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DEVELOPING COMPETENCY BASED SCENARIOS FOR MIDWIFERY PRACTICE IN SLOVENIA

RAZVOJ SCENARIJEV, KI TEMELJIJO NA KOMPETENCAH ZA BABIŠKO PRAKSO V
SLOVENIJI

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KLJUČNE BESEDE: *kompetence, babice, scenariji*

ABSTRACT

Introduction: This article presents four scenarios as single cases which are being tested for targeting appropriate midwifery competencies. Such scenarios could be used for educational and research purposes.

Methods: Case study was used, where scenarios were presented to midwives, and taped interviews were performed in 2004 and 2005.

Results: Analysis of the data demonstrates that competencies are generally well targeted. On the other hand, the responses indicate the medicalisation of the health system through routine practices being used in maternity care.

Discussion: This research provides an insight into Slovenian midwifery care with some critical findings. However, some valuable recommendations for midwifery research and training are given.

IZVLEČEK

Izhodišča: Predstavljeni so štirje testirani scenariji, ki se nanašajo na določene babiške kompetence. Tako razviti scenariji bi lahko bili primerni za uporabo v izobraževalne in raziskovalne namene.

Metode: Kot metoda je bila uporabljena študija primera iz let 2004 in 2005, kjer so v intervjujih babice odgovarjale na predstavljene scenarije.

Rezultati: Analiza podatkov kaže, da se scenariji v večini primerov nanašajo na kompetence. Odgovori kažejo tudi na medikalizacijo zdravstvenega sistema z uporabo rutinskih metod in praks v skrbi za ženske.

Diskusija: Raziskava ponuja kritičen vpogled v slovensko babiško nego. Podani so predlogi za nadaljnje raziskave in nadaljnje izobraževanje.

Introduction

The author's interest in the topic of midwives' competence began as she commenced her post-graduate studies at Glasgow Caledonian University. There, she discovered the nature of midwifery practice in a number of different countries in the world, as she worked with students from around the globe on problem-solving exercises related to midwifery throughout the world. From much earlier she had always intuitively felt that pregnancy and birth were normal events in a woman's life. She was privileged to see a midwife providing true, woman-centred care to a friend of hers, and since then she has always felt the midwife is the most appropriate primary caregiver that will respect a woman's choices throughout maternity care.

Conversely, as a student in the Midwifery Department of the College for Health Studies in Slovenia,

the author usually saw midwives in the role of obstetric or paediatric nurses, being nothing more than a »helping hand« to doctors, in a system of fragmented, medicalised maternity care. Although she completed her education as a midwife, she was never able to recapture the special feeling that had first led her to seek this education. However, when she entered her post-graduate studies she found that the doors to another world opened, thus enabling her to broaden her horizons considerably.

Midwifery education in Slovenia has been adjusted to European Union (EU) regulations. This should produce competent midwives able to take full responsibility for their actions. This more professional status and greater autonomy will bring with it autonomous decision-making and, therefore, professional responsibility and accountability. The concern remains that, while technically competent,

Slovenian midwives are unable to practise fully according to the International Definition of the Midwife (ICM, 2005), and thus the topic of this article (which is a snapshot of the author's master's dissertation) was established.

This pilot research was part of a larger EU competency research project exploring midwives' competencies throughout Europe. Although the primary aim of the research was to see if the scenarios developed for this project target specific competencies of midwives, this study has also given insight into the current situation of the competencies of midwives in Slovenia.

Competence

There is no single clear definition of the term »competence« in the literature. Indeed, the literature appears confusing and contradictory (Giro, 1993), and the term competence seems to be over-defined (Eraut, 1994). In fact, competence appears to be a nebulous concept (Watson et al., 2002) defined in various ways by different people.

In his review of the definitions and meanings of competence, Eraut (1998) distinguishes between those authors who treat competence as a socially situated concept – i.e. the ability to perform tasks and roles to the standard people expect – and those who define it as individually situated – i.e. as a set of personal capabilities or characteristics to perform tasks and fill a role. Eraut and Boulay (2001) argue in favour of a socially situated definition, as the notion of competence is central to the relationship between professionals and their clients; recommending using the word »capability« to describe the individually situated concept of what a person can think or do. Whether or not a person's capability makes them competent in a particular job depends on their being able to meet the requirements of that job. Hence, competence in a job is defined as the ability to perform the tasks and roles required to the expected standard (Eraut, Boulay 2001).

From an American perspective, Nagelsmith (1995) summarises competence in her literature review as a combination of knowledge, skills, attitudes and values. Throughout her concept analysis she also notes that there is often a perceived need to specify competencies for nursing students, and that these will vary depending upon the context in which the competencies are to be practised. She refers to formal and informal definitions of competence which, according to her, are the basis for the understanding of competence. However, as the primary foci of her article are reflection, visualisation, analysis, perception, thought and contextualisation of competence in relation to basic nursing education, her work has limited value for qualified midwives.

In relation to midwifery, Worth-Butler, Murphy, Fraser (1994) literature review indicates the importance of an adequate definition of the competent midwife in the rapidly changing midwifery needs of childbearing women and society. They acknowledge the UK government's recognition of midwives as the only professionals equipped to provide care for women experiencing normal pregnancy and childbirth. However, they also point out that the government gives no clear definition of what constitutes competence in midwifery. According to Worth-Butler, Murphy, Fraser (1994), this could be a threat to the facilitation of the needs of childbearing women and their families, especially as these become more clearly articulated. Worth-Butler et al's literature review covers issues such as competence in midwifery, nursing and industry, but the primary focus of their discussion is to discover what might constitute a definition of competence in midwifery. They give guidelines to the baseline of competence, but no specific definition of competence is established.

Development of competence

In order to »delineate the knowledge, skills and behaviours that would characterise the domain of competencies of a midwife who is educated according to the international definition of the profession« (Fullerton et al., 2003) in 1996, the International Confederation of Midwives (ICM) agreed to proceed with a two-phase study through which core competencies would be developed (phase I). Subsequently, in 1999, a study reviewed the competencies for their relevance in ICM-member associations (phase II). They named them »essential competencies«, but the term »core« and »basic« are considered to have the same meaning (Fullerton et al., 2003).

The study was conducted in 17 ICM Member Associations during 2001. Extensive field testing was undertaken by 1,271 practising midwives, 312 educators, 333 senior level midwifery students from 22 countries, as well as 25 regulators from 20 countries (ICM, 2002). A total of 214 individual competency statements within six domains were presented for consideration and comment. Almost all of the competencies were supported by a great majority of the persons/groups involved in the testing, with many receiving universal support. In April 2002 the ICM discussed and adopted the Essential Competencies for Basic Midwifery Practice, thereby establishing it as an official ICM document (ICM, 2002). While the authors used a robust sampling technique, they were unable, due to financial resources, to carry out a power calculation. To ensure validity the authors also acknowledge that in some regions, accessibility rather than representativeness directed the sample. An additional limitation of the study is that it drew on competencies

designed in the USA, rather than generating them from ICM members worldwide.

It is hard to compare the ICM's essential competencies with the Core Competencies for Midwifery Practice developed by American College of Nurse-midwives (ACNM). From reading ACNM's Core Competencies for Midwifery Practice it is noticeable that from time to time they are very general and do not focus on procedures, tasks and skills. This is also a problem in certain parts with the ICM's essential competencies. The ACNM's Core Competencies for Midwifery Practice have newborn care limited up to 28 days post partum, while the ICM competencies give newborn care for up to two months. On the other hand, the care of the woman according to the ACNM exceeds the ICM, as the ACNM take into consideration the women that are aging (i.e. menopausal, post-menopausal).

Although the ICM (2002) states that the essential competencies for basic midwifery practice are based on the values, vision, strategies and actions used by those who attend to the health needs of women and childbearing families, by missing out the major section of the care of aging women, the ICM are removing this responsibility from midwives and transferring it to other health professionals.

Methods

As mentioned above, the dissertation was part of a larger research project which is running in several European countries. The overall aim of this research was to test the fit between scenarios and ICM essential competencies. The aim of this dissertation is to test in Slovenia four of these scenarios designed to assess midwives' competencies.

The case study was chosen as the most appropriate methodology to address the research question. The rationale behind this is supported by Yin (2002), who states that an exploratory case study is appropriate to determine the feasibility of the desired research problems. Also, Field and Morse (1989) and Polit and Hungler (1998) suggest that case studies are in-depth investigations of a phenomenon, which according to Yin (2002) may also be a project or programme. Therefore, a case study can be seen as not only a research method, but also a methodology.

Case study has been promoted by researchers across a number of disciplines such as psychology (Yin, 2002; Bromley, 1986), education (Stake, 1985), law and medicine (Stake, 1995). Case study has also been used in midwifery; for example Maloney (1992), in order to explore midwives' perceptions of midwifery practice, used a critical reflective analysis approach to five practising midwives. This multiple case study produced much significant information, which changed midwifery practice in New

Zealand. The single case approach study was used by Fleming (2003) in order to explore the meaning of the experience of abdominal hysterectomy for a woman. She identified four major themes relating to participants' experience and justified well the rationale for choosing this research approach. In general, nursing and midwifery research books, such as Polit and Hungler (1998) or Skodol (1999) frequently refer to case study as an accepted research approach.

An embedded multiple case study explores four different scenarios, where each scenario is treated as a case according to Yin's (2002) criteria. Each case has been tested at least six times (see method section) and each scenario interview is considered as a unit of analysis. Bergen and While (2000) point out that the most important factor of replication logic, in such cases as in this dissertation, is that the data in sub-units is not pooled across cases, but is rather analysed within the cases themselves.

A group of experienced midwives, drawn from clinical and academic settings in Glasgow, developed 27 scenarios which target specific ICM essential competencies. These were carefully designed to address each of the ICM competencies, yet to represent realistic practice situations in Europe. Two scenarios addressed the pre-conception period, 17 the antenatal period, four labour, two the post- and two the neonatal period. In addition to this part of the project, all the scenarios are being tested in Slovenia as well as in Scotland, Germany and Kosovo in a project led by Glasgow Caledonian University. These countries were carefully chosen to reflect one long-standing member of the EU (UK), one country half of which was an original EU member (West Germany), one new EU member (Slovenia) and a non-EU member (Kosovo). Some preliminary work on this project has been published (Fleming et al., 2006, Zakšek et al., 2006).

All scenarios have already listed target competencies from the ICM (2002). This was done by the group of clinical and academic midwives who originally created the scenarios. The scenarios were translated into Slovenian and were verified by an experienced midwife who spoke fluent English.

Each scenario was tested at least six times.

Ethical issues

Relevant permission was sought for this project. Ethics permission was sought, in the first instance from Glasgow Caledonian University, and later from the clinical setting authorities who gave their verbal consent to allow the participation of their employees in the study. The main ethical issues in the dissertation are those of informed consent, anonymity, confidentiality and the right to withdraw.

Study setting and sample selection

The sampling strategy was approved by all those participating in conducting the European study. In Slovenia the setting for the labour scenarios part of the study was mostly in two large hospitals, and the setting for the other scenarios was in other appropriate clinical areas.

Midwives who work in clinical settings which cover the chosen scenarios were selected to participate in this research. *Purposive sampling* (Patton, 1990) was used in this research. With this approach, early sample members are asked to identify and refer the researcher to other people who meet the eligibility criteria (Polit, Hungler, 1998). Therefore the author approached a few midwives she knew from her own midwifery training. They later directed her to their colleagues for further interviews. This *snowball or chain sampling* is a sub-type of purposive sampling and is often used to capture appropriate participants for information rich interviews (Patton, 1990).

Inclusion criteria were the following:

- Midwife.
- Three years of practice.
- Volunteer.
- Working in an area the scenario covered.

One important criterion was that the midwives who were interviewed had to work in the area that the scenarios covered. For example, if a scenario targeted labour competencies, the author approached midwives working in the labour ward.

She approached them directly.

As soon as they had given verbal consent, she approached their supervisor. This was not required, but the author knew that if midwives were »compelled« by their supervisor to participate, the answers might not be as good as they could be. Also, by asking the midwives first, she already knew that they were willing to participate. Two supervisors invited her to a meeting at which she presented the study. After this, verbal approval had to be acquired from the authorities of the clinical setting. No supervisors requested documentation.

Data collection

Evidence for case studies can come from six sources: documents, archival records, interviews, direct observation, participant-observation and physical artefacts (Yin, 2002). Although he discusses the strengths and weaknesses of each one of these, Yin concludes that none of them has an advantage over the others. He recognises that case studies can use both quantitative and qualitative methods of data collection.

Focused interviews were used as the data collection tool in this dissertation. Yin (2002) supports focused interviews as an appropriate data collection tool. He prefers interviews that are open ended in nature. It is best to ask only leading questions, but this may not completely serve the purpose of the interviews. In this study, the scenarios that are given are considered to be focused on specific competencies, but the interviews were totally open and directed by the participants.

All the midwives the author interviewed were informed that they would be recorded during the interview. They were provided with a description of a case, a paper, and a pencil. They were instructed to read the scenario and to take five minutes to think about what they would do if they were the midwife in this scenario. In those five minutes they could also write down bullet points. They were told that additional information on the scenario could not be provided. The author then turned on the tape recorder, and they talked about the scenario until they told her they had nothing more to add. Each scenario usually took over half an hour. Altogether, the interviews took around three months to tape and transcribe.

Data management and analysis

Yin (2002) considers data analysis one of the least developed and most difficult aspects of a case study. Although admitting that strategies and techniques are not well defined, he recognises that examining, categorising, tabulating and testing data address the initial propositions of the case study.

In this dissertation a systematic framework approach was used for data analysis and presentation. The systematic framework approach was described by Ritchie and Spencer (1994) as an alternative for analysing qualitative data and to overcome the problems recognised by the above-mentioned authors.

This approach has five steps:

- Familiarisation: the investigator becomes familiar with the amount and diversity of data collected.
- Identification: the investigator defines a framework.
- Indexing: the data from every case are applied to the framework.
- Charting: data are lifted from the investigator's original context and rearranged according to the appropriate thematic reference.
- Mapping and interpretation: the investigator defines a strategy which illuminates the dynamics of the phenomena under investigation.

After taping the interviews, they were transcribed, verbatim where possible. Sometimes matching English

phrases were substituted for literal translations. (For example: »Ženo damo na čisto« literally means »we put the woman on the clean«, which was rendered in English as »we clean the woman«).

Interviews were listened to and read through several times to assess the diversity of the data and key words were identified. Beyond the literal meaning of the text, key words which illuminated the subtext were also noted.

For example, when a midwife said:

»First, I would ask the woman how she feels, then I would...after that, I would...«

This sentence produced many different keywords which matched the ICM essential competencies, but »priority setting« (not one of the ICM essential competencies) was also extracted as a key word in this context.

Extracting keywords from the transcripts was very time-consuming. Each of the transcribed texts was searched sufficiently (never fewer than three times) for new keywords to be identified. These key words were translated into English and competencies drawn from them (see Example 1). The targeted ICM essential competencies were identified.

Example 1:

Case 6/1

Sentence SLO: »Posnela bi CTG.«

Sentence ENG: »I would record a CTG.«

– Key words:

-recording ctg-

– Drawn competence (midwife would):

-record ctg-

– Matching ICM competence:

4(a)6: »measures to assess fetal well being in labour«

In general, all statements from the participants were converted into appropriate competencies and highlighted in an Excel spreadsheet, where expected competencies were highlighted in yellow, making them easier to read if appropriate competencies were targeted.

This systematic procedure was carried out in all cases and recorded in the same way. The same table is presented so that it can be easily checked by anyone, as every step of the analysis was made for each case. Data analysis for this study is stored in a file where every case is stored under its own code. The codes are assigned systematically; the first interview for scenario six is coded as 6/1; similarly, the third interview taped for scenario 13 is coded 13/3.

Following the analysis of the data, the first results showed that some of the competencies did not match

the scenario. This could have been either because they are country specific or for other reasons. In research meeting groups, the researchers decided to either discard some of the competencies, or more commonly, had to add competencies not on the initial list.

Results

Scenario 13

»Mary is 20 years old; she has been married for 1 year; her husband is 23 years old. She arrives at the health centre to see the midwife; she thinks she may be pregnant because she cannot eat due to nausea and vomiting at different times of the day. She is so tired that she falls asleep in the middle of the day. Her mother has told her she must be pregnant, but Mary doesn't understand how she could have become pregnant because she has always used contraceptives. After Mary's pregnancy is confirmed, she is very emotional, ranging from delight to disbelief. The midwife proceeds to talk to Mary about her pregnancy and her health.«

Discussion

This ante-natal scenario describes a young pregnant woman who is uncertain of her feelings about being pregnant meeting her midwife for the first time. The scenario applies well to the Slovenian situation. As mentioned at the beginning of the chapter, Mary would meet a midwife in a specialized outpatient clinic or receive a visit from a district midwife. The former situation would more probably arise, because women usually turn to gynaecological specialized outpatient clinics when they are pregnant.

Midwives' limited role in ante-natal care (cf. the beginning of the chapter) was reflected in their responses to the scenario. Both midwives working in specialized outpatient clinics and district midwives were strong in the second domain of the ICM essential competencies; their answers for the third domain also showed that they have some knowledge of counselling during pregnancy; but all failed to demonstrate any skills which would target the competencies in domain 3 (b). It was expected that their answers might be limited, but it was not expected that they would fail to target such simple competencies as »assessing maternal vital signs«. Although they are autonomous in some procedures they perform which are also listed under 3 (b) domain, they failed to express any skills and rather referred Mary to a doctor. This appears to be an example of learned helplessness (Freire, Shor, 1987), and is a consequence of the medicalised health system dominant in the previous regime, and which Slovenia is now trying to reform.

Comparing this phenomenon in other participating countries it became obvious that the same situation appeared with Kosovar midwives. This can be linked to a joint history, when both countries were once part of the same country under the same communist regime. Health care was highly medicalised at that time, with doctors considered superior to midwives, who at that time had only secondary-level education. It has to be acknowledged that although ICM's essential competencies strongly emphasise the midwife's autonomous role, they also include referral to doctors.

However, midwives were very strong in offering emotional and non-judgemental approaches to women like Mary. Most of them showed a partnership approach in which, says Pairman (2000), the midwife offers information, and the woman is supported in making informed decisions about her care. Indeed, the midwives interviewed did not try to influence any decision, but presented certain facts and options Mary could find useful.

Conclusion

When the Slovenian results were compared to those of other countries, both the qualitative data and those from the Excel spreadsheet were considered. The expected competencies were slightly adjusted, although it was felt by researchers who are participating in the wider European project that it was unnecessary to modify this scenario.

From the results that emerged it was evident that this scenario can be used for educational and research purposes.

Scenario 6

»Soraya is 20, and lives 10 miles from her nearest maternity hospital. She is now at term and looking forward to the birth of her first child. At 1 am Soraya is woken with weak contractions, which recur every 20 minutes, and her back aches. Her husband contacts a friend who is going to be with Soraya until she goes to the hospital. By 5am the contractions feel much stronger and are coming 3-4 minutes apart, and Soraya is beginning to feel anxious and wishes to go to hospital. At 6am Soraya reaches the hospital and is met by a midwife who assesses her status. Both Soraya's husband and a friend are with her. The midwife is with Soraya throughout her labour. Soraya refuses any pain relief, and her husband and a friend rub her back. At 11.50, her membranes rupture and at 12 midday Soraya feels the urge to push. At 12.40, a baby boy is born, weighing 3.5kg, with an Apgar score of 9 and 9. Mother and baby bond immediately. Fifteen minutes later, the 3rd stage is completed; actual blood loss is minimal.«

Discussion

The scenario describes a non-interventionist birth which is still a rarity in Slovenia. One of the participants described this birth as »alternative«. In Slovenia the word »alternative« has a negative connotation. Sometimes it is used to describe people who do not live by »what most people consider to be a norm«. So if a woman refuses pain relief and insists on spontaneous rupture of membranes, she definitely would be stigmatized as an »alternative« person. The fact that the scenario applies well to Slovenian circumstances only in the first two sentences soon became obvious.

It was expected that all participants who spoke about the first and second stages of labour followed the same routine practice, with procedures still being performed without evidence-based practice, such as administering an enema or rupturing membranes. It was shown in clinical trials that women find enemas embarrassing and unpleasant, and there is no proof that enema has any influence on delivery time. Further, research indicates that rupturing membranes does not shorten labour by any significant amount, but increases the risk of infection (Goer, 1995). The situation in Slovenian midwifery is a consequence of changes in midwifery education in the last 20 years and is rapidly being improved by »newcomers«, i.e. newly graduated midwives who are now employed.

Midwives interviewed about this scenario all had over 15 years of experience, and 15 years ago women had even fewer rights to decide for themselves. Although enemas and shaving of the perineum is a woman's choice, it was expected that midwives would introduce these procedures to women as necessary, more or less without the chance of their making choices for themselves. This kind of procedure, according to Chalmers (2000), are abusive and make woman feel psychologically and physically battered. ICM essential competencies do not mention any such procedures.

Another of the expected findings was midwives' reliance on doctors. Although midwives spoke about doing things according to doctors' instructions, this does not mean that they are unable to do things by themselves. Again, the hierarchical structure is what keeps midwives in place.

It was not expected that midwives would talk extensively about procedures which they carry out on a newborn baby. The phrase »taking care of the baby« encompasses all the procedures performed after a baby is born. However, if this research were conducted by someone with no knowledge of the Slovenian maternity service, this term could have created difficulties for the researcher.

Conclusion

When the results were compared to expected ICM essential competencies, it soon became obvious that

midwives failed to target the expected competencies in the fourth domain, which describes the first and second stages of labour, but did well on the part which describes the third stage of labour. As already mentioned, of the six participants interviewed, four spoke briefly about the first and second stages of labour procedures, and two not at all. In comparing the results with those in other three countries participating in this research, it became evident that they had similar results.

Researchers felt that this was because the scenario is too long, so midwives have too much information, and either speak briefly about the first and second stage procedures, or even tell the story from the end. Therefore it was necessary to split the scenario. We divided the scenario, and gave midwives each part separately, as follows:

Scenario 6 revised

»6 a) Soraya is 20, and lives 10 miles from her nearest maternity hospital. She is now at term and looking forward to the birth of her first child. At 1 am Soraya is woken with weak contractions, which recur every 20 minutes, and her back aches. Her husband contacts a friend who is going to be with Soraya until she goes to hospital. By 5am the contractions feel much stronger, and are 3-4 minutes apart, and Soraya is beginning to feel anxious and wishes to go to the hospital. At 6am Soraya reaches the hospital and is met by a midwife.

6b) Soraya, who is having difficulty coping with contractions, is attended by a midwife throughout her labour.

6c) At 11.50 her membranes rupture, and at 12 midday Soraya feels the urge to push.

6d) At 12.40 a baby boy is born, weighing 3.5 kg, and with an Apgar score of 9 and 9.

6e) Shortly afterwards the placenta is delivered.«

Scenario 5

»Blerta has just given birth to a 4.5 kg baby boy; the third stage was completed 20 minutes later, and appeared to be without complications. Whilst drinking a cup of tea, Blerta comments on the fact that she feels she is losing a lot of fluid vaginally and is now feeling nauseous. On checking Blerta's vaginal loss, it is found she is sitting in a pool of blood. Blerta begins to shiver, is feeling more nauseous and slightly dizzy.«

Discussion

This scenario clearly describes post-partum hemorrhage. Although in Slovenia PPH is recorded after

women experience blood loss over 500 ml of blood, this estimate is sometimes deceptive. Women with severe anaemia could not stand even a smaller amount of blood loss. It is almost impossible to meet extremely anaemic women in Slovenia. There is poverty in some areas, but women are usually well taken care of during pregnancy, and cases of anaemia are treated.

As has been shown from the data above, midwives who participated in this study set clear priorities for carrying out essential first aid and assessing the cause of the haemorrhage. All of the midwives were able to demonstrate competence in the management of PPH according to the ICM's criteria, because »Manage post-partum hemorrhage« is listed as a single competence (ICM, 2002) unlike the third stage of labour, in which several competences are listed.

In comparing the results in Slovenia with those from the other three countries, it became clear that midwives in Europe use different procedures to manage PPH. According to the WHO's, UNPFA's, UNICEF's and World Bank's »Managing complications in pregnancy and childbirth, manual for midwives and doctors« (2000) procedures for acting in the case of PPH are clearly listed and are appropriate for the Slovenian setting. Additionally, the ICM and FIGO (ICM, 2006) gives similarly concise instructions for the prevention of PPH, while acknowledging that this is not always possible.

The competencies the researchers expected as a result of this scenario did address these wider issues, and the author has shown above how midwives thought beyond the first aid measures, suggesting that the ICM's essential competencies could be widened when they are next revised.

One of the unexpected findings concerned documentation. The author expected, as had the whole research team, that participants would have talked about this essential part of the scenario. In reality, only one of midwives mentioned how procedures and observations need to be recorded. In discussion with other researchers and from our own practical experience, it was believed that this was so routine that participants simply forgot to mention it. This was confirmed in the interviews, where it was seen that in such emergency situations midwives do prioritise the procedures they think are most important. The way they decide what to do first depends on their perception of the situation. It also depends on their ability to participate in such interviews; many claimed that they would know what to do if a particular situation occurred, but describing the procedures in an interview is something different.

Less unexpected was the finding that the midwives in this study were heavily reliant on doctors' instructions, even though many were very experienced and knew exactly what to do and how to do it. The behaviour of the midwife appears to suggest a learned helplessness (Freire, Shor, 1987), with hierarchical

structures keeping the midwives in their prescribed place in the social order. As Lukes (1974) points out, this reinforces and maintains professional practices based on the belief that doctors are superior to midwives. This is not unique to Slovenia, as the results from the Kosovar midwives showed a similar pattern. It could be linked to the recent communist regime in these countries, in which no one was allowed to act outside their own roles. The ICM's essential competencies targeted by this scenario do not exclude referral to a doctor, but do strongly indicate the midwife's autonomous role.

Conclusion

When the Slovenian results were compared with those of the other countries, both the qualitative data and those from the Excel spreadsheet were taken into account. The expected competencies targeted by the research were slightly adjusted, but it was felt unnecessary to make any substantial changes to this particular scenario.

From the results derived from all four countries it was evident that the scenario can be used for educational and research purposes, as initially intended.

Scenario 4

»Mohammed was born weighing 2.5kg. He is now 24 hours old, very sleepy, not feeding well and jittery. He has a small cephalo haematoma, looks slightly jaundiced, and is quite cool to the touch.«

Discussion

The scenario describes a 24h old baby boy with jaundice and some other potential health problems for whom no information on place of birth or his mother is given. As was expected, the fact that scenario does not give enough information on Mohammed e.g. where he was born, where he was found, was disturbing for the majority of midwives participating.

As can be ascertained from the data above, midwives assessed the situation first and later set priorities. As in the other scenarios, this was called *priority setting*. This is not a competence listed in ICM (2002). ICM essential competencies do mention decision making, but priority setting seems to be a higher level competence. And indeed, Juceviciene and Lepaite's (2005) hierarchical structural unity, confirms that. They claim that performance at different hierarchical levels demands different levels of competence. According to the authors, this is a fourth level competence, which could be called *the holistic competence*.

We can make decisions on what to do next, but we also need to know what is most urgent, meaning that we have to know how to prioritize. Priority setting was also a competence which emerged strongly in testing

this scenario in other countries participating in this research. As expected, midwives later talked about essential first aid, depending on how serious they thought the situation was.

The finding that midwives in Slovenia fail to meet competencies under the fifth domain, of discussing post-natal care for women, was unexpected. They did mention the mother, but briefly, and did not target any of the expected competencies under this domain. Similar results were found among Kosovar and Scottish midwives, who also gave weak replies in this section of ICM essential competencies. German midwives targeted the fifth domain very well.

Less unexpected was the discovery of another competency which is not listed in ICM, but in Slovenia it is much respected. This is ensuring a safe environment for the baby in its broader or narrow meanings. This competence was not obvious in other countries.

Conclusion

When the Slovenian results were compared with those in other countries, the expected competencies targeted by the researchers were adjusted. It was felt by the researchers that another sentence, which would make midwives to target the fifth domain, needs to be added, as below.

Revised scenario 4

»Mohammed was born weighing 2.5kg. He is now 24 hours old, very sleepy, not feeding well and jittery. He has a small cephalhaematoma, looks slightly jaundiced, and is quite cool to the touch. His mother is having trouble breastfeeding.«

However, the research team felt it was unnecessary to re-tape this scenario, and were unanimous that the revised scenario could be used for educational and research purposes.

General discussion

Four case studies have been presented. As each of them represents a single incident intended to capture different competencies as specified by ICM 2002, it is not the intention in this section to draw comparisons between the results. It is important that each case (scenario) be allowed to stand independently. However, as has been shown in the previous four sections, there are commonalities with regard to midwifery practice in Slovenia. The author first comments on this, as, although individual midwives' competence was not the focus of this study, the themes derived from the data cannot be ignored. Following that, the author will discuss how the Slovenian results have influenced the larger project and contributed to the further development of the scenarios on an international basis. She

would then draw some conclusions from her findings, discuss the limitations of this research, and present some recommendations with regard to midwifery education and practice. The author will outline some suggestions for further research, again based on the findings of this study.

Midwifery practice in Slovenia

Midwifery education, as well as the whole education and health system in Slovenia, has undergone several significant changes in the last 20 years and this has influenced the nature and scope of midwifery practice.

In midwives' responses to the scenarios, it is evident that medicalisation in maternity care still prevails. There are still some routine practices followed without evidence-based practices with any clear explanation and without respecting the mother's informed choice. Olsson, Jansson, Norberg (2000) performed a study to assess the influence of midwives on medicalisation. They found out that a mechanistic and medicalised understanding of childbirth seemed to dominate the discussions of midwives with women and couples at the ante-natal and post-natal consultations they videotaped.

In scenario six, for example, this was evident in explaining routine practices from shaving perineums, administering enemas, rupturing membranes, routine intravenous infusions and oxytocin in labour, to labour being in the dorsal position and delivery in lithotomy position. These are all practices which are not evidence-based, but midwives blindly perform them, as this is the doctrine they are supposed to follow, and while women may choose alternatives, this is not generally encouraged (Goer, 1995).

This leads to the next phenomenon evident in every scenario, »learned helplessness«. This is the behaviour of midwives constantly referring the mother to a doctor. As mentioned in scenario five, it is the hierarchical structure that keeps midwives in their prescribed place in the social order. In Slovenia, is probably because of the fact that midwives in the communist regime had »only« secondary education, and doctors were superior to midwives. But Kirkham (1999), while interviewing UK midwives, also found »learned helplessness and guilt« among the respondents, which spoke of a world in which they were constantly threatened by blame. She concludes that working in a blame culture disempowers professionals, and indeed, this was most evident in scenario 13, where midwives were so »doctor orientated« they forgot to mention even simple tasks such as measuring blood pressure or estimating the date of delivery, which they do routinely. It has to be acknowledged that the ICM essential competencies mention »appropriate referral during care«, or »working collaboratively with other health workers«, but also strongly recommend auton-

omous work and autonomous decision making by midwives.

Prioritising was also common to all scenarios. Usually after midwives assessed the situation described in the scenario they began to prioritise and make decisions on what they would do first. As mentioned in the discussion section of scenario three, this was called *priority setting*, and as Juceviciene and Lepaite's (2005) hierarchical structural unity confirms, this is a higher level competence than decision making. Although ICM essential competencies speak of »responsibility and accountability for clinical decisions«, they do not introduce decision making as one of the competencies, but as a framework for midwifery care. According to ICM (2002), a five step decision making plan »utilizes a variety of sources of knowledge and is dynamic, responding to the changing health status of each woman«. Although ICM speaks of a woman-centred approach, this plan reminds very much of the nursing process, and in the author's opinion, is a shift away from a woman (family) centred approach. However, priority setting did not clearly emerge in every scenario only in Slovenia, but in all the countries participating in this research.

Following are the discussions of the scenarios:

Scenario development

As indicated, the scenarios chosen here were part of a larger project (Fleming et al., 2006). The four scenarios reflected different stages of the ante-natal, labour, post-natal and neo-natal periods. While these choices appear to show a fragmented approach, they actually reflect the nature of maternity care in Slovenia. As such, the results from this dissertation have succeeded in making a substantial contribution to the further development of the scenarios in the four countries.

The research team, in its effort to embrace all the competency domains, had no option but to fragment the pregnancy continuum. Following the review of the initial findings, those related to the first ICM competencies domain were found to appear in all the scenarios tested in this dissertation, although we had not expected to find them in scenario four, for example. The first domain (Fullerton et al., 2003) focuses on essential knowledge and skills derived from the social sciences, public health and ethics that promote culturally competent professional behaviours and practices. To address such knowledge and skills, pseudonyms were chosen in each scenario - many of them reflected names from different parts of the world and the subjects of the of testing may have been immigrants.

Of particular note in Slovenia was competence 1(a)8 in the first domain, which defines »advocating with women for a variety of safe birth settings«. This com-

petence could never be targeted in Slovenia, while the only current option for the place of birth would be a hospital. This, however, was not the case in Germany or Scotland, but could be linked to Kosovo, where women when in labour go to their nearest unit, whether this is a health centre or a secondary or tertiary hospital. This can not be considered as a variety of different options, because it is related to accessibility.

What for some countries was an everyday occurrence, for others might have been unprecedented or even unknown. A very good example of this is a sentence in scenario five, mentioning that the woman had a cup of tea. While this was quite normal to Scottish midwives, German participants did express some confusion, while Slovenian participants responded negatively and blamed this cup of tea on some of the problems which occurred later in this scenario.

The fact is that each scenario starts with a different story based on one aspect of maternity care. At the beginning, all scenarios had a variety of competencies from several domains which they were supposed to target. After comparing what participants said with the corresponding ICM essential competencies, it soon became apparent that if a scenario concerns only one part of maternity care, then only those competencies from corresponding domains (which are corresponding areas of midwifery care) should be expected. For example, scenario 13 presented a case of ante-natal care, so only competencies from the second and third domains were targeted. This, however, does not apply to the first-domain competencies (see the second paragraph of this section). The research team was unanimous on this.

In terms of the wider project, we also found that there were some competencies which were not targeted, so some scenarios were modified and retested; some were not retested; some were abandoned and others remained unchanged. However, it is mentioned at the end of each case scenario used for this dissertation how and why it was changed if applicable.

General conclusion

Every case scenario has its own conclusion, but even so, there are some general conclusions which can be drawn from the completed research.

The revised scenarios are appropriate for use in the Slovenian situation. They are understandable and apply well to the Slovenian situation; all the stories in the scenarios could easily happen in the everyday work of a midwife. As mentioned above, the four scenarios reflect different stages of the ante-natal, labour, post-natal and neo-natal periods separately; this implies fragmented care, which is also in reality applicable to the Slovenian situation.

The Slovenian findings are compatible with those of other countries. Although there were some issues which were typical of Slovenia (see to the previous section), the findings are compatible with the other countries participating in this research. However, in some aspects the limited role of midwives (in ante-natal care, for example) prevented them from expressing certain skills or knowledge which midwives from another countries did.

Revised scenarios target appropriate competencies. The answers of participants show that scenarios do target appropriate competencies in Slovenia, as well as in the other participating countries. As mentioned, the participants' statements were converted into appropriate competencies and highlighted in Excel spreadsheets. The only problem regarding the cases in this dissertation was in scenario six, which was revised by being divided into several parts and taped again; the result was that the new scenario targeted appropriate competencies.

Not all the expected competencies were demonstrated by participants in this study. This was mainly related to the scope of midwifery practice. In Slovenia and Kosovo, as mentioned in the previous section, it was not possible to target 1(a)8 competence, because there were no birth settings. It was also not possible to target competencies such as:

2(b)9 Take or order cervical cytology smear (Pap test)

4(b)14 Repair an episiotomy if needed

4(b)21 Repair vaginal/perineal lacerations and episiotomy

4(b)33 Apply vacuum extraction or forceps

4(b)36 Perform manual removal of placenta

4(b)37 Identify and repair cervical lacerations

These competencies are in the sole discretion of a doctor, and in Slovenia are never performed by a midwife.

Some of the competencies would not be performed anywhere in Europe, such as competence 3(b)21, »Perform external version of breech presentation«. So to target this competence, we would need the scenario to be taped in a country outside Europe.

Recommendations for midwifery education

Past education programmes for midwives in Slovenia used standard assessment and teaching tools. Now that midwifery education is at degree level and corresponds to European directives, it is the time to introduce new methods of teaching, assessment and learning. Below are some recommendations derived from this study.

Scenarios are appropriate learning tools. It has been stated by several educators, like Mikl (2003), Cautreels (2003) or Stomp (2003), that scenario work requires but also stimulates creativity, imagination and sensitivity to, and reflection on trends, developments and needs.

When developing a new assessment tool, such as scenarios (McMartin, McKenna, Youssefi, 1999), it is imperative that the developers establish its trustworthiness. In the case of a tool designed to elicit a written response from students, the scoring mechanism and process must also be rigorously tested in order to support the tool's trustworthiness. The process of recreating the scenario which this research team used worked well in all participating countries.

Furthermore, this dissertation has shown that *scenarios can be used to assess the developing competencies* if clear links between scenarios and competencies are established and proven.

Scenarios can be used as teaching tools particularly in problem/inquiry based learning situations. Scenarios can be considered as hypotheses of possible future situations specifically designed to point out the special features and potential risks specific situations may present. Also, Cautreels (2003) is convinced that scenarios can be a stimulating activity, broadening one's horizons. Scenario work can create a very rich learning environment, contributing to a number of competences for educators.

Universal scenarios for midwifery could be developed. Also, this dissertation has shown that there could be universal scenarios which could be used either as assessment or learning tools in all EU countries, which could contribute to harmonising midwifery training in the EU.

Limitations

There are some limitations that need to be acknowledged and addressed regarding this study.

The first limitation concerns the author, as a novice researcher and for the first time performing this type of research, which could have caused the data to be less rich than otherwise. This was particularly noticeable in scenario six, where an inappropriate sample was initially recruited.

However, there was also the benefit that the author herself is a midwife from this system; this enabled her to understand the situation and the system, and even the phrases midwives used. For example, the phrase »taking care of the baby« encompasses every procedure performed after a baby is born, without the realisation that many ICM essential competencies would, falsely, not be counted as targeted.

The second limitation concerns the fragmented approach to maternity care that the scenarios reflect. Each scenario was based on one part of maternity care, and therefore it implemented fragmented care, which in Slovenia, rather than a limitation, is closer to reality.

A minimum of six interviews per scenario were carried out, while a larger sample may have increased the range of results. However, the answers did for the most part address the expected competencies.

While the sample chosen represented the Slovenian situation, the midwives interviewed had over 15 years of experience, or six or fewer years of experience. This is because of the closure of the midwifery school in 1984. Additionally, these were midwives with different types of qualifications, trained under different regimes. While some had secondary level education in midwifery, others had the equivalent of a degree.

The final limitations refer to the fact that midwives were also not familiar with this type of research, which is perhaps why their answers were more like bullet points and very brief. Some things they were supposed to mention are so natural and ordinary tasks, that they completely overlooked them. This does not mean they are not carrying out these tasks. This mostly relates to written documentation, which midwives by law are required to do, and which they do, but somehow they fail to mention. This could be the result of a limitation of the data collection instrument.

Recommendations for further research

Scenarios and associated competencies could be converted into a questionnaire and used to survey a much larger sample, making it possible to make generalizations about the Slovenian population.

On the other hand, we could combine taping the scenarios with observation. In this way, more competencies might emerge, but it might be a long time before a scenario appeared in the real world.

The above study could contribute to a large-scale international study, which would really give us an insight into midwifery practice and possibly reveal competencies which may not be encountered in the ICM essential competencies. This occurred in this research, and the possibility of widening this research internationally might also reveal even more surprising data.

Using a multimedia approach, the scenarios could be developed to have a closer representation of reality. This is already being done – Glasgow Caledonian University is developing scenario six in a multi-media version, so it might be interesting to test and compare the results with what we have so far with participants being able to test themselves at various points in the scenario.

Scenarios could be used for teaching and research. As they might be helpful teaching tools, they could

also be very useful in determining the scope and nature of midwifery practice in different countries.

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