

The Good, the Bad and the Ugly

The experiences of midwives who transition work settings: A  
qualitative descriptive study

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## ABSTRACT

This research explores the experiences of midwives as they transition work settings. It has been found that these experiences are both positive and negative. Midwives relish working with women in a capacity that brings them joy and sustains them within the profession. They achieve this with the valued support of their families, practice partners and colleagues. However, there are numerous stressors on midwives including financial, emotional, physical, family commitments, bullying and work demands, which impact on the ability of the midwife to fulfil these obligations. This dissonance leads to increased levels of stress and fatigue and in order to manage this, the midwives who participated in this research appear to transition work settings.

By analysing the lived experiences of nine midwives in Aotearoa/New Zealand who have transitioned work settings between core and LMC (or vice versa) in the previous two years, I have explored the research question ‘What are the experiences of midwives who transition work settings?’ using a qualitative descriptive research framework. Face to face interviews were conducted with midwives around the South Island of Aotearoa/New Zealand using semi-structures interview questions, followed by transcription and thematic analysis. Four main themes emerged, *ideal midwife*, *movement happens*, *support and obstruction and things have changed*. The themes and subthemes are discussed in depth through this work and literature used to support the discourse.

The main finding was that transitioning work-settings is a way of remaining professionally and personally sustained in the current system of maternity care in Aotearoa/New Zealand. Other findings were that support from family, colleagues and managers, as well as the relationships with the women, are imperative for midwives in either work setting to remain sustainable. That the lack of support, bullying, harassment, poor remuneration and family commitments, are stressors that impact on the working lives of midwives and contribute to their decisions to transition work settings. There are implications from this research for midwives, DHB, workforce planning, educators and the wider profession.

**Keywords:** midwife, work settings, transition, sustainability, bullying and horizontal violence, relationships with women.

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# Chapter One: Introduction and Background

## 1.0 Introduction

This research investigates the experiences of midwives in Aotearoa/New Zealand who transition from one workplace setting to another during their careers i.e. from being an employed midwife to being self-employed and vice versa, in order to answer the question: What are the experiences of midwives who transition work settings? Listening to and exploring the narrative of midwifery colleagues will enable me to gain a deeper understanding of this process, explore their personal experiences, levels of resilience and their personal and professional sustainability.

Developing a deeper understanding of this transitioning process will help midwifery stakeholders shape and develop future strategies for education, funding, recruitment and retention of staff. Then midwifery education providers can ensure that graduates are not only work ready for either setting, but are able to negotiate the transition process successfully, ensuring their longevity in the workforce. It will enable the District Health Boards<sup>1</sup> (DHB) to manage the loss of experienced staff, who at various points of their careers will transition work settings. It will enable them to plan and prepare for the impact this will have on the skill mix and stability of workforce in the maternity units. The Ministries of Health, Education, and government workforce planning strategists will be able to utilise the findings of this research in order develop their policies and budgets to ensure that there is a sustainable midwifery workforce within this country. It will for midwives, provide an insight to this process and a clearer understanding about the factors which may influence their decision to transition work settings.

This study used a descriptive interpretive approach and included one-to-one semi-structured interviews of nine midwives from Aotearoa/New Zealand. These midwives had transitioned from one workplace to another in the previous two years. The key findings are positioned around transition as supporting sustainability of midwifery practice for midwives. There were a wide variety of reasons for the transition process, for some midwives it fitted in with their

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<sup>1</sup> Organisations established by the New Zealand Public Health and Disabilities Act 2000. Responsible for ensuring the provision of health care within a defined geographical area

personal lives at that time; others chose it as a part of their career plan. Other midwives transitioned for less positive reasons including lack of support from practice partners or managers<sup>2</sup> within the workplace. Some of the other reasons were stress, fatigue, burnout and lack of job satisfaction.

The four main themes to emerge from analysis were: An ideal midwife – an expression of the midwives' perception of the 'type' of midwife they wish to be; Movement happens – midwives change their work environment for a number of diverse reasons; Support and obstruction - focuses attention on the need for on-going and continual support from family, colleagues, and peers and management if employed; and finally, things have changed – illuminates the impacts of changes within maternity services and midwifery care over the years.

The participants interviewed defined themselves first and foremost as midwives, that this is an essential part of their identity as opposed to midwifery just being a job, stating that they were passionate about the work they did. Conversely many also felt they were either burnt-out or could become burnt-out if they did not change their work setting. Stress, fatigue and guilt were other emotions that they felt either just before or during the transition process, which sometimes led to the need for professional support. Many of them were exploring other ways to remain in the profession by moving and working overseas or changing existing workplaces and workloads.

What this means is that midwives who are passionate about the profession, many of whom have received their pre-registration education in the Aotearoa/New Zealand tertiary education setting, at a personal and financial cost to them, are transitioning work settings. This transitioning impacts on the workforce within the health system, the level of experience that midwives have within the workplace in both core<sup>3</sup> and community-based Lead Maternity Carer (LMC)<sup>4</sup> practice and on the women as users of maternity services. It also means that midwives who have familiarity with the complexities around the provision of care in this country are considering leaving to work overseas, with some leaving the workforce because

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<sup>2</sup> Management structures within the DHB either in-line manager or senior management teams

<sup>3</sup> A midwife, whose main place of employment is working rostered shifts in maternity units.

<sup>4</sup> A person who is chosen by the woman to coordinate their pregnancy care. In Aotearoa/New Zealand 90% of women choose a midwife to be their LMC. Obstetricians and GP's can also provide LMC care. LMC Midwives provide continuity of midwifery care at home or in the maternity units, throughout the antenatal intrapartum and postnatal period and up until six weeks following birth.



of an inability to remain personally and professionally sustained within the current system of maternity care.

The next section provides a background to the thought processes that led to the development of the research question for this study. The Aotearoa/New Zealand maternity and midwifery system is described, a brief overview is provided as to why this research is necessary, along with the initial brief literature search which demonstrates a paucity of literature on this subject matter. Finally, an outline of the subsequent chapters is provided.

## 1.1 The New Zealand Midwifery and Maternity System

The definition of a midwife in Aotearoa/New Zealand is taken from the International Confederation of Midwives (ICM)<sup>5</sup>, 2011 which states that:

A midwife is a person who has successfully completed a midwifery education programme that is recognised in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global standards for Midwifery Education, who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’, and who demonstrates competency in the practice of midwifery

To practice midwifery within Aotearoa/New Zealand a midwife must have an annual practicing certificate (APC)<sup>6</sup> issued by the Midwifery Council of New Zealand (MCNZ)<sup>7</sup> after meeting the required competencies<sup>8</sup> for entry to the register of midwives in Aotearoa/New Zealand. The competencies in Table 1 provide a synopsis of the minimum expectation of the skills, knowledge and attitude a midwife needs to practice midwifery in this country.

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<sup>5</sup> ICM provides support and representation for the World’s midwives, strengthening the professional organizations of midwives. It is divided into six geographical regions and represents 113 countries.

<sup>6</sup> Registered midwives are legally required to hold an APC issued by the MCNZ before they can practice; this is renewed on an annual basis after meeting the recertification requirements of MCNZ.

<sup>7</sup> Regulatory body of midwifery in New Zealand.

<sup>8</sup> Competencies for entry to the MCNZ register provide details of the skills knowledge and attitudes expected of a midwife to work within the Midwifery Scope of Practice (MCNZ 2014)

In order to maintain an APC, the midwife also needs to meet the requirements of the MCNZ Recertification Programme (MCNZ, 2014) which includes an annual signed declaration of competence to practice, demonstrating competency across the midwifery scope of practice, maintain a professional portfolio, attendance at compulsory and elective education sessions as defined by the MCNZ. The midwife should also be involved in professional activities for example student supervision, as well as engaging in a biennial midwifery standards review (MSR). This is the forum in which a midwife presents to a peer and a consumer, and where she discusses the portfolio, clinical outcomes, consumer feedback and reflects against the standards of practice or Turanga Kaupapa<sup>9</sup>.

**Table 1:**

**The Competencies for Entry to the Register of Midwives (MCNZ, 2014)**

Competency	Definition	Brief description
One	‘the midwife working in partnership with the wahine/woman throughout the maternity experience’,	The midwife enables the wahine/woman to make informed choices about her pregnancy and childbearing experience. This partnership, sharing of knowledge and maintaining an equal power balance is paramount for the relationship to work. The Aotearoa/New Zealand context of midwifery is one where the wahine/woman remains in control of her birthing experience.
Two	‘the midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care’	This can be achieved by applying researched based knowledge and skills to promote and protect physiological childbirth.
Three	‘the midwife promotes practice that enhances the health of the wahine/woman and her whanau/family which encourages their participation in health care.	Reflecting the fact that midwifery is a primary health service and that the midwife shares her knowledge to enhance the wahine/woman’s health and wellbeing, an example of this could be a referral to a service that supports wahine/women to become smoke free.
Four	‘the midwife upholds professional midwifery	Reflecting the relationship that the midwife has with the profession, the professional body MCNZ, the professional

<sup>9</sup> Developed by Nga Maia o Aotearoa (The Brave) Midwives, to provide ‘clear guidelines on Tangata Whenua values and cultures and provide cultural guidelines for midwifery practice to ensure that basic cultural requirements are met for Māori women during pregnancy and birth’ (MCNZ 2012)

	standards and uses professional judgement as a reflective and critical practitioner when providing midwifery care'	organisation New Zealand College of Midwives (NZCOM) as well as the woman and the wider community
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During the process of this research in 2017 the Recertification Programme requirements were refined (MCNZ 2017). The changes were that midwives must attend a combined emergency skills day which includes maternal collapse and resuscitation, new-born resuscitation and increasing skills for maternity emergencies. As well, they must participate in a minimum of eight hours of self-selected elective education annually, to demonstrate engagement in the profession in order to contribute to practice and support colleagues in a number of ways. A further change was for the MSR to be undertaken every three years instead of every two years (MCNZ 2017). The rest of the requirements are as defined in the previous paragraph.

The Midwifery Standards of Practice provide guidance for the midwife to practice in her chosen workplace using a research-based approach and Turanga Kaupapa has been adopted by the MCNZ and NZCOM as the mechanism that 'gives life and meaning to the midwifery profession's recognition of Māori as Tangata Whenua<sup>10</sup> and the professions obligations under the Te Tiriti o Waitangi<sup>11</sup> (Treaty of Waitangi)' (MCNZ, 2012, p.5). The midwife establishes a personal development plan which should be completed prior to the next MSR (MCNZ 2012; MCNZ 2014; MCNZ 2017; NZCOM 2015).

Midwives in Aotearoa/New Zealand work within a defined Scope of Practice (MCNZ 2014; NZCOM 2015) as autonomous practitioners working in partnership with the wahine/woman providing continuity of care, advice and support throughout the antenatal, intrapartum and postnatal period up to and including six weeks following the birth of the pēpē/baby.

Throughout this process the midwife promotes and protects physiological childbirth and breastfeeding. She works collaboratively with other health care providers, including general practitioners (GP), obstetric and paediatric colleagues, identifying any complications that may affect the pregnancy, wahine/woman or pēpē/baby, and refers to the most appropriate medical practitioner in accordance with the referral guidelines (Ministry of Health [MOH]

<sup>10</sup> Tangata Whenua: Māori indigenous people of Aotearoa/New Zealand born of the whenua or placenta of the land where ancestors have lived and where the placenta is buried (Tangata Whenua n.d p3)

<sup>11</sup> An agreement made between Māori and the British in 1840. The founding document of Aotearoa/New Zealand

2012). Within the New Zealand Midwifery Scope of Practice, the midwife also has a role in health promotion for the wahine/woman and her whanau/family (MCNZ 2014; NZCOM 2015).

A midwife can choose to practice in many different work environments which can vary from homebirth to providing tertiary level care within the current maternity system in Aotearoa/New Zealand (MCNZ, 2014; NZCOM, 2015). However, the majority of midwives choose to either work in two distinct settings; either as an employed midwife within the local DHB in the primary<sup>12</sup>, secondary or tertiary level facilities or as a self-employed LMC, working in the primary health care setting and providing care for a caseload of up to 45 to 50 wahine/woman a year (MCNZ, 2015). However, in all work settings ‘the midwife remains responsible and accountable for the care she provides’ (MCNZ, 2014, para. 4). The remaining midwives on the register are employed in other roles including education, management, quality and safety, and locum midwives in rural and urban settings.

Within the Aotearoa/New Zealand context of midwifery, primary care is part of the public health care strategy which is designed to ensure that the conditions needed for people to remain healthy are met. This is based on the social model of health where a holistic approach is undertaken and includes the social determinants of health which are economic, social, cultural and socioeconomic status. (Rasanathan, Montesinos, Matherson, Etienne & Evan, 2011; Thorogood, 2015; WHO, 2008).

Primary midwifery care is based in the community and is, in the majority of cases, the initial and sometimes only point of contact for wahine/women during their pregnancy journeys. Health care professionals that work in this environment are skilled in providing this level of care and include midwives working as LMC. Secondary maternity care is loosely defined as health care that is provided by specialist services for example radiologists. Wahine/woman do not have direct access to these services and they are usually accessed following a referral from a primary health service provider, whereas tertiary level care is defined as being highly specialised dealing with complex issues that can arise for some wahine/woman and pēpē/baby, it includes the specialities of fetal-maternal medicine, neonatology and maternal high dependency units (Thorogood, 2015).

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<sup>12</sup> Primary care health care provided in the community covering a broad range of health services including diagnosis, treatment, education and screening (MOH, 2018b; Barnett & Barnett 2004).

The other framework documents that define midwifery in the Aotearoa/New Zealand context are MCNZ Code of Conduct (n.d.), Cultural Competencies (2012) and Code of Ethics (NZCOM, 2015) and The Health Practitioners Competency Assurance Act of 2003 which provides the framework for the regulation of health professionals within Aotearoa/New Zealand (MOH, 2003).

## 1.2 The Problem

As a student midwife in the UK University system many years ago, the Aotearoa/New Zealand model of midwifery described above was classed as the ‘gold standard of midwifery care’, and what we, as students, should aspire to and aim to achieve within the health care system. I was very privileged to hold a New Zealand passport and have the qualifications and support needed to migrate and work in Aotearoa/New Zealand after gaining a number of years midwifery experience in the UK.

I have worked in Aotearoa/New Zealand in many capacities initially as a continuity of care midwife<sup>13</sup>, a short period of time as core midwife and more recently, 12 years as a full time LMC in an urban/semi-rural environment. Throughout this period I have always had a strong interest in education, and the ambition, that at some point in my career I would become a full-time midwifery educator. In order to meet my goal, I planned and worked towards this over many years, initially working with students, then gaining additional educational and post-graduate qualifications, working in part-time education roles while maintaining a case load, and eventually the transition nearly five years ago to becoming a full-time educator.

Initially when working as a LMC in a semi-rural area of the country, all seemed stable and the majority of midwives appeared to be satisfied with their chosen work environments. Over the past five to ten years it has become apparent to me that midwives do not appear to be as content in their work as they once were. Many of them are vociferous in voicing their opinion at the deplorable nature of their (current) working environment.

Personally during these past years, I have observed that many midwives appear to transition from one work environment to another during the course of their careers, especially from

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<sup>13</sup> Employed by the DHB, but carrying a caseload of women similar to a LMC midwife

LMC work to core work, and vice versa. Observing the midwifery community, it has become obvious that some of these moves are sudden and can occur with little warning. It is not uncommon to hear statements like ‘Sally has started a case load’ or ‘Felicity is moving to core’. As this is so different from my personal experience of ‘career planning’ and transitioning from working as a LMC to an educator, I started to wonder how midwives plan their working life, when and why do they change work environments, and what are their experiences, planning and motivation behind this process.

When midwives transition their work places it would be valuable to understand their experiences of this process and whether it is seen as a positive or negative move; is it something that is planned with colleagues, managers and family, or is it just a sudden realisation that they need a change. Thinking deeper about this phenomenon, I questioned if it was the uniqueness of the maternity system within Aotearoa/New Zealand (Grigg & Tracy, 2013) that makes this transitioning conceivable. Does the ease and ability to transition from a self-employed LMC to being employed and vice versa enable this movement to occur? This could be especially pertinent when a core midwife decides to become an LMC, as she, with the minimum of equipment, can very quickly build a case load of clients. Whereas this transitioning process could be more difficult for a LMC who wants to work as a core midwife in either a primary or tertiary environment, as she would potentially need to wait until there was a midwifery vacancy available and also have to undergo the necessary but sometimes lengthy recruitment processes.

The problem that I think exists is multifactorial, including possible intergenerational differences, with younger women entering the profession possibly seeing midwifery as a ‘job’ that fits in with their family, whereas older midwives may have viewed it as vocational, a career for life. This could account for the transitioning in work places as midwives look for ways in which to maintain their family/work/life balance. Michael McQueen (2011) in his book ‘The new rules of engagement, a guide for understanding and connecting with generation Y’ (Gen Y) defines Gen Y as anyone who was born between 1980 and the late years of 1990, and goes on to document that adults from Generation Y may have five to seven career changes during their working life (McQueen, 2011). Could the midwives who are classified as Gen Y, be impacting on the midwifery workforce of Aotearoa/New Zealand? Could it be that working in a different workplace can be considered one of the career changes that McQueen has identified?

Another possibility that causes midwives to look at their careers is the increasingly difficult working environment, where both LMC and core midwives are working with women who have increasing health needs and complexities in their pregnancies (Yelland, Winter, Draycott & Fox, 2013). This fact has been outlined in the gender equity pay claim that NZCOM are currently negotiating with the government where it is stated that the ‘scope of duties for community based LMC midwives has increased incrementally...the changes to the population structure and complexity of maternity cases in New Zealand’ (NZCOM, 2015a, para. 9). Alongside this are the operational and organisational constraints that midwives are under when working in the core setting including staffing levels and attrition rates (Curtis, Ball & Kirkham, 2006; Finlayson, Dixon, Meadows & Blair, 2002; Jennings, 2015; Wells, 2003) and the potential impact these may have on midwives working within these environments.

Midwives are also faced with media representation of the profession, which appears to provide a sensationalised perspective of midwifery with headlines that include ‘Bad outcomes for new babies more likely with a midwife’ (Murphy & Flynn, 2016, para. 1), ‘New midwives should not lead care’ (Wilson, 2015, para. 5) and ‘Midwife failed to recognise problem’ (Johnston, 2015, para. 1). It could be construed that this negative media coverage regarding midwifery could also lead to increased stress and anxiety within the profession having a negative effect on midwives who attempt to manage this by transitioning from one work environment to another.

It appears that some individuals choose a career and either remain in that profession, or retrain to move into another sphere of work. As a comparison with midwifery, the nursing career pathway tends to be working mainly in a hospital setting with specialisation into other clinical areas including paediatrics, theatre or mental health, or diversifying into education or management positions (Nursing Review, 2014). Police officers can also specialise into other areas including the dive squad, dog handling or the armed offender’s squad (Careers NZ, n.d.), however there is also similar career progression into management and educational roles as the police officer becomes more experienced and qualified. There is dearth of literature from either of these professions which is comparable with the midwifery career pathway of moving from employed to self-employed during their working life.

The sustainability of LMC midwives in Aotearoa/New Zealand has been researched by Wakelin and Skinner (2007) who found that there were growing concerns regarding the

impact of providing 24/7 continuity of care to wahine/women. A plethora of literature is available regarding midwives leaving the profession (Birth Project Group, 2016; Curtis et al., 2006; Pugh, Twigg, Martin & Rai, 2013), but an initial literature review shows that there appears to be little available evidence regarding the phenomenon of midwives (or any other professionals) transitioning practice settings as described in the Aotearoa/ New Zealand context of midwifery.

### 1.3 Research question

The research question ‘What are the experiences of midwives who transition work settings’, will explore this phenomenon in order to gain a depth of understanding around the drivers and motivation for midwives to change their work settings throughout their career.

Aim:

- Explore the process of transitioning work settings between core and LMC or LMC and core, for midwives in Aotearoa/New Zealand.

The objectives in order to achieve this aim are:

- Document midwives experiences of transitioning work settings from core to LMC and vice versa.
- Analyse the material and relevant literature in order to provide a deeper understanding of the drivers and factors that contribute to the midwives’ transition process.
- Elaborate on factors which impact on the decision of midwives to transition work settings.

### 1.4 Summary

In summary, I have provided a brief overview of the NZ context of midwifery and the partnership model of care, discussed my interest in this subject matter, provided a brief



literature review, posed the research question, and defined the aim and objectives. The following chapter will be a literature review of the salient issues.

## 1.5 Outline of Chapters

### Chapter One: Introduction

Chapter 1 introduces the research topic of midwives transitioning work settings and the implications for midwifery stakeholders. It then goes on to explain my interest in the midwifery workforce and why midwives appear to transition work settings on a regular basis. The methodology and main themes are outlined, a brief literature review is provided, alongside a description of the current model of midwifery care in Aotearoa/New Zealand. Within this chapter the research question is posed, then the aim of this research and objectives identified.

### Chapter Two: Literature Review

Chapter 2 provides a comprehensive review of the literature and explores many aspects of midwifery from a national and international perspective. The review of the literature explores issues that affect midwifery from a number of perspectives including professional, historical, cultural and societal. Midwifery is then compared and contrasted with other professions that have similar educational requirements as well as occupations where the workforce can also be employed or self-employed. Finally within this chapter the gap in the literature is identified regarding the transitioning process of midwives within Aotearoa/New Zealand.

### Chapter Three: Research Design and Methodology/methods

Chapter 3 provides a detailed account of the chosen method and methodology. Background information on research methods relevant to this research is discoursed. This chapter then introduces the participants, their recruitment process, interview settings and how their stories were collected. Following on from this, there is a discussion about thematic analysis, ethical considerations and rigour. Lastly the safety of participants is discussed including maintaining confidentiality, ensuring privacy, and the storage of the recordings and written transcripts.

### Chapter Four: Findings

Chapter 4 presents the findings from the transcripts. Direct quotes from midwives are utilised to illustrate the four main themes and subthemes which emerge from the thematic analysis. The four main themes are, ideal midwife, movement happens, support and obstruction and lastly things have changed. Within this chapter midwives' work settings, transitional experiences and stressors which impact on them are clearly identified.

#### Chapter Five: Discussion and Conclusion

Chapter 5 looks at the impact that stressors have on midwives within the profession and how these can contribute to the process of transitioning work settings. This final chapter called the Good, the Bad and the Ugly demonstrates how the midwife values the partnership with the women they work with and cherish the ability to provide quality care; it goes onto describe factors that contribute to midwives transitioning work settings including the 'tug of war' between work and family commitments; lastly this chapter explores the ugly, the culture of bullying and horizontal violence experienced by some of the midwives who shared their stories.

The drawing together of these concepts, discussions and ideas provides the conclusion to this work, identifies the need for further research and the implications for midwives, stakeholders, the wider midwifery community and most importantly the women and whanau/families midwives work with.

## Chapter Two: Literature Review

### 2.0 Introduction

A midwife in Aotearoa/New Zealand has the opportunity to work in a variety of environments and can transition from LMC to core, or vice versa, as well as having the opportunities to work in other settings which include but is not limited to education, management and research.

There is a growing body of evidence researching the difficulties around recruitment and retention of midwives within both the DHB in Aotearoa/ New Zealand and the UK National Health Service<sup>14</sup> (NHS). This literature review will discuss some of the issues midwives face in the workplace, explore other occupations where it is possible to transition from employed to self-employed, and will look at other careers within the health care system where it is more difficult to move across work settings or become self-employed.

### 2.1 Search Strategy

Te Waharoa search engine of Te Pātaka Kōrero on-line library at Victoria University of Wellington was utilised to conduct the literature search. Databases searched included Scopus, Medline, ProQuest, ScienceDirect, Ebsco and CINAHL, Cochrane Library, PubMed and Nursing and Allied Health Collection. The initial search was conducted prior to and while writing the research proposal. Searches have continued at various stages throughout this work to clarify points and explore themes that arose following thematic analysis.

The search strategy used subject headings, keyword searches and searches using author names. The initial search used the keywords ‘midwives’ (truncated to ‘midwi\*’ to ensure plurals are included), ‘profession’, ‘leaving’, ‘retirement’ and when limited to articles, generated 960 results. Filters were applied to ensure all results were written in English, were peer reviewed, had a publication date from 1980 to current, leading to 527 results.

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<sup>14</sup> The public health sector in the United Kingdom

The initial key word search identified minimal research on midwives who transitioned from one work environment to another during their careers so the search was widened to incorporate the following terms, ‘leaving midwifery’, ‘burnout’, and ‘midwifery attrition’. Following this, filters were again applied and the following subject areas were searched individually: nurses, nursing, midwifery, women’s studies, job satisfaction, recruitment, retention, workforce and midwives. This yielded a total of 138 papers of which, abstracts were read. The literature search for the comparison to other occupations followed a similar search strategy replacing midwifery with ‘architect’, ‘dentist’ and ‘nurse’. Approximately 50 to 60 papers were selected to inform this research.

This literature review will initially focus on the causative factors which lead midwives to become dissatisfied with their working environment and review literature from the historical, and a national and international perspective. It will then explore the reasons why midwives stay in the profession, the recommendations to retain midwives in the workforce and reduce the attrition rates. The literature review will then go on to provide a brief overview of other professions where it is possible to transition between being self-employed and employed.

## 2.2 Issues within the workplace for midwives

There are a plethora of issues for the midwives in the current midwifery workforce not only in Aotearoa/New Zealand but Worldwide. Much of the current literature on this subject focusses on issues relating to the difficulties in recruitment and retention of midwives, exploring themes that include: poor remuneration, the dissonance between work and personal life, bullying and harassment, the inability to form meaningful relationships with the women midwives work with, and the ongoing chronic staffing shortages.

A seminal piece of research commissioned by the Royal College of Midwives (RCM) and the Department of Trade and Industry ‘Why midwives leave’ was completed in 2002 in the UK, as a response to the staffing shortages within midwifery at that time (Ball, Curtis & Kirkham 2002).

This robust study conducted in the UK involved all midwives who notified their intention to practice with the registering body in the UK (the United Kingdom Central Council) for

Nursing, Midwifery and Health Visitors (UKCC) in 1999 but who had not done so in 2000; this generated a sample group of 2325 midwives. This two-phase study consisted of an initial postal survey of 250 midwives who were chosen randomly, followed by interviews with 28 from this group. Phase two had a pilot study of a further 100 midwives and the majority of the remainder of midwives were also surveyed. The response rate for the survey was an incredible 50%. Limitations of this work are listed as difficulties in recruiting two discrete sample groups as first planned, delays in sending and receiving the surveys, and surveys going to midwives who were still practicing, ill or had died. The researchers also acknowledge that midwives who had planned retirement may be under-represented (Ball, Curtis & Kirkham, 2002).

The participants in the research were mainly mid-career midwives with an average of 11.3 years length of service in the profession. Almost 50% of the midwives who had left the profession felt that they had been unable to provide women with the care they deserved, leading to dissatisfaction and them ultimately choosing to leave the workforce. Furthermore, 39% of respondents said their decision to leave was because they could not be the type of midwife they wanted to be. Another 26% stated it was because they could not form the meaningful relationships with the women that they were working with or were unable to provide the quality of care to the women they were looking after, when working within the constraints of the NHS (Curtis, Ball & Kirkham, 2006).

Similarly, Finlayson and colleagues (2002) explored the extent of the NHS nursing and midwifery shortage in the UK. It had been identified that there was a struggle to recruit staff, especially in inner-city areas. The reasons given for this were low pay rates, changing nature of the job, staff feeling undervalued, and the fact that nearly a third of nursing and midwifery graduates did not take up an APC after leaving the education sector. They conclude this work by saying that the low morale and high staff turnover may have had an impact on the care that the users of the service were to receive. These findings and subsequent government strategies to improve staff moral within the NHS are comparable with Curtis et al., (2006) article on the midwifery workforce.

The recommendations from the 'Why do midwives leave' report (Curtis, et al., 2006) were varied and it was suggested that there were systemic faults within the UK midwifery service and some factors that needed to be addressed were the inadequate staffing levels on the maternity units, facilitate positive changes within the culture of midwifery which include

addressing bullying and horizontal violence as well as leadership issues. This research also determined that levels of remuneration needed to reflect the experience of the midwives working within the NHS and policies put in place to ensure this is acknowledged and midwives are adequately recompensed.

In 2016, the 2002 'Why do midwives leave' study was revisited by the RCM. They again surveyed midwives who had left the profession in the previous two years or who were planning to in the following two years. Unfortunately the conclusion of this second report found that little had changed between the original study in 2002 and this one in 2016 (M. Kirkham, personal communication, June 8, 2018; RCM 2016). The majority of midwives who had left the profession continued to do so because of midwifery staffing levels and unmanageable workloads. Midwives continued to feel undervalued as employees, were poorly remunerated for their level of expertise and work requirements. Despite the promise of reforms, management issues and bullying remained an issue within the NHS (RCM 2016).

Within the Aotearoa /New Zealand context of midwifery, similar findings were described in an unpublished survey conducted by a regional branch of NZCOM and one DHB in 2016. Although limited in scope the questionnaire found results that were similar to the UK report. Ninety-one midwives participated in the survey and 74% of these completed the whole survey. The midwives worked in the following areas: LMC midwives (58%), core midwives (39%) working in both primary and secondary care, with the remainder (3.5%) in other maternity roles.

The midwives who completed the survey stated that the main cause of dissatisfaction was the poor staffing levels within the unit, with 78% of the respondents reporting that understaffing impacted on their working environment and could impact on the care that the women they worked with received. Over one third of the respondents to the survey also mentioned that there was a lack of clarity in the interface between primary health care providers and the secondary and tertiary level providers (Canterbury and West Coast Region NZCOM, 2016).

Although this is a survey of only one DHB within Aotearoa/New Zealand it can be extrapolated that if this survey was conducted throughout the country the findings may be similar. There were also a number of midwives (14%) who identified issues with the management structure, and indicated that a culture of bullying impacted on their working life (15%). A further 18% mentioned a lack of respect between practitioners. (Canterbury and West Coast Region NZCOM, 2016)

This is corroborated by Hunter's (2004) research with Welsh midwives and student midwives. This three-phased qualitative research explored the experiences of 27 student midwives in their first and final years of education, an opportunistic sample group of 11 midwives and a purposive sample group of 29 midwives working within the NHS.

Hunter found that midwives who worked in the hospital setting focussed more on meeting the high level needs of the service and, by necessity, had a more medicalised viewpoint. Whereas providers who worked within the primary health care system concentrated more on a holistic, individualised approach to the women they were working with. Hunter's research concluded that this dichotomy within the workforce can be a contributing factor for 'low morale and poor retention' (Hunter, 2004). She does state that there were some limitations for this research as it was conducted within one geographical location and should be repeated in other areas with different demographics.

A telephone survey of 94 midwives, exploring the sustainability of practice as an LMC within Aotearoa/New Zealand, was conducted by Wakelin in 2007. While undertaking her Master's (MA), she explored the fact that there were growing concerns regarding the sustainability of LMC midwifery practice within Aotearoa/New Zealand. LMC Midwives engaged in practice stated that the reason they worked as community-based midwives was for the relationships they formed with the women they worked with. Wakelin also found that the converse also applied, that it was because of these relationships and the lack of work-life balance that over 78% of the midwives surveyed had considered leaving practice (Wakelin & Skinner 2007).

This compares with the findings of much earlier work carried out by Engel (2000) and McLardy (2003). Engle recruited five midwives and explored their sustainability within the LMC model of care. She found that these midwives had identified that there was 'potential for burnout and loss of social contact if a balanced approach to working in the continuity of care model' was not adopted (p. 119) and concludes by saying that funding needs to underpin this way of working to ensure that midwives are able to provide the level of care they wanted to provide and the women deserved. Whereas McLardy (2003) interviewed six midwives from both core and LMC settings for her research and also determined that community-based midwives could become overwhelmed by providing continuity of care to the women that they work with, leading to an inability to balance work/life commitments.

Three LMC midwives who had recently stopped working were interviewed in 2011 about their reasons for leaving (Cox and Smythe 2011) for an article. In the conclusion to the article, Cox and Smythe (2011) emphasise that the profession needs to ‘actively explore strategies that support the on-going practice of LMC midwifery in NZ’, that midwives are committed to providing both woman-centred care and continuity of carer but the personal cost for many midwives is unsustainable. This view is supported by Wakelin and Skinner (2007) who conclude their research by providing recommendations that could make community based midwifery more sustainable, including working in small group practices where funds are pooled and midwives are able to get quality time off-call so they can maintain a good work life balance, and ultimately it could be hypothesised, to enable them to be more sustainable in practice.

In another major study Pugh, Twigg, Martin and Rai (2013), surveyed 712 midwives from Western Australia representing 44.5% of practicing midwives in the region. Despite the fact that midwifery services in Australia differ from the Aotearoa/New Zealand model of care, with the majority of midwives working in employed settings as opposed to being self-employed, the findings of Pugh and colleagues (2013) study also corroborated the themes of poor remuneration, part-time female workforce, the health sectors inability to recruit and retain staff, poor management structures and heavy workloads as the previous studies discussed above.

In order to retain the midwifery workforce one recommendation is that the government needed to explore a variety of options which midwives thought would improve their working conditions. These options included midwives having the choice of flexible working arrangements and improvement in workloads and practice conditions; especially ones that would enable them to build professional relationships with the women they were working with, leading to increased job satisfaction (Pugh, et al., 2013; Versaevel, 2011).

There have been a number of articles which discuss the importance of looking after midwives to prevent attrition from the workforce (Skewes, 2014; Sullivan, Lock & Homer, 2011; Versaevel 2011). Some of the factors that could be considered include how to support the mainly female workforce and enable them to balance family and work commitments (Curtis, et al., 2006; Versaevel, 2011). For example, Skewes (2014) and Sullivan et al., (2011) discuss the impact that shift work has on the health of midwives and how organisational changes in the timing and rotation of the roster can have a positive impact on midwives remaining in the



workforce. Interestingly, the introduction of flexible rosters was explored as a means for midwives to balance their work and family commitments with the implementation of family friendly work policies within the NHS. While these policies allowed some midwives to balance their own needs of family life, there were unintended consequences within maternity units as managers were unable to maintain adequate staffing levels or skill mixes in the working environment. It was also felt that these policies could exacerbate existing tensions between staff 'when family friendly working hours leave 'unfriendly' gaps in the roster that have to be filled by others (Curtis, Ball & Kirkham, 2006b, p. 264).

A multinational cross-sectional survey of midwives from seven very diverse countries (Czech Republic, Italy, Poland, Portugal, Slovakia, Singapore and South Korea) was carried out to explore the intentions of 1190 midwives around their levels of job satisfaction or plans to leave the profession. For the midwives who were planning to leave the profession a variety of reasons were given including financial, lack of support, but the imbalance of working life and family, as well as limited job satisfaction were the main factors (Jarosova, et al., 2016).

There is a multitude of literature available some of which is discoursed above, on why midwives leave the profession which paints a bleak picture of the profession. Therefore, for this literature review, it is also important to understand and explore why midwives choose stay in the profession despite this negativity and what could be construed from the reading above as minimal levels of job satisfaction. The question that remains to be answered is what sustains these midwives and enables them to stay in practice?

Sullivan, Lock and Homer (2011) conducted a piece of research using a two-phase descriptive design to investigate the reasons midwives stay in the profession. The first phase was conducted with 36 midwives across four focus groups to ensure the questionnaire was applicable to Australian midwives, and used a revised version of the 'Why do midwives stay' questionnaire (Kirkham, et al., 2006). In the second phase of the research, the questionnaire was distributed to midwives who worked north of Sydney Harbour and into the surrounding areas of Hawkesbury River and Central Coast which comprised of a group of seven maternity units ranging from primary to tertiary level care. There were a total of 209 respondents to the survey which equated to a response rate of 53%. Sullivan and colleagues found that midwives stayed in the job because they were proud to be midwives and enjoyed their work and felt that they made a difference to the women they were working with. It appears that the

structure and organisation of the workplace also contributed to job satisfaction (Sullivan et al., 2011).

Another perspective on this is offered by Versaevel (2011), who also found that midwives who were autonomous practitioners and formed professional relationships with the women they were working with had increased levels of job satisfaction. That for these midwives, their support mechanisms were the relationships with their family, significant other, and colleagues within the workforce. It was found that these factors improve the retention of midwives in the workforce. The setting for this research was in Ontario, Canada. All midwives working in the province were surveyed via email, using a web based questionnaire modified from the 'Why Midwives Stay' survey (Kirkham 2006) and there was a response rate of 37%.

Both Sullivan et al., (2011) and Versaevel (2011) had limitations within their research. Versaevel was limited by the response rate of 37%; although Sullivan et al., had a much higher response rate (50%) with half of the total population of midwives responding. Both areas were geographically different and had different models of health services. The surveys were limited by the participants being located in one area of the respective countries, which could lead to bias. However, it is interesting to note that the findings from these international pieces of research have very similar themes around the retention of midwives in the workforce from a national perspective.

Similar themes were expressed in 2016 by midwives in the UK, who had left the profession or were thinking of leaving the profession, they stated that factors that would encourage them to stay or return to practice included a change in staffing levels and workload, increased wages and a change in workplace culture (RCM 2016). Retention of midwifery is also discussed in Sullivan et al., (2011) who find that midwives remain in the workforce because of the enjoyment of the job, pride in being a midwife, working with women and their families, this then leads to increased job satisfaction and feelings of being valued by women, colleagues, peers and management.

The findings of this study are corroborated in another cross-cultural study by Hildingsson et al., (2016) where 2585 midwives from Sweden, Aotearoa/New Zealand and Australia were surveyed on their personal, professional and employment details and included the 'Perceptions of Empowerment in Midwifery Scale (PEMS)' (p. 64). The findings of this survey were statistically significant ( $p < .001$ ) in the majority of subsections when compared.

A significant finding was that midwives from New Zealand and Sweden had a stronger professional identity (p. 68) compared with midwives from Australia, stemming from working in a well-developed primary health service which leads to increased autonomy and empowerment (Hildingsson et al., 2016) and it can be construed increased levels of job satisfaction.

Together, these studies provide important insights in the current state of midwifery from a national and international perspective. They explored the issues of recruitment and retention of midwives in the work place, midwives reasons for leaving or thinking of leaving the profession, and the factors that will impact on this in a positive or negative way. In the following section some of these themes will continue as midwifery is compared to other professions.

## 2.2 Other Occupations

Midwives have a very unique position within Aotearoa/New Zealand's work force, providing specialist services for women of child bearing age (Grigg & Tracy, 2013). The majority of midwives have obtained a Bachelor degree from an Aotearoa/New Zealand tertiary level education provider (48.8%), others report gaining a midwifery qualification following a nursing qualification (22.2%) or gaining their qualifications overseas (29%) (MCNZ, 2016).

This section of the literature review will explore other professions with similar entry level qualifications in order to compare career pathways and levels of remuneration.

On the Ministry of Business, Innovation and Employment Occupation website (MBIE) (2017) it is possible to download a phone app that is called 'Occupation Outlook' which is a tool for exploring education and career opportunities for the top 100 occupations in Aotearoa/New Zealand. Included occupations are divided into six main themes; Construction and Infrastructure, Creative Industries, Manufacturing and Technology, Primary Industries, Service Industries, and Social and Community, which includes midwifery.

Within these categories it is possible to ascertain some other occupations that require both a Bachelor degree level of education and a career pathway where being employed or self-

employed is a possibility. Two of these with similar education requirements to midwifery are architects and dentistry.

Architects who have completed a three-year Bachelor to become a registered architect can design buildings and provide advice regarding the safety and construction of buildings (MBIE, 2017). With the Canterbury rebuild and housing shortage in Auckland, there is a demand for their services across New Zealand. Architects have an estimated annual income of up to \$72,500 per annum. Statistics show that two years after graduation the majority of graduates were either employed or in post-graduate education. Career pathways within this industry are dependent on the company the Architect works for. According to the MBIE (2017), some graduates will end up running their own business.

Dentistry is another profession that requires a tertiary level qualification, Bachelor of Dental Surgery, which is studied over five years. Once qualified, all dentists need to be registered with the Dental Council of New Zealand. As with architects', dentists' income vary with experience and the size of practice they choose to join. Annual income is estimated to be \$69,500 with the majority of dentists setting up their own practice following registration.

Other occupations where it is possible to be either employed or self-employed include some job opportunities within the Construction and Infrastructure section of this website, for example, electricians, plumbers and roofers. Entry into these occupations is either by apprenticeship or by gaining qualifications at a National Certificate level, although registration is still required with the appropriate board (MBIE 2017).

In comparison, midwifery requires a four-year Bachelor's degree and registration with the MCNZ, the average income for Midwives on the Ministry's website is \$67,000, and a career pathway that says midwives choose to work as either LMC or are employed to work rostered shifts in maternity hospitals (MBIE, 2017). There is a further breakdown of the statistics regarding midwifery in the 2016 workforce survey conducted by MCNZ. There are 3023 midwives currently holding an APC, of these a total of 36.6% midwives were case-loading with 89.3% of these midwives being self-employed. Whereas 50.7% of midwives on the register of midwives state core midwifery was their main employment situation (MCNZ, 2016).

Comparing these two other professions with midwifery, both of have similar educational requirements and provide opportunities to be either employed or self-employed. The initial

literature review found no research which discussed the experiences of dentists or architects who transitioned work settings between employed to self-employed and vice versa.

However, when widening the search to include a larger search strategy, including searching for levels of stress or job satisfaction within these professions, some literature was found that explored these aspects of dentists' or architects' work life. A piece of research from the UK was conducted using a mixed method approach, titled 'The impact of self-employment on architects' job satisfaction' (Sang, Dainty & Ison, 2008). These authors investigated the positive and negative aspects of being self-employed. As approximately 30% of architects within the UK are self-employed these figures are similar to the percentage of midwives within Aotearoa/New Zealand who are self-employed as LMC. The findings in the research by Sang, et al., (2008) discuss that being self-employed increases job satisfaction as an autonomous practitioner, but leads to greater stress levels due to the insecurity of having to maintain a viable business within the industry. The respondents in the research also reported that it was increasingly difficult to maintain a balance between work and home life. Within the conclusion of the research it also stated that this was a complex issue for architects and that there are both positive and negative aspects of being self-employed (Sang et al 2008).

Similarly the literature search did not identify specific research regarding dentists transitioning between work settings. There were however two studies regarding the causes of occupational stress in both dentists and dental students. One study identifies that dentists perceive their profession as more stressful than others in the health sector and that stress increased with longer working hours and heavy workloads (Gangwar & Kiran, 2016; Naidu, Newton & Ayers, 2006). In a systematic review of the causes and impact of stress on dental students, academic pressure was the highest stressor with burnout and psychological illness being the result of these pressures (Elani, et al., 2014).

It would therefore seem that these two professions have similar issues regarding the impact that working conditions, internal and external stressors, career satisfaction and being valued, as midwifery in Aotearoa/New Zealand, which is evidenced by the literature presented from a national and international perspective. However there remains little research on the effects and experiences of midwives, dentists or architects who transition from one work setting to another over the course of their career.

Comparing midwifery educational requirements and the career progression of our sister profession, Nursing, provides another perspective. To be awarded a Bachelor of Nursing a

student needs to complete a three year degree and gain registration with the Nursing Council of New Zealand (NCNZ) prior to practicing. There is the opportunity to work in specialised areas and these can include aged and primary care, as well as mental wellbeing. The remuneration for nurses depends on their experience and work situation (NCNZ, 2015).

The vast majority of nurses are employed within the DHB and salary ranges from \$47,000 to \$67,000 per annum (MBIE, 2017). Nurses who work outside of the DHB earn considerably less, especially if employed in aged care. There are limited opportunities for self-employment within nursing with less than one percent of registered nurses classified as self-employed in the NCNZ profile of the New Zealand nursing workforce data produced in 2015 (NCNZ, 2015).

Literature has been presented that compares other professions with midwifery through an educational and financial lens. During this process a gap in the literature has been identified around midwives transitioning work settings. This will be examined further in the next section.

## 2.3 Identification of gap in literature

There is a plethora of literature easily found regarding midwives leaving the profession. Equally easily available are articles about keeping midwives in practice and the profession. However there is a dearth of literature regarding the phenomenon of midwives transitioning work settings between self-employed in the community, and DHB employed and vice versa. There is also limited research regarding midwives who transition into other employment pathways for example education, research or governance. This literature review has clearly identified a gap regarding the process of midwives transitioning work settings from LMC to core and vice versa. Therefore this research will be designed to record and explore midwives experiences of this process. The methodology and research design will be discussed in the following chapter.

## Chapter Three: Research Design

### 3.0 Introduction

This chapter will discuss how and why the methodology was chosen, the design of the research, recruitment of participants and then go on to discuss how the data gathered was analysed in order to obtain the themes. The purpose of this research is to interpret the experiences of midwives as they transition work settings. I will present the midwives' experiences and give voice to a phenomenon that has not previously been researched in the Aotearoa/New Zealand context of midwifery.

### 3.1 Methodology

The decision regarding the most appropriate methodology and research design for this thesis took some time to refine, with initial thoughts being to apply a phenomenological approach. As an emerging researcher I started to read a vast array of books and articles on how to choose research methods and initially concentrated on phenomenology with little understanding of the concepts or philosophies behind it. During this time I was also refining the research question and planning the research proposal.

When determining the research design and while considering a phenomenological approach (Cluett & Bluff, 2006; Steen & Roberts, 2012), I found that phenomenological research was similar in some ways to a descriptive interpretive approach, as it still produces descriptive-rich data where participants discuss their own thoughts, ideas and feelings about a particular situation; this is sometimes called their 'lived experience' (Cluett & Bluff, 2006; Steen & Roberts, 2012; Mutch, 2005). This phenomenological approach was initially considered as it is a popular method chosen by researchers who want to listen to stories and find the meanings behind them and appeared to fit well with the holistic philosophy of midwifery (Robinson, 2006 pp. 152-202).

Over the months, a clearer understanding of the research question, the potential size of this project, as well as the rigors required for phenomenological research, was formed. This method was discarded as, with further reading, it became obvious that the phenomenological approach requires an in-depth understanding of the ‘philosophical underpinnings and suppositions of this method’ (Smythe, 2012, p.6) and, as this research is time limited, gaining the depth of knowledge required to have this level of understanding would impact on the timeliness of this project. At this point the decision was made to explore the descriptive interpretive research framework and methodology.

Preliminary reading around descriptive interpretive research resonated with me and aligned with the research I wanted to conduct. It also fit within the available timeframes. Making this decision enabled me to focus my reading firmly on descriptive interpretive research methods. Smythe (2012) writes ‘it is wise to name and understand one’s research from the start’ (p.5) as this will help to guide the design of the research and provides a structure for how the research will be conducted.

The question informing the research design was ‘what are the experiences of midwives who transition work setting?’ According to Smythe (2012) and her article titled ‘Discerning which qualitative approach fits best’ it appeared that in order to answer this type of question a descriptive interpretive approach was best, as the intention was to gather information by recording the lived experiences of midwives, as they transition work environments.

The aim of this research then, is to explore the process of transitioning work settings between core and LMC or LMC and core, for midwives in Aotearoa/New Zealand. The objectives are: to document midwives experiences of transitioning work settings; analyse the material and relevant literature in order to provide a deeper understanding of the drivers and factors that contribute to the midwives’ transition process; as well as elaborate on factors which impact on the decision of midwives to transition work settings.

Qualitative or social science research has always been thought to be a poor cousin to quantitative or scientific research. Within quantitative research there is a hierarchy of evidence, this ranks methods of research and the evidence from them; in the scientific world only the most robust evidence should be used to inform practice. In scientific research, the best evidence for use in practice is obtained from being able to limit the amount of variables that may impact on your research (Fitzpatrick, 2007).



This research hierarchy is often depicted as a pyramid with four or five levels with the most 'prestigious' forms of scientific research like systematic reviews, meta-analysis and randomised controlled trials, sitting at the top of this pyramid. The lesser forms of research, for example cohort studies, case studies and cross-sectional studies, sit lower on the scale (Fitzpatrick, 2007). These pyramids of evidence often exclude qualitative research. In an article by Thorne, Kirkham and MacDonald-Emes (1997) qualitative research is discussed in the following terms, 'within the traditional empirical science domain, description serves as the crudest form of inquiry' (p.170). Giorgi (2005) echoes this when he talks about there being a 'prejudice that quantification is the royal road to science and that qualitative analyses are intrinsically inferior' (p. 79).

Qualitative research is derived from a number of scientific fields of expertise, but these did not fit the unique requirements of nursing and arguably midwifery research. This led to researchers seeking methodologies which sought to explore and understand nursing philosophies (Thorne, Kirkham & MacDonald-Emes, 1997; Latimer, 2006). They determine that research about nursing knowledge has had to evolve outside the traditional constraints of epistemological study, these being phenomenological within philosophy, grounded social theory in sociology and ethnography within anthropology (Thorne, Kirkham & MacDonald-Emes 1997).

Over the years nursing research had developed its own path within research disciplines (Koch, 1994; Latimer, 2006). Thorne et al., (1997) talk about a research methodology that has no name as yet but that it 'involves description of and interpretation about a shared phenomenon from the perspective of those who live it' (p.171). At the end of this article they surmise that interpretive or qualitative descriptive research could be used effectively within the nursing profession (Thorne et al., 1997). In this article they also discuss the limitations of both the quantitative and qualitative traditions of research in the nursing domain. The pros and cons of this research method is further highlighted by Latimer (2006), when she critiques Koch's original 1994 work and talks about how having to justify qualitative research can sometimes weaken the position of the researcher.

Qualitative descriptive research provides a theoretical and methodical framework for research in the context of applied sciences, of which midwifery is one arm along with our sister

profession, nursing. This type of research is able to ‘generate a better understanding of situations that occur in the contexts in which health practice develops and ... enabling the development of knowledge to support clinical practice’ (Rebouças, Thorne, de Souza, de Brito & Alencar, 2018, p.3). This research framework has now been used for various studies that analyse the experiences and perceptions of health professionals, patients and caregivers in a myriad of diverse situations (Rebouças et al., 2018).

As this research is based on the experiences of midwives, this understanding and information concreted the thought that the use of a qualitative descriptive framework was the right methodology for this research.

A potential issue for using a qualitative descriptive design for research is that it can be difficult to determine the required number or sample size of participants to ensure that a richness and saturation of data is reached (Steen & Roberts 2012). At the start of the research journey I initially thought that I would interview around 10 to 15 participants, thankfully, with the support of my supervisor, the decision was made to limit the number to nine participants. With hindsight and looking at the vast amount of data generated through these interviews, this number should have been reduced further or a time limit imposed around the duration of the interviews.

The strength of utilising qualitative descriptive research is the simplicity of the approach, a question is asked, answered, themes found and analysed. However, some of the limitations with this approach are that the depth of the analysis is very dependent on the researcher and the way the data is themed, with the louder ‘voices’ in the thematic analysis sometimes being perceived as the most important while other quieter ‘insightful’ voices are overlooked (Smythe, 2012, p.6). Thematic analysis is discussed later in this chapter in section 3.5.4

## 3.2 Setting

Core and LMC midwife participants from around the South Island of Aotearoa/New Zealand were invited to take part in this research. It was anticipated that some of the material disclosed could be considered contentious as it was believed that the midwives might be discussing issues within practice partnerships, the workplace or regarding management, and therefore they may not wish their colleagues to know they had participated in this research. Therefore, the interviews were conducted in an environment that the participant felt

comfortable in and where they were able to share information freely. The choice of venue for interview was chosen by each individual participant, to ensure they felt their confidentiality could be maintained; the expectation was that the majority of these interviews would occur within the participant's home.

### 3.3 Participants

A sample group of nine participants (one pilot and eight other participants) were enrolled from maternity units across the South Island of Aotearoa/New Zealand. The participants were initially recruited through posters (Appendix Four) displayed at maternity units within the South Island. Emails were also sent to the South Island NZCOM regional chairs, with a request to disseminate the information to the regional members. By utilising both methods to obtain participants it was possible to obtain a cross section of midwives from around the South Island who worked across all practice settings, especially midwives who have transitioned from LMC to core and vice versa in the previous two years. Demographic information was not collected for this research.

There was a possibility of not being able to obtain a large enough sample group, and if that occurred the plan was to recruit via chain or snowball referrals from other participants (Robinson, 2006). The proposed number of participants was limited to a small group as opposed to the larger number of participants required for quantitative research, where the research findings are generalised as opposed to exploring a given phenomenon. Smythe (2011), states that these number of participants will 'yield as much data as one can think through' (p. 41) and enable the researcher to value every contribution to the research. Whereas Steen and Roberts (2012) feel that the number of participants should be limited to the number required to reach saturation of data. However, Thorne, Kirkham and MacDonald-Emes (1997) state that larger group sizes are manageable using a descriptive interpretive framework.

The inclusion criteria for this research was that participants had to be midwives who are on the Midwifery Council of New Zealand (MCNZ) Register of Midwives and have transitioned from one work setting to another, or left the profession after a period of transitioning within the last two years of their midwifery careers. The exclusion criteria, for this research was

anyone who had transitioned work settings outside of the stated timeframe and who was not on the MCNZ Register of Midwives at the time of the interviews.

### 3.3.1 Recruitment

Recruitment of participants was by purposeful sampling. This method of recruiting was used to ensure that participants for this research met the criteria for the intended area of study. This further ensured that the sample group had the qualities needed to participate in the research, opposed to recruiting participants using another method, for example random sampling, where each member of society has an equal chance of being selected and therefore the criteria may not be met (Mutch, 2005; Steen & Roberts, 2012). Purposeful sampling also reduced the amount of time it took to recruit participants which enabled the research to be undertaken in a timely manner.

A letter outlining the research was given to potential participants as part of the recruitment process (Appendix Three); questions and concerns were addressed prior to the start of the interviews. Informed consent was obtained and the consent forms completed and filed prior to the interview commencing (Appendix Two).

## 3.4 Data Collection

Data Collection began with the pilot interview and was followed three weeks later by a number of interviews at various locations around the South Island of Aotearoa/New Zealand.

### 3.4.1 Pilot interview

A pilot interview was conducted three weeks prior to the start of the remaining interviews. The purpose of the pilot study was to collect preliminary data and pre-test the semi-structured interview questions (Connelly, 2008). It was also used as a way to practice my interview skills as a researcher and a trial-run for framing the research questions (Teijlingen &

Hundley, 2002). This proved important, as in order to let the midwives tell their own stories, I needed to be able to complete the interviews without leading the participant or being drawn into discussing my own pre-conceived ideas.

This pilot interview took place when both of us were available during a lunch time. From the pilot interview I found that I needed to let the conversation flow, using the semi-structured interview questions as prompts when the participant was veering away from the main points of the interview. There was also a point when we had stopped the recording and the participant wanted to expand on an idea that she had during the main part of the interview, with her permission, I began the recording again to capture this information. For the other interviews I made the decision to keep the recording devices running a little longer, with the participants consent, to ensure I had captured all relevant information.

It has been found that pilot studies can skew the findings of research if these results are included with the main research findings (Connelly, 2008). Therefore it is usual practice not to include these results in the main portion of the research. However, this 'contamination' has been found to be less of a concern for qualitative data collection and analysis. In some cases it was found to be a way of improving how the subsequent questioning is conducted, as the researcher can refine the way the questions are asked for the remainder of the participants (Teijlingen & Hundley, 2002). Therefore for this research the pilot study findings have consciously been utilised as the information received added to the richness of the other participants' information. Following the pilot interview it was determined that there was no refinement necessary for the proposed semi-structured interview questions.

This pilot interview appeared to be a positive process for both of us, for myself to practice interviewing, managing the recording device, and to keep notes, for the participant, who, while she was providing feedback on my interview technique, also expressed the thought that it felt good to be able to share her story.

### 3.4.2 Interview questions

Five semi-structured questions were devised for this research (Appendix Five) these were trialled during the pilot interview. The questions were devised to allow for both open, closed and prompt questioning throughout the interviews, enabling data to be collected that was both descriptive and exploratory (Cluett & Bluff, 2006; Steen & Roberts, 2012; Hicks, 1996). The use of a semi-structured interview format has been found to allow the researcher to maintain some control over the questioning process during the interviews (Steen & Roberts, 2012) and ensured that the participants were able to remain focussed on the questions.

Another positive of one to-one interviews is that it allowed the research participants to speak openly and frankly about their experiences (Cluett & Bluff, 2000). This is the opposite of focus groups where both the group participants and group dynamics need to be taken into consideration (Steen & Roberts, 2012). More importantly the one-to-one interview allows the discussion of more contentious issues in a confidential and private setting. It has been found that the confidentiality of focus group participants can be breached inadvertently by the participants following data collection (Mutch, 2005).

### 3.4.3 Recording devices

The other learning from the pilot interview was the need to have two recording devices and that I needed to be comfortable and competent in using them. This allows a back-up recording. For the initial interview I only used the recording app on my phone. This recording was then downloaded into an audio file; this was when the issue of two devices was highlighted; I realised that this information was so precious and that I was not confident using the programme to save this file, there was a danger that it could be deleted or lost. As the need for two recording devices was identified, following discussion with my supervisor a Livescribe Echo<sup>®</sup> 2 GB Smartpen recording device was loaned from Victoria, University of Wellington.

In my opinion it is imperative to have a backup recording device, as during one of the later interviews, the participant was interrupted by a phone call and asked for the recordings to be

paused while she took it, inadvertently one of the devices was not restarted when the interview recommenced, leaving just a single record of the last part of the interview. The other beauty of using the loan device was that notes could be taken during the interview which linked into the recordings, and when transcribing the speed of playback could be slowed.

#### 3.4.4 Transcribing

Following the pilot interview, I had my first attempt at transcribing the information that had been recorded on my phone and downloaded to my computer. This was an arduous process which involved a lot of rewinding of the voice file, however as I became more confident I was able to transcribe the information more efficiently with my typing skills improving exponentially during this time. Although this was a slow process, I felt that I had a clear picture of the information that the participant shared in this interview. I therefore made the decision that I would transcribe all of the other interviews so that I would have the same intimate knowledge of those recordings as well. This transcribing then needed to be factored into the timeline for completion of this project.

#### 3.4.5 Further data collection

After completion of the pilot interview, appointments and travel arrangements were made to go and interview the other midwives who had volunteered to be part of this research. It soon became apparent that I needed to remain flexible with interview dates and times, fitting in with the work commitments of these midwives. The majority of them were employed and subject to having shifts changes or were LMC midwives with women and babies who obviously took priority over this research.

The identity of participants has been protected by conducting the interviews away from the work place if the participants were more comfortable with this. A numbered system was used for identification purposes during transcribing and pseudonyms utilised throughout the thesis and these will be used for any subsequent publications. All documentation and written transcripts are securely stored in a filing cabinet in my office at the Nursing, Midwifery and

Allied Health department, Manawa building, Ara Institute of Canterbury. Audio files of the interviews are stored and backed-up in a secure online repository, that is password and 2FA (two factor authentication) protected. This ensures that the confidential material is only accessible to the researcher.

In the rest of the work these midwives will be linked to their recordings by the use of the following pseudonyms: recordings one and two<sup>15</sup>, Anne; three, Sue; four, Chris; five, Debby; six, Andrea; recordings seven and eight, Maggie; nine, Sian; ten, Philippa; and 11, Rachael.

### 3.5 Data Analysis

‘The purpose of data analysis is to bring systems and order to an often unwieldy data set ... the goal is to extract meaning and present the study’s results’ and ‘that the reader is convinced of their credibility’ (Knalf & Webster, 1988, p. 206). There is an argument that says there is a lack of ‘codification techniques’ available for qualitative research and very little guidance on the use of the ones that are available. Knalf and Webster (1988) describe specific techniques for coding depending on the qualitative research conducted.

A decision was made to follow Knalf and Webster’s (1988) method of coding the transcripts of the interviews. That is using a thematic analysis approach. Thematic analysis is defined as a method for grouping themes and patterns obtained from the research participants (Braun & Clarke, 2006; Bogdan & Biklen, 1982), or as a method of organising and understanding the data collected (Cluett & Bluff, 2006). Data gathered was transcribed by the researcher into written script and then underwent analysis. The data was open coded and common themes developed (Steen & Roberts, 2012).

The process of thematic analysis is discussed by Rebouças et al., (2018), as a process by which initially broad themes are identified to have a clear overview of the material, then the focus of attention moves to question ‘what is going on’ or ‘what can I understand from this’ in relationship to the overarching themes. They also suggest that there has to be an intimate relationship with the material, obtained by constant engagement with the transcripts.

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<sup>15</sup> Anne and Andrea have two recordings as recording interrupted and then recommenced



The themes were categorised and then re-coded using a manual process as opposed to a computer software package, as I felt that I would better manage the manual process and gain a deeper understanding of the transcriptions and the information they contained. A process of reading and re-reading the scripts took place which identified the common themes, key words and phrases. A number of different processes were utilised during the analysis phase, these including mind mapping, use of white boards and coloured marker pens, and highlighting relevant words and phrases in the written transcripts, and took place over a number of months. The last time was while writing the first draft of the thesis for submission, during this time the themes continued to coalesce and evolve into their final configuration. By following this process, four themes emerged from the data and once collated this enabled me to gain a depth of understanding about the midwives' experiences when transitioning work places (Smythe, 2012). Throughout this process emerging themes were discussed with my supervisor on a regular basis. A visual representation of this process is illustrated in Table 3 below which has been adapted from Smythe's 2012 article on research methodology.

These themes will be discussed along with the subthemes that were identified. It was difficult to let the themes just emerge and not to have any preconceived ideas on what these would be. Braun and Clark (2006) discuss this phenomenon in depth in their work on using thematic analysis in psychology. They state that 'it is not uncommon to read about themes emerging from the data' (p. 80) which appears passive in nature and does not take into account, that researchers are active rather than passive in the research process.

For the analysis of the transcripts a more inductive approach needed to be applied as the themes themselves bore little relationship to the questions asked at interview, or to the theoretical standpoint that was initially taken. Braun and Clark (2006) identify that the most important aspect of thematic analysis in research is that the theoretical frameworks and methods match what the researcher wants to know and that the researcher recognises the active part they have in the thematic analysis of the raw data (Braun & Clark, 2006).

Literature was then utilised to support the discussion of themes within this paper (Smythe, 2012). Braun and Clarke (2006) discuss the flexibility of descriptive interpretive as a research method because of the 'theoretical freedom' that it provides the researcher (p. 78). The limitation of this approach is that the robustness of the analysis is determined by the

researcher when ‘unpacking’ the data and is limited by the material that the participants provide (Smythe, 2012).

**Table 2**

**Visual representation of thematic analysis**

<p><b>Research question</b></p> <p>What are the experiences of midwives who transition work settings?</p>
<p><b>Interview questions</b> (anything that will elicit answers to the main research question)</p> <ol style="list-style-type: none"> <li>1. Tell me about your career to date?</li> <li>2. What factors influenced your decision to move from core to LMC (or vice versa)?</li> <li>3. What were your experiences of the process of transitioning workplaces?</li> <li>4. What is your career plan?</li> <li>5. Where do you see yourself in 5 years’ time?</li> </ol>
<p><b>Interview data</b></p> <p>I started as an LMC a community LMC, did that for a few months and while I waited to get a part time position at the hospital I felt that I needed that support ... I think 0.4 at the hospital and kept a caseload right through gradually building up to 0.8FTE at the hospital, still kept the caseload I found that I was a little bit reluctant to give them up totally, it was, there was people that came back and said oh we really want you and I also wanted to keep my hand in across the scope ... as well in that time I went and took up a position of facility cover at [remote rural primary unit] because I again I like that variation that change of pace and that exposure to primary care and that actually suited me well the whole blend of primary secondary and LMC was kind of the best of all worlds, um, at the same time pretty hard to juggle</p>
<p><b>Initial analysis</b> (key words representing points that may be raised in other interviews highlighted)</p> <p>I <b>started</b> as an LMC a community LMC, did that for a <b>few months</b> and while I waited to get a part time position at the hospital I felt that I needed that <b>support</b> ... I think 0.4 at the hospital and kept a caseload right through gradually building up to 0.8FTE at the hospital, still <b>kept the caseload</b> I found I found that I was a little bit <b>reluctant to give them up totally</b>, it was, there was people that came back and said oh we <b>really want you</b> and I also wanted to <b>keep my hand in</b> across the scope ... <b>as well</b> in that time I went and took up a position of <b>facility cover</b> at [remote rural primary unit] because I again I like that <b>variation</b> that change of pace and that exposure to primary care and that actually <b>suited</b> me well the whole blend of primary secondary and LMC was kind of the <b>best of all worlds</b>, um, at the same time pretty <b>hard to juggle</b></p>
<p><b>Later analysis</b> themes began to emerge from the similar stories, such as</p> <p><b>Support</b> needed from family, practice partners and management, hard to juggle</p> <p><b>Best midwife</b> wanting to do the best job possible, pressures of working this way, model of care; working with women</p> <p><b>Transitioning</b> process that happens, working is not just one main job but a bit of everything, keeping hand in or working across the scope of practice, movement is a way of professional and personal sustainability</p>

**Linking with literature:** Literature is then used to support and highlight, or to contrast and contradict these themes. These would then be used to generate new ideas that may have not been published before.

### 3.6 Ethics

There are six ethical standpoints within qualitative research that maintains the safety of the participants and ensures that the research portrays a truthful account of the information shared. I have framed this research using the six headings below which were taken from Parahoo (cited in Steen and Roberts, 2011, p108). I have endeavoured to articulate each ethical tenet from the perspective of this research. These are:

- Beneficence – the midwifery profession should benefit from the findings of this research.
- Non-maleficence – this research will not cause any psychological harm to the participants.
- Fidelity – there is an element of trust between myself, as the researcher, and the midwives interviewed.
- Justice – fairness for all the midwives who have taken part, and sharing their stories to ensure this happens.
- Veracity – this research is truthful and based on the midwives' interviews and transcripts, then supported by literature.
- Confidentiality – respected throughout this work and information is written in a way that protects identity.

Ethics committee approval was applied for at the start of 2017 when the research proposal was submitted. This was granted on the 9<sup>th</sup> May 2017 (approval number 24448) through Victoria University of Wellington Human Ethics Committee (HEC). This research has followed their processes and protocols throughout. Clear concise information was presented to the participants prior to the interviews in the form of an information letter (Appendix Three), consent form (Appendix Two), and the opportunity to ask questions and/or to opt out of the research; ensuring consent was gained and the decision to participate in the research was an informed one (Cluett & Bluff, 2006).

### 3.7 Te Tiriti o Waitangi Considerations

Principles of Te Tiriti o Waitangi (The Treaty of Waitangi) and cultural safety were maintained throughout this research by ensuring that midwives were not excluded from the research due to ethnicity or culture. The principles of Partnership, Participation and Protection were of specific consideration in this work; Partnership recognises that Māori are partners in research, and therefore bring their own body of knowledge including traditions, culture and values to the research partnership; Participation allows Māori to be able to decide if they want to participate in research, if the research is specifically on Māori then the design and implementation should ideally also be by Māori; and Protection which recognises that Māori rights are protected by making sure the research is beneficial and equitable to all involved (Hudson & Russell, 2008). It is anticipated that the recruitment process will capture a representative cross section of midwives, including Māori and Pasifika.

### 3.8 Rigour

In qualitative descriptive research rigour or trustworthiness has to be maintained. Couched in simple terms this means ‘can the findings of this research be trusted?’ (Korstjens & Moser, 2018, para. 4). These tenets are credibility, transferability and dependability (Baillie, 2015; Thorne et al., 1997; Sandelowski, 1983; Sandelowski, 1986).

Koch (2006) discourses on the use of a decision trail as a method to ensure the trustworthiness of qualitative research. The researcher writes this decision trail into the work by detailing why certain decisions have been taken regarding the chosen methodology and process of analysis, leading to a more robust process of rigour and credibility (Koch, 2006). Rigour is established when these points are made visible and therefore become auditable, ensuring that another researcher can follow the decision making process around the research methodology, and a reader of the research can act as an auditor as they read through the work (Koch, 2006).

Credibility is established by the researcher being aware of their own biases and prejudices. There is a possibility that because of the researcher’s attachment to the work, it is easy to

form preconceived ideas about what the conclusion of the research should be. As I am passionate about the midwifery profession, there is a possibility that I would not want to hear any disparaging information presented in the interviews. In order to recognise and monitor my own prejudices I kept a private journal of thoughts (preconceived ideas) around the interviews and described positive and negative ideas that arose when transcribing. My own belief system has been challenged throughout this work and an example of this was identified following the pilot interview, where I noted as a journal entry that ‘I needed to be careful when phrasing questions’ meaning that it would have been very easy to lead the participant in a different direction with subtle changes in the way questions were asked. Koch (2006) discusses prejudices in the following way:

... Prejudices are not necessary erroneous or necessarily distortions of truth. Our situatedness as interpreters, our own historicity, do not constitute an obstacle. Prejudices are the conditions by which we encounter the world as we experience something. We take value positions with us into the research process. These values rather than getting in the way of research make research meaningful (p. 92).

The next tenet is transferability as defined by Lincoln and Guba, in Korstjens and Moser’s (2018) work and refers to the degree that the results from one study can be transferred to another study. For this research, transferability was ensured by using detailed and contextual information about the participants and their stories, for example the length of time on the MCNZ register of midwives. Korstjens and Moser (2018) classify this as ‘thick description’ (p. 122). Confirmability is ‘concerned with establishing that the data and interpretations of the findings are not figments of the inquirer’s imagination, but clearly derived from the data’ (Korstjens & Moser, 2018, p. 121). It is anticipated that there is confirmability in this research, as it is my belief that similar findings from this study would be replicated by other researchers.

### 3.9 Summary of the chapter

In this chapter I have discussed the research design that I have used for this research, this includes a discourse on qualitative descriptive research which is supported by relevant

literature. This was followed by a discussion on the research design, methodology and recruitment of participants. I have endeavoured to describe the rigour in this work by clearly and logically describing the choice of methodology, providing illustrations on how this was achieved in order to provide a ‘decision trail’ as defined by Koch (2006), and have also discussed the tenets of credibility, transferability and dependability as described by Thorne et al (1997) and Korstjens & Moser (2018). There was also information provided on how the thematic analysis was conducted and coded including the use of a table to highlight the main points. Within this chapter I have also discussed the protection and storage of confidential information and how privacy has been maintained for the participants. In the following chapter, I will discuss the findings and themes that emerged from the one-to-one semi-structured interviews.

## Chapter 4 Findings

### 4.0 Introduction

The four main themes and sub-themes which emerged from the thematic analysis will be discussed in this chapter. I will broadly outline the midwives' work history with information from MCNZ Midwifery Register, maintaining confidentiality by removing any identifiable information. Then I will discuss the material from the interview transcripts utilising direct quotes from the participants to illustrate each theme and sub-theme.

The four main themes are: 'an ideal midwife', 'movement happens', 'support and obstruction', and 'things have changed' (Table 3). Within these themes, there were a number of sub-themes which will be discoursed in detail throughout this section. These sub-themes became more apparent as the process of thematic analysis continued and familiarity with the rich material grew.

The first theme of the 'ideal midwife' has four sub-themes: *midwifery identity*, thoughts and ideas that the midwives express that make them the midwife they want to be; *women at the centre* of the picture, which shows how the midwife is aware that her decision to transition work settings can impact on the women she is working with; *guilt and stress*, exploring the dichotomy between work and personal lives; and finally the *midwives physical and mental wellbeing*.

The next theme (two) 'movement happens' explores the midwives' experiences as they transition work settings. The first sub-theme *movement* looks at some of the reasons midwives make the decision to transition work settings. The next is *career planning* and how this impacts on the decision process. The final sub-theme is about *remuneration* and how this influences the participants' decision to transition work settings.

The third theme is headed 'support and obstruction' and explores factors that provide support for the midwives, including family and practice partners, and others that obstruct or hinder the midwife in the workplace, including workload and family. This section will also look at the participants' experiences of horizontal violence and bullying behaviour and how this may

also be an influence to transition work settings. The four sub-themes for this section are *family support, practice partners, management and horizontal violence*.

The final theme (four) materialised after many of the midwives interviewed expressed their thoughts that things have changed since the present model of maternity care began in Aotearoa/New Zealand and includes the subtheme *changing needs of women*.

**Table 3**  
**Themes and sub-themes**

Main theme	1 Ideal midwife	2 Movement Happens	3 Support and Obstruction	4 Things have changed
Sub-theme	Midwifery Identity	Movement	Family Support	Changing needs of women
	Women at the centre	Remuneration	Practice Partners	Communication
	Guilt and stress	Career Planning	Management	
	Physical and Mental wellbeing		Horizontal violence/bullying	

#### 4.1 Participants

There were nine midwives interviewed for this research and at the time of the interviews they were all on the MCNZ Register of Midwives and all held a current APC. One has since stopped working as a midwife, she remains on the register but no longer holds an APC.

Seven of the midwives graduated from three different academic institutes within Aotearoa/New Zealand with a Bachelor of Midwifery degree and entered the MCNZ Register of Midwives between 2004 and 2015. Two of the midwives interviewed registered initially in the United Kingdom in 1990 and 2009, but also registered in Aotearoa/ New Zealand within the same timeframes as the other midwives

At the time of interview the midwives had collectively, approximately, 100 years of experience in the midwifery profession, with 80 years' experience in Aotearoa/New Zealand as LMC and/or core midwives, working within the current model of midwifery care. The amount of years within the workforce varied between three and 14 years. Seven of the nine



midwives interviewed continue to work as either LMC or core midwives, the other two are exploring different career pathways.

## 4.2 Ideal Midwife

During the thematic analysis the participants used a lot of emotive language as a means of expression. This ranged from positive to negative feelings about the profession, women they were working with and themselves as midwives (Table 4). In my opinion this emotive language sets the scene for the section on ideal midwife and therefore these emotions and feelings are illustrated below.

**Table 4**

**Midwives' emotions and feelings around midwifery and women**

<b>Positive Emotions around Midwifery</b>	<b>Negative Emotions around Midwifery</b>	<b>Positive Emotions around Women</b>	<b>Negative Emotions around Women</b>
Autonomy	Disengaged	Relationships	Compromise
Perfectionist	Burnout	Idealist	Grief
Integrity	Scared	Hopeful	Stress
Satisfying	Sadness	Determined	Piecemeal
Enjoyment	Unpleasant	Rewarding	Cost
Determined	Lonely	Meaningful	Traumatic

The midwives interviewed had a clear vision of the type of midwife they wanted to be within the workforce, regardless of their working environment. It appeared that they endeavoured to be the best possible midwife they could, despite of, and within the constraints of their chosen way of working. All of the participants talked about doing the best job they possibly could and the fact that they tried to work in a positive way with the women. They talked about being '*autonomous*', being a '*perfectionist*', having '*integrity*', '*being determined*', '*satisfied*' and '*getting enjoyment*' from their roles within midwifery. Many talked about their personal philosophies of midwifery (Anne, Chris & Sian) adding to the picture of them knowing the sort of midwife they wanted to be. In this instance, 'perfectionist' is used as a positive term by the midwife, but this could also be construed in a negative way. When talking, these

midwives also conveyed a deep understanding and commitment that the women should always be at the centre of the care they provided.

#### 4.2.1 Midwifery Identity

At points throughout the interviews the midwives discussed a notion which I have called their 'midwifery identity'. It appears for some of them, once they had taken on the role of a midwife, this is what started to define them as a person: *'I saw myself being a midwife forever, I was so happy in the job, I loved it ... I will be a midwife till I am 75'* (Debby). The midwife who has recently stopped working as an LMC continues to describe herself as a midwife first *'... for 26 years of my life ... I was a midwife, I know it is a job but it almost becomes a part of your make-up, you are a mother, a wife, a woman but you are also a midwife'* (Rachael). Others talked about being passionate about midwifery and *'always wanting to be a midwife'*, *'love being a midwife'*, *'not giving up midwifery'* (Andrea, Sian & Philippa).

In the current climate of midwifery in Aotearoa/New Zealand it was heartening to hear that nearly all the midwives interviewed described themselves as midwives first and foremost, appearing to have pride in the profession, themselves and their role within it. These women expressed many emotions that will be discourses in this section but the prevailing one was how passionate they were about the profession and the women they work with. This was expressed in a variety of ways: *'the essence is working with them [women] in a meaningful satisfying way'* and *'I do this job because I really love midwifery and love working with the families'* (Anne), *'it's about supporting women and being with women'* (Sue) and *'once you start doing it [LMC] they become your women and then they become beautiful women'* (Chris) and Andrea who says *'to do what the woman needs, I do miss ... that big journey with them'* or Philippa who talks about the profession in the following terms *'I do love it, I really do, it is a very special job'*. However, it was Debby who summed up her both her own passion for midwifery as well as the passion that the other midwives expressed within their interviews, with the following statement:

*I saw myself being a midwife forever ... not a midwife in the general broad sense but a midwife as I was. I saw me doing this forever I was so happy in that job, I enjoyed*

*it, I loved it ... I loved it ... and I loved the journey of the women who became a mum, I loved that whole journey* (Debby).

Although as stated previously, midwives saw themselves in a positive light, at times through the interviews they also talked about other much more negative emotions; *'being disengaged', 'burnt-out', 'sadness', 'scared', 'lonely' and 'unpleasant'*. These more negative emotions became much more frequently used when the midwives were discussing factors leading up to transitioning work environments.

#### 4.2.2 Woman at the Centre

The midwives interviewed discussed the fact that regardless of where they were working the women remained at the centre of their care. Anne calls herself an *'idealist'* and discussed how she tries to stay true to her midwifery philosophy of providing woman-centred care, but that the environment around her makes this challenging at times. She states that the *'essence of midwifery is working with the women in a meaningful satisfying way'*. Other midwives interviewed discussed similar concepts, that they liked the *'autonomy to work with women in their own way', 'enjoyed supporting the women'* and that they *'loved the midwifery'* (Anne & Sue). Debby discussed a comparable theme when she stated that she *'loved the journey of the women who became a mum'*. This theme of the woman being the centre of the care continued throughout the interviews with statements which indicated that the midwives placed the woman in paramountcy in the following ways, *'doing what the women need', 'taking care of the women', 'women needing support'* (Sue, Chris, Debby & Andrea), *'everything upmost is done for your women'* (Chris), *'love working with families'* (Sue). Whereas Rachael and Andrea discussed the same theme but from the viewpoint of a core midwife, stating that the *'women still need 'midwifing' even if their LMC was not available'* (Sian) and Andrea who says that she tries to preserve some of the woman's wishes in a secondary setting by keeping *'the things she can normal for that family'*. Many of the participants interviewed discussed that the relationship with the women they worked with, either as an LMC or as a core midwife, was one of the most important to them, and that they will miss this as they transition work settings or consider leaving the profession.

### 4.2.3 Guilt and Stress

The midwives discussed both internal and external factors which impacted on their working lives and ultimately led to the decision to transition. Regardless of the practice setting, they felt they were being pulled in different directions. This tug of war between their personal midwifery philosophies, family and work environments manifested itself in different ways.

The analysis showed that guilt, and the subsequent increase in stress, appeared to be a compounding factor for midwives prior to transitioning workplaces. Midwives discussed the impact this had on them throughout the interviews. In the pilot interview the prompt question ‘What were the factors, what were the things that influenced your wanting to transition?’

Anne answered

*So for me the main thing has been a tug of war between two parts. One is my midwifery philosophy and the work I find rewarding ... makes my heart sing and the demands it has on my family ... then I find the demands being on-call really difficult with young children, so after a period of time I become really tired of that and I transition back again (Anne).*

Sue also discussed this dichotomy between work and family commitments when she stated that ‘on my son’s birthday he turned 17 and I was down here [urban secondary unit] with a labour and birth, we eventually caught up with him ... but on that important day I was not there’. Debby discussed the decision to move from LMC practice to a core setting as a very emotional experience for her - ‘I didn’t want to transition ... I just couldn’t do it anymore that was really traumatic for me ... I just couldn’t do it anymore I just had to stop (Debby) and goes onto say that ‘it was pretty messy’. Philippa states really clearly that if she hadn’t transitioned work settings at the time that she did, that she would no longer be working as a midwife.

The midwife (Rachael), who has recently left the workforce, talked about the point that she had gotten to when she knew that she could no longer work as a midwife in any setting: ‘... I just got up one day and just couldn’t do it anymore, and I have never done any midwifery since that day’. However this was not an easy decision as she goes onto say:

*I felt like I had let everyone down, I felt like the women were relying on me, they had chosen me to be their LMC ... I felt that I had let them down left them in the lurch ...*

*it was probably a good six months before I stopped feeling incredibly guilty ... it made me incredibly anxious because about what they would think ... but I still felt that I had let every-one down [emotional] (Rachael).*

Sian explained that she felt emotional and guilty for transitioning work settings but that she did not want the women to *'feel a sense of guilt around your moving jobs because of the nature of them being, them having to call you, you having to go to their birth'*. Similar thoughts were expressed by Anne who talked about how she had signed up to work with the women as a LMC and that she understood the commitment that she had made to them for the duration of the pregnancy.

Some of the midwives discussed the impact the process had on their practice partners when transitioning from a LMC to core role *'yeah she was by herself ... it was probably tough on her'* (Andrea) said one midwife, another talked about *'leaving her [practice partner] in the lurch'*, but had a *'desperation to finish'* (Sian). She went on to discuss how she tried to make this transition process better for her practice partner by helping her to find another person to work with. Looking at transitioning the other way from core to LMC one midwife said that it was *'sad to be letting go, and particularly the doctors and junior doctors were like "you can't go"'*.

It seems as though there is an understanding of this transitioning from other midwives in the core and practice settings and, from the interviews, they seem to support the midwives as they move between the two settings. Chris and Andrea discuss the support that they got from core midwives when transitioning from a core role into LMC. Anne identifies the support she had from her practice partners when she made the decision to give up her LMC practice stating that they were fantastic, but that it was sad for all involved. Debby goes onto talk about her ex-practice partners, who have ceased working with her during the last few years, she is clearly supportive of their decisions to leave the partnership, regardless of the reason given for leaving, but goes onto say that you *'grieve for that practice partner and the professional friendship that has been lost'*.

A couple of the participants describe their experiences when working with less experienced or new members of staff and how this increased their stress levels especially when working as core midwives. Rachael discusses how difficult it is to work with inexperienced junior doctors:

*...and finding when we had a new intake of doctor's ... junior doctors don't always make decisions based on experience so a lot of it is they are unsupported at night, and you [LMC] could see someone struggling at night and that you weren't happy with the CTG (cardiotocograph), and just the stress of having to deal with their lack of knowledge (Rachael).*

This is echoed by Philippa who says that *'some of the doctors are a bit rubbish ... so you are doing something that you know is wrong, because they are ego based and you're sitting there going "But, but what about?" and your voice isn't heard'*, she goes on to say *'as they [the doctors] got to know me, it did make a difference, being forthright and standing up for yourself'*.

Although many of these themes were similar for both groups of midwives, it was noted that midwives who were transitioning from LMC practice to core midwifery, had one theme that was notably different from their colleagues who were moving in the opposite direction. Midwives who were LMC's discussed the breakdown of the practice partnership as a factor for transitioning work settings. There were a number of reasons why this occurred but ultimately the breakdown of a practice partner relationship was the momentum for the transition. This is illustrated by the following statements *'unable to find a new practice partner with a similar philosophy of care'* or because their *'current partner midwife was moving away from the area'* (Debby & Rachael) or that the practice relationship ended because of the *'differing philosophies'*, as was the case for Andrea.

Midwives who have been working in the DHB setting appeared to find that their personal philosophy differs from that of the corporate environment. Both Debby and Maggie talk about *'being just another person in the system'* and later on in the conversation about *'not feeling valued or safe'* and Sian who says:

*I think that is the whole thing of being part of a big institution you can't change anything ... you have to live with the stupid red tape and rules and things it just actually affects your ability to provide care (Sian).*

#### 4.2.4 Effects on physical and mental wellbeing

All of the midwives who were interviewed discussed the physical manifestations of working within both the core and LMC role and how before they transitioned work settings; these became one of the factors that influenced their decision to transition or leave the profession. They also talked about the grief process that went along with the decision making process.

There were a number of disparate words and phrases that led to the theme ‘effects on physical and mental wellbeing’ related to working within the current maternity system in Aotearoa/New Zealand. The positive ones have been discussed previously in section 4.2.1.

Worryingly some of the more negative phrases could be construed in a way to show that the majority of the midwives interviewed had very negative thoughts about themselves and their role in the profession (Anne, Chris, Debby, Andrea, Maggie, Sian, Philippa & Rachael). Some of these were, midwifery came ‘*very close to finishing me*’, ‘*completely break me*’, some felt that they had ‘*gone nuts*’, or even that ‘*I’m not going to be here*’, ‘*can’t do it anymore*’, leading to being ‘*disenchanted and disenfranchised*’. Rachael states that she hid from her family the fact that she was unable to function as a midwife; ‘*I don’t think they [my family] realised how unwell I was becoming; I would often say that I wasn’t very busy when I stayed at home*’ (Rachael).

One of the midwives interviewed also talked about ‘*being scared for women*’ when she was discussing the manifestation of her feelings and thoughts. This group of midwives went on to talk about how they were trying to manage these issues and for some, their coping mechanisms were ‘*disengaging from the profession*’ or for others ‘*possibly not staying in midwifery*’. One midwife summed this up by saying that sometimes we need to remember that we are ‘*still people*’ (Anne, Sue, Chris, Debby, Maggie, Sian, Philippa & Rachael).

When talking about the actual process of transitioning work settings, a number of the midwives interviewed talk about how this affected their physical and mental wellbeing. Anne said that prior to transitioning, that she was feeling really tired, flat and down, burnt-out, that she became ‘*a little bit unpleasant*’ and suffered with insomnia on a regular basis. She understood that where she was working was not good for her health, but because of the emotional stress was unable to make a decision. She had got to the point where she needed to seek professional support to make the decision to move away from midwifery for a period of

time to maintain a good life/work balance. Although she went on to '*disengage*' from the profession for nearly a year she felt sadness for letting go of a way of working which she had previously enjoyed.

Sue also talks about sustainability within the profession and although she endeavours to maintain a good work life balance, acknowledges it gets stressful and that she finds that she has a '*tension going on*'. A number of the midwives interviewed discussed being '*burnt-out*' or discovering that the way they were working was not sustainable (Anne, Sue, Debby, Andrea, Sian & Rachael). Andrea goes on to say that '*the cost to her was physical, mental and financial*'.

Many of the midwives talked about the ways they were affected by being on call. This could manifest as anger '*I hated being on-call*', '*when the phone goes and you want to throw it against the wall, you know you have finished LMC*' and how they thought that theoretically they had made all the right moves to be sustainable '*taking regular time off to be with our families, essentially everything that I thought that should sustain practice*' (Sian).

From a core perspective, Chris talks about how she felt tired all the time, with her body-clock being all over the place, while working the shifts that were required to staff the maternity unit she worked on. She indicated that transitioning from early, late and night shifts all within one-week impacted upon her physically. Maggie has similar sentiments when she says that she finds shift work '*very challenging*' and the '*continual chopping and changing of your shifts I find it impossible to reconcile a normal life around*' when describing her experiences in a tertiary unit.

The midwives who worked LMC just prior to transitioning also talked about sleep deprivation; '*I was just exhausted ... getting into bed every night with the fear that I would not be able to stay there*' (Rachael). Sian talks about the sleep deprivation and the impact it had on her intimate relationship with her partner '*my sleep pattern was severely affected because you had to sleep just in case*' and how for her this affected the physical intimacy with her partner especially when she had women due to birth '*then you are almost scared to, do I initiate sex tonight or not because so and so is due*'.

A number of the participants were vehement about the powerlessness they felt being midwives in the current climate of midwifery. The following quote will be used to sum up



this section of the analysis with Sian discussing how she sees her and the woman's place within the current midwifery system:

*they [women] were entitled to every bit of care they received from me even though I feel that it was a really shitty thing that I had to provide care in the way in which I had to provide care, but that wasn't their fault and it wasn't my fault, we are two women stuck in this crazy system that forces us to work in such an insane way at times, sometimes they are beautiful, but sometimes it is crazy insane and dangerous* (Sian).

#### 4.2.5 Summary

In this section I have provided details on the theme 'ideal midwife', I have explored the fact that the midwives interviewed had a clear vision of the type of midwife they wished to be, and that the woman remains at the centre of that partnership. I went on to discuss how the participants feel guilt and stress around some of the internal and external factors on their lives, and finally how this guilt and stress can affect physical and mental wellbeing. In the next part of this work, I will explore the transition process in more detail.

#### 4.3 Movement Happens

The second theme 'movement happens' looked for the key words 'transitioning' or 'moving'. In the interviews this was the question that created the most discussion. All of the midwives participated in this study because they have changed their work from core to LMC or vice versa, and for some this has occurred a number of times during their careers to date. In the pilot interview time frames were mentioned and the participant discussed the motivation between the periods of transition that she had done over the years. This movement within midwifery practice seems to be a normal and accepted part of practice.

In the pilot interview, Anne discussed her reasons for transitioning as a way of remaining sustainable within the profession as well as juggling the demands of work and family. Andrea succinctly summed up the impact that working as a LMC midwife had on her family with her

statement *'I have been the maybe mummy, the maybe friend, and the maybe sister and then the maybe aunty'*. Similar themes were discussed in depth by other participants during their interviews. When Rachael discussed her reasons behind her decision, she indicated it was not because her children were young but that she needed to spend more time with them:

*When I made the transition my children were in their mid to late teens and I was very aware that they would probably go to university and leave home in the next 5 years ... the reason I went back to working core then was just to have a more structured life so that I could say to them I am off Thursday and Friday*

The following quotes from the participants further illustrate this movement and factors that influence it.

*I have fairly regularly transitioned probably every 18 months to two years since then between core and working as an independent midwife in the community or as an employed midwife on a team providing continuity and core midwifery in a secondary unit (Anne).*

This midwife went on to explain her reasoning behind the movement:

*so in core I didn't find it as sustaining, I find within about nine months ...then I find the demands of being on call has been difficult with young children so after a period of time I become really tired of that and I'll transition back in again (Anne).*

This continued with the other midwives who were interviewed *'since doing my training, I went straight into LMC [and] did some employed work within the Trust, but now it is just purely a caseload in myself [sic] self-employed'* (Sue). Chris clearly discusses the motivation for her to change work environments and the driving forces behind her decision making saying that she *'fell in love with core midwifery'* and her *'career plan was to end up as a charge midwife working in a tertiary unit'*.

For one midwife there was a key event that motivated her change of employment:

*...but one of the big driving forces for me [move to LMC] was last year ... suddenly out of the blue I got a letter from Midwifery Council wanting to review my practice on a particular case ... and as a core midwife I dealt with it the best I could with the constraints that were around me ... so then that is when my decision came from to go out LMC (Chris).*

Whereas Debby talks about the start of her career and how she has changed work settings during that time:

*I went into the maternity unit as 0.8 FTE<sup>16</sup> for 12 months and then 0.2 [FTE] for a further 6 months while I built up a caseload and I did case load LMC with some casual shifts ... until 2016 I delivered my last baby February I think it was, 2017... and now I am doing casual shifts at maternity and locum work (Debby)*

Andrea graduated in 2004 and 'went straight out (LMC) into the support of two really strong midwives' and 'moved from partner to partner and transitioned into core midwifery two years ago. This midwife went onto state that:

*I honestly believed that I was only ever going to be an LMC, I couldn't ever see myself doing core, and of course the perception around here seems to be once you graduate you must work at the hospital for two years to get your skill level up.*

The motivation for Maggie was slightly different as there were no positions available in the core setting 'I would have gone to the hospital when I first graduated had there been a job available but there wasn't'. She talks about her work settings clearly and demonstrates how the non-availability of a position as a core midwife influenced her choices:

*I started as an LMC, a community LMC, did that for a few months and while I waited to get a part time position at the hospital I felt that I needed that support ... I think 0.4 at the hospital and kept a caseload right through gradually building up to 0.8 FTE at the hospital, still kept the caseload I found, I found that I was a little bit reluctant to give them up totally, it was, there was [sic] people that came back and said oh we really want you and I also wanted to keep my hand in across the scope ... as well in that time I went and took up a position of facility cover at [primary unit] because I again I like that variation that change of pace and that exposure to primary care and that actually suited me well the whole blend of primary secondary and LMC was kind of the best of all worlds, um, at the same time pretty hard to juggle (Maggie).*

Sian transitioned recently and during her interview stated that:

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<sup>16</sup> FTE Full time equivalent 1.0 is full time 37.5 to 40 hours in the working week or 5 days working eight hour shifts, 0.8FTE is 80% of FTE and usually means working 4 shifts in the working week and reduces sequentially to 0.2 FTE which is one shift in a week.

*I know midwives who have moved in and out, in and out and they do it every three years or whatever and they somehow get this equilibrium for them and they keep some of their passion alive by going and doing some community midwifery (Sian).*

Although Philippa did not do her midwifery education in Aotearoa/New Zealand, she discusses the transition in work environments since she has been in the country:

*and then I moved to New Zealand and I started working within two weeks of arriving at [urban tertiary unit] and then after a year or so I started working as a hybrid midwife (working as an employed midwife in both a primary and tertiary unit) at [primary unit] ... and I worked there for 18 months before they closed it, and I worked at the [primary unit] for two shifts a week [urban tertiary unit] for one shift a week (Philippa).*

She goes on to say ... *'and then I left [urban tertiary unit] and they closed [primary unit], so four months later I decided to take up the opportunity to be an LMC'* (Philippa). However it is Rachael who clearly showed the transitioning work settings in this statement:

*I was employed by the DHB initially, working on the ward and then after two months I applied for a job as a continuity midwife within the [same] DHB, and then I worked for continuity from the March through to the September when I paid back my bond and decided to go and work as a self-employed midwife from September 2004 to February 2009 when I decided to go back and work for the hospital ... in February 2010 I became a self-employed ... in April 2016 I stopped working in midwifery completely then (Rachael).*

She goes on to state that for her as a LMC the main motivators for leaving the workforce were exhaustion, sleep deprivation and that some of the on-call aspects of the job influenced these decisions *'getting into bed every night with the fear that I would not be able to stay there'* (Rachael).

Following these interviews it became more apparent that the transitioning process for these midwives had occurred throughout their careers to date; that within differing periods of time they had all moved either from core to LMC or vice versa. That in some cases, like Chris, this was influenced by a complaint through the Health and Disability Commissioner. Others were influenced by job opportunities, for example Debby, where there were no positions available and Philippa with the closure of the primary unit she was working in. Whereas others moved

for family reasons, like Rachael who wanted *'to have a more structured life so I could say to them [the children] I am off [shift] Thursday and Friday'*.

Two of the midwives interviewed discussed the possibility of leaving midwifery in Aotearoa/New Zealand and moving overseas to Australia to work as midwives there. Maggie clearly stated that it was her intention to work short-term contracts in Australia. Debby was still to make a decision if this will be part of her transition process. The reasons they gave were that they perceived that it was better working conditions and could work on their own terms. Maggie gives her reasons as *'it will actually tick off one of our life goals ... see more of the country'* and *'get paid reasonably well'*, *'short term nature suits me'*, and sadly the *'fact that Australian midwifery is much different than NZ is more of an attraction than a detraction because for the responsibility and accountability that is on you here in New Zealand'*. Debby also implied that because of the lengthy recruitment process for a permanent position within the DHB and despite the fact that she was already employed as a casual midwife *'Yep it was crazy so I had to get references and all that stuff, and the police check done and yardy yardy the whole nine yards'*, the move to Australia would be an easier option.

The analysis shows that the ability to move easily between LMC and core settings by increasing or decreasing their employment contracts and caseload numbers, depending on which way they were transitioning, enabled midwives to manage the transition process as seamlessly as possible, causing the least disruption to the women and colleagues.. Debby talks about how she made her transitions and the way she decreased her contracted hours with the DHB while she built up a caseload and conversely increased them when she was transitioning back into core work. Sian states that she *'had started work at the hospital before I finished up my caseload completely, there wasn't ever a kind of a final finish date and a start so that was weird'*.

Anne talks about the planning that she put into her transition and how she found that this was a long process when moving in and out of roles and while she was doing this, she would keep the women at the centre of this process:

*...so for every time I transitioned there was a nine-month transition period, if I was core I would start booking women for independent practice and finish up work when those women were about 32 or 33 weeks, finish up my shift work and transition into full time LMC at that point. When I decided to transition into core I would stop*

*booking, I would carry through with the caseload that I had booked and the n transition once I had carried out all the work that I had committed to (Anne).*

Another midwife discussed how she viewed the process and that she found the transition from LMC to core easier as she had a date to work with; *'you know on x date you are going to start your job and you have an income coming in'*. However, it is interesting that she was also thinking about if she could *'still pick up the occasional postnatal'* (Sian). This is echoed by Andrea who is also employed by the DHB but said that *'I still do the odd LMC client'*. This thought continues in a similar vein with Chris talking about how she has always *'done a few private women during the year'*, discussing the fact that even though she was employed full time with the DHB she found the time to also work as an LMC, and while she has now progressed to a full-time self-employed midwife she still maintains a casual contract at the local secondary unit (Chris).

Maggie has a slightly different perspective as when she graduated there were no core midwifery roles available in her local DHB. That she started as a *'LMC a community LMC, and how she kept working a 0.4 FTE (full time equivalent) at the urban secondary unit'* and *'kept a caseload right through'* until she was working 0.8FTE for the DHB but like the others interviewed she *'was a little bit reluctant to give them [caseload women] up totally'*. She said that one of the reasons that she wanted to do this was to continue to work across her scope of practice as a midwife.

It was also noted that the majority of the midwives interviewed took on additional roles apart from their main employment position, either as a core or LMC midwife. From the nine women interviewed, seven were working as LMC or core midwives and five of them had additional contracts with the DHB or otherwise undertook additional roles, for example casual midwives within the DHB or working as locum midwives for the Rural Midwifery Recruitment and Retention Service (RMRR).<sup>17</sup> One of the midwives interviewed talked about being a 'hybrid' midwife; she was employed by the DHB through an employment contract that covered both the tertiary and primary units, however, she also provided locum cover for a midwifery team in the local area (Philippa).

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<sup>17</sup> A Ministry of Health funded initiative to support and sustain midwifery in rural communities (MMPO 2013).

There were only two midwives who mentioned the difficulty in combining roles. Sue stated during her interview that *'I don't think you can do both, if you are on shift here [primary maternity unit] and a LMC client goes into labour you can't say right I am off shift'* and Maggie indicated she found all the roles she had *'pretty hard to juggle'*. Sue, who is currently an LMC, does talk slightly whimsically about what she perceives to be the benefit of working as a core midwife; *'I feel that core work down here would be very attractive, you know, set hours, time off ... support around your education et cetera'*.

Although none of the midwives gave any clear reasons why they took on the additional roles within the workplace, it could be suggested that this was a method of boosting their income when LMC numbers were low or their contracts were part-time only.

#### 4.3.1 Remuneration

Financial issues and remuneration were mentioned by a number of participants. This section will explore these in a number of ways including when midwives are initially leaving the education facilities, working as a LMC or core midwife, and how finances and other financial implications impacted on the process of transitioning work settings for those interviewed.

Maggie talked succinctly about the need to earn a wage as soon as she entered the register of midwives:

*Yeah you need to get to work, that was huge actually. I would have gone to the hospital here when I first graduated had there been a job available but there wasn't and yes you come out after three years of study, I had given up a job where you know there was a reasonable salary and spent all my savings and knew that I didn't have a lot of years left to have a big student loan ... and I needed to get out and get working and earning money (Maggie).*

It was also apparent that finances impacted on other decisions that some of the midwives made. Sian talks about the positives of being an employed midwife, *'I elected to do permanent nights ... so then you can book the minimum of child care to get through'*. Others talk about the positives of being an employed midwife and the fact that there is a salary, the opportunity to work some overtime, paid annual and sick leave, and how for them it is an

advantage. Whereas another midwife who had left LMC to work in the core setting stated that *'I don't want to take on that responsibility of Section 88 of being self-employed, and then having to think about ACC, taxes and all that, can I say crap'* (Sian).

Other financial implications for LMC midwives are highlighted when wanting to take time away from the work setting and how detrimental this is to their income:

*...a couple of times going on holiday and you absolutely put work out of your mind but you still come back to whatever has happened while you were away that you now have to deal with sometimes that is women leaving your care, therefore a loss of income, women have birthed, another loss of income ... somebody has had a miscarriage in this time ... I just didn't like my income being so intricately tied to all of those things either ... if you do call your back-up to come in for a birth you do have to pay them, if you do go away on holiday and those births happen you still got [to pay them] for it.* (Sian)

The midwives who are self-employed further discuss how they need to manage their workloads in order to meet the cost of having time away and needing to pay their back-up or a locum midwife. Some of the midwives talked about having to gradually increase the number of women in their caseloads from 5/6 a month to 7/8 per month in order to *'pay the bills'* and *'the increased cost of locums'*. Other midwives go on to discuss how they *'can't pay to have time off with low numbers'* and *'the worry about numbers'* this leads to them having *'no break'* or *'not having time for myself'*.

A number of the midwives interviewed discussed the fact that they felt they were underpaid for the amount of responsibility they held being a midwife in Aotearoa/New Zealand. Maggie says:

*...for all the responsibility and accountability that is on you in New Zealand as a midwife and you are simply not compensated for it, and I don't mind at all getting more money for less responsibility in that field [Australia] ... I have taken full responsibility for situations and activities that we don't get paid enough to do* (Maggie).

she goes on to say *'I've had enough of doing a job that we are underpaid for and I would no longer be prepared to [do that] at this stage in my career'*.



Some of the midwives appeared to be in a slightly different financial position where they were not so reliant on their own income but aware that this may be different for other midwives:

*... We are quite lucky that we don't rely on my income, really, I don't have to work. I know some other LMC's they have to work it is their bread and butter; they are paying the mortgage ... for me it was never income. (Sue)*

Philippa further corroborates this, *'Well I am lucky I've got a partner who's got a decent income. So that makes a huge difference. Although we have had a really rough year last year, he has been made redundant twice'*.

When talking specifically about transitioning it was apparent that during this process the financial implications were part of the considerations around moving. Andrea who said *'and the LMC money was still dribbling in from my caseload that I had finished, but it's never been about the money for me, it's about doing the best job I can'*. Anne talks about this in a similar way when she states:

*...actually because most of the money is, the bigger money for LMC is the birth, the postnatal, I found the money carried through alright ... I needed to stop shift work when they were 32, 33 weeks pregnant but actually you got no significant LMC income coming in at that point so there was that kinds 8, 9, 10-week gap that you needed to be able to financially sustain while still paying all the financial costs of being an independent midwife. (Anne).*

#### 4.3.2 Career Planning

When the participants were asked about their career plans within midwifery, it became apparent that some of the midwives had none or very loose career plans; *'I think when I first qualified I had a plan of where I was going'* (Sue). Others were aware that they wanted their careers to move in certain directions and the two main ones appeared to be education or management. Whereas others felt that there was no or very limited opportunities for progression, up-skilling with education, and/or no clear career pathway within the profession.

Chris also talks about the lack of career progression stating there is *'no progression through midwifery you are either a core midwife or a LMC midwife'*. Chris, and one other midwife, talked about the fact that there is no career progression as a LMC midwife but slightly better opportunities as a core midwife. Sian stated that she felt that working as a core midwife offered a better career pathway than being an LMC as there is *'no motivation to you know have a career, to go up the ladder to increase my income'*. This becomes a factor in transitioning because she felt that she needed the motivation of career progression as a motivator to work better (Sian).

It appears that some midwives think about career progression from the start of their careers and they plan ways to progress within the profession. Anne discusses her career plan as moving away from hands-on midwifery to teaching *'my career plan was always to end up in teaching because it was an area that I really wanted to be in'* (Anne) and was working towards this goal by undertaking postgraduate studies. Chris also indicated her plan includes teaching; *'my career plan right at the get go was that I would end up in teaching' 'I knew that was where I wanted to go'*.

Other midwives mentioned progressing up the career ladder by moving into the managerial side of midwifery; *'not long after I came here [semi-urban secondary unit] or within the space of two or three years one of them would have been to take on the manager's role here'* (Chris). Later in her interview, Chris also talks about moving into a managerial role if the right role was available, commenting that already during her career she had worked in these senior positions initially as a charge midwife in an urban tertiary unit, as well as a manager in a remote rural community hospital. In the interview she discussed the fact that this progression to a leadership role happened while *'she was quite new in her career'*.

Two of the midwives interviewed made it clear that managerial positions are not something that they were interested in as part of their career plan. One stated *'I like being with the women, I don't want to be the charge midwife'* and had even turned down the opportunity to take up a managerial position when offered *'I have been asked to consider being a clinical midwife leader in another unit a primary unit, no, no. That's not me'* (Debby). Andrea simply stated *'no, I am not a leader'*.

Others who were more disillusioned with the Aotearoa/New Zealand maternity system discussed the possibility of moving to another country to work as a midwife *'I was toying with the thought of going to Australia on short term contracts'* (Debby) and *'I intend to leave*

[Aotearoa/New Zealand] *and go to Australia and do short term contracts around the smaller towns*’ (Maggie). Whereas the interviewed midwife who had recently left the profession stated that she had no intention of returning to midwifery and that she was on a different, less stressful career pathway (Rachael).

Some of the midwives interviewed also had plans for postgraduate study but these were not always focussed on midwifery; ‘...*post-graduate midwifery study, but I was also quite interested in doing a naturopathy course or diploma, just something a little bit different that would complement midwifery*’ (Sue). Philippa also thought of study as a way to progress her career and looked at a Masters pathway that incorporated Sociology. Some of the midwives interviewed felt that despite the fact that post-graduate education was available, it did not help them to progress up the career ladder or lead them to any other career pathways.

As an alternative viewpoint, one midwife discusses the process of career planning in a more positive light. She stated that the reason she had transitioned into part time core work was because ‘*We’re [midwife and husband] sort of trying to fit a retirement in now while we’re still fit enough to do it*’ (Andrea). Maggie also spoke of the transition period in a positive way, although she was planning to work in another country, by stating that ‘*short term contracts around smaller towns and interesting places and actually tick one of our [midwife and husband] life goals as well*’ (Maggie).

It seemed during some of the interviews that when the participants were talking about their career progression they were also exploring ways to make the midwifery profession more sustainable for them. Often this was through looking at different work settings and ways of working which included different shift patterns or working in different practice settings.

#### 4.3.3 Summary

In this section I have described the theme of movement within midwifery practice and the transition that appears to occur on a regular basis for some of the participants interviewed. I have also linked this with the sub-themes of remuneration and career planning.

## 4.4 Support and Obstruction

The third theme that appeared from the interviews is that of ‘support and obstruction’. Support is a theme with both positive and negative connotations which midwives talked about in their interview; for example family could be a great support network but they could also be obstructions when it came to working with the women. The midwives discuss support from a variety of sources, some focussed on their life partners when making the decisions around transitioning work settings and others on the relationships between practice partners. Midwives who were currently, or who had been working in the DHB, also talked about how they sought support from their peers and management, and how when this support was perceived as lacking this could lead to a culture of horizontal violence and bullying. Lastly this section will look at mental wellness and the psychological support that some midwives needed to stay within the profession or, as in one case, enable them to make a decision to leave.

### 4.4.1 Family support

The sub-theme of ‘family support’ emerged throughout the interviews in a number of ways. Some midwives found that support from their family, especially their life partner, was essential as a way of ensuring they were able to meet the requirements of being an LMC or core midwife, parenthood and other family commitments. Sue sums this up well when she talks about her husband:

*My husband thinks I work too many hours ... but he is very supportive ... he always stepped in when the kids needed to go to sport and he'll cook tea ... he'll come down and pick me up because I don't have a car here [transfer into a secondary unit from rural primary unit] and the kids have grown up with me being on-call ... so they don't complain if they don't see me for a couple of days. (Sue)*

Other midwives interviewed also talked about their husbands/life partners as their main avenue of support when struggling with practice issues or decision-making processes. Debby talks about her husband in these terms when she made the decision to transition work settings

because she had no practice partner for a number of years; *'my darling [husband] out there and he[sic] would tell you that is was pretty messy, I am actually surprised that he stuck around'*. Andrea also talked about the subtle pressure that she felt she was under when working as an LMC and how this contributed to making the decision to also transition to core work *'...although my husband would never say it there was this pressure that I felt from him, and I was always putting my foot in the wrong place'* (Andrea).

Many of the midwives specifically describe the support they got from their families both when making the decision to transition and during the process of moving work settings. In the pilot interview, Anne alluded to this as part of the transition process and how the support she was looking for influenced the decision that she made; *'so I would tend to talk to my husband about that'* and *'so when I am talking to him [husband]'*. Debby discussed how her husband supported her while she was in the process of making the decision to transition work settings and touched upon the increased stress in their relationship. Philippa clearly states that her *'family was definitely the biggest one [support]'* and that *'having a really supportive family'* made the transitioning process easier for her.

#### 4.4.2 Practice Partners and Colleagues

The theme regarding working with practice partners had definite positive and negative strands throughout, and sometimes within, the interviews. Andrea discussed how positive the experience was of leaving the education setting and going directly into LMC work. A huge contribution to this was that she had *'the right fit'* in the initial partnership that she had; *'the partnership was really successful and I worked with [midwives name] as well and that worked really well'*. Other midwives also continue to express the support of their practice partners in equally positive ways; *'the key to managing all that has been to work with really supportive and reliable practice partners'* (Maggie); *'they were amazing'* (Rachael); *'the partnership has been really successful'* (Andrea). Sue talks about a casual partnership with another midwife in the remote rural area she works who supports her to have the occasional weekend off:

*... has been good at backing me up ... and has always said if you ever get stuck and she has looked after women in labour for me until I can get there ... so we would*

*cover each other for time off, but we wouldn't have a set weekend off and so on, it would be as per need and if I or her had more than one woman labouring or birthing at the same time the other would provide the care and step in. (Sue)*

Philippa discussed her experiences of transitioning work settings from DHB to LMC midwifery in a very positive way. That for her, finding the group of midwives that she wanted to work with '*renewed her passion for the midwifery profession*' after working in a core setting in both tertiary and primary units. Chris discusses transitioning into LMC work and how she continued to seek support from her new practice partner and how they are still going through the process to make that work for them as a pair of midwives working together; '*... she said we need to have coffee on Friday afternoons ... that actually we just need to talk over our different caseloads and which ones we have concerns about because you could be looking after them next weekend*' (Chris). Other midwives interviewed also discussed the relationships that formed with their practice partners especially when seeking guidance and support with the women they were working with in their caseloads or work environment.

Debby talks about the need for a practice partner and that lacking this support network impacted severely on her ability to continue working as a LMC:

*... it was forced upon me because I had no practice partner and when I reflected back over the 10 years prior I had been an LMC I had a practice partner for five of those years only ... I just couldn't do it couldn't do it anymore ... and the lack of support ... and the lack of support minus a practice partner (Debby).*

She goes on to talk about the perceived lack of support for her as a midwife from all of her LMC midwifery colleagues '*no support and no back-up not just because you had no practice partner but from your colleagues in the community as well*' and when she did receive that support how this was valuable to her '*...so the few midwives that did it [cover] for me I was so grateful, I would have done the world for them*'. She talks about how she tried to manage the situation and find a practice to join by writing to the midwifery schools to approach the graduating midwives. What she found was that only a few midwives felt that they were able to support her and these were usually core midwives even though '*all my colleagues knew that I needed a practice partner and needed support*'. Furthermore this support from core midwives was dependent on their own work load and with it came limitations as they could cover for a weekend here and there, but, as this midwife found, this '*was fine in the short*

*term but is not sustainable over the years'* (Debby). Her plan is now to work as a core midwife until she is able to find a long-term practice partner, and then consider going back out into full time LMC work, but is slightly disheartened *'there is no one in the woodwork that I can see coming out'*.

Although this midwife talks initially about the support of some core colleagues a little further on in the interview, she describes a discussion that happened between her and a core midwife:

*...once I became a full time LMC there was a lot less support from my core midwifery team ... even if you have been here for 24 hours it doesn't matter, you call in your practice partner, no we are not going to watch over you and make sure that you are making a safe decision, even when they knew I was solo, they still said call in your practice partner ... I just needed some help to manage this.* (Debby)

She can clearly recount the time she made the decision to give up LMC practice and this came about while she was looking for support and the opportunity to debrief a complex situation that had occurred with a woman that she had been working with. Looking initially to her obstetric colleagues *'I just needed some help to manage, this is not a consultation requirement I just need some help to manage. I need to talk about did I do the right thing, could I of [sic] done better'* and goes on to say *'but you don't have it [opportunity to debrief] so you suck it in until one day you end up giving up LMC because you can't suck it in any longer [emotional and crying]'*. Debby talked about how this impacted on her personal and professional life and the grief that she experienced when having to make the decision to finally transition to a core midwifery role. This sentiment is echoed by Rachael; *'I just got up one day and just couldn't do it anymore, and I have never done any midwifery since that very moment [emotional and crying]'*.

Interestingly when Anne spoke about transitioning from LMC to core she still sought support from her practice partners and describes how they supported her in the decision that she was making at the time; *'They were really supportive of my decision, they were fantastic, they were definitely, it was sad, it was sad for all of us, cause it was not what any of us wanted'*. Anne went on to discuss her plans if she was ever to practice clinically again; *'... if I was to practice clinically again it would be back in a supportive practice ... independent practice within a supportive partnership or supportive group of midwives which enables you to give really good care'* (Anne). Many of the midwives also talk about the distress felt when they either had to inform colleagues of their decision to leave the partnership or LMC practice

(Anne, Chris & Rachael). Sian states that she went as far as trying to recruit a new midwife for the practice partnership that she was planning on leaving, in order to minimise the disruption for her soon to be ex-practice partner.

Other forms of support include mentors; Andrea had *'the support of two really strong mentors'* and Sian discussed how she was also supported by her mentor. Others have sought support from other professionals including counsellors *'she [mental health practitioner] has been amazing'* (Debby) and psychiatrists (Anne). The midwives also mention support from friends (Sian & Rachael), ex-practice partners, clinical coordinators (Sian), and core and obstetric colleagues (Maggie). At least one midwife (Philippa) sought support from the New Zealand College of Midwives (NZCOM) chairperson to discuss the transition process and another accessed the employment assistance programme (EAP) through the NZCOM.

#### 4.4.3 Management

When discussing the theme of support many of the midwives interviewed talked about the role that managers had prior to making a decision to transition work settings. This was especially evident when one of the midwives interviewed discussed that fact she felt *'very unsupported'* by management when a critical incident occurred within her workplace; *'as a core midwife I dealt with it the best I could with the constraints that were around me ... so then that is when my decision came from to go out LMC'* (Chris). She goes on to talk about management in the following terms *'yeah, the immediate management here were fully supportive of us and looking after us ... but the management further up wasn't'*. Maggie, talks about the management in the following similar terms *'I know my time has come to an end working within a DHB the autocratic bureaucratic [sic] of what it is like means that the woman centred care seems to come last'* or *'people like me who come through and get belted around a bit and think ... I am not ready to roll over and lie down and die for you [DHB name] and give up, just because I have to work here'* (Maggie).

Other midwives also talked about the lack of support within the DHB; *'lots of constraints being in a secondary unit without 24/7 theatre coverage'*, *'feeling unsafe working for the DHB'*, *'clinical director said to me that none of us are safe working in our profession'*, *'being*



*another person in the system', 'not being valued' (Anne, Sue, Chris & Debby). Maggie sums this up in the following way 'I have never worked with less competent managers in my life and I feel safer emotionally and professionally safer on the chain of a freezing works than I do in the hospital'. She goes onto quantify why she has made this statement and thinks that 'it is because the quality of the management and leadership training does not exist, the mind-set is not on developing manager's and leaders'.*

Anne when discussing working at a secondary unit said that she found:

*...the lack of support really challenging because there are so many clinical incidences which have a real significant impact as a midwife but there is no time to focus or debrief with the woman or other midwives and so I find that really dissatisfying ... ... the tertiary unit was staffed so much lower than it is now overnight, and so it was really unsatisfying and often it didn't feel a safe place to be working and that was really quite challenging. (Anne)*

Chris compared the two different units that she had worked in '*... I felt very safe and secure at [urban tertiary unit] ... we all worked really hard as a team'*, whereas when she moved work environments she talks about the opposite:

*... lots of constraints being in a secondary unit without 24/7 theatre cover that I was used to in the tertiary unit ... I felt quite unsafe working for this DHB [semi-rural DHB] and it didn't particularly help when the clinical director said to me that none of us are safe working in our profession (Chris)*

When a complaint occurred within the unit she was working, it became evident that she looked for support from the management as well as her family; this is evident in the statement that she made as she discussed this process and the impact that it had on her:

*...but one of the big driving forces for me [move to LMC] was last year ... suddenly out of the blue I got a letter from Midwifery Council wanting to review my practice on a particular case ... and as a core midwife I dealt with it the best I could with the constraints that were around me. (Chris)*

She goes on to discuss the support that she received from the management and her perception of why it was offered in the way it was:

*... and yeah the immediate management here were fully supportive of us and looking after us, but the management further up wasn't because I feel that they were more looking after the DHB they would have put us 'under the bus'. I know there was an objective about the complaint because it went from here to Midwifery Council ... because it was around safe staffing. (Chris)*

She also talks about '*not just being another person in the system*' and alluded to wanting to be seen as a person rather than just someone to fill the roster, '*I don't think we are valued as much as we could be*', however also says it's '*nice to acknowledge that I am a good part of the team, but still you guys don't support me, I still don't feel safe and so this can happen again at any minute's notice*' (Chris).

Andrea discusses her perspective of working for the DHB in a tertiary setting, echoing Chris, and describes the fact that she feels '*unsafe in lots of ways being a core midwife*' and '*not really supported by management ... they just aren't there*'. She does however go on to talk about how management works under its own constraints of budget, staffing and safety. This remains a worrying theme that many of the core midwives discuss. Andrea states clearly that her time working as a core midwife has reached a point of crisis for her '*I know my time has reached an end working [core] within a DHB ... it is like we are no longer people ... it is a really sick toxic scene*'.

Sian also discusses why she thinks some women leave the DHB workforce:

*I think that it is the whole thing of being part of a big institution you can't change anything ... you have to live with the stupid red tape and rules and things, it just actually affects your ability to provide care. (Sian)*

Philippa discusses the system [DHB] in the following terms; '*the system is just crazy. That's still better than working at [urban tertiary unit]*'. When Rachael describes the reasons for transitioning from core midwifery back into LMC, she discusses some of the reasons and one of these was also the management:

*...the management absolutely I believe it begins with the management, as long as the midwives are doing their jobs, trying to keep out of trouble and do everything above board, that is all they care about, they don't have a genuine interest for the outcomes of women [clients]. (Rachael)*

Whereas Chris feels *'very safe and secure at [urban tertiary unit] ... we all work really well as a team'*. Sian also positively describes working as a core midwife *'I love being in the hospital'*. Others talk about enjoying the team work when working as a core midwife, the support from colleagues and not having to justify yourself if you are unwell (Chris, Maggie, Debby & Sian). This would suggest that there is collegial support, which is positive, rather than the discussions regarding management styles which appears to be a negative factor for working in the core setting.

One midwife acknowledges that it is easy to get caught up in the negative aspect of working as a core midwife. She has made a decision that she hopes will enable her to remain sustainable in her role as a core midwife *'I am not going to get dragged into it, the politics and what's going on down the [secondary urban maternity unit] I don't care what they think of me'* (Andrea).

Although these midwives discuss the perceived lack of support from management and colleagues, others clearly see that their colleagues are supportive and were able to see the role that management had within the workplace in a more favourable light. Chris indicated *'the immediate management here was fully supportive'*, and when talking about working in a different DHB she discusses feeling *'safe and secure'*. This is further evidenced by Maggie, who talks about *'waiting to get a part-time position at the hospital, I felt I needed that support'*, and Sian who talks about *'falling in love'* with core midwifery and all the positive benefits of being employed, as opposed to being self-employed as an LMC, including regular wages, annual and sick leave.

Sian states how she has formed a supportive bond with her ex-practice partner and how this process helps her to remain focussed on working as a core midwife by offering a different perspective:

*...we [ex practice partner] talk on the phone maybe once every two or three weeks and it becomes quite a good outlet of the core versus LMC ... and we have quite a good relationship where we can be quite frank about our discussions, so that can be helpful, and maybe she is part of how I hope to stay grounded a little bit [working as a core midwife] ... she has the primary care voice that is pretty loud'* (Sian).

Some of the midwives interviewed discussed the support they received from other professional colleagues while working in a core setting. An example from the interviews is

*'junior doctors [who] were like you can't go'* (Chris). Another midwife talks about enjoying the *'employed aspect of being a core midwife'* while others talk about enjoying the team work when working as a core midwife, support from colleagues and not having to justify yourself if you are unwell (Chris, Maggie, Debby & Sian).

#### 4.4.4 Horizontal Violence/Bullying

The theme of 'horizontal violence and bullying' emerged as the midwives discussed their workplaces and their colleagues, peers and management. The themes of bullying, harassment and horizontal violence within the workforce cannot under any circumstances be classed as a means of support, it is included in this section as a way of illustrating the negative effects these behaviours have on the midwives who experience this within the workplace and how it may have influenced their decision to transition work settings.

Although not all the midwives used the terms horizontal violence or bullying, they used other words and phrases that conveyed the same information; *'horrible to each other'* *'strong personalities'*, *'put-down'*, *'not supportive'*, *'judged'*. These views came from midwives who were working in either setting. Other subtle themes were *'resistant to new ideas'*, *'core and LMC needs to be two ways'*, *'no understanding of each other'* and, from one midwife, the feeling of being *'culturally isolated'* (Anne, Sue, Chris, Andrea, Sian, Philippa & Rachael).

Debby talks about horizontal violence and how she perceives that it is present in every aspect of the midwifery workforce; *'LMC to LMC, LMC to core, core to core, core to LMC, it goes right around the block and it's nasty'* (Debby). She mentions it again when she talks about seeking support from colleagues when she needed some time off, when this was not forthcoming she was told that *'my practice was unsafe and that I wasn't doing things correctly and that no-one wanted to help because we all know you are not a safe practitioner'*. She goes on to talk about when working as a LMC that *'there was a lot less support from the core midwifery team'* and also said that *'even if you have been here for 24 hours it doesn't matter ... no we are not going to watch over you and make sure you are making a safe decision'* when she had been working with a woman in labour for a long period of time and was trying to ensure the safety of the woman she was working with.

Maggie who talks about being *'belted around a bit'*, using this term to define the process of adjusting to the DHB work environment and her treatment by other members of staff who felt

that she was an easy target for criticism and gossip. Another midwife talked about the relationship she has with her LMC colleagues when she was working as a core midwife; *'I don't think we are valued as much as we could be collegial wise ... I feel sometimes that particular LMC's think we are here to work for them and it is almost as if they were paying our wages some-days'* (Chris). Andrea discusses how her practice partner *'put her down and made to feel like I was second rate'*. Maggie talks about being dissatisfied and *'the sense of bullying'* which is what led her to consider working overseas as alternative to working in Aotearoa/ New Zealand.

#### 4.4.5 Summary

The third theme looked at ways the midwife is supported or conversely obstructed as she carries out her work. Support has shown to be provided by family members, peers and practice partners. Obstruction can also be because of family as well as management and the bullying culture within the work place. In the next section I will discuss the theme that 'things have changed' for the women midwives are working with.

### 4.5 Things have changed

'Things have changed' is a theme that emerged from the data when the midwives were discussing issues that impacted on the way of working. Initially this was just looking at the changing demands of women but with deeper analysis it appeared that these midwives felt that a number of other changes impact on their way of working. The subthemes in this section are the perceived increase demands from women, changes in communication and how remuneration influences the way midwives work.

#### 4.5.1 Perceived changes in the needs of Women

Throughout the interviews, one of the themes that quickly emerged was that there are a number of changes in the demands from the women that midwives are working with. There is a strong perception that these have increased. This appears to be for a number of different reasons from the increased complexities of pregnancy, to the socioeconomic issues that some women have. Throughout the interviews this theme emerged a number of times and Maggie clearly identifies that this is an issue for her; *'some women have really high demanding expectations ... but there is a sense of entitlement to your time at whatever day or night it is'*. Other midwives also discuss that the demands from some women are exceptional and Sue says *'I don't even get a day off at the moment'* when she discusses the demands of being a rural LMC. Chris talks about the fact that she *'provided all the support and comfort they [woman] needed that at times she felt that this was still not enough for some of the woman'* when she was working with as an LMC.

Anne also discusses the fact the *'women themselves have changed and have increasing expectations'* on the midwives they are working with during their pregnancy. Other midwives talk about the women who *'have you there every week for whatever reason they can make up'* (Debby). Another midwife talks about her belief that *'women and their families have higher expectations of you ... they don't just want a midwife they want a friend ... a social worker'* and she goes on to say that, in her opinion:

*The younger generation's expectation is that they would not come to clinic two or three times in a row, but they need their WINZ (Work and Income New Zealand) form filled in so they need to see you in the next 10 minutes. (Rachael).*

#### 4.5.2 Communication

A number of midwives interviewed mentioned the role that technology, especially texting, and the way this impacted on their lives outside their midwifery role, has been playing; *'The young women we are looking after have been brought up in this world of technology, texting to them is just second nature'*. This midwife goes on to say that sometimes if you are unable to meet with the woman or comply with her wishes immediately you *'...just get texts that are filled with abuse'* (Rachael). Maggie talks about a similar theme *'you get a text at 2 o'clock in the morning on a weekend to tell you that I am going to be at my father's tomorrow ... they*

*just presume you are at their beck and call*'. As does Chris who states *'I have had a few texts that blow you out of the water ... sore teeth at 10 o'clock at night'* and another midwife who finds that the women she works with call you *'at all hours of the day and night'* (Sue).

#### 4.6 Summary of Chapter

In this chapter I have written about the four main themes and subthemes that emerged during the data analysis. I have ensured that the midwives' voice is strong throughout this chapter by using numerous examples to illustrate the themes and subthemes. In Chapter five, I will discuss these in depth and use literature to support or repudiate these findings.

## Chapter 5 Discussion ‘The Good, the Bad and the Ugly’

### 5.1 Introduction

This discussion will concentrate on the main findings of the four themes discussed in Chapter Four. These will be discussed in depth and relevant literature will be used to support the analysis. I am going to use the idiom ‘The Good, the Bad and the Ugly’ as a way of structuring this discussion. This is the title to a cult spaghetti Western starring Clint Eastwood, and this phrase is now commonly used in the Western world when discussing or describing a serious matter in depth. In this discussion ‘the Good’ refers to the positives, ‘the Bad’ to the negatives and ‘the Ugly’ as the things that could and should be eliminated (The Good, the Bad and the Ugly n.d.). Broadly speaking, the midwives and the relationships they form with women are the good; the bad are the many stressors and issues that midwives face on a daily basis; and the ugly is the horizontal bullying and violence in the work place.

In the discussion, I will initially look at the midwife-woman relationship and how the support from family, practice partners and peers enable this. Then I will discuss issues that increase the stressors for midwives working both as a LMC and core midwife. This will include family, generational differences, the perceived changes in women and remuneration. I will further link this into how increased stress can affect physical and mental wellbeing. Lastly I will tie all these factors together and discuss how transitioning work settings could be a way to remain sustainable both personally and professionally.

#### 5.2.1. The Good: Midwife, woman and partnership.

The majority of participants wanted to remain part of the midwifery profession and be the best possible midwife they could be. The participants appear to love being with women throughout their pregnancy journey and mainly discuss midwifery and working with women in positive terms.



Their midwifery philosophy placed the woman firmly in the centre of the partnership. The partnership model of maternity care is unique to Aotearoa/New Zealand (Grigg & Tracy, 2013). The woman being at the centre of the midwifery partnership is one of the four philosophical underpinnings stated in the Guilliland and Pairman 2010 edition of 'The midwifery partnership; a model for practice', one of the framework documents for the profession in this country.

Within this document, the other cornerstone ideologies are: midwifery is woman centred, midwifery provides continuity of care, and pregnancy and childbirth are considered normal life events. The opening statement from this section of the document is that 'midwifery only exists to facilitate the optimal experience for the pregnant women and their babies'. It would then be easy to extrapolate that the midwife is the person who needs to ensure that this happens. This document also acknowledged the fact that the woman brings with her to the partnership her own experiences, culture and is self-determining (Guilliland & Pairman, 2010). What is also interesting to note is that nowhere within this section of the book is the midwife ever identified as having other professional or personal expectations. The midwife is expected to manage her own experiences and culture within this professional framework with little guidance.

Kirkham et al., (2006) found that midwives remained in the profession when they were proud to be midwives, enjoyed their work, and felt that they made a difference to the women they were working with. Similar themes were found in Versaevel's (2011) research which found that midwives who were autonomous practitioners and formed professional relationships with the women they worked with had increased levels of job satisfaction and tended to remain in the profession longer. These relationships are one of the major factors a number of midwives' state as a reason to stay in the profession (Cox & Smythe, 2011; Sullivan, et al., 2011; Wakelin & Skinner, 2007; Fenwick et al., 2012) and conversely, if they are unable to form this relationship or don't have the time to nurture it, it is the reason they leave (Curtis, Ball & Kirkham, 2006; Cox & Smythe, 2011).

A small but relevant piece of research from 2011 found that three midwives who were leaving LMC practice were also 'passionate, compassionate and caring midwives who offered women centred care' (Cox & Smythe, 2011, p. 17). However, for these midwives, their way of practicing was unsustainable for them. Cox and Smythe sum this up in the conclusion by

saying 'paradoxically it is the drive to offer woman excellent midwifery care that can undo the wellbeing of the midwife' (Cox & Smythe, 2011, p. 21). It is not apparent if the midwives in this study were leaving the midwifery profession or transitioning work settings from LMC to core work.

There are a number of other significant pieces of research that have similar findings. Enabling midwives and women to work in meaningful ways leads to the midwives having more job-satisfaction and increases staff retention. A robust relationship has also been found to be more beneficial to the women the midwives are working with (Kirkham, 2007; Sullivan, et al., 2011). Research has also found that there is an improvement in the quality of service to clients within the workplace when this relationship is working effectively (Pugh, et al., 2012).

### 5.2.2 The Good: Support

Research has also shown that support from family enables the midwife to be buoyed when there is an unexpected outcome or tension within the work place. The participants interviewed for this research discussed support in a variety of different ways but family, significant others and practice partners featured strongly as a theme.

This is a common thread in both midwifery and nursing workplaces. An Australian qualitative study in 2016 found that midwives and nurses who maintained strong family networks also have increased resilience within the workforce. Furthermore this external support network enabled midwives and nurses to feel more 'emotionally secure' when dealing with unexpected or complex outcomes (Cox & Smythe 2011; McDonald, Jackson, Vickers & Wilkes, 2016).

Support from friends and family was deemed as essential by a number of midwives when Sandall (1997) explored occupational burnout in the workforce. Similar results to Sandall's work can be found in Versaavel's (2011) descriptive exploratory work 'why do midwives stay' and McDonald et al., (2016) which found that the midwives who remained in the profession or who had increased levels of resilience also had excellent support networks in

the form of husband/significant other, extended family networks and good friends. Research findings by Crowther and colleagues (2016) and Hunter and Warren in 2014 also have very similar findings.

In Versaevel's work (2011), midwives were asked to rank in order who they sought support from. Partners and family were placed in the top three rankings, separated by work colleagues, as a valuable mechanism for enabling them to maintain practice.

Support in the form of practice partners<sup>18</sup> is fairly unique to Aotearoa/New Zealand. However there is still some evidence to suggest that working collegially in practice partnerships is valued by midwives who are employed or self-employed as LMC's within the current model of midwifery within Aotearoa/New Zealand (Wakelin & Skinner, 2007), and that the 'nurturing of these relationships' (Hunter et al., 2016, p54) enabled them to enhance the relationships with the women and midwives they were working with. Gilkison et al (2015) also found that having good working relationships with practice partners leads to more personal and professional sustainability. Research in 2004 investigating the levels of stress in mental health workers, found that when there is an increased level of support from co-workers this leads to a decrease in the levels of stress that mental health workers feel (Jenkins & Elliot, 2004; Coffey & Coleman, 2001).

The benefits of positive working relationships within the midwifery context are discussed within Fenwick et al., (2012) Australian research where newly graduated midwives describe the relationships with colleagues in ward settings. In this work the graduate midwives found that the level of support they received either increased or decreased their sense of confidence in their role as a midwife. Midwives who made a positive difference on how these graduates felt were described as being positive, compassionate, reassuring and approachable. This in turn leads to the graduate midwives feeling supported when asking for help, more able to seek support, and enables them to ask questions without feeling belittled (Fenwick, et al., 2012).

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<sup>18</sup> Practice partner in this work is defined as LMC midwives working together in pairs or small groups to offer formal and informal support to each other.

These sentiments are comparable to findings from the UK which found that good team-work was a factor that led to increased levels of job satisfaction for the midwives who were employees in small midwifery-led partnerships for the London Hospital Trust (Yoshida & Sandall, 2013). The building of good working relationships between colleagues and therefore practice partners has been shown to increase job satisfaction, and work becoming more rewarding. Similar findings were found in research from Bakker, Groenwegen, Jabaaij, Sixma and de Veer in 1996. It has also been shown that this also leads to increased trust and knowledge sharing between the midwives, which ultimately leads to increased safety for the women that these midwives are working with (Hunter, Berg, Lundgren, Ólofsdóttir, & Kirkham, 2008).

Throughout this section, I have discussed the themes that corresponded to the positives that the midwives saw working within midwifery, however there was also a number of themes which described the negative aspects of working as a midwife. These will be discussed in the next section called 'Challenges'.

### 5.2.3 The Bad: Challenges

As stated previously, there is a gap in the literature regarding the transitioning of midwives from one work setting to another. There is however, a plethora of literature available regarding midwives who have left, or are considering leaving, the workforce. As a comparison to the literature was used to demonstrate the positives of the woman-midwife relationship, literature will now be used to show the ramifications when these meaningful relationships are unable to be formed and the effects on the individual midwives and the midwifery workforce.

### 5.2.4 The Bad: Inability to be the Midwife you want to be

Following on from the previous section around support, there is a good quantity of literature that discusses the effects of not being able to be the type of midwife you want to be.

A seminal piece of research commissioned by the Royal College of Midwives and the Department of Trade and Industry, 'Why midwives leave' was completed in 2002 in the United Kingdom. It was in response to the staffing shortages within midwifery at that time. The 'Why do Midwives Leave' and subsequent articles from the research, discuss the main reasons for midwives leaving the midwifery profession in the United Kingdom. The main findings were that midwives left because they were unable to be the type of midwife they wished to be, had the inability to form meaningful relationships with women, or were unable to provide the quality of care to the women they were looking after when working within the constraints of the National Health Services (NHS) (Curtis, Ball & Kirkham, 2006).

Other literature also shows that midwives who are not able to work in a way or in a capacity that enables them to combine their personal philosophies and working life, may eventually leave the profession (Cox & Smythe, 2011; Gilkison, McAra-Cooper, Fielder, Hunter & Austin, 2017; Sandall, 1997; Jarosova et al., 2015; Pugh et al., 2013; Curtis, Ball & Kirkham, 2006).

Midwives interviewed wanted to be the best midwife possible and work with women in a way that makes a difference and ensure the best possible care. There appears to be a dissonance between the way midwives want to work and the partnerships they want to form with women. This proves a decisive factor in retaining midwives in the workforce and highlights a number of internal and external stressors that can impede this. In one way the Aotearoa/New Zealand model of care could be compared with the United Kingdom maternity system in so much as there are community and hospital-based midwives. It appears that the reasons the midwives interviewed for this research, who are transitioning work environments, and the midwives who left the profession in the United Kingdom nearly 30 years ago, are essentially the same.

The participants in this study and research by Gilkison and colleagues (2017) indicate that many core midwives working within the Aotearoa/New Zealand maternity services are already being pushed to the limits of personal sustainability. In my opinion they are sandwiched between the needs of the women and the needs of the corporate structure around them, and, like the filling in the sandwich, when put under pressure they will eventually be squeezed out. Pressures on beds, minimal staffing, t-crossing and i-dotting, finances and budget constraints, all impact on the way in which midwives are able to work. In the

interviews, midwives alluded to the fact that their own personal philosophies differed from those of the corporate environment. It can be construed that this will result in midwives who work in core settings being unable to practice midwifery in the way that they wish, which could include staying true to the partnership model. Some, due to the pressure to conform to the medicalised model of childbirth, felt unable to battle to maintain their own professional identity as a midwife. Hunter (2004) discourses on conflicting ideologies of the midwife and work setting and the impact this can have on the levels of satisfaction that a midwife has in her workplace. One midwife interviewed talked about consciously trying to mitigate this environment by '*still midwifing the woman*' (Chris).

According to Dixon et al., (2017), professional recognition is one of the factors that increases job satisfaction for midwives working within the DHB. If midwives are unable maintain their professional status within the work force, this will eventually lead to them either transitioning work settings or leaving the workforce.

### 5.2.5 The Bad: 'Tug of War' between working life and family commitments

As midwifery is a woman dominated profession for many of the midwives interviewed the first and foremost stressor for them was a dichotomy, or 'tug of war', between their working lives and family commitments.

The research by Kirkham et al., (2006) showed that the second most common reason (41% of respondents) for leaving the profession was because of family commitments and cited either child care issues or starting parental leave as the root cause? Other research, exploring why midwives leave the profession, has also found similar themes regarding the conflicts that some midwives face when working in the profession and juggling family commitments (Jarosova, et al., 2016; Sullivan et al., 2011; Cox & Smyth, 2011). Jarosova et al., (2016) in a multinational, cross-sectional survey of midwives from a number of healthcare systems from around the world, found that midwives working in hospital settings were concerned about the impact of the job on their family commitments. Wakelin and Skinner showed this impact to be huge when they carried out a telephone survey to identify why Midwives were leaving the profession in 2007. They identified that only 22% of respondents had planned time off-call

and completely away from their caseload, and also that from the 94 midwives surveyed 86 of them would work with a woman in labour for 24 hours before they would call in another midwife to take over care.

Although much of the research discussed above is about midwives leaving the profession, it could also be surmised that, as Wakelin and Skinner (2007) suggest, working long, sometimes unsocial hours, and not taking regular time off not only interferes with family and personal commitments but could also be a reason for transitioning work settings. There is a piece of recent research which further supports this by Dixon, et al., (2017) which studied the wellbeing of nearly a third of Aotearoa/New Zealand midwives. It determined that the model of care within the country 'is sustainable but does require careful consideration of professional and family commitments' (p. 11).

#### 5.2.6 The Bad: External stressors

Throughout the transcribing there were a number of themes that became apparent as stressors which impacted on the way the midwives were able to function in the workplace. The first one that emerged was that the midwives felt that there was poor remuneration for their expertise, both as primary health care providers and as experts of the more complex midwifery required in the secondary and tertiary settings.

It appears one of the ways that the midwives interviewed managed this shortfall was by having a number of paid roles within the workplace. Many were not only a core midwife but they also took on some LMC and casual work or were not only working as a LMC but would also have a casual contract for the DHB or do some locum work. A number of the midwives interviewed discussed the way in which their caseloads had increased over a period of time for them to remain financially viable. Caseload numbers was also discussed when midwives with fewer clients felt that they were unable to afford locum midwifery services or to pay their practice partner to cover weekends off. This was especially evident for the midwives who worked rurally. An article by Crowther (2016) supports this theme when he/she discusses remote rural midwifery as being 'an expensive hobby' (p. 26).

The NZCOM are currently in negotiations with the government regarding the pay equity claim (NZCOM, 2015a). Since the claim, there has been some increased funding for LMC midwives with changes to section 88 of the New Zealand Public Health and Disability Act 2000 (Section 88). A Primary Maternity Services Amendment Notice 2018 came into force on 1st July 2018 (MOH, 2018), however as yet no additional payments have been made to midwives, as the frameworks around these payments are still under negotiation (V Clapham, personal communication, August 7, 2018). Commendable progress, however this funding does not yet adequately address the gendered issues of pay equity, decades of gross underfunding for both LMC and core midwives, or consider the proposed new funding model (Guilliland, 2018).

There are recently settled pay negotiations between the New Zealand Nurses Organisation (NZNO), of which a proportion of employed midwives are members, and the DHB multi-employed collective agreement (MECA) is negotiating employment conditions and wages. These negotiations have a focus on safe staffing and pay parity (A New DHB MECA, 2018 p. 7). Participants who were employed by the DHB talked about the levels of staffing as an issue for them and how at times they felt it was unsafe for the women.

This fragility around income has led to an emerging social class that Standing (2011) calls the Precariat. This is defined in a number of different ways, two of which can be related to midwifery. Where income streams are not secure, as in the case of LMC midwives who are essentially self-employed but who have no means of negotiating their fees, midwives are dependent on maintaining their case-load numbers in order to generate income (NZCOM, 2015a). Just over 50% of the midwifery workforce is employed as core midwives, a number of whom are on short term or casual contracts because of family circumstances (MCNZ, 2016). According to Standing (2011) both of these circumstances are precarious working situations, leading to increased stress, tension and ultimately political instability for workers in these situations (Standing, 2011, pp. 15-17). In the midwifery workforce in Aotearoa/New Zealand, it could be construed that this unrest is already happening, with the sometimes acrimonious wage negotiations that are currently underway.

The claim (NZCOM, 2015a) also discusses how ‘the scope and duties for community midwives has increased incrementally and significantly’ (para. 9), and that the current funding does not take into account the increased costs that midwives face in their working environment e.g. petrol or equipment. It goes on to say that this is affecting the care that



women are receiving as there is ‘an alarming increase in the number of midwives leaving the profession’ (NZCOM, 2015a, para. 10). These findings were substantiated by the midwives I interviewed, who talked about the expectations from DHB and the ‘Government’ regarding the increasing level of care they are now expected to provide for the women that they are working with.

Many of the midwives talked about how they were now working with women who have more clinical, psychological and social complexities within their pregnancies, leading to increased workloads and costs for all midwives. Research has indeed shown that there is increasing complexities for some of the women midwives are working with; comorbidities from social deprivation, increasing rates of diabetes and obesity, and other health issues a woman had which could lead to increased risk of pregnancy complications for mother and baby (Bird, et al., 2016; Thorogood, 2015; Yelland, et al., 2016). This in turn increases the workloads for all staff, including midwives who are working in both core and LMC roles. In a health service that is underfunded and understaffed, this will lead to increased stress, fatigue and affect the morale of the midwives (Yelland, et al., 2016).

Another stressor the midwives interviewed talked about was that things have changed. They were vociferous about the changes in women’s expectations from them as their health care providers. They felt that it was now a cultural norm for women to contact them via texting and cell phone outside of their normal working hours, for non-urgent matters like changing appointments or seeking advice on conditions unrelated to pregnancy. Through the interviews the midwives talked about a sense of entitlement from some of the women.

Exploring this through a social lens, one explanation could be generational differences between midwives and women. The mean age of birthing women in Aotearoa/New Zealand is 30 years old (Stats NZ Tatauranga Aotearoa, 2017). This places them firmly as Generation Y, born between early 1980 and late 1999 (McQueen, 2011). The average age of midwives is approximately 47 (MCNZ, 2010; MCNZ, 2016) meaning the majority are on the cusp between Baby Boomers and Generation X (McQueen 2011).

It has been found that some of the traits of Generation Y can lead to difficulties in interactions with the older generations, as was highlighted in the thematic analysis, one of these is communication. Generation Y has grown up with instant communication via texting or SMS (short message service), Facebook, and Instagram ... day and night! Generation Y

resides in a world where seeking information instantaneously via these networks is the cultural norm (McQueen, 2011, pp79-86).

They have also been brought up with constant reinforcement from those around them in their formative years that they unquestionably deserve the best (McQueen, 2011, p45). It could therefore be extrapolated that seeking constant reassurance from the midwives they are working with, regarding pregnancy or parenting issues, is just a way of ensuring they continue to get the best for them and their baby's. To them this information should be available instantaneously, and in their mind the best person to provide that information is the midwife who has told them they are available 24 hours a day, seven day a week; hence the text in the early hours of the morning about 'what happens if I ate crayfish for dinner'.

Baby Boomers may interpret this as a sense of entitlement. To them, there is etiquette around texting as a way of communication derived from their own set of values and cultural norms. I know while working as a LMC, I would not consider contacting a woman outside what I perceived as socially acceptable hours, defined by my own cultural norm. Baby Boomers could therefore interpret the fact that women who do this are being disrespectful (McQueen, 2011, p. 73).

As a generalisation, Baby Boomers were raised with the belief that life was meant to be hard and that if you work hard then in the end you will get your just rewards. Work hard at school, pass exams, and choose a career or vocation was considered the normal path of this generation. Whereas Generation Y are found to have a belief that life is actually meant to be easy. As a result they will frequently change their goals and focus if they are not achieving and meeting their own expectations rather than trying to meet the expectations of older generations (McQueen, 2011). However, these generational changes cannot be considered in isolation as during this time midwives and the midwifery climate have also changed.

The history and development of the current system of midwifery in Aotearoa/New Zealand is well documented in the book *Women's Business* and includes the legislative, social and cultural changes that occurred from the inception to the re-emergence of midwifery in the late 1980's to 2010 (Guilliland & Pairman, 2010a). Of note, since the 1990s there have only been minor adjustments to current model of midwifery. In my opinion during this time, there have been a number of societal, generational and cultural changes that impact on the midwives and women, which have not been recognised or reflected within this current model of care.

As well as generational changes, consumerism has grown exponentially (Sweeting, Hunt & Bhaskar, 2012) since the current model of midwifery was established within Aotearoa/New Zealand. Some members of society now view the world through a lens of consumerism and individualism. Health is now deemed a business, driven by a neoliberal ideology of profit and efficiency as opposed to a model which serves the ‘public good’ and is usually funded and provided by the government (Davis, 2017 p. 135). This business model of health is now the cultural norm and midwives have a dissonance between the organisational needs of the DHB, running a business, the needs of women, and being the type of midwife you want to be.

The final stressor that emerged as a theme was the interaction between midwives themselves. Midwives from both core and LMC found that when working together there is a tension between, and misunderstanding about, the roles of core and LMC midwives. How they should work with each other, as opposed to against each other, has, in the past, been called the primary secondary interface. From the transcripts, core midwives felt that the LMC midwives thought they were there to work for them. LMC midwives felt that the core midwives didn’t understand how tired they were.

The other factor that contributes to these interactions is the interpretation of the funding document Section 88 (MOH, 2007), and how this leads to confusion around the roles of primary and secondary midwifery; for example whose role is it to manage the induction of a woman’s labour or support a woman breastfeeding while she is in a secondary unit? None of this is new and was being written and debated about in 2002 by Earl, Gibson, Isa, McAra-Cooper, McGregor and Thwaites. It is hard to see what, if anything, has changed in the past 15 years.

Throughout the interviews midwives spoke about the physical and mental effects being shift workers or on-call commitments, had on them. There is research that supports the fact that shift workers are affected both physically and mentally by disruption in circadian rhythms (Vogel, Braungardt, Meyer & Schneider, 2012). The physical effects are: increased incidences of gastrointestinal disorders, increased risk of cancers, metabolic issues and cardiovascular disease. Studies have found that there is a link between depressive disorders and irregular work schedules but, because of the complex psychosocial factors surrounding work environments, the correlation of these factors is more difficult to measure (Vogel, Braungardt, Meyer & Schneider, 2012; Kalmbach et al., 2018). However, a recent study of interns found that their mood was negatively affected due sleep deprivation resulting from

shift work (Kalmbach et al., 2018). Added to this the stress of midwifery practice and it is easily extrapolated that there may be a number of midwives working within the current system of maternity care that are experiencing some of these physical and mental manifestations of shift work.

A very recently published piece of research by Geraghty, Speelman and Bayes (2018) discourses on the stressors that midwives feel in the work environment. Their findings are very similar to the midwives' stories in this work. This research supports the themes found in this research and my own opinion that all of these tensions, (workload, money, primary secondary interface, unsocial hours and changes in women including midwives) which can be just niggly in themselves but sometimes insurmountable as a collective, lead to midwives being stressed, tired, and sometimes just plain mean to each other (Curtis, Ball & Kirkham 2006a). This behaviour, along with increases in stress levels and some midwives' individual personality traits, can lead to more unpleasant issues of horizontal violence and bullying. This will be discussed in depth in the next section

### 5.3 The Ugly: Bullying and Horizontal Violence

The themes of bullying, harassment and horizontal violence within the midwifery workforce emerged quickly during the analysis of the transcripts. It was apparent that all of the midwives interviewed had experienced one or more incidences of bullying within her career. For some of the participants, it was a reason for transitioning work settings. Bullying, horizontal violence and harassment appeared to part of the culture in the units the midwives were working in or attended as LMC midwives when accessing primary, secondary or tertiary level care. Some of this was overt, with snide comments or gesticulations (for example eye rolling) and for others it was a sense of feeling culturally isolated and unsupported when complex situations arose. This is included in the discussion section of this work to emphasise the extremely damaging and negative effects this can have on the lives of midwives who experience it. In this section, I will define bullying, harassment and horizontal violence. This will then be followed by a discussion on how this can affect a person physically and emotionally and lead onto how this can affect the work force.

Although nursing and midwifery are very different, they are both female dominated professions and therefore it can be assumed that the behaviours exhibited, and the results of these, will be similar. For this section the literature will be used interchangeably with specific midwifery literature included wherever possible. There is a plethora of nursing articles on bullying behaviour within the workplace (Douglas, 2014; Duffy, 1995; Goldberg, 2008; O'Connor, 2017; Ole, 2016) but there appears to be a limited number which discuss this phenomenon solely in midwifery (Hastie, 1995; Heath, 2014; McKenna & Boyle, 2016).

A bully is defined as someone who uses physical or psychological means or force to get his or her way, especially by intimidating or hurting others who may be smaller or weaker (Medical Dictionary, 2009). Being bullied is defined in a number of ways but ultimately any behaviour that impacts on another in a negative way, which eventuates in them being unable to stand up for or defend themselves, can be classified as bullying (Beasley & Rayner, 1997).

A person who is a victim of bullying can be subjected to any number of behaviours which can include one or more of the following: humiliation, being blamed for something that is not their fault, exclusion from social activities or conversations, being criticised, having rumours spread about them, being gossiped about, being stripped of or given excessive responsibilities (Randle, 2011).

The terms bullying and harassment are sometimes used interchangeably to describe the same behaviour by a person, however harassment has some subtle differences to bullying and focusses on personal attributes including gender and race, and, in extreme cases can involve physical harm, spying and stalking (Randle, 2011; Heath, 2014).

Horizontal violence is defined as violence directed to one's peers (Medical Dictionary, 2009) and is thought to be 'endemic in the workplace culture' and according to Hastie (2016) who writes that this behaviour is 'unacceptable and destructive'. Wilkie defines horizontal violence as behaviour that is 'generally non-physical but is psychologically, emotionally and spiritually damaging' (Wilkie, 1996 cited in Hastie 2016). A number of authors, Hastie (2016), Heath (2014), and Taylor (2017), further define the behaviour that can be typically demonstrated by a person who is being the perpetrator of violence, this can include but is not limited to: gestures that can be interpreted as belittling to another e.g. deliberate rolling of eyes, verbal abuse and 'humorous' put downs, gossiping, sarcasm, slurs and jokes based on

personal attributes including ethnicity or sexual orientation, exclusion, elitist attitudes and behaviours that lead to an imbalance of power amongst peers (Hastie, 2016; Heath, 2014; Taylor, 2016).

An extreme example of the ramifications of horizontal violence is provided by Hastie (1995) when she describes the suicide of a young midwife and personal acquaintance. The midwife named Jodie Wright felt that she was unable to 'measure up' or meet the demands of other staff members who were working on the same unit as her. Hastie describes Jodie as a passionate and enthusiastic midwife who usually coped with problems in a constructive way, but ultimately took her own life. Her suicide note firmly pointed the finger of blame at the workplace. Hastie goes on to compare her own personal experience of harassment and bullying with Jodie's that occurred whilst she was working as an agency midwife in a large maternity unit. The bullies on this occasion were said to be well established midwives who had the moniker of 'the big five'. They were well known within the workplace as people to avoid and whose behaviour was dismissed as being just the way they were. Hastie is a midwife who describes herself as:

*... a mature woman, an experienced nurse and midwife and have worked in many and diverse various [sic] situations. I have academic qualifications and am currently studying. I am intelligent, a feminist, and a political activist for women's issues. I promote and support social justice principles and read extensively on ethical and moral dilemmas in nursing and midwifery. I am deeply concerned about aboriginal health. I am a mother. I have all the qualifications and experience necessary to demand reasonable behaviour from another human being and work colleague. I did not do it (Hastie, 1995, p.7)*

She discusses the disempowerment she felt in this situation and how, despite the fact that she feels that she should be well qualified and have the ability to tackle the behaviour, she was still unable to challenge this destructive onslaught from the midwives she was working with (Hastie, 1995).

This behaviour occurs because of socialisation within both midwifery and the nursing professions. Poor behaviour is perpetuated because that is the way it has always been (Begley, 2002; Delez, 2003; Taylor 2016). Many older midwives who came through the

'school of hard knocks' can probably remember being told to 'stand' when sister entered the room and being publicly berated because the bed wasn't made correctly or the bedpans not polished to the correct streak-free shine.

It is thought that horizontal violence is a direct result of the historical patriarchal oppression of the nursing profession due to its beginnings in the male dominated field of medicine. This then leads to negative and aggressive behaviour in the oppressed group which perceives themselves as powerless (Duffy, 1995; Hastie, 2016; Randle, 2016). This socialisation is also evident within midwifery and can manifest in a number of ways from learning to understand and adapt to the hierarchical system that student midwives are exposed to during clinical placements (Begley, 2002), to midwives who enter the workplace at similar times forming groups that exclude other members of staff (Heath, 2014). Professional socialization is the way in which the culture and values of an organisation become internalised by either a student or new staff member. When that person is socialised into a culture that includes bullying or horizontal violence this then also becomes the norm for them when they qualify or reach senior positions and so the problem is perpetuated (Delez, 2003; Ole, 2016).

A study by Reynolds, Cluett and Le-May (2014) used an interpretive phenomenological approach to investigate the lived experience of newly qualified midwives as they transition into practice settings. Here the midwives talk about having to 'survive' and 'pass through an initiation period' before being accepted by more senior colleagues. Although this article is not specifically on aspects of bullying or horizontal violence, the language of survival and initiation would suggest that there is bullying occurring in a covert psychological way and fits the definitions above (Reynolds, Cluett & Le-May, 2014). Another small piece of Aotearoa/New Zealand research, again although not specifically focused on horizontal violence or bullying, discusses the lack of support from peers and colleagues in the workplace (Cox & Smythe, 2011).

Literature from the UK shows that up to 85% of workers within the health industry have either been bullied or have witnessed someone being bullied (Heath 2014). Similar statistics are given by Beasley and Rayner (1997) when they surveyed other workforces and found that 53% of employees had been bullied and 78% had witnessed it happening to others. In an article by O'Connor (2017), bullying behaviour is described by two nurses in a number of ways, which include gossiping, sabotage, exclusion and rudeness, and is given as the

reason they left the profession (O'Connor, 2017). These findings are repeated in the RCM 'Why midwives leave revisited' report (2016) where the findings showed that some midwives who had left or were thinking of leaving the profession had experienced bullying from their colleagues (19%) and from management (11%).

This culture of horizontal violence or bullying is endemic within the health profession, manifesting in subtle or not so subtle ways as discussed above. I wonder how many of us have decided not to get involved, kept our head down, turned a blind eye or told a victim of bullying 'it's OK' and that 'it is just the way the perpetrator is' (Goldberg, 2006). How many of us really recognise how dangerous this behaviour is?

The midwives interviewed discussed ways they managed the stress in their lives and some found they needed support outside of the ones already discussed. Seeking professional counselling, mentor support or being treated by a psychologist was seen as another way of managing the pressure on them.

## 6.0 Implications for workforce and the profession

There are a number of implications of this research for the midwives and women who are part of the current system of care. Midwives are hardworking and have an inherent resilience to adversity however, the current climate of poor remuneration and increasing work demands places the sustainability of midwives under threat. In this section, I will discuss the implications for the midwifery workforce and ultimately the profession as a whole. Although steps are being taken to address the financial aspects in both core and LMC settings, there remain a number of other factors which in my opinion impact on midwifery in Aotearoa/New Zealand.

From a professional perspective there needs to be a framework of support established which encompasses all midwives. This research shows that midwives have a number of stressors on them that influence the ways in which they negotiate their life and work; that there are societal and cultural changes in both the women we are working with as well as within ourselves as the midwifery workforce. Midwives tell us that the support they receive from



family, friends and colleagues is invaluable. Currently there are also a number of formal support mechanisms in place within midwifery, for example Midwifery First Year of Practice (MMPO, 2013), as well as more informal processes through group practices and peer support.

Providing a system of support which ensures that midwives are able to maintain professional boundaries, workloads, and are able to have a critical friend who challenges and discusses their midwifery decisions, could be a valuable mechanism in ensuring that midwives remain sustainable.. This could be modelled on Māori and Kaumātua; wise women or kuia who are the ‘storehouses of knowledge’ (Higgins & Meredith, 2011) and support the younger generations or the Pasifika midwives through their established Aunties and Nieces support network. Midwives, who are already experienced mentors and leaders in the profession, could work with a small group of midwives and provide mentorship to navigate these complexities. There are some models of small group mentoring that have already been established and researched within Aotearoa/ New Zealand, with results that show this is a valuable process providing the midwife mentees with a safe space to explore the ‘challenges of practice’ (Lennox, 2011, p.237).

In my opinion this should be a formalised process funded by Health Workforce New Zealand and developed by MCNZ. It could be incorporated into the established recertification process as a way to show engagement within the profession and maintain professional standards for practice (NZCOM, 2015).

This research has also shown that midwives transition out of core settings and, for the employers of nearly 50% of the midwifery workforce in Aotearoa/New Zealand, this will impact on the skill mix and level of expertise within the workforce. DHB’s need to be aware that the transitioning process is ongoing and ensure that there is some recognition as to why this occurs. Within the DHB this could mean that when critical incidences occur, policies and protocols are utilised to support everyone involved to be debriefed. Designing a new shift system could also be explored that suits the way in which women function within the workforce. Ultimately the interface between midwives from core and LMC has to be clarified and become unambiguous both from a DHB and Government perspective.

This research also suggests that midwives who transition into core found the recruitment process to be lengthy and at times unnecessarily complex; for example if you are employed on a casual contract why is the full recruitment process needed when moving to an employed contract, references and police checks would have already been completed. These are

unnecessary barriers and affects the ability of the DHB to employ midwives to fill these gaps in a timely manner.

There needs to be investment into career planning and financial recognition of experience for both core and LMC midwives, in order to provide motivation for those who want to advance their careers. Additionally there needs to be structures in place within the profession that recognises and rewards post-graduate education. This will hopefully be addressed within the current NZCOM and Government co-design funding document, and should be tenets that continue to be negotiated strongly as research has found that this recognition sustains midwives professionally.

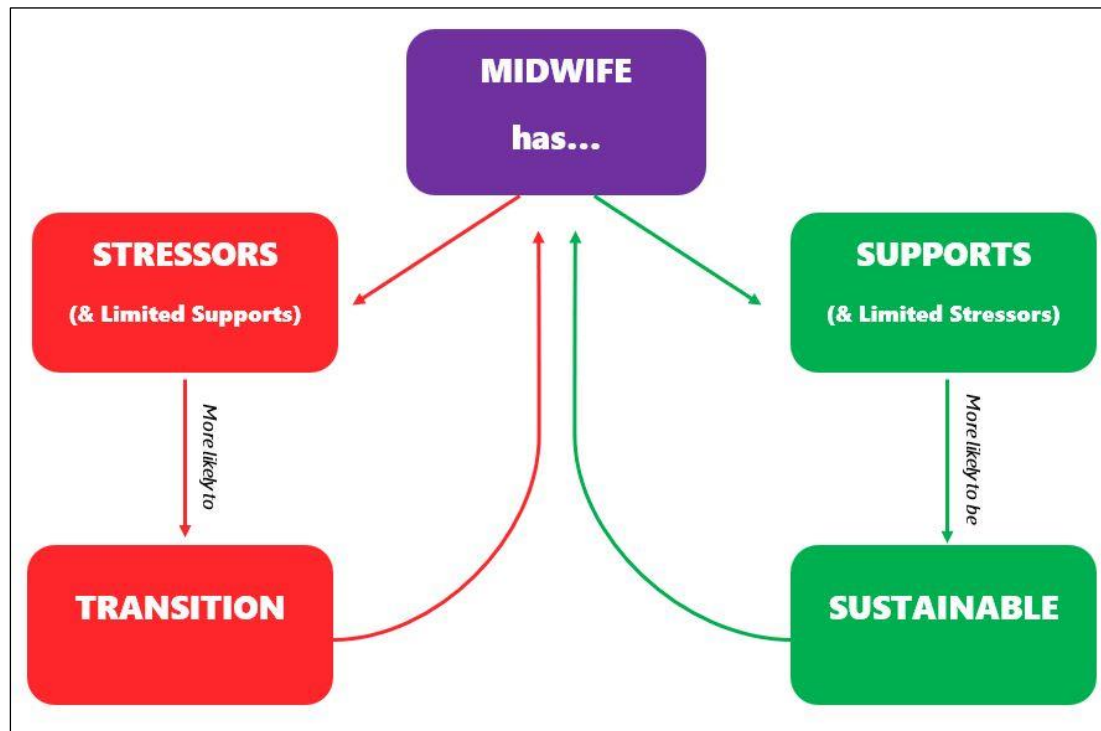
Educators need to provide frameworks that ensure that graduates remain both professionally and personally sustainable within the profession. The investment in their education from a personal and financial perspective is a viable investment and educators need to prepare the graduates to work across both settings competently and confidently. Current and future students need to be educated in ways to navigate the complex intrapersonal relationships with women, peers and colleagues.

Lastly, midwives need to understand the implications that bullying and horizontal violence have within the work environment and make a sustained personal effort to end this culture across the workforce. In all areas of midwifery, it is imperative that there is zero tolerance to bullying and horizontal violence. There needs to be substantial education and a multidisciplinary approach put in place to end the culture of negative socialisation that continues to perpetuate this behaviour.

## 6.1 Conclusion: Transition as a way of being sustainable

This research was undertaken to answer the question ‘What are the experiences of midwives who transition work settings. It appears that these experiences are both positive and negative. Midwives relish working with women in a capacity that brings them joy and sustains them within the profession. They achieve this with the valued support of their families, practice partners and colleagues. However, there are numerous stressors on midwives that are

financial, emotional and physical. Things like family commitments, bullying and work demands impact on the ability of the midwife to fulfil their obligations. This dissonance leads to increased levels of stress and fatigue and in order to manage this, the midwives who participated in this research appear to transition work settings.



**Figure 1: The process of transition**

Transition appears to part of the ‘life-cycle’ (Figure 1) of a midwife dependent on personal, family and life style choices. The process of transitioning is a mechanism which allows them to juggle all of the internal and external factors in an effort to remain personally and professionally sustainable; as one midwife said in her interview ‘I transition to find the ideal way of working’. Many of the midwives interviewed talked about their children, child care costs and if it was more financially viable to work night shifts as opposed to LMC. This is especially relevant when exploring this from a feminine perspective. The realisation that this continued ‘tug of war’ between work and family life, which many female dominated professions are consistently challenged with, continues to be a gendered issue.

Figure 1 is a representation of this process and the circuitous nature of the transitioning process. If a midwife has good support structures in place and a minimum of stressors this enables her to remain sustainable in the workforce. Conversely, if she has a minimum of

support structures and increased stressors, it is more likely that she will transition work settings.

From a professional perspective, midwives know all the things they should be doing in order to remain sustainable: working with supportive practice partners and colleagues, maintaining a good work/life balance, sleep well, exercise more, take regular time off and have a manageable workload. They unreservedly want to continue to provide the care that is needed, working in partnership with the woman. They know that to meet their own definition of an ideal midwife is ‘difficult but achievable’ and transitioning is a way ‘to make this work’

A particularly resonant definition of sustainability is taken from McAra-Cooper et al., (2014) work ‘to enable something to continue to exist, whilst maintaining the mental and physical wellbeing of the agent’ (p. 27). Subsequently, I will conclude that transitioning work settings is a way of allowing the midwife to endure by navigating the stresses that exist for her, in her personal and professional life, and enables her to maintain her physical health and mental wellbeing

## 6.2 Further Research

There is a need for further research into the process of transitioning work settings. I have defined it as a way of being sustainable but it is also possible that transitioning is a precursor to midwives leaving the workforce and episodes of movement become more frequent as the midwife becomes more stressed and burnt-out. Deeper understanding of this process may enable the profession, educators and recruitment to incorporate this in workforce planning. There needs to be research into the proposed framework of support to explore if it would be beneficial to midwives and ultimately to the profession. The culture of horizontal violence and bullying needs examining further and ways to break the cycle of socialisation researched and implemented. Research is needed to gain a deeper understanding of the complex generational, social and cultural changes that are influencing both the women we work with and ourselves to ensure that the implications of this are incorporated into future models of education and midwifery care in Aotearoa/New Zealand.

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## Appendices

### Appendix 1 Midwife consent form

<b>Midwife Consent Form</b>
<b>Career and transitioning workplace research</b>

**Melanie Welfare (Midwifery, Ara)**

**Supervised by R. Maude (Victoria University of Wellington)**

I have read the information sheet for the one to one interviews for Registered Midwives and my questions have been answered. I understand that participation in an interview is voluntary. I understand that the interview will be audio recorded for later transcription.

*I agree to participate under the following conditions:-*

- My name or any other identifying details will **not** be used in any publications of this research.
- I may decline to answer any questions
- I can ask for the audio recorder to be turned off at any time during the interview.
- I can view a copy of the transcript from my interview to check for inaccuracies or to withdraw any comments that I made that I do not want to be included.

- I may withdraw at any time, without giving any reasons, up until two weeks after the transcript has been sent to me for checking.
- The tapes will be transcribed by a transcriber who has signed a confidentiality agreement.
- No names or identifying personal information, names or identifying features of any workplaces will appear in the interview transcripts.
- The Ara copy of this consent form, the tapes and the transcripts will be stored securely for five years and then destroyed.

Name of participant \_\_\_\_\_

Signature of participant: \_\_\_\_\_ Date \_\_\_\_\_

Signature of researcher: \_\_\_\_\_ Date \_\_\_\_\_

If you would like to view the transcript, please note you email address:

\_\_\_\_\_

This research project received ethical approval from the Ara Academic Research Committee Ethics Committee on 24448

## Appendix 2 Consent to Interview



### **The experiences of midwives who transition work settings: a qualitative descriptive study.**

#### **CONSENT TO INTERVIEW**

This consent form will be held for five years.

Researcher: Melanie Welfare. Graduate School of Nursing, Midwifery and Health.

Victoria University of Wellington.

- I have read the Information Sheet and the project has been explained to me. My questions have been answered to my satisfaction. I understand that I can ask further questions at any time.
- I agree to take part in an audio recorded interview.

I understand that:

- I may withdraw from this study at any point before December 1<sup>st</sup> 2017, without giving any reason, and any information that I have provided will be returned to me or destroyed.
- The information I have provided will be destroyed five years after the research is finished.
- Any information I provide will be kept confidential to the researcher and the supervisor. I understand that the results will be used for a Master of Health Research report and a

summary of the results may be used in academic reports and/or presented at conferences.

- My name will not be used in reports, nor will any information that would identify me.

•	I would like a copy of the transcript of my interview:	Yes	No
•	I would like a summary of my interview:	Yes	No
•	I would like to receive a copy of the final report and have added my email address below.	Yes	No

Signature of participant: \_\_\_\_\_

Name of participant: \_\_\_\_\_

Date: \_\_\_\_\_

Contact details: \_\_\_\_\_



## **The experiences of Midwives who transition work setting: A qualitative descriptive study**

### **INFORMATION SHEET FOR PARTICIPANTS**

Thank you for your interest in this project. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to take part, thank you for considering my request.

#### **Who am I?**

My name is Melanie Welfare and I am a Master's student in Midwifery at Victoria University of Wellington. This research project is work towards my thesis.

#### **What is the aim of the project?**

This project explores the experiences of midwives who in the past two years have transitioned work settings from employed to self-employed or vice versa. It will also investigate factors that contribute to this process as well as the impact if any this has on the midwifery workforce within Aotearoa/ New Zealand. This research has been approved by the Victoria University of Wellington Human Ethics Committee [24448].

#### **How can you help?**

If you agree to take part I will interview you in your home. I will ask you questions about your midwifery career. The interview will take approximately one hour. I will record the interview and write it up later. You can stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any point before December 1<sup>st</sup> 2017. If you withdraw, the information you provided will be destroyed or returned to you.

#### **What will happen to the information you give?**

This research is confidential. This means that the researchers named below will be aware of your identity but the research data will be aggregated and your identity will not

be disclosed in any reports, presentations, or public documentation. However, you should be aware that in small projects your identity might be obvious to others in your community.

Only my supervisors and I will listen to the recordings, read the notes or transcript of the interview. The interview transcripts, summaries, and audio recordings will be kept securely and destroyed five years after the research ends.

**What will the project produce?**

The information from my research will be used in my Master's thesis.

**If you accept this invitation, what are your rights as a research participant?**

You do not have to accept this invitation if you don't want to. If you do decide to participate, you have the right to:

- choose not to answer any question;
- ask for the recorder to be turned off at any time during the interview;
- withdraw from the study before December 1<sup>st</sup> 2017;
- ask any questions about the study at any time;
- receive a copy of your interview recording;
- read over and comment on a written summary of your interview;
- be able to read any reports of this research by emailing the researcher to request a copy.

**If you have any questions or problems, who can you contact?**

At any point if these interviews cause you to become distressed or you find that you need further support of counselling please contact your GP for referral or if you are an employed midwife the EAP services on 0800327669

If you have any questions, either now or in the future, please feel free to contact either:

<b>Student:</b>  <b>Name: Melanie Welfare</b>	<b>Supervisor:</b>  <b>Name: Dr Robyn Maude</b>  <b>Role: Research Supervisor</b>
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<b>University email address:</b> <a href="mailto:melanie.welfare@vuw.ac.nz">melanie.welfare@vuw.ac.nz</a>	<b>School: Graduate School of Nursing, Midwifery and Health</b>  <b>Phone: +64 4 463 6137</b>  <a href="mailto:Robyn.Maude@vuw.ac.nz">Robyn.Maude@vuw.ac.nz</a>
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#### **Human Ethics Committee information**

If you have any concerns about the ethical conduct of the research you may contact the Victoria University HEC Convener: Associate Professor Susan Corbett. Email [susan.corbett@vuw.ac.nz](mailto:susan.corbett@vuw.ac.nz) or telephone +64-4-463 5480.



# Research Participants Required

Please tell me about your midwifery career. I would like to talk to midwives who have moved from LMC to core (or core to LMC) in the past two years

One to One anonymised Interviews

This research is part of my Masters Theses and is supervised through Victoria University Wellington

For more information contact:

Melanie Welfare

[melanie.welfare@ara.ac.nz](mailto:melanie.welfare@ara.ac.nz)

039408299 or 0212258299



## Appendix 5 Interview questions



### Semi Structured Interview Questions

6. Tell me about your career to date?
7. What factors influenced your decision to move from core to LMC (or vice versa)?
8. What were your experiences of the process of transitioning workplaces?
9. What is your career plan
10. Where do you see yourself in 5 years' time?

