Challenges to implement evidence-based midwifery care in Bangladesh. An interview study with medical doctors mentoring health care providers

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ABSTRACT

Background: In 2013 the first midwives in Bangladesh to be educated according to international standards completed their course and were awarded a diploma. Sixty percent of their training took place in clinical placement sites. In order to achieve appropriate mentor support while in clinical practice, a mentorship programme was initiated whereby local doctors were appointed by Save the Children. The aim of this study is to describe the mentors' purpose and the actions they took to improve midwifery care at clinical placement sites. Their appointment was intended to support local Health Care Providers (HCPs) at clinical placement sites meant for educating midwifery students in evidence-based midwifery care.

Methods: An open-ended interview study with 14 mentors. The data was analysed using content analysis.

Results: The main category, the theme that emerged from the analysis was “Creating commitment”. “Creating commitment” describe how the mentors; the medical doctors employed by Save the Children, “Motivate”, “Educate”, “Mentor”, “Advocate” and “Communicate” (subcategories) to creating commitment for quality midwifery care “In the organization of care” and “In clinical care practices” (categories). As intended, they enabled HCPs, midwifery students, and newly graduated midwives to provide quality midwifery care.

Conclusions: Using medical doctors’ status and power to support the development of a newly emerging midwifery cadre in a country where midwifery is just emerging as a profession is because midwives integrated in the health system will improve the birthing process, improve life chances for newborns, and reduce morbidity and mortality in Bangladesh. It is recommended for implementation in other similar national contexts.

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Introduction

The World Health Organization (WHO) has published a consolidated set of evidence-based recommendations on quality intrapartum care [1]. These recommendations resulted in the publication of a WHO labour care guide in 2020 [2]. This is, in essence, a user’s manual listing the specific evidence-based practices that should be implemented during the labour and immediate postnatal periods [1]. Among other evidence-based practices, skin-to-skin contact for newborns [3], dynamic positions in labour and/or birth [4], and delayed umbilical cord clamping [5] were recommended. The guide [2] recommended that these practices were to be implemented by all Health Care Providers (HCPs), in order to provide quality midwifery care to women and newborns [6]. These WHO recommendations [1,2] have been incorporated as policies in the government of Bangladesh’s evidence-based midwifery initiative [7,8]. In this study the midwifery care components: skin-to-skin contact for the newborn in the immediate postpartum period [3], dynamic birth positions in labour and/or birth [4] and delayed umbilical cord clamping [5] were used as proxy measures for impact in improving safety for women and newborns [9]. Providing such care [1,2] is not always easy, especially for countries that do not have a well-established culture of quality labour care. In Bangladesh, for example, the first midwives to be educated according to international standards only graduated in 2013 [7]. Sixty percent of their education took place in clinical placement sites. While the government of Bangladesh recognized the importance of providing these midwifery students with practical training that reflected the latest WHO standards, they lacked the ability to address this problem swiftly and the reason was that many of...
the existing practitioners are still not fully aware of WHO best practice [10-13]. Against this background, Save the Children, as an implementing partner to the United Nations Population Fund (UNFPA) was invited by UNFPA to introduce a mentorship programme that placed medical doctors at the midwifery students' clinical practice sites to help improve clinical practice among the HCPs who were acting as supervisors to midwifery students. The mentors were placed in a selected number of public health facilities. Evidence-based midwifery care was meant to be taught by the HCPs when mentoring students at the clinical sites where the midwifery students got their clinical education. The organisation, Save the Children was employed by UNFPA to monitor standards in midwifery care and to monitor the progress towards improved caring practices at the clinical sites where the midwifery students were posted and to improve the students' transition to practice [14]. They utilized medical doctors who were part of their Save the Children’s Mentor initiative to strengthen the national Bangladeshi midwifery programme [7,8]. The use of doctors to monitor and support midwifery care can be discussed, when it is known that often they are the barrier to implementing evidence-based midwifery care and prefer a medical model [15-17]. UNFPA using Save the Children’s Mentor initiative had two motivations by employing “midwife friendly” medical doctors working as mentors to HCP in a health system where medical doctors, in general, prefer a medical model of care [8,16]. Save the Children is a trusted organization in Bangladesh [18] and medical doctors are a respected cadre of HCPs who can effectively advocate for new practices, such as the acceptance of a new body of trained midwives [13,16,19]. Doctors have been used as clinical mentors since 2017 to support the promotion of an evidence-based midwifery care model in Bangladesh [20], but little data has yet been collected on the support they offer and the services they provide. Thus, collecting working experiences from the Save the Children mentors themselves is an important way to gather information about midwifery students’ transition to clinical practice, the role of the mentorship programme, and how it can be improved. The aim of this study is to describe the mentors’ purpose and the actions they took to improve midwifery care at clinical placement sites meant for educating midwifery students in evidence-based midwifery care.

Materials and methods

An inductive qualitative design was chosen. Data was collected through semi-structured open ended individual interviews based on a topic guide and analysed by inductive content analysis [21,22]. In this study, HCPs are defined as people who provide supportive care during labour and birth, such as midwives, senior staff nurses, nurses, nurse-midwives, consultants, medical doctors, and paediatricians. We use the word mentor for the Save the Children mentors and the word supervisors for the HCP.

This study obtained ethical clearance and ethical research guidelines have been followed and considered [23]. All those invited to participate in the study were fully aware the interviews were voluntary, confidential and they could withdraw from the interview any time without giving a reason. Ethical approval was obtained from the Bangladesh Ministry of Health and the Directorate General of Nursing and Midwifery. The deputy director of Bangladesh’s national midwifery programme at Save the Children in Bangladesh was informed about the study and gave their permission.

Setting and participants

The midwifery students in Bangladesh who graduated in 2016 carried out their clinical placements at public health facilities. These facilities were located in Upazilas, sub-districts, in each of Bangladesh’s 8 divisions. The facilities were either Upazila health complexes, district hospitals, or medical college hospitals, and each of the 14 mentors participating in this study were employed at one of these sites. All of the mentors were qualified medical doctors with Bachelor of Medicine or Bachelor of Surgery degrees and between 3 months and 3 years of clinical experience in the field of maternity care. Maternity care and midwifery care are different. The medical doctors after being employed as mentors were linked with the Dalarna University/UNFPA mentorship programme [20]. They supported the implementation of the midwifery curricula in theory and students’ clinical education. Together with the midwifery educators they got specific skills lab training provided from Dalarna University/UNFPA [24], to understand midwifery care i.e. care expected to be provided by a midwife to the minimum ICM standards. All of the mentors were local Bangladeshi female doctors in their thirties, recruited and employed by Save the Children, contracted for two years to improve midwifery care at clinical placement sites. This included mentoring of the HCPs. The HCP in turn were engaged in the supervision of midwifery students and newly graduated midwives, guiding local practitioners and hospital managers in evidence-based midwifery care to move evidence midwifery care forward at the clinical sites. In the result section we do not differentiate HCP from local practitioners but mention hospital managers separately.

Material

A topic guide inspired by the ICM core competencies for midwives [25] and the Midwifery Services Framework [26] was developed as the basis for the mentor interviews. The topic guide was semi-structured and included open ended questions related to the mentors’ experiences of supporting local HCPs in their supervision of midwives assisting local HCPs to implement evidence-based care at the placement sites. The topic guide was built around topics such as working environment, HCPs’ work, supporting local HCPs in their supervision of midwives, newly graduated midwives, guiding local practitioners and hospital managers in evidence-based midwifery care at clinical placement sites to help mediate midwifery care. Together with the mentors, the topic guide was modified and then tested in practice with the first four mentors. The final topic guide was then used to guide the semi-structured interviews. All the interviews were audio-taped, but no recording was used for one of the interviews due to a technical error.

Data collection

An invitation letter was sent to the mentors by the first two authors and their oral and written informed consent was obtained with a 100% response rate (n = 14). All those invited agreed to participate. The individual interviews were carried out by the first two authors in a quiet room at the participant’s workplace and lasted for approximately 45 min. The interviews were conducted in English and Bangla and digitally recorded.

Analysis

The English parts of the recordings were transcribed word-for-word. The Bengali parts were first transcribed word-for-word and then translated into English by an experienced translator. The resulting transcripts, which together comprised 169 pages, were analysed by all of the authors using the content analysis method inspired by Elo and Kyngäs [21,22]. First, all of the transcripts were read several times so that the authors became familiar with their content. Second, the authors searched for meaning units and the texts relating to them were extracted. The meaning units were then condensed and coded, grouped based on similarities and differences in the text constituting the content of a sub-category, and subcategories were grouped into two generic categories at a higher abstraction level. Thereafter the text codes, sub-categories, and generic categories were finally organized into one overarching main category, the last meaning at the highest abstraction level.

Results

See Table 1.

“Educate”, “Mentor”, “Advocate” and “Communicate”.

Creating commitment

All of the participants in this study said that being a mentor had been difficult. They started their work being enthusiastic and looking forward to showing local HCPs about new midwifery practices, but the reality was quite different. It had taken time and effort to create a sense of commitment amongst local HCP that evidence-based midwifery care was important and necessary. The HCPs were unclear about the scope of practice a midwifery student should have and what they should, and should not, be doing. The mentors tried to motivate, educate, support, and advocate for their important role as supervisors and to provide them with information and advice about evidence-based midwifery and how to communicate this message to their midwifery students.

Mentors were aware that introducing new practices would not be easy but were positive about their ability to do so. One said:

“There is a traditional way of caregiving and the existence of the long-term practices is a barrier and gradually we are overcoming it through continuous upgrading of their skills”. (IDI, 11)

– In the organization of care

Motivate

A majority of the participants agreed that one of the difficult aspects of their work had been to convince the facility managers and local HCP supervisors that evidence-based practices, such as skin-to-skin contact in the immediate postnatal period, dynamic positions in labour and/or birth, and delayed umbilical cord clamping, were important to encourage amongst the student midwives. Motivating them was not easy.

“You have said that the head of the department is very helpful. Yes, but I have to motivate her and that is not an easy task” (IDI, 1)

Mangers and HCPs welcomed the relatively new evidence-based midwifery care model in Bangladesh into their existing organization of care, but it was the mentors who had to motivate them to encourage these new practices amongst the students.

“We have to motivate the nurses to utilize and gain the required knowledge for the improvement of midwifery care. After all, they will supervise the midwifery students” (IDI-12)

Educate

The mentors were instructed to focus on encouraging the introduction of three midwifery care components: skin-to-skin contact for the newborn in the immediate postnatal period, dynamic positions in labour and/or birth, and delayed umbilical cord clamping.

“I am teaching the midwifery students from the nursing college and I following it up with the certified midwives and nurses”. (IDI, 13)

The mentors sought to educate the health care professionals around them through their practice, both on the wards and in the delivery room. They put up posters showing skin-to-skin care of the newborn in the immediate postnatal period and dynamic positions in labour and/or birth. A birthing stool was provided at each facility along with other equipment such as chairs and birthing balls. Beds were placed upright so that dynamic birthing positions could be supported. The mentors gave lectures on the physiology of upright versus lithotomy positions, and they showed various birthing positions in simulation-based learning situations. The mentors were able to arrange for the student midwives to be admitted to the delivery rooms, so they could witness live births in action and begin to practice using these new methods:

“The midwifery students were not able to enter into any delivery rooms to practice a year ago but now they are getting the opportunities. (IDI-12)”

The mentors constantly emphasized that the practices that they were encouraging not only followed the WHO guidelines but also corresponded to the Bangladeshi government’s policies. It was not easy to get the student midwives opportunities to practice these new methods, but they did see the situation gradually changing.

Mentor

The mentors understood that their role was to mentor those HCPs who were supervising the midwifery students. In doing so they knew that their main responsibility was to establish evidence-based midwifery care practices in the labour wards and to create an enabling environment for the midwifery students. They realized that mentoring the clinical HCPs was important if the new cadre of midwives were to be introduced to new methods.

“We are mentoring the health professional to avoid the traditional ways of labour, birth and newborn care and encourage them to start to implement evidence-based practices instead”. (IDI 12)

Advocate

The participants also spoke about their involvement in meetings, advocating for implementing evidence midwifery care practices at the clinical practice sites. They realized that it was important to persuade HCP about these new practices. At these meetings, then, the mentors talked about the opportunities there were for midwives and health care professionals to take one of the free massive online open courses (MOOC) in professional midwifery and what is involved. Meetings were used to create enthusiasm for the implementation of the three new midwifery practices: skin-to-skin contact, dynamic labour, and delayed cord clamping.

“We had a series of meetings with the managers and HCPs including the gynaecology consultant and explained the meaning of evidence-based care. The gynaecology consultant became very supportive in terms of implementing the evidence-based care components”. (IDI 12).

The mentors acted as vital intermediaries between the various stakeholders in midwifery care.

Communicate

From the conversations with the mentors, it became clear that formal communication with managers was essential because they were the decision makers. The mentors checked to make sure that the health care facilities had the proper equipment for the provision of quality midwifery care. If an Upazila health complex did not have all of the equipment stipulated in the labour room protocol - birthing stool, and birthing ball. The mentors reported this to the respective manager and donors.

Table 1
The main results, generic categories, and subcategories.

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<th>Sub-categories</th>
<th>Creating commitment</th>
<th>In the organization of care</th>
<th>In clinical care practices</th>
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“I am also coordinating by communicating with different stakeholders for logistic supply and quarterly monitoring visit accompanied with the quality improvement team following the WHO standard checklist” (IDI 9).

The work mentors did to ensure that facilities were fully equipped and functional was beneficial for both the midwifery student’s clinical practice and the mothers and newborns.

– In clinical care practices

The mentors were not sitting on the sideline as the concept of ‘mentor’ somewhat suggests. They actually, worked clinically together with the HCP and the midwifery students and communicated with the senior doctors and midwifery faculty from the midwifery institution in charge of clinical teaching from the theoretical institution. The work that the mentors did in a clinical setting can also be grouped under the following five headings.

Motivate

The mentors tried to motivate the HCPs and managers to be supportive and attentive to their instructions, in hope that this would lead to their widespread adoption, even when the mentors were not there to oversee the processes.

“If I am present, then all of them work as instructed and if I am not there nobody follows the instruction to provide skin-to-skin care of the newborn in the immediate post-partum period, dynamic labour and/or birth positions, and delayed umbilical cord cutting. As a mentor, you also need a person on the “inside” you can trust and who would support the mission when you are not there” (IDI 6)

As this quote suggests, some of them found ‘insiders’ who they could trust to encourage these new midwifery practices, even after they had left.

Educate

The participants in this study recounted how they had stressed that midwifery students needed to get the opportunity to practice in clinical placements what they had learned in theory. Only with this experience could they gain the respect of other maternity professionals that would allow them to work with real-life deliveries. The mentors had worked hard to encourage the supervisors to give the midwifery students access to delivery rooms, for instance, and to continually reiterate the importance of the new evidence-based practices. They reflected on how it was important for the new midwives to receive regular updates from their supervisors, such as in the form of refresher training.

“These refresher pieces of training should be organized quarterly. The certified midwives are losing their memories and in a few years they will lose everything they have learned” (IDI, 14).

The mentors suggested that there was a risk that midwifery students could inherit harmful practices from HCPs who did not want to change regardless of what they had been instructed by the mentors. There was some resistance to the new methods among the HCPs, according to the mentors.

“I have noticed they want to skip the delayed umbilical cord clamping or the dynamic labour and/or birth positions or the skin-to-skin care of the newborn as they think it is not useful. There are some long traditions in the health care practices and it will take time to change the scenario even with the best education possible” (IDI, 5).

Mentor

Providing onsite mentoring and monitoring the clinical performance of the local HCPs was, according to the mentors, the most effective way to ensure that they supervised the midwifery students according to the correct protocols and standards. Mentoring involved listening to the stories recounted by supervisors of newly graduated midwives struggling to implement these new evidence-based practices and worrying about being sidelined or actively prevented from advocating them again in her workplace. One mentor said:

“A young newly graduated midwife helps the mother with a non-lithotomy position. From the WHO guidelines, she knows this is quality midwifery care and evidence-based practice. Nobody else of the HCPs listens to the midwife’s idea of a dynamic position and the poor young midwife will have to put the mother in a lithotomy position even if she wants to listen to the mother’s wish and try a non-lithotomy position. The midwife will be neglected and scared of their survival in the workplace by all other HCPs after this and the evidence-based care provision of the mother will be of second order for her after that day” (IDI, 1).

In a clinical context, mentoring more importantly meant modeling best practice by taking part in live deliveries and showing the HCPs, and by extension the midwifery students, how these new evidence-based practices worked and the positive impact they had on the birthing process. One mentor talked about showing their colleagues, encouraging a woman first wanting to give birth in the lithotomy position to try a different dynamic positions. The health care provider and a midwifery student were present when they discussed this alternative approach. They were present when, after consideration, the woman agreed to deliver in a dynamic position, have her umbilical cord cut late and have her baby placed skin-to-skin at her breast after birth.

“The patient wanted to have lithotomy position, but I encouraged and described the advantages and disadvantages of dynamic positions and then she agreed to the dynamic positions…” (IDI, 12).

The process of giving birth in Bangladesh, like other countries in Asia, is a communal event that involves the whole family in the decision-making process. It is not just the woman giving birth who must be persuaded to adopt new methods, it is her husband and relatives as well. The mentors interviewed here talked about the importance of including this wider body of decision-makers when trying to introduce new evidence-based practices.

Advocate

From a clinical perspective, the conversations with the mentors demonstrated that local willingness to continue these new evidence-based practices was based on the government’s provision of suitable equipment and medicines. The mentors said that at the meetings they attended local managers and HCPs were pessimistic about their ability to continue at least some of these new practices. It doesn’t cost anything to implement skin-to-skin contact and there are lots of ways to improvise around dynamic birthing positions, even if you don’t have special medical equipment. So they wondered, what is the problem here?

“They perform the evidence-based midwifery care services and to continue I am raising the issues of lack of supplies both to the government and to donors and the shortage of equipment, let’s see how far I could progress” (IDI, 7).

Communicate

The mentors reported that they had, overall, positive experiences of communicating with the different medical actors they encountered while on the project. They had a positive relationship with the other doctors at the health facilities because they shared the same profession and could assist with cases when there was a lack of local staff. They felt it was easy to speak to the nurses, midwives, and midwifery students...
because they were doctors and their views and opinions regarding midwifery practices and what should be done were widely respected. In this sense, the hierarchical structure of the Bangladeshi medical system worked in their favour and made it easier for their message to be received and adopted.

“There is a good professional relationship in the facilities between mentors and the doctors, nurses, midwives, midwifery students because the manpower is also limited. The mentors and midwifery students have a supportive working environment and possibilities to implementing evidence-based midwifery care when they are needed as workforce” (IDI, 11).

The mentors believed that talking to the families, explaining the new methods, and showing them the objects used to facilitate these new approaches would ‘change their conservative mindset’. The mentors encouraged the local HCPs to support the midwifery students to involve the family in their discussions around these new evidence-based practices.

Discussion

The aim of this study was to describe the actions and activities that medical mentors carried out when seeking to improve midwifery care at clinical placement sites and to support the education of midwifery students in evidence-based midwifery care. The results describe how medical doctors employed by Save the Children encountered a range of obstacles within the Bangladeshi health care system when they began to work at local health care facilities. This study shows that employing mentors, either for midwives acting in a supervisory role or for midwives themselves, particularly in a country where the midwifery profession is relatively new, [19] offers a significant benefit to the practice of midwifery and the extension of evidence-based methods and behaviours. Byrskog et al. [13] has described the social, economic, and professional barriers that influence the realities that midwives face in Bangladesh. Their study, which examined the midwifery educators responsible for preparing midwifery students for clinical reality, identified barriers that were very similar to the challenges outlined by the mentors in this study. The midwifery educators greatly appreciated medical doctors who were positive towards the midwifery profession because their status meant they could advocate for the new midwife cadre and in particular, could encourage managers and others to allow midwifery students to practice midwifery while on their clinical placements. This study showed that midwives struggle to be accepted is the mentors thought this was the way forward for Bangladesh to promote its new cadre of midwives is to improve their claim to equality within the health care sector and by so doing ensure that they have a more sustainable future. Without mentors present at the health care facilities where the midwifery students are posted for their clinical practice it is possible that the introduction of midwives to the delivery wards will take even longer than anticipated. In their position as medical doctors, mentors are able to stand by the side of the mother and advocate for her in each step of the process. As medical doctors, mentors have the expertise, and the authority, to show the HCPs and the midwifery students in live situations how to perform evidence-based care in normal birth. The Bangladeshi health system seems not to tackle the culture of medical dominance, equal to the situation in India [29]. This study does not suggest the dominance of the medical system continues even if medical doctors mentoring HCP have enabled change when introducing midwifery care practices in clinical practice. The question for the future is how to make sure midwives have an equal status to doctors within their scope of practice [30]. It is time to find a way for Bangladeshi midwifery students to acquire the clinical skills that are a required element of their education and training. In the short term medical doctors, mentors, have the power to monitor the performance of HCPs and midwifery students and in so doing, can support these students, and newly graduated midwives, and empower them to adopt and implement the new practices they have learned at college. The mentors themselves thought this was the way forward for Bangladesh’s recent midwifery graduates. It was of no use sending them out on clinical placement if they were not allowed, or encouraged, to practice evidence-based midwifery. When evaluating the success of a newly implemented midwifery training programme, clinical placement sites need to be included, and not just the content of courses [31]. This is because clinical placement is such a large part of midwifery education programmes - not only in terms of the time students spend on it but also because of the number and quality of the skills they are expected to acquire there [11,32].

Online mentorship has been attempted in Bangladesh on the theoretical part of the midwifery programme [20] and seems a realistic option for mentoring mentors in quality midwifery care. This study was carried out before the COVID-19 outbreak. Today, with the negative impact the pandemic is having on health care education, and clinical practice training, in particular, HCPs face even greater challenges when implementing new midwifery practices [33]. Now is perhaps the time to reconsider both theoretical and clinical midwifery education. Online theoretical education might be a partial way forward [19] but for the skills-based lab sessions and placement elements that rely on physical presence, getting people in a room together so they can be shown what to do physically and more innovative ways are now required.

The transferability is limited in this qualitative study with only 14 participants. When reading the dependability, the main strength is its rigorous process of data gathering and analysis. The main limitation is that being relatively young medical doctors and women might have played a role in how effective they were as mentors and hence the results. However, because the study focused on mentors’ perspectives, and there were only 14 mentors employed, including all of them in this study must be considered satisfactory with regards to confirmability. It also shows that it is possible to evaluate a charitable development programme in a way that is simple and cost-effective yet still provides useful results. Views from managers and other health care professionals involved in the mentorship programme could, however, have contributed different perspectives on the implementation of new midwifery practices, strengthening the trustworthiness of this study [22].

Despite better maternal and newborn care worldwide, there is a need for continued improvement, a need made even greater by the COVID-19 pandemic [28]. According to the Lancet Commission on Gender and Global Health, not a single country has been able to promote flourishing, sustainable, or equal health care to the population [28]. With the results of this and previous studies [13,16] in mind the best that can be done in Bangladesh to promote its new cadre of midwives is to improve their claim to equality within the health care sector and by so doing ensure that they have a more sustainable future.
Conclusions

The reason we want the midwifery students to adopt evidence-based practices in clinical practice before graduating is because midwives integrate in the health system will improve the birthing process, improve life chances for newborns, reduce morbidity and mortality [9], and it justifies this whole process of intervention and change using medical doctors’ status and power to support the midwife cadre in a country where midwifery has been newly introduced or is in a weak position. The intervention assisting in the establishment of evidence-based midwifery care is helpful for the entire Southeast Asia region [34]. A study to find out if a mentorship programme to medical doctors employed as mentors to HCP can operate at clinical placement sites as an online activity. A question that needs to be discussed for the future is how to make midwives have an equal status to doctors within their scope of practice.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

References


