Midwifery in Lithuania: Addressing the Barriers to Realization of Midwives' Competence in Midwifery Care

Olga Riklikienė[1], Marius Strička[2], Liudvika Starkienė[2], Laima Matulevičiūtė[2], Jūratė Macijauskienė[3]

[1]Department of Nursing and Care, Faculty of Nursing, Medical Academy, Lithuanian University of Health Sciences, [2]Department of Preventive Medicine, Faculty of Public Health, Medical Academy, Lithuanian University of Health Sciences, [3]Department of Geriatrics, Faculty of Nursing, Medical Academy, Lithuanian University of Health Sciences, Lithuania

Key Words: *midwife; competence; midwife-attended births; autonomy; focus group discussion; Lithuania.*

Summary. *Background. Despite the recent important developments of midwifery practice in Lithuania, maternity care is still operating under the medical paradigm and with a biomedical model of care. This study was part of a national project on the analysis of the health care workforce and focused on professional rights, duties, responsibilities, competence, functions, and work load of midwives in order to investigate midwifery practice and propose recommendations to the Ministry of Health of the Republic of Lithuania.*

The purpose of this paper was to report on findings from the focus group discussion on midwives' competence and extent of its realization in midwifery care in Lithuania.

Material and Methods. A multiprofessional focus group discussion was conducted for this study. The group consisted of official representatives from professional associations and higher educational institutions, health care funding, midwives and obstetricians/gynecologists. Three preliminary assumptions on the topic were made by the researchers and 4 leading questions matching those assumptions were announced for the group to structure the discussion.

Key Conclusions. Participants of a focus group discussion identified a series of key elements that impedes the implementation of competence acquired by midwives and limit the work to full extent of their capacity and education. These included the following: the domination of medicine and weak authority of the midwife in decision-making, a lack of opportunity to practice across the full spectrum of maternity care in all levels of health care, the invisibility of the midwifery service in regulation of payment and scientific research, the lack of clear vision about what midwifery is and what it is midwives must do on their own within the community, low motivation of midwives themselves to function according to their competence and the full potential of their role. These issues must be addressed and embraced if the midwives in Lithuania are willing to fulfill their role in practice according to their education and legally regulated scope of practice. The balanced work load for midwives at the hospital also would help overcome existing barriers and increase physical capacity and professional motivation of midwives as well.

Introduction

In Western countries, midwifery is a profession in its own right (1). The international definition of a midwife (International Council of Midwives, 2005) provides scope for midwives to practice according to the full potential of the role. The midwife is recognized as a responsible and accountable professional who works in partnership with women to give the necessary support, care, and advice during pregnancy, labor, and the postpartum period, to conduct births on the midwife's own responsibility, and to provide care for the newborn and the infant. This care relates to preventative measures, promotion of normal birth, detection of complications in a mother and a child, assessment of medical care or other appropriate assistance, and the carrying out of emergency measures. This role of the midwife includes giving health counseling and education not only for the woman, but also within the family and the community. The midwife has an important task in antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health, and child care (2).

In countries with a range of different models of maternity care, the changing role of midwives is recognized in relation to "new models" of care and need for midwives to further develop their skills in order to take responsibility and work to the full

Correspondence to O. Riklikienė, Department of Nursing and Care, Medical Academy, Lithuanian University of Health Sciences, Eivenių 4, 50161 Kaunas, Lithuania
E-mail: riklikiene@hotmail.com

Adresas susirašinėti: O. Riklikienė, Lietuvos sveikatos mokslų universiteto Medicinos akademijos Slaugos ir rūpybos katedra, Eivenių 4, 50161 Kaunas
El. paštas: riklikiene@hotmail.com

potential of their role (1). Some of the factors influencing these "new models" are availability and competence of the maternity workforce, resources, and authority for decision-making. The definition of competence, defined by the International Confederation of Midwives, refers to "the basic knowledge, skills and behaviors required of the midwife for safe practice in any setting; answer the question: 'What does a midwife do?'" (3).

Scandinavian midwifery practice usually is considered as the best model for Lithuanian midwives because of the close geographical location, similar historical pathways, and European perspective. Today in Sweden, midwives are the women's first choice of a caregiver during pregnancy and childbirth as well as for reproductive and sexual health services (4). This role is strengthened by legislation stating that midwives are autonomous, responsible, and accountable for care given during normal pregnancies and deliveries.

Long before the Independence, students-midwives were trained during 2-3 years at the Medical School, primarily by medical doctors. The midwives' training course of 3 years at the Medical School was stopped for 2 years in 1998 (1998–2001) because of the need for program improvements and low demand of specialists. From 2003, the college study program (diploma level) of 3.5 years was launched with the first graduation of 18 midwives in 2007. In 2010, for the first time in the history of Lithuania, 20 students were enlisted into the 4-year university study program on midwifery at the Lithuanian University of Health Sciences. So, the first graduation of midwives with a bachelor's degree is expected the next year.

After the Independence of Lithuania was restored and health reform was innitiated in 1991, the Lithuanian Society of Midwives more strongly voiced the goal for autonomous and independent practice. The Lithuanian Standard of Practice for the Midwife gives the definition of midwifery care as "part of health care that encompasses health care of women, prevention, counseling and assistance throughout the life span, also care of newborns at health care institutions, in patients home, families and communities" (5).

It was evident that the developments in midwifery during the last decade, like registration with licensure for midwifery practice, professional standards and educational programs at the university level for the new generation of Lithuanian midwives would enable them to be distinctly recognized and protected to practice at the full scope of their competence. Unfortunately, despite the recent important developments, maternity care in our country is still operating under the medical paradigm with a biomedical model of care. Up to now, the role of midwives in the care of childbearing women, particularly for those working in the hospital system, is not clear.

In this article, we discuss the extent by which the competency of Lithuanian midwives is realized in midwifery care and address the barriers that prevent them to embody full educational and professional capacities.

Material and Methods

We employed a qualitative, exploratory study design using focus group discussion in the Lithuanian University of Health Sciences in Kaunas, the second largest city of Lithuania, in spring 2011. Focus groups provide an exploratory approach to elicit a new insight and diagnose problems with or gather information about services by examining information about a topic from a new angle (6).

Participants. The discussion group was multiprofessional and included 16 official representatives of educational institutions (university and college) where midwives are trained (N=3) and the National Health Insurance Fund (N=1), midwives from different working places (primary care center, university, and regional hospitals) (N=7), obstetricians/gynecologists working at primary, secondary, and tertiary health care institutions (N=3), and community nurses (N=2). A double role of some participants was related to their clinical position and professional activity in the Lithuanian Midwives Association, Lithuanian Nurses Association, and Lithuanian Obstetricians-Gynaecologists Association. The invitation letter to participate in the focus group discussion was addressed directly to the executives of target organizations by e-mail 3 weeks before the event. The agreement to participate was given to the researchers by e-mail or phone. The participants arrived from 3 different cities of Lithuania: Vilnius, Kaunas, and Šiauliai.

Discussion Planning. In order to formulate the focus of group discussion, 3 assumptions were taken into consideration by the researchers according to the previous data of the Project (7), public declarations of professional community of midwives, and researchers' professional experience. First, it was presumed that midwives are highly trained during their studies, majority of them has had practical experience of many years and actively participated in continuing education, constantly improve their knowledge through national and international conferences and seminars, although they do not realize their high competencies in real everyday practice because of limited possibilities. Second, it was supposed that professional roles and functions of midwives and obstetricians-gynecologists duplicate one another in practice because of several identical activities that are regulated by the Standard of Practice for the Midwife as well as the Standard of Practice for

the Physician. Third, it could be a reason that well-prepared and experienced midwives possibly go beyond their commission and do this illegally because some activities performed by them are not listed in the Standard of Practice for the Midwife. In such a case, their practice becomes illegal and brings uncertainty and even danger for professional practice and future career. The consideration of the main focus of the discussion (hypotheses) helped the researchers prepare well-phrased and definitive questions in advance and to increase the validity and reliability of the data. It is suggested that groups conducted to test hypotheses would need a relatively structured agenda (6).

Organization of the Discussion. The names, professional qualifications, and affiliations of participants were listed by them on a separate registration form before the discussion started.

At the beginning of the discussion, the Project's (7) aim and separate task related to midwifery practice were presented to the participants. Data were collected using a semi-structured interview guide of 4 leading questions matching assumptions above that were announced to the group depending on the flow of the discussion: 1) "Do midwives realize their competence acquired in midwifery care? If yes, to what extent?" 2) "Do midwives realize their competence in the full scope of their practice: primary- and secondary-level care, outpatient and inpatient care, and perinatal care?" 3) "What are the barriers, if any, for complete realization of competence for midwives in midwifery care?" and 4) "What would help improve the realization of competence in midwifery care for midwives? What changes are necessary?"

At the end of the discussion, each member was invited to summarize his/her opinion. Discussion lasted for 2 hours and 5 minutes and was moderated by the principal researcher, a university lecturer with a PhD degree. This was decided because an overall understanding of the study was deemed necessary in order to keep the focus group on task. A colleague of the moderator made field notes and observed group dynamics.

Data Analysis Technique. Based on the qualitative content analysis, the opinions and views of participants were recorded and transcribed by the researcher into the 17-page text. Two researchers individually, a nurse and a public health specialist, analyzed the transcription, coded it by meaning units, grouped according to common themes, and validated with original quotes of participants (6, 8, 9). The codes and themes were examined by the principal researcher who led the development of the subcategories and main categories. The final analysis of findings in a table of main categories, subcategories, and quotations was delivered to all participants asking them to react to the accuracy and completeness of the preliminary findings by e-mail (member validation or "member check") to increase the study credibility (9, 10). Several responses were received by the authors without any comments or corrections in relation to the study findings, but the appreciation of participants for the possibility to participate and share the information was expressed.

Ethical Considerations. Approval from the Regional Committee on Bioethics of the Lithuanian University of Health Sciences was obtained for the whole Project and separate activities with focus group discussion included. Every participant was informed about the purpose and the matter of the group discussion (group size, discussion length proposed, tape recording, confidentiality of data) with the written invitation sent by email. They were asked in advance to confirm their participation by phone or e-mail and express their free decisions to participate. Signed consent forms were collected on the discussion day just after the participants arrived to the meeting place. Transcription was anonymous without any names, duties, or affiliations.

Findings

The 3 main thematic categories were constructed and described the spheres of midwifery care for the realization of professional competencies acquired by midwives. Those 3 categories related to the following: 1) independent activity of a midwife at attending normal (physiological) births; 2) midwifery practice at the primary level of care; and 3) a high workload. The first 2 categories were directly connected with midwives' professional competency and its extension possibilities; the last one was more about working conditions and organizational obstacles that enable midwives to work to full extent of their capacity.

Independent Practice at Midwife-Attended Births. As relatively new practice for Lithuanian midwives in leading the care of women at physiological birth without any physician's assistance and intervention, midwife-attended births were the widest topic of the discussion. There were 9 subcategories of issues identified that prevented midwives from practicing according to their full role and scope of competencies concerning normal births.

The results proved that important transformational changes in midwifery are in process in Lithuania, as midwife-attended births practice formally exists since 2010. Although the rate of **midwife-attended births is minimal** and depends on the health care institution, this is almost daily practice in perinatology centers at university hospitals "where there are good conditions for midwives to practice independently with the minimal assistance of physicians." However, in peripheral maternity units, births are led by the obstetrician. The participants

noted that at the beginning, the practical reason for introducing midwife-attended births was not the deliberate act toward the extension of midwives' activities but the reality of lacking health workforce: "they [perinatology centers] faced a shortage of obstetricians-gynecologists, mostly for gynecologic patients; exactly this was the beginning, the need forced the result." The shortage of physicians' increases, "normal births and normal pregnant women have more access to midwives than before."

Moreover, the trust in and satisfaction with midwife-attended births were expressed by participants-physicians saying that "a number of deliveries was delegated to midwives and they [physicians] were satisfied with their competencies and qualification; midwives performed their duties very well, no questions about that." At the same time the interaction of midwives and obstetricians-gynecologists, even if trusting, are restricted by **disciplinary subordination** in relation to normal births. It was explained by organizational requirements and rules that "to attend normal birth, a midwife has to coordinate this with a senior physician and get his/her permission and agreement." Such a condition decreases the professional autonomy of a midwife. Further, at the end of the attended birth, the signature and stamp of the physician is required in the health record of women "to confirm the procedure and share the joint responsibility for the midwife-attended birth."

The present situation is determined by a **legal dilemma concerning the reimbursement** of the health service by the National Health Insurance Fund to the provider when "the clinical diagnosis (the same in case of birth) has to be confirmed by a clinical administrator or a head of the unit, in other cases – the senior physician; the Fund will not cover the midwife-attended birth without a signature of the administrator." The service payment regardless of the provider was the solution proposed by the discussion group and recognition of "the signature and stamp of the physician equal to that of a midwife, with the same service cost." Further, the participants logically concluded: "if my competency is appropriate, if my duties enable me, then my signature should be enough [to confirm the procedure]."

It is obvious that physicians' concerns and fears of formal "blind" approval arise and create **interprofessional tension** when "physicians in many cases are not willing to confirm the actions of midwives even if they have 20-year practice experience," leaving fewer opportunities for midwives to practice according to their knowledge, skills, and competencies. The participants of the discussion advocated for setting more clear boundaries for the midwife's scope of practice "strictly defining at the national level," where the competency of the midwife ends and he/she needs to refer the case to someone with more knowledge and expertise. A general standard for midwife-attended birth was demanded by the group; it would assure safe practice and "all others will be safe; now neither a midwife nor a physician or an administrator feels safe."

The discussion participants, physicians in particular, **questioned the relevance of present knowledge of midwives** on an attended birth procedure and recognized the need for additional continuing education and knowledge renewal for safe midwifery practice. Similar education was provided when the care of mothers and healthy newborns was delegated to midwives some years ago through an accompanying educational course with some institutional documents, e.g., practice standards, procedure description, and documentation sheets.

The participants raised a concern that beyond the legal obstacles for autonomous practice, Lithuanian midwives professionally are still closely attached to the **historical tradition to work under supervision** of physicians when for "many years midwives felt comfortable and safe to stand behind the physician, to work and not take the responsibility." Just during the last decade, midwives raised their voices for essential changes and sought midwifery care where the "midwifes are responsible for what they are doing and supervision is not necessary." A personal motivation of midwives to practice autonomously and be independent was recognized as an important prerequisite to broaden their competencies and obligations as "midwives themselves have to be motivated to work in another way."

The lack of empowerment of midwives by obstetricians-gynecologists and insufficient support from colleagues also have an impact on professional independence of the midwife, so "the goodwill from the physician is very important; it is so that we [physicians] disempowered midwives, we kept them from doing many things." It was confirmed that "if the midwife has a license, the physician must trust in his/her abilities to work and lead the birth; if they cannot, it means he/she is not able to work at all and if the physician does not trust the midwife, he/she remains a servant."

Not only midwives, but also as a society, Lithuania are still broadly influenced by the **tradition of medical dominance at birth**. Women and their families often have inappropriate expectations or even concerns for independent midwifery care. The invisibility of midwives in health care, and insufficient information and education of families was highlighted with the suggestion to inform women at primary health care level about the practice of midwife-attended births because now "pregnant women are not informed well and treat delivery similar to heart transplantation." The confirmation followed: "If we [physicians] express the attitude toward mid-

wife-attended birth, nobody will look for a physician." Focusing on reallocation of duties and competencies the discussion group emphasized the need to avoid interprofessional contraposition and proposed "the expansion of midwives' competence in the way to prevent negative opinions about one profession's intention of taking work from another profession." A supportive work environment and collaborative relationship with medical colleagues would prevent midwives from possible misunderstandings.

It emerged that **inappropriate midwifery documentation** "is a problem as in most hospitals, midwives do not fill in the medical documentation; they are not able to write notes in the medical [birth] record." The documentation was linked to autonomous responsibility and evidence of midwife's work: "How can the midwife be responsible if he/she does not fill in any documentation?" Midwifery documentation that does exist is institutionally approved, but is not equal to medical documentation that is nationally certified.

Midwifery Practice in Primary Health Care. Two subcategories were extracted from this thematic category of data. Practitioners and educators from the focus group fully agreed on **the repetition or takeover of midwife's duties** in primary care, where their functions are constantly duplicated by community nurses and family physicians, and obstetricians-gynecologists. At present, the postnatal care of a mother and a baby is provided by a community nurse and a family physician only, as is education of young couples on sexual health, reproduction, and parenting. It was agreed that "obstetricians-gynecologists are more frequently requested by women with gynecological problems, and unfortunately, the accessibility of such services currently is not good, and patients need to wait up to several months." The patients complain about the situation and use out-of-pocket payment in order to get an earlier visit. It was the question in the discussion: "If the shortage of physicians exists why do they want more work, which could simply be delegated to midwives?" Accordingly, another point was started by a participant and with a direct response: "How many functions can we [physicians] delegate to midwives legally? The fewer the number of physicians, the more functions we will have to delegate."

The Scandinavian model where the midwife is responsible for women's health at every step of care was suggested by an educational representative. It was confirmed that "it is possible and necessary to separate the duties of physicians and midwives in primary health care, not duplicate functions, and save resources." The advantage of midwifery care was further acknowledged as "he/she [midwife] is a better educator than a physician as he/she teaches in more simple ways and with more empathy; this [function] is regulated, but the country is lacking economic planning and thought about saving costs." The aspects of effective communication, trust, encouragement, confidence in understanding the emotional factors of woman were all intertwined as important components of quality and continuity of care: "midwives communicate a lot, women are more open with them, they are more focused, midwifery care is less medicalized – it is a pleasure to observe the midwife's work." The independent midwifery practice according to the opinion of group participants was also linked to cost-effectiveness of care stating that "the Lithuanian [health] system could save more, if more actions and functions would be entrusted to midwives." These arguments justify the importance of more rapid transition from medicalized childbirth toward a woman-centered model of continual midwifery care.

Discussion group agreed on the **invisibility and weak promotion of midwifery practice in the community** as "no analysis of independent midwifery practice was completed at university hospitals during last 3 years; even one exists, administrators are not aware of the results." It is promising that at least in some institutions, "special additional statistical measures were introduced to evaluate midwives' activity." It is obvious then that "until midwives demonstrate their competent activities during normal births, nobody will trust in them; the objective evaluation of cost and service is urgent." Collaboration in the field of research was highlighted revealing that "midwives need the support of physicians, universities and colleges, professional unions in order to start evidence-based analysis and improve research." Publicity and evidence-based information about "how a midwife successfully performs physician's tasks and how the physician performs midwife's duties" was recognized as important.

High workload as an institutional condition was also mentioned in the barriers to expand competence of midwives. It was agreed that it is up to the individual institution to decrease the requirements for midwives on mother and newborn care. The participants suggested this midwife/patient ratio for Lithuania as 1:1.5 or 1:2, facing the reality that 1:1 is "the model of a rich country."

Discussion

The original meaning of the word midwife is "being with a woman" (4). It is imperative that the postmedical movement toward woman-centered midwifery care should be characterized by independent practice of an experienced midwife who provides a choice at the birth place and promotes an equal, trusting, and respectful relationship with the pregnant woman (11). This view was shared during the focus group discussion where the competence of

midwife was interconnected with the provision of accessible, patient and professional, safe, high-quality, continuous, and woman-centered midwifery care.

In Lithuania, along with the changing situation of midwifery care, more efforts are necessary for transition from a medical to a midwifery model with the belief that midwifery, according to the Parratt's model (11), is a profession in its own right with equal working relations with other professions. Of note, the personal motivation of midwives to make changes toward professional autonomy was one of the barriers for independent midwifery care mentioned in this study. Davis-Floyd suggests that midwives could be autonomous in action and thought, although just those who are autonomous in thought, even if they are working in a system that defines them as subordinate, are often able to blend or manipulate the system in order, most of the time, to give truly woman-centered care (12). Certainly, in Lithuania, similarly to other countries, many midwives are already socialized into the medical model of childbirth and may find "independent" practice challenging or even threatening and it is not something they will come to without support. In order to achieve changes, midwives need to believe that birth is a bio-psycho-social event, not a medical one (11). The success of changes depends on the midwives' willingness to be active in a transition process and to seek the delivery of quality care.

Despite the organizational culture that respects midwives' abilities and ensures collaborative practice, the national legal regulation for midwifery exists, financially forcing practitioners to duplicate services or take responsibility without any input. To solve this, the boundaries in midwife's and physician's work and responsibilities have to be changed and then continue with financial reforms. Midwifes, having a viable system of backup, have to work in the scope of their competence with determine what they may do independently and what to transfer to a physician when their own judgment tells them it is necessary.

The correct understanding of a midwife's role in the community is an initial step. However, a society will be ready to accept this relatively new midwife's role when health care professionals understand each other. The relationship between the midwife and the obstetrician should be based on mutual respect and trust. Most challenging is to overcome the damaging stereotype that midwives outside the hospital are ignorant and unsafe. David-Froyd suggested that watching midwives work, getting to know them, and having friendly conversations with them could be mind-opening experience to change the stereotype (12). Obstetricians-gynecologists are likely to recognize midwives as equal team members, and this is promising for the future improvements. Visibility of the midwife's role in the community may be strengthened through providing education and information to the public. Women and their families need to be aware of their choices in order to make free and right alternative decisions.

High-quality midwifery care depends on the professional preparation of new midwives and continuing education of those practicing. The advantage of the midwifery training system in Lithuania is the option of a traditional direct entry to midwifery education in an educational institution. This is a tremendous value in the autonomy and helps overcome the experience of other countries where midwifery is a postgraduate nursing "specialty" with the risk for students to be indoctrinated into the medical model through their nursing training (11). In other words, the student-midwife will not learn autonomous midwifery if he/she is trained to be dependent on the system (12). Ideally, midwifery, as every profession or even much more, would benefit from more students-future midwives who feel "called" to the profession entering the system. At the same time, the biggest challenge and request for the system is to be changed to accommodate this new generation of midwives appropriately to their vocation and preparation.

The introduction of new models of woman-centered care in a postmedical birthing paradigm increases a midwife's scope of practice (11). The recent study reports the increase of midwife-attended births in the United States (8.1% of all vaginal births in 2009) where data on attendance at birth by midwives have been available on the national level since 1989 (13). Thus, in order to provide the best possible midwifery care and supply the profession with the evidence about this, midwives need to educate themselves and their peers, read scientific literature, and be involved in scientific investigations. The ongoing research should be expanded during formal education as well as through collaborative research studies at practical level. It is understandable that the current movement toward woman-centered continuity of care is creating many challenges for practicing midwives, health care managers, educators, and health policy makers.

It is obvious that midwifery care is different from standard medical or nursing care in so many ways, which it is near impossible for physicians and nurses to generate regulations that facilitate the practice of midwifery, as good regulations should do (11). In this case, midwives themselves should be active in the development of their profession and initiate necessary alterations in order to deliver competent midwifery care. Essential midwifery competences are developed and supported through education, regulation, and professional associations (4). Therefore, we hope that our study, as the first effort to articulate the competence of midwifes and sphere

of their practice at the national level joining practitioners, educators, managers, and decision-makers, would assist the future directions and necessary developments of midwifery in Lithuania.

Limitations. Identifying the participants for our study, the reasonable sample was selected as it is recommended for a focus group. Nonetheless, the group participants reflected the population of interest. The qualitative design using focus groups with the convenience sampling limits the generalizability of the findings. Another limitation relates to methodology of focus group discussion and its design for which a minimum of 2 or 3 groups must be held (6). We decided that in our case, intergroup heterogeneity would be the best, so the representatives from the different area of interest (medical and midwifery practice, midwives' education, professional organizations, financial bodies, health care administration) would participate. With this decision, the authors also recognized that this shortcoming most certainly has had an effect on the data presented. Although the use of focus group was highly effective to address the most serious barriers of midwives' independent work, the conclusions that might be drawn from the findings need to be very cautious and serve like initial data on key issues for further investigations but not the definitive conclusions. In addition, we recognized that the inclusion of consumers – women and their families – would help get a wider perspective on the phenomenon.

Implications of Findings for Practice and Further Research. The study shows that some barriers for the realization of midwives' competence in Lithuania are present and should be addressed with decisions and actions for their elimination. This study was the constitutive activity of the project "Analysis of health workforce number, requirement and pilot "day photograph" measurement of workload [in Lithuanian]" (7). The following recommendations were suggested to the project contracting authority: 1) initiation of necessary legal acts for regulation of midwifery practice and midwives' independence level in the defined framework of competencies; 2) negotiation with the National Health Insurance Fund on refunding midwifery service in a legitimate way; 3) clear, self-contained, nonduplicative functional description of midwives, physicians, and nurses; 4) delegation of wider educational and health promotion activities for women, families and community in the professional practice of midwives; 5) normalization of midwives' workload with setting principles for the proper calculation; 6) development of midwifery documentation at primary health care centers and hospitals; 7) encouragement and support of research on midwifery issues and best practice with involvement of midwives themselves; and 8) strengthening professional identity of the midwife in society as an independent, autonomous and competent member of the health care team.

Further research studies on midwifery care should collect the views of women as consumers in order to address their expectations and satisfaction with different spectrum midwifery services provided.

Acknowledgments

The authors thank the participants of the focus group discussion that have contributed to the study sharing their experience. We also would like to thank Prof. Laima M. Karosas, RN, PhD, APRN, from University of Quinnipiac, Connecticut, United States, for her help in language editing of the manuscript.

This study was provided in the frame of the research project "Analysis of health workforce number, requirement and pilot "day photograph" measurement of workload" under the project "Systematic analysis of health sector reforms aiming at better implementation of European Union health policy" (project No. VP1-4.2-VRM-05-V-01-004) according to the priority No. 4 "Fostering administrative competences and increasing efficiency of public administration" (objective „Better implementation of EU policies") under the Operational Programme for the Development of Human Resources 2007-2013.

Statement of Conflict of Interest

The authors state no conflict of interest.

Kodėl Lietuvoje akušeriai negali realizuoti profesinės kompetencijos klinikinėje praktikoje?

Olga Riklikienė[1], Marius Stričkа[2], Liudvika Starkienė[2], Laima Matulevičiūtė[2], Jūratė Macijauskienė[3]

[1]Lietuvos sveikatos mokslų universiteto Medicinos akademijos Slaugos ir rūpybos katedra,
[2]Lietuvos sveikatos mokslų universiteto Medicinos akademijos Profilaktinės medicinos katedra,
[3]Lietuvos sveikatos mokslų universiteto Medicinos akademijos Geriatrijos klinika

Raktažodžiai: akušeris, kompetencija, akušerių prižiūrimi gimdymai, autonomija, grupinė diskusija, Lietuva.

Santrauka. Nepaisant pastarųjų metų reikšmingų akušerinės praktikos pokyčių, motinos ir vaiko priežiūrai vis dar būdingas medicininis požiūris ir biomedicinos modelis. Šis tyrimas atliktas vykdant nacionalinį projektą, susijusį su sveikatos priežiūros išteklių analize. Siekiant įvertinti akušerio praktiką bei pateikti rekomendacijas Lietuvos Respublikos sveikatos apsaugos ministerijai, tyrime didelis dėmesys buvo skiriamas akušerių profesinėms teisėms, pareigoms, atsakomybei, kompetencijoms, funkcijoms ir darbo krūviui.

Tyrimo tikslas – pristatyti grupinės diskusijos rezultatus apie akušerių kompetencija ir jos realizavimo klinikinėje praktikoje trukdžius.

Medžiaga ir metodai. Organizuota daugiaprofesinė grupinė diskusija. Grupę sudarė profesinių organizacijų, mokymo institucijų, Valstybinės ligonių kasos atstovai, akušeriai, gydytojai akušeriai-ginekologai. Tyrėjai iškėlė tris hipotezes ir suformulavo keturis su hipotezėmis susijusius esminius diskusijos klausimus.

Išvados. Diskusijos dalyviai nurodė keletą svarbių trukdžių, kurie neleidžia akušeriams realizuoti turimos kompetencijos bei riboja jų veiklą, nepaisant profesinio pasirengimo. Išvardytos problemos: medicinos dominavimas ir menkas akušerių autoritetas priimant sprendimus, ribotos galimybės vykdyti visas motinos ir vaiko priežiūros veiklas visuose sveikatos priežiūros lygmenyse, atskiro akušerinių paslaugų apmokėjimo nebuvimas, mokslinių tyrimų akušerijos srityje neplėtojimas, neaiškus akušerio vaidmuo visuomenėje, silpna pačių akušerių motyvacija panaudoti profesinę kompetenciją. Šiuos trukdžius privalu analizuoti ir pašalinti norint, kad akušeriai Lietuvoje galėtų panaudoti savo žinias ir gebėjimus teisiškai apibrėžtose akušerinės priežiūros ribose. Tam pasitarnautų ir akušerio darbo krūvio nustatymas ligoninėje, tuomet būtų galima padidinti akušerio fizinį pajėgumą ir profesinę motyvaciją.

References

1. Homer CS, Passant L, Brodie PM, Kildea S, Leap N, Pincombe J, et al. The role of the midwife in Australia: views of women and midwives. Midwifery 2009;25:673-81.
2. Definition of the midwife. International Confederation of Midwives. Hague; 2005.
3. Essential competencies for midwifery practice. International Confederation of Midwives. Geneva; 2002.
4. The state of world's midwifery 2011: delivering health, saving lives. World Health Organisation, 20 June 2011, Durban, South Africa. Available from: URL: http://www.who.int/pmnch/media/membernews/2011/2011_sowmr_en.pdf
5. Ministry of Health of the Republic of Lithuania. Dėl Lietuvos medicinos normos MN 40:2006 „Akušeris. Teisės, pareigos, kompetencija ir atsakomybė" patvirtinimo. (Standard of Practice for Midwife "Midwife. Rights, duties, competence and responsibility.") 2006-04-03, V-245; Vilnius.
6. Nassar-McMillan SC, Borders LD. Use of focus group in survey item development. Qual Report 2002;7(1):1-18.
7. Lithuanian University of Health Sciences. Analysis of health workforce number, requirement and pilot "day photograph" measurement of workload [in Lithuanian]. Final report to the Ministry of Health. Vilnius; 2011.
8. Holloway I, Wheeler S. Qualitative research in nursing. 2nd ed. Oxford: Blackwell; 2002. p. 236-8.
9. Gibson F, Bamford O. Focus group interviews to examine the role and development of the clinical nurse specialist. J Nurs Manag 2001;9:331-42.
10. Pool I, Poell R, ten Cate O. Nurses' and managers' perceptions of continuing professional development for older and younger nurses: a focus group study. Int J Nurs Stud 2013;50:34-43.
11. Newnham L. The midwife's role: challenges and changes in the post-medical movement towards woman-centered midwifery care. Aust J Midwifery 2001;14(4):12-5.
12. Davis-Floyd R. Autonomy in midwifery: definitions, education, regulation. Midwifery Today Childbirth Educ 1997; 42:21-2.
13. Declercq E. Trends of midwife-attended births in the United States, 1989-2009. J Midwifery Womens Health 2012;57: 321-6.

Received 16 January 2013, accepted 5 February 2013