level of satisfaction during their medical care and can also support their decision to come back to the hospitals’ services or not. The emotive individualised attention afforded to birthing mothers and the confidence given to these patients that the nurses and the hospital will deliver safe services are critical for success. This study therefore argues that an appropriate combination of nurses’ high level of competency and appropriate empathy towards the anxious birthing mothers will make their medical care more holistic in nature.

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