EVALUATION OF COMPETENCY IN MIDWIFERY

Margaret Peters

Paper presented at the 11th Annual Congress of the Australian Perinatal Society
Hobart, Tasmania — July 20-23, 1993

Midwifery is not unique among the professions in seeking to attain, sustain and evaluate the competency of those who enter and work in the profession.

There is probably no greater slur you can apply to a colleague, than to tell them, or have others tell them on your behalf that they are incompetent. We all hold dear the opinion we are competent in what we do, to believe otherwise is to admit we should not be doing it, and in the broadest sense should not be in practice.

The subject I have been asked to address is one of great complexity and I do not have a simple answer, to the question posed, how do you evaluate competency in midwifery?

I do know when I take my car to the garage what I expect of my encounter with the mechanic, a vehicle that functions better than when I left it with him. If I get that I am satisfied, but a fellow mechanic may rate the performance of the person attending my car with a more critical approach. It is my encounter with the mechanic, my interactions with him or her, his appreciation of my problems and his ability to turn my description of the problems I have with the car, his knowledge of the workings of the car that gives me the outcome I desire – a car which goes, and causes me no problems thereafter.

This is a simplistic approach but so often an evaluation of performance is based on personal experience and expectations and in this, midwifery is no different from any other occupation. Knowledge of what the members of the profession do is an essential prerequisite on which to base expectations of outcomes from an encounter with a practitioner.

I do know what a midwife is, the international definition puts it quite simply. "A midwife is a person who having been regularly admitted to a midwifery education program duly recognised in the country in which it is located has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery".

The statement goes on to describe the sphere of practice for such a person, as giving "supervision, care and advice to women during pregnancy, labour and in the post-partum period".

> she conducts deliveries on her own responsibility,
> cares for the new born and the infant,
> detects abnormal conditions in mother and child,
> procures medical assistance,
> executes emergency measures in the absence of medical help,
> provides health counselling and education for women and within families and communities,
> her work involves antenatal education and preparation for parenthood and it includes certain areas of gynaecology, family planning and child care.

She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service.[1]

The question is how do I, you and the many others concerned to be so assured know the midwife is competent aside from being legally licensed to practice in that state or territory.

This is what I have been asked to address today. How do all those who interact/interrelate in whatever capacity evaluate if the midwife is competent.

How does the midwife her/himself answer the same question. The response could be, easy, but in fact it is a complex activity and certainly it is timely to consider the question and the Australian Perinatal Society is not alone in this matter.

The Commonwealth Department of Employment Education and Training is expending a great deal of energy through the National Office of Overseas Skills Recognition, on the subject and also the National Training Board set up by the Commonwealth and State Ministers responsible for vocational training, in establishing competency standards.

I know the Australian College of Midwives is supporting the establishment of competencies for beginning midwifery practice.

Glover, in a paper presented at the 7th Biennial Conference of the Australian College of Midwives (Perth, September 1991) suggests that the global definition of a midwife does not adequately describe the role of the midwife in this country.[2]

It also may be time to consider that question within the profession – or should we accept the definition for what it is, a description of the potential of the midwife attainable in many countries if not in ours at this stage. You could well ask why consider the content of the definition while reflecting on the evaluation of competency in midwifery.

The answer lies in the premise on which the Australian College of Midwives based the Standards for the Practice of Midwifery, the definition.

The four basic standards the College has described are:

Professional responsibility and accountability
Midwifery practice
Health education and legislation
Policies and procedures.

Following each stated standard is described the process and the outcome behaviour interpretations.[3]

These standards have been used extensively in many places where midwives are educated and employed to guide the development of midwifery services and the practitioners.

They attempt to describe what the community can reasonably expect of a midwife, the language is clear, the consumer in the main should have no difficulty in understanding the meaning of each despite the writing of them by midwives for midwives.

Can we use these standards to help determine the competency of a midwife practitioner? I believe they can be used together with other tools some of which are still in development.

The American College of Nurse Midwifery has put it quite succinctly in a statement issued in February 1992 which states, "midwifery practice is based on these (that Colleges) Core Competencies, the Standards for the Practice of Nurse Midwifery and the American College of Nurse Midwives, Codes of Ethics" the statement continues – "Core competencies delineate the fundamental knowledge, skills and behaviours expected of a new graduate".[4]

Work has been done in Melbourne and is proceeding in South Australia to determine the core competencies for Australian midwifery graduates.

Recently the International Confederation of Midwives adopted an International Code of Ethics which the Australian College of Midwives will be considering at a national conference to be held in Adelaide in September this year.

So Australian midwives are moving to bring together the fundamentals which will contribute to the profession's adoption of core competencies.

According to a Department of Employment, Education and Training Research Paper, 'A Guide to Development of Competency Standards for Professions', "elements of competency represent discrete identifiable components of segments of professional performance".

They should be written such that they:

(i) integrate the knowledge, skills, attitudes and other important attributes associated with an identifiable aspect of professional performance in the workplace.

(ii) are expressed in terms of performance in the professional workplace.

(iii) can be readily understood by the profession and the community it serves.

(iv) are recognisable and demonstrable in the workplace.

(v) amendable to assessment by a qualified assessor.[5]

This message seems clear enough, and if applied could lead to the effective evaluation of competency in midwifery at all levels. The challenge is to not only identify the core competencies required for midwifery practice but to also do so for midwifery practitioners as they progress up the ladder of professional development. To be experienced or senior does not necessarily mean to be skilled or competent although the terms are often used to infer this status.

Perhaps our difficulty rests within the concept of a midwife is a midwife, then again it may be the size

and nature of the unit in which the midwife functions.

Can we reasonably expect the same degree of competency from a midwife in an isolated rural centre as the one who works in a busy city tertiary centre within one of its specialised units?

I am inclined to support the belief that "competency is the ability to perform the activities within an occupation or function to the standard expected in employment,"[6] as affirmed in the DEET Guide. To me this means that yes, you can be equally competent as a midwife in outback Australia as the midwife who functions in a premier tertiary centre in a capital city. The differences are not so much in what they do or how they do it, but what is the performance required of them in the situation in which they are employed, by their employers, their clients, their co-workers, and other professional groups with whom they collaborate to achieve a common and agreed outcome in maternity care.

It is possible for a midwife to be perceived as good by one group, unhelpful and not so good by another, and a leader by another. The values we place on practice can differ according to what is expected of the practitioner.

The consumer may prefer the midwife who has effective communication skills and is woman-centred in her work; a colleague may respect those elements in her practice but, for example, deplore her failure to access the progress of labour accurately. An obstetrician or neonatologist may place a greater emphasis on technical skills and unquestioning responsiveness to medical direction.

Professional relationships are built on many factors but clinical competence is a crucial element of those relationships.[7]

Often we judge clinical competence in terms of abilities that relate to technological or motor skills. A review of two months of complaints in a maternity hospital reveals that most of the problems relate to poor communication skills, lack of competency in client provider interactions across a number of professional groups, not only midwives.

It could be said in some circumstances that do do the best you could, while keeping the client fully informed makes a less than satisfactory outcome more acceptable. How many of us have seen what we would rate as less than satisfactory care being accepted by the recipient as reasonable, because of the use of effective communication skills.

The American College of Nurse Midwives has identified certain concepts and skills from the social sciences and public health that permeate all aspects of midwifery practice. Among them are – constructive use of communication skills and communication and collaboration with other members of the health team.[8]

When you think about it, these concepts, often unwritten in the formal evaluation tools, are all too frequently the basis on which we make a judgement on the "competency" of the midwife.

You will recall that I commenced this paper by reflecting that no professional readily accepts evaluation as incompetent.

Substandard practice is not overtly endorsed by professional bodies, employers, or colleagues, and certainly not by the recipient of the care. Yet we are often challenged to develop tools that reasonably and fairly evaluate performance in the practice setting.

Supples, in a paper 'Self Regulation in the Nursing Profession, Response to Substandard Practice' within nursing in the USA, makes the statement and quoting from Moore, "professional self-regulation includes primary and sometimes exclusive responsibility for disciplining those of the profession who fail to meet standards of professional competence". She goes on to point out that exclusive control may lead to the protection of the non-competent from other interested parties.[9]

One of the conclusions she draws from her study is that while safety is not an issue employers will allow the profession to self-regulate the practice in an agency, that as dismissal is so rare, reports to regulatory agencies are even rarer, this is not often an issue, and further that this leads to the retention of some proportion of inept members who are through the professional body (of fellow workers) supported by well developed helping processes.[10]

I suspect that if this study was replicated in Australia it could well come to the same conclusions in most of the health care provider professions, not only

midwifery. The degree of tolerance of such situations is, I also suspect, diminishing.

The community is expecting more of those who provide the care in the health system, therefore, we must continue to improve our evaluation processes.

To do this we must be able to describe in measurable terms the performance level we expect of the practitioner, but it is only one element of a process that has been described by Hunt and Meech as: "Competencies can be used as a coherent foundation for the various elements of human resource management linking job design, the selection and promotion system, staff training and development, career path planning, and performance management, and feed back".[11]

So to be able to ascertain the amount of attainment of competency we need to describe what it is we are looking for in the practitioner. Ensure that all concerned know what that is and are prepared to invest resources in both a corporate and personal sense to the reaching of the goals set.

We need to reach agreement that this must be done by the profession, reflect what it is that the consumer is seeking in her care provider, and where it is appropriate, "arrive at consensus through the force of better argument alone" suspend all prior judgements and assume general agreement is possible on any issue.[12]

This process needs to occur if we are to reach agreement on what is a competent midwife, to replace the concept of a good, experienced senior midwife with performance measurements that satisfy the midwives and those with whom they interact at all levels.

For this to be achieved I believe the other professions with which midwives co-work should be willing to reciprocate the privilege of setting standards for evaluation.

Competent midwives working with sub-standard other, non midwife practitioners, does not lead to a quality maternity service. Employers, managers of maternity health services have a responsibility for ensuring that the same processes are utilised for the measurement of competent practice in that service.

As we struggle with adjustments to health care funding arrangements, so does it become crucial for the factor that makes up the greatest component of expenditure to be the best which can be recruited and retained.

Productivity is a word not often applied to midwifery services yet it is an appropriate one to use if you wish to gain an appropriate return on the money invested in the provision of a profession based service.

Substandard practice does not lead to productivity. Effective evaluation of midwifery practice should lead to improved "productivity", but not necessarily so, if there has not been any attempt to use research and quality assurance to evaluate clinical care. The midwife who has not sought to determine in a critical fashion if there is a need to change what it is she does in her day to day practice, cannot remain competent.

Many will be familiar with the work of Benner who has described the five levels of proficiency, as novice, advanced beginner, competent, proficient, and expert.[13]

To advance up this scale of increasing ability you must increase your knowledge, reflect on your practice, enhance your skills.

I am often intrigued by how difficult it is to include in performance evaluation tools something of these concepts and have them really accepted by the evaluatee and the evaluator. We do tend to want to be perceived as competent and proficient in all situations.

The adjustments required when relocated from one practice setting to another can be profound. For example the midwife who relocates after five years in a delivery suite to a special care nursery may find it a painful experience to accept that her level of competency is reduced in the new setting; unless the process by which she/he is recruited to this new situation is managed so that the evaluation of performance is based on a set of competencies that are not formulated on universality but more reflective of the individual's stage of development in that setting.

Rankin, in her paper 'Excellence is a Journey not a Destination', states the manager can "mutually establish and agree upon performance expectations or standards with employers relative to their jobs

and the goals they set. Poor standards or the absence of any formal standards confuse and ultimately demotivate employees".[14]

The same could be said for having more than one group of standard setters, for midwives to whom the practitioner has to react.

Midwives should be the standard setters, the identifiers of the level of competence required for practice, the evaluators of competency, but they should not believe they can do this in an enclosed order; others will want to influence this process and their comments and advice should be considered, evaluated and dealt with as appropriate.

However, the prime responsibility of the midwifery profession is to peruse quality in practice through competency, and just as midwives respect the right of other professions to set their standards of practice, establish their core competencies, codes of ethics, so must the right of midwives to do the same be respected and supported.

At the end of that activity what we should have is a higher level of performance based on agreed standards which are set and regularly reviewed, so that the quality of care given is one which is driven by evaluation of not only the care-giver, but the system and the environment within which she practices.

Ultimately, the evaluation will be done not by the midwives, nor by her fellow workers but those who consume the care. The women whom she attends, the families who attend the maternity units of this country. It is they who will know if they got the care they wanted, they needed, in a way they found helpful, useful and ultimately not hazardous to them. If this happens they will have been attended by a competent midwife.

References

1. International Definition of a Midwife Adopted by ICM FIGO WHO 1972, revised 1990.
2. Glover P 'The Development and Validation of Competencies for Beginning Midwifery Practice – Research Report', Proceedings 7th Biennial Conference of the Australian College of Midwives Inc. 11-13 September, 1991, p120.
3. Australian College of Midwives Inc. Standards for the Practice of Midwifery 1989, p5-20.
4. Avery MD, Del Giudice GT, 'High Tech Skills in Low Tech Hands. Issues of Advanced Practice and Collaborative Management'. *Journal of Nurse Midwifery* 38, 2, March-April 1993, p135.
5. Heywood L, Gonczi A, Hager P. 'A Guide to Development of Competency Standards for Professions', Department of Employment Education and Training, National Office of Overseas Skills Recognition Research Paper No. 7, Australian Government Publishing Service, April 1992, p34.
6. Heywood L, Gonczi A, Hager P, *op cit,* p3.
7. McLain B 'Collaborative Practice: A Critical Theory Perspective'. *Research In Nursing and Health* 11, 1988, p.391.
8. Avery MD, Del Giudice CT, *op cit,* p13S.
9. Supples JM 'Self Regulation in the Nursing Profession: Response to Substandard Practice' *Nursing Outlook* 41, 1, Jan-Feb 1993, p20.
10. Supples JM, *op cit,* p24.
11. Hunt C, Meech L, 'Competencies and Human Resource Management in the Department of Immigration, Local Government and Ethnic Affairs' *Journal Royal Institute of Public Administration Australia* 40, 4, December 1991, p444.
12. McLain B, *op cit,* p392.
13. Benner P, *From Novice to Expert Excellence and Power in Clinical Nursing Practice* Addison-Wesley, California, 1984.
14. Rankin N, 'Excellence is a Journey, not a Destination'. Proceedings of International Paediatric Nursing Conference, 2-5 June 1992, Sydney, p62.