Valuing Moments of Connection

The experiences of hospital midwives in maternity units in Aotearoa/New Zealand

By

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Abstract

This research explored the experiences of employed midwives in maternity facilities in Aotearoa/New Zealand. In Aotearoa/New Zealand, midwives mainly work in the community as a case loading midwife or are employed within an institution.

Aotearoa/New Zealand midwifery research has mainly focused on the unique community case loading model, with a lack of research focussing on employed midwifery, especially the strengths of employed midwifery. Due to the shortage and declining workforce of midwives nationally and internationally, there is abundant research exploring the reasons midwives give for leaving practice. Research as to why midwives stay in practice in Aotearoa/New Zealand is not as evident.

This study used a qualitative descriptive methodology with an appreciative inquiry lens. Appreciative inquiry (AI) uses a positive framework to interview participants, giving an affirmative lens to the results. This allows the researcher to discover what works well in a system rather than the traditional method of identifying problems. Midwives from different locations in Aotearoa/New Zealand were interviewed face to face or by zoom. The principles of AI were used to develop semi-structured interview questions, which were transcribed and analysed by thematic analysis.

Four main findings were identified: *Midwife heart and soul*, *advancing practice roles*, *work-life balance,* and *tension in the institution*.

Employed midwives value the relationships they form with wāhine/women and their whānau/families and being able to provide the care they consider is a high standard. They are also sustained by achieving work-life balance and being able to advance their practice role. However, tension in the institution leads to frustration and limits midwives' autonomy and growth.

There are implications from this research for midwives, maternity facilities, and the wider profession.

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Chapter One: Introduction

1.0 Introduction

In Aotearoa/New Zealand, midwives choose to work in variety of workplace settings. This research gives voice to midwives that work in maternity facilities (employed midwives), by exploring what they think are the strengths of working within an institution. Their motivations for staying in midwifery will be explored.

This study used a qualitative descriptive methodology with an appreciative inquiry lens to conduct semi-structured interviews with midwives. Six midwives were interviewed, all of whom had been registered as midwives for at least eight years and were currently working as hospital midwives. Thematic analysis was used, with four main themes: 'midwife heart and soul', ' 'advancing practice role', 'work/life balance' and 'tension in the institution'.

The participants valued the connections they made with wāhine/women[1], [2], as the heart and soul of midwifery, endeavouring to provide the best care they could. These moments of connection were at times fleeting, however midwives appreciated they could still provide care that made a difference. The theme of advancing practice roles that the hospital-based midwives engaged with provided the participants interested in their work, with non-clinical or specialist midwifery roles offering midwives another facet to their work. Balance in their work was something midwives aspired to, with boundary setting an important aspect of finding work-life balance. In their clinical work, they wanted to be engaged and work hard, but have the space to be able to form meaningful connections with wāhine /women and their whānau/families.

The final theme, tension in the institution, was brought about when asking midwives about the support they could receive when extending their careers. A lack of support from the institution they worked in was felt by all participants, with feelings of powerlessness.

These findings provide opportunity to celebrate the joy hospital midwives find in the connection they make with wāhine/women. An appreciation that hospital midwives form

[1] The terms wāhine/women will be used throughout this research. Acknowledgement of a changing landscape is given, with The New Zealand College of Midwives currently in a consultation phase regarding the use of gender inclusive language without undermining the primacy of wāhine/women in birth (Bartle, 2020).

[2] Te reo Māori is used in common words where applicable in this research, such as wāhine/women, pēpi/babies, whānau/family.

partnerships in fleeting moments of connection is important, for hospital midwives, and their managers, as well as the wider profession. Further exploration by midwifery managers and workforce planners to find how they can enable extension of hospital midwives' roles will keep midwives interested and satisfied in their work. Preparation by student midwives to face the tensions that arise in the institutions may better equip them for this workplace setting.

1.1 Background

This section explores the Aotearoa/New Zealand maternity system, and the history of midwifery in Aotearoa/New Zealand, to place this research in context. The thought processes that lead to this research are described, with a brief literature review introducing the gaps in the literature. The research question is outlined, followed by a summary of chapters in this thesis.

1.1.1 New Zealand maternity system

This research takes place in Aotearoa/New Zealand. The development and continuation of the maternity system will be discussed in this section, as it is considered unique. This is due to the incorporation of midwives as autonomous practitioners, and the partnership model of care, prioritising power sharing and mutual trust and respect between midwives and wāhine/women (Guilliland & Pairman, 2010). In Aotearoa/New Zealand, a midwife is defined by the International Confederation of Midwives (ICM)[3](2017) definition, which states:

> A midwife is a person who has successfully completed a midwifery education programme that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education and is recognised in the country where it is located; who has acquired the requisite

[3] ICM represents professional associations of midwives across the world, with 143 members associations representing 124 countries, over 1 million midwives.

> 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.

This definition is broad, yet accurate in the way it defines midwifery. The way in which midwives work in Aotearoa/New Zealand will be explored in more detail in this chapter, beginning with setting the scene of how midwives gained autonomy.

1.1.2 Journey to autonomy

Midwifery has developed into an autonomous profession in Aotearoa/New Zealand over the last 100 years. This has been brought about by regulation and public support, both by consumers of maternity services and political campaigns. This journey is important to understand the unique maternity system in Aotearoa/New Zealand and the place midwives hold within this system.

Before 1904, hapū/pregnant Pākehā (European) women were attended by other women with birthing experience, whereas Māori women had their traditions of whānau (family) centred birth care (Donley, 1986). Recognition and regulation of midwives and childbirth practices were introduced by the 1904 Midwives Act, which was passed to ‘Provide for the Better Training of Midwives and to Regulate the Practice of Midwifery’ (Midwives Act 1904). Midwives practised autonomously, within the full scope of normal pregnancy. This changed over time, with the growing interest of medicine in the childbearing space.

By the 1960s, with the rise in the use of pain relief and the specialty of obstetrics, midwives were relegated to the role of birth assistant (Donley, 1986). Maternity services had centralised, shifting from home and community care to large tertiary hospitals. By 1971, changes in the Nurses Act deemed midwives could no longer independently care for pregnant women, further dismantling midwifery autonomy (Guilliland & Pairman, 2010). Stojanovic describes this series of events as the ‘nursification’ of midwifery. This was met with opposition from consumers of maternity care, midwives and doctors (2008).

Consumer groups were formed from the 1950s, established by women, midwives and doctors who were concerned about maternity services. Such groups included the Homebirth Association, La Leche League, Parents Centre, Maternity Action Alliance, Save the Midwives and Maternity Services Consumer Council, all of whom shared common concerns around routine management of pain in labour, lack of informed decision making by wāhine/women and their families. These consumer groups and midwives recognised the need for direct-entry midwifery education[4] and the importance of reinstating legislation discarded in 1972 (Donley, 1986) for a return to autonomous practice in midwifery. The New Zealand College of Midwives was established from the Midwives Section of the New Zealand Nurses Association (NZNA)[5]. With the support of these consumer groups and political backing, the 1990 Nurses Amendment Act was enacted, resulting in registered midwives providing autonomous care to pregnant wāhine/women throughout their pregnancy, childbirth, and postpartum journey (Ministry of Health, 1990).

The establishment of the Midwifery Council (MCNZ) in 2004, representing a separation from the regulatory body for nurses (Nursing Council of New Zealand), provided the final step in achieving a fully regulated midwifery profession (Guilliland & Pairman, 2010). Comparator countries, including Australia, Canada, Ireland, The Netherlands, The United States and The United Kingdom, have seen a similar shift in the midwife's role across a similar period, with the change from a medicalised model of care. New Zealand is unique amongst these comparators, except for The Netherlands, with a community-based model of care where women choose to have care led by midwives, free of charge through the public health system (Rowland, McLeod & Froese-Burns, 2012). The steps to autonomy and establishment of a regulated profession saw conception of a theoretical framework- the midwifery partnership model- which explains the philosophies that underpin the midwife-wahine/woman relationship.

[4] As opposed to a midwifery qualification following a nursing qualification. This prepares midwives to practice across their full scope, producing midwives who are specialists in normal childbirth and identfies midwifery as a separate career pathway (Pairman, 2006).

[5] NZNA from 1909-1993, now New Zealand Nurses' Organisation (NZNO)(Sargison, 2018).

1.1.3 The midwifery partnership model

An integral facet of the midwifery model of care in New Zealand/Aotearoa is the partnership model, describing the unique relationship between the wāhine/woman and the midwife. Partnership in this context is described as 'being with' women as opposed to 'doing to' women, as seen in the biomedical model of care (Miller & Bear, 2018). This concept has enabled the woman-centred care model, where midwives and wāhine/women and whānau/family build a relationship of mutual trust, and decision making can be made confidently by the wāhine/woman in an informed manner (Guilliland & Pairman, 2010).

1.1.4 Being a midwife in Aotearoa/New Zealand

While the definition of a midwife is the accepted International Confederation of Midwives version, the Midwifery Council of New Zealand (MCNZ) further define the scope of practice of a midwife[6]:

> The midwife works in partnership with women, on their own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the new-born. The midwife may practise in any setting, including the home, the community, hospitals, or in any other maternity service. In all settings, the midwife remains responsible and accountable for the care they provide. (Department of Internal Affairs, 2010).

Midwives in Aotearoa/New Zealand must hold an Annual Practicing Certificate (APC). An APC can only be applied for after completing education, either a four-year bachelor's degree in Aotearoa/New Zealand or an approved overseas programme and passing the national midwifery examination. Once practising, midwives must maintain competence to a set of standards set out by the MCNZ, known as the recertification programme (Midwifery Council of New Zealand, 2021a).

One standard midwives must meet is participation in the Midwifery Standards Review (MSR) process, conducted by the professional body, the New Zealand College of Midwives. This

[6] The scope of Practice statement for midwives in Aotearoa/New Zealand is currently under revision, with consultation ongoing (Midwifery Council of New Zealand, 2022b).

review is taken at regulated intervals by all midwives holding an APC. Midwives present evidence of maintaining professional standards of practice and Turanga Kaupapa[7], working in partnership with wāhine/women and colleagues and reflect on their practice with specially educated reviewers, one of which is always a consumer of maternity services (New Zealand College of Midwives, n.d.). The review includes anonymous written feedback received from wāhine/women the midwife has provided care for, and also colleagues the midwife has worked alongside. The MSR demonstrates the importance placed on reflective practise and continued consumer involvement in Aotearoa/New Zealand. All midwives must meet these professional standards and demonstrate working within the scope of practice as a midwife in Aotearoa/New Zealand, regardless of their work setting (Guilliland & Pairman, 2010) (Midwifery Council of New Zealand, 2021a). These workplaces can vary widely, as discussed below.

Midwives in Aotearoa/New Zealand may choose to work in a variety of workplaces, with some choosing to work in different jobs across various settings. Community case-loading midwives provide primary care to wāhine/women and their pēpe/babies from early pregnancy, labour and birth, up to six weeks postpartum. Wāhine/women choose their primary caregiver, with 86.9% choosing a midwife as their primary caregiver in 2017 (Ministry of Health, 2019). Most community case-loading midwives work in an on-call arrangement within a community-based group practice, and are self-employed, paid by the government under Section 88 of the New Zealand Public Health and Disability Act 2000, the central legislation for primary maternity care. Section 88 provides referral guidelines, enabling community case-loading midwives to collaborate with specialists when working with women with risk factors or any conditions which arise in pregnancy, labour or postpartum. This ensures clear criteria for referral and enables a shared care approach, with primary care midwives generally continuing to provide midwifery care (Grigg & Tracy, 2013). The other main work setting is employment by a maternity unit, such as a primary unit, focussed on primary care for wāhine/women experiencing uncomplicated pregnancies, or within a secondary or tertiary level hospital.

[7] Turanga Kaupapa are guidelines that ensure cultural requirements are met for Māori during pregnancy and childbirth, integrated into the midwifery standards of practice to recognise Māori as tangata whenua (indigenous people of Aotearoa/New Zealand) (Midwifery Council of New Zealand, 2021b).

1.1.5 Hospital midwifery

In Aotearoa/New Zealand, midwives employed to work in a maternity unit hold a core understanding of how that service operates. (Midwifery Employee Representation and Advisory Service, 2014). In 2022, a survey of all midwives holding an APC identified their place of work, giving an insight into the ways of working in Aotearoa/New Zealand. Fouty-eight percent of midwives reported their main employment type was a hospital midwife, working in primary, secondary or tertiary settings[8] (Midwifery Council of New Zealand, 2022a). Hospital midwives generally work rostered and rotating shifts, providing a 24 hour service to wāhine/women and their whanau, providing full labour and birth care or in collaboration with the woman's chosen primary care midwife, or specialist obstetrician. Hospital midwives also provide care for wāhine/women with high risk pregnancies requiring inpatient antenatal and postnatal care (Grigg & Tracy, 2013). Hospital midwives may work across a variety of specialist roles, such as diabetes specialist midwife, research midwife or as an educator in midwifery.

1.2 Positioning myself in the research

I have worked as a midwife in New Zealand for ten years, predominantly as a hospital midwife, employed by District Health Boards (DHBs). As a student, our education focused on practising as a community midwife, with 20, eight hour shifts in a hospital placement over our second year of training and no specific hospital placement in our third and final year of the midwifery degree.

Upon graduating, I was accepted into a new graduate programme in a busy tertiary hospital. The team environment and camaraderie lead to friendships and many informal debriefing opportunities, which were essential factors in my first year of practice. My undergraduate education was structured around understanding and valuing community midwifery more highly than hospital midwifery. I therefore expected to work a few years as a hospital midwife and eventually transition to working in the community. It seemed this was a

[8] A primary maternity facility provides care for wāhine/women who are expecting normal births and their pēpe/babies who are at low risk of complications for labour and birth care, with care by midwives. A secondary facility is a hospital provides care for normal and complicated births, with obstetric, paediatic and anaesthetic services. Tertiary facilities are hospitals which can provide care for wāhine/women with complex pregnancies and include extensive multidiciplinary services (Ministry of Health, 2019).

stepping stone on the way to what I perceived to be a more fulfilling role. Even now, when explaining my job to the general public, I have to hold myself back from describing myself as "just a hospital midwife".

As my career progressed, I found both large and small changes helped keep my interest and passion in hospital midwifery, with little desire to work as a community midwife. These ranged from moving areas of work, coordinating small projects and taking on various roles within the workplace. Being part of setting up a community midwifery team came at a time when I was feeling disillusioned with hospital midwifery and shift work- a few nights per week on call and developing a relationship with wāhine/women and their whānau provided the change I needed to keep me passionate and interested in midwifery, whilst continuing to work shifts part time.

A regular part of working within a team was debriefing and discussing workplace options. After a challenging shift or complex event, my colleagues and I would find ourselves contemplating career options. They would range from changing factors within our workplace or transitioning to community midwifery to changing careers entirely. While much discussion would take place around alternate career options, very few actioned this. The reasons behind this, I believe, are multifactorial. However, it led me to wonder what is behind the choice to work in an institutional maternity unit.

In Aotearoa/New Zealand community, midwifery-led care had been a long and hard-fought-for journey. What are the factors hospital midwives give behind this decision to work in a hospital setting?

In my experience, the decision to be a hospital midwife has been influenced by many factors, all in a state of flux. At times, teamwork and camaraderie have been why I enjoy my work, at others, because I would not get paid the equivalent for the same number of hours in any other position in midwifery. At all times, I identify as a midwife and can not imagine any other job would bring me the same level of fulfilment and satisfaction - it can be a career of extreme highs and lows. I find having the consistent support of fellow midwives as well as nurses and medical staff is reassuring. The thought of leaving the profession altogether has been one which I have occasionally talked about, but never seriously considered acting on.

1.3 Identifying the research problem

There is extensive international research evidence about those midwives who do leave the profession. Burnout, lack of support from colleagues and managers, and dissatisfaction with the midwifery model are consistent themes throughout this research (Curtis et al., 2006; Fenwick et al., 2018). On the other hand, midwives choose to stay in midwifery because they have a good working relationship with their colleagues and feel they have support from their managers which sustains them in their profession (Sheehy et al., 2021). Building relationships with the women they care for and a general feeling of satisfaction and passion for their jobs were also reasons midwives give for staying in their work (Bloxsome et al., 2019; Kirkham et al., 2006; Sullivan et al., 2011). These are all international studies within maternity systems that differ to Aotearoa/New Zealand, and may not be directly applicable to the unique way in which midwives here work. Literature that focuses on the reasons hospital midwives stay in midwifery is limited, with research continuing to focus on why midwives leave the profession.

In Aotearoa/New Zealand, research tends to focus on community case-loading midwifery, with little insights into hospital midwifery. Two studies focussing on hospital midwives in Aotearoa/New Zealand do not ask the question of why midwives choose to work in institutional maternity units, however give some insight into this indirectly (Gilkison et al., 2017; Wynn-Williams, 2006). Midwives are sustained in their work as a hospital midwife through developing skills valuable to their work and quickly developing rapport with women in a fast paced, ever-changing environment (Gilkison, McAra-Couper, Hunter & Austin 2017). When exploring why midwives transition work settings, which is an option in the Aotearoa/New Zealand maternity system, the researchers found transitioning from hospital to community midwifery and vice-versa is a tool midwives used to remain professionally sustainable, and remain in midwifery as a profession (Welfare, 2018). Increasingly midwives are under pressure in their work, with a decreasing workforce in hospitals, as well as an increase in the medical complexity of birthing women (Dixon, 2019). Media describe midwives as ‘overwhelmed’ ‘let down’ and use wāhine/womens experiences of inadequate care to demonstrate a shortage of midwives (Duff, 2021; One News, 2021). There is a gap in the research in the context of a demoralised workforce, therefore looking into why midwives choose to remain in the profession, and especially as a hospital midwife in an

institutional setting is important. The question of why do midwives choose to stay working in maternity institutions is the gap in the research I wish to explore.

The methodology used for this research project has been chosen keeping this question in mind. Appreciative Inquiry (AI) is a narrative-based process based on the belief that focussing on the positive aspects of a system will proliferate positivity in the participants. Questions are asked in stages- first discovering what is best about the participants current work situation, then moving towards how this could be even better, and using the Appreciative Inquiry principles to help participants plan for a postitive future (Cooperrider, 2008). Using AI as a methodology will elicit mostly positive responses from participants, which stays true to the empowering language of the research question, exploring the choices hospital midwives make (Fitzgerald et al., 2003).

1.4 Research question

This research asks the question, "why do experienced New Zealand hospital midwives choose to work in maternity units?"

The aim is to use an appreciative inquiry lens with qualitative descriptive to explore what midwives feel are the strengths of working in an institutional maternity facility.

The objectives are

- To discover what influenced hospital midwives to begin practice and what sustains them
- To assist hospital midwives in exploring what they feel are the strengths of hospital midwifery
- To involve hospital midwives in identifying where there is potential for growth in their work and how they can achieve growth

1.5 Outline of thesis

Chapter One: Introduction

This chapter introduces the context in which midwives work in Aotearoa/New Zealand, with a brief background explaining why the maternity system is unique and why this influences the way midwives practice. The research methods and methodology are introduced. It

explains my interest in the research topic and why it is important in the current midwifery landscape. The chapter introduces the research question, aim and objectives.

Chapter Two: Literature Review

Chapter two gives context to the research question and identifies the gap in the literature. The review explores international literature, many identifying why midwives leave the profession but very much less research addressing why midwives choose to stay in midwifery. Aotearoa/New Zealand research is investigated, focusing on hospital midwifery and the unique way this integrates into the Aotearoa/New Zealand context.

Chapter Three: Research Design and Methodology

A qualitative description methodology and how I have used that with an appreciative inquiry lens is introduced in chapter three. Appreciative inquiry as a methodology in corporate research is given context, then the applicability to this smaller study is considered. The 4-D cycle is outlined, and how these are used in practice when interviewing participants. The recruitment and interview process are discussed, ethical concerns and how Te Tiriti o Waitangi has been integrated into the study process.

Chapter Four: Findings

The words of the participants are used in chapter four to illustrate the four main themes. The four main themes are: midwifery heart and soul, advancing practice role, work-life balance, and tension in the institution.

Chapter Five: Discussion

Chapter five uses the findings to illustrate the implications, in relation to the current literature. The implications for the workforce and further research are discussion, along with limitations of the research. Appreciative inquiry provides a framework for structuring this chapter.

Chapter Two: Literature Review

2.0 Introduction

The focus of this literature review will be on why hospital midwives choose to work in maternity facilities. In Aotearoa/New Zealand, midwives can work across various work settings. These include, but are not limited to, working in a hospital setting, in the community, either employed or self-employed as community case-loading midwives, in education, research or management. An exploration of midwives in all work settings will be made, as this adds context to midwifery practice in Aotearoa/New Zealand. What midwives enjoy and find value in will be explored, however, to position this work the reason midwives leave midwifery and dissatisfaction within the profession will also be discussed.
A national and global shortage of midwives has been a growing concern (World Health Organisation, 2018), affecting the quality of care for wāhine/women and their whānau/families. The news media and literature document this shortage extensively (Duff, 2021; Fenwick et al., 2018). This shortfall is multifactorial, with midwives leaving the profession contributing to research data with exit interviews. There is a body of research looking into why midwives leave the profession, which will be reviewed here. However, whilst there is emerging literature documenting the reasons midwives stay in the profession, there is still a gap in research focussing on this.

Literature was gathered using the New Zealand Midwifery Research Database, provided by the New Zealand College of Midwives at (https://portal.midwife.org.nz/research-search?mode=JDMRC) and Te Waharoa search engine of Te Pātaka Kōrero online library at Victoria University of Wellington. The databases searched included ScienceDirect, ProQuest, Ebsco, PubMed and Wiley Online Library. The search terms were midwi*, intention-to-stay, job satisfaction, retention, and workforce. The search was limited to articles in English, with a broad range of dates, from 2011-present. However, some seminal works outside these dates were included. Reference paths were followed by the researcher, after finding relevant articles, and the literature search was continued throughout the study.
Irrelevant literature was discarded, with many search results focussing on only the nursing profession. Whilst job satisfaction in midwifery is well researched, articles rarely include

research about midwives' intentions to stay in the profession. This is a serious oversight given the needs of childbearing wāhine/women, their whānau/family, and the international and national state of the midwifery workforce.

2.1 Implications of staff shortages

There is an overall deficit of nurses and midwives in the global workforce, and the World Health Organisation predicts a further nine million are required to meet demand by 2030 (World Health Organisation, 2018). While this approximation applies to nursing and midwifery, it also highlights the importance of sustaining health professionals in their careers. There is evidence of a positive correlation between job satisfaction and patient satisfaction in international nursing research (Alnuaimi et al., 2020). Internationally and in Aotearoa/New Zealand, there is a 'midwife shortage', with midwives feeling the future of the profession is unsustainable. High attrition rates and resulting staff shortages have led to rationing of care by midwives (McKenzie-McLean & Broughton, 2019). Chronic staff shortages were shown to negatively affect safety in the workplace and the care received by mothers and babies in the United Kingdom (UK) (Hunter et al., 2019). The implications of this care rationing affect midwives' job satisfaction and maternal and infant safety, giving justification for exploring the factors behind this shortage of midwives.

2.2 Why midwives leave

There is substantial international evidence to support the reasons midwives give for leaving midwifery, one of which is burnout (Curtis et al., 2006; Fenwick et al., 2018; Wakelin & Skinner, 2007). This is one of the main reasons midwives give for leaving the profession. Burnout as described in the literature is psychological stress when external demands on an individual exceed their adaptive abilities. Burnout develops over time, with individuals displaying signs of general fatigue, an indifferent attitude towards their work and a feeling of insufficiency in work ability. While stress may help an individual focus and therefore be advantageous, burnout is a product of chronic stress over time and has serious adverse effects (Moss et al., 2016).

2.2.1 Burnout

A study by Fenwick, Lubomski, Creedy & Sidebotham in 2018 surveyed 990 midwives working in Australia and explored factors contributing to burnout. The findings showed midwives were dissatisfied with their work-life balance, with those with less than ten years of experience more likely to report burnout (Fenwick et al., 2018). Burnout in relation to an individual's career is usually associated with chronic stress in the workplace and is characterised by emotional and physical exhaustion, leading to reduced job productivity. These can lead to absenteeism, strained relationships between co-workers and high turnover rates at an organisational level. At a personal level, burnout can lead to emotional exhaustion, physical fatigue, and depression and impact a worker's family life (Alvey, 2020). When the quality of support received by midwifery managers was perceived to be low, the associated levels of burnout in employed midwives were high. Studies carried out overseas identified supportive management as a reason midwives stayed in the profession, which indicates this may be a defining factor in midwives' workplace satisfaction and intention to stay (Bloxsome et al., 2019). While many other factors may be implicit in a worker's dissatisfaction with their job, burnout is frequently cited in the midwives' job satisfaction research.

Years of experience and the association with burnout correlate significantly with a UK study investigating work-related stress amongst midwives. When looking into the demographic details of the midwives who identified as having high levels of work-related emotional stress in the UK, they were most likely to be aged 40 and below, working in a clinical setting and have less than ten years of experience in the profession (Hunter et al., 2019). The study suggested that midwives who had stayed in the profession longer may either be de-sensitised or accustomed to their potentially adverse working conditions or have a stronger sense of professional resilience. Those that reported the most frustration tended to be younger and newly graduated midwives.

2.2.2 International literature on workforce shortages

Reports and news articles claim workforce shortages in certain areas (United Nations Population Fund, International Confederation of Midwives, & World Health Organization, 2014). Dissatisfaction with midwifery is the main reason midwives left midwifery in the UK.

Other reasons included family commitments, ill health, career change and retirement (Curtis et al., 2006). Midwives who left, citing dissatisfaction, were concerned about the standard of care they were able (or unable) to provide to wāhine/women and their families due to time constraints and increasing workload, describing midwifery care as 'disjointed and unsatisfactory'. There was a lack of support from managers, who were described as inflexible and did not consult with midwives on planned changes. Midwives felt they had little ownership over these changes and that affected their work. The diminishing workforce created many stressors for the staff who stayed at work, culminating in burnout for some.

2.2.3 National literature on sustainability

In Aotearoa/New Zealand, a survey of community-based midwives by Wakelin and Skinner (2007) looked into the sustainability of their practice and their intention to leave. The balance between a satisfying personal life and the demands of midwifery was discussed. Midwives placed high value on the relationships they formed with wāhine/women and the way they perceived continuity of care deepened these relationships. However, long hours and a lack of structured support led to exhaustion, and intention to leave the profession. This research was brought about by issues around the midwife shortages in Aotearoa/New Zealand at that time.

An article titled 'Maternity statistics and what they tell us about midwives' changing work environments' in the New Zealand College of Midwives Midwifery News reported an increase in medical complexity in birthing wāhine/women. This complexity is coupled with a shrinking workforce in hospitals, both in headcount and full-time equivalent staff (Dixon, 2019). The author suggests that high workloads and poor staffing lead to midwives being unable to provide good care to wāhine/women, leading to decreased work satisfaction, mirrored by overseas literature (Hunter et al., 2019). Midwives tend to work fewer hours, which was not further explored in this research; however, the author suggested this may be a coping mechanism for hospitals' increasing workload (Dixon, 2019). This is on a downward trend, with midwives decreasing the number of hours worked per week, with 40.7% of midwives working 32 hours or less per week, down from 46.4% in 2020 (Midwifery Council of New Zealand, 2022a). Midwives surveyed in 2017 preferred working on a part-time or casual basis. When asked what the main contributing reason for working part-time was, no

elaboration was given on the factors behind this preference (Midwifery Council of New Zealand, 2017)[9]. Therefore, it begs the question of why midwives stay in the workforce.

2.3 Why midwives stay- midwifery identity and support

There is a growing body of literature exploring why midwives stay in the profession and what sustains their practice. An integrative review by Bloxsome et al. reviewed six studies in Nigeria, Canada, Greece, and the United Kingdom, examining midwives' job satisfaction and intention to stay within the profession (2019). All the papers in the review found a significant correlation between midwives' workplace satisfaction and a valued relationship with colleagues and managers. Themes included institutional processes such as effective and meaningful support from managers and colleagues. This resulted in greater workplace satisfaction, with positive feedback from managers being valued, but this was seldom provided. Other more professionally orientated themes were building relationships with wāhine/women they cared for, having passion for the job and the variety of the work were also themes represented in this study. There was an acknowledgement in this research of midwives' general enjoyment of their job giving them a sense of accomplishment and included having shift work that fitted around family commitments and better money than other jobs. This integrative review is the only literature that analysed studies from several countries about midwives' reasons for staying in practice.

Analysing the individual studies included in the integrative review gives a deeper insight into the reasons midwives give for staying in their profession and what contributes to job satisfaction, which is a common reason midwives give for staying in midwifery.

Kirkham and colleagues conducted a two-phase study in 2006, which involved in-depth interviews with 15 midwives and a postal survey of 562 midwives identified as working in the National Health Service (NHS) (Kirkham et al., 2006). The researchers found that midwives stayed in midwifery because they enjoyed their job and were proud to be a midwife. When asked 'what keeps you going?', the top-ranked answers were work colleagues, supportive partners, and a positive outlook, reiterating the importance of

[9] The most recent New Zealand midwifery workforce survey with adequate numbers of midwives responding to this question (n:1152 part time midwives out of a total 3122 midwives holding a practicing certificate in 2017).

support and relationships outside those formed with the wāhine/women and their families. Enjoyment and love of the job were defining themes of the study throughout both study phases. Participants described midwifery in favourable terms and felt it was a crucial part of their identity. Another central theme running through the study was that "the good days outweigh the bad"(p.20), identifying that there can be a delicate balance between staying, enjoying and loving midwifery or leaving practice (Kirkham et al., 2006).

In Australia (Sullivan et al., 2011), midwives stayed in the profession because they enjoyed their job, stated they were proud of being a midwife and found job satisfaction. Sullivan, Lock and Homer replicated the 2006 Kirkham study to investigate why Australian midwives stayed in their jobs, with similar findings to the more extensive study (Kirkham et al., 2006). Relationships with colleagues and wāhine/women were highlighted as a significant factor in staying in practice. Practising in a way that supported wāhine/women fully and created meaningful relationships was a significant source of job satisfaction. Midwives may also stay in practice by having time out of their career- 47% reported taking between one and 25 years out of midwifery practice, a quarter of these were to take care of children. However, many did not specify their reason for time out (Sullivan et al., 2011).

Versavel in Ontario, Canada also adapted the more extensive Kirkham study to explain why midwives stayed (2011). The findings were consistent with the UK study, although there were some vital differences- Ontario midwives found their work more enjoyable as their career progressed, rather than less. This was a finding from the quantitative phase of their research and not further elaborated on. Fifty-nine percent of midwives in this study had been practising for five or more years, providing a more solid perspective on why midwives stay in the profession. The study briefly touched on the fact that partners, families and colleagues were important support mechanisms that supported midwives to continue to practice (Versaevel, 2011).

Another study used grounded theory asking why midwives stayed in their jobs in Western Australia, interviewing and analysing data simultaneously (Bloxsome et al., 2020). In this case 14 midwives were interviewed, with the core finding that midwives loved being midwives, describing the profession as "who they were" and linking their job with their

identity. This finding is consistent with other more extensive studies (Bloxsome et al., 2019; Kirkham et al., 2006; Versaevel, 2011). While the midwives could not define what they meant by love, they used the word frequently throughout the study, describing the pride and passion they take in their work, stating they see it as a 'calling' rather than merely a job. Midwives saw midwifery as a profession that defined them for life, even when they were no longer working. The research highlighted the midwives' relationships with wāhine/women, but also relationships provided support, camaraderie and kept midwives going. This was not limited to midwifery colleagues alone but doctors and support staff (Bloxsome et al., 2020).

2.3.1 Early career midwifery

There is little research identifying why midwives have different motivations and factors influencing their decision to stay in midwifery practice at different times in their careers. Sheehy, Smith, Gray and Homer focussed their research on one time period- their definition of early career period, six to seven years post qualification (2021). Twenty-eight midwives underwent semi-structured interviews to determine what influenced their workforce participation Findings were consistent with research that investigated why midwives stay in the profession at any career stage, which was support from colleagues and managers. However, a finding not noted in other studies was that midwives valued out-of-work socialisation with colleagues to influence workforce participation. This may have been categorised under general support in other studies; however, identifying these separate support modes is useful. Midwifery as a vocation was also a significant theme. The authors found that, in this study, satisfaction in the workforce does not mean eliminating the factors which made midwives dissatisfied, instead, factors that positively influence workforce participation also assist in retention. To work to their full potential, midwives needed support with continued professional development and career progression strategies (Sheehy et al., 2021).

2.3.2 Safety in the status quo

As well as looking into different points in a midwives' career as individuals, much can be gained from looking at midwives' perceptions when their institution is going through a

period of change. Continuity of care was advanced as a way forward for midwifery in the UK and researchers began looking at the midwives' response to the idea. Appreciative inquiry was used as the methodological approach when exploring midwives' perceptions of a potential change in working patterns which provided greater continuity of care for wāhine/women (Sidebotham et al., 2015). Midwives struggled to visualise the benefits of potential change. Researchers suggested midwives had reached a passive acceptance of the status quo, limited by the structure and processes of the employing institution. This research sought to discover the potential strengths of a system change and found a general mood of negativity within the organisation.

2.3.3 Resilience

Resilience was seen as an attribute that midwives built up over time in practice; however, others saw it as something they had inherently. Self-awareness played an essential part in building resilience, and midwives found they used support from others to build their sense of resilience and help others. Resilient strategies may be seen as an emotional withdrawal to cope with work, which was mentioned in this study, but not investigated further (Crowther et al., 2016).

2.4 Aotearoa/New Zealand Context

Aotearoa/New Zealand has a unique maternity system, where 94.2% of wāhine/women who registered with a Lead Maternity Care provider in 2017 chose a community case-loading midwife as their primary carer. A small number choose an obstetrician or general practitioner as their primary maternity carer (Midwifery Council of New Zealand, 2017). Midwives who work in hospitals can be compared to other hospital-based midwives overseas. However, the difference is the unique way that hospital midwives work with community case-loading midwives and supported by legislated autonomy which is not the case in other countries must be considered.

In Aotearoa/New Zealand, literature exploring why midwives stay in their profession has not been conducted to a great extent. Much of the research is focused on community case-loading midwives, though more research is emerging on hospital midwives. Hospital

midwives may have a different outlook on what keeps them in midwifery, hence the reason for focussing on those who work in a hospital setting in this study. Midwives who provide continuity of care experience continuous relationships with wāhine/women and their families from booking until six weeks after birth, unlike the episodic care provided by midwives who work shifts in a maternity unit. In a study based in the UK, community midwives found sources of job satisfaction that hospital-based midwives did not find to the same extent (Crowther et al., 2016). Therefore, job satisfaction is possibly different for community case-loading midwives and for hospital midwives.

2.4.1 Hospital midwifery in Aotearoa/New Zealand

Comparisons between hospital-based and community-based midwives have been explored further in Aotearoa/New Zealand research. Employed midwives are more likely to have moderate to severe anxiety levels than self-employed midwives and higher levels than the general population (Dixon et al., 2017). Aotearoa/New Zealand midwives undertook an online survey and were asked to identify their work status, as either employed, self-employed, or both. The researchers identified the category 'employed' as 'generally shift work', working within an institution. This study found stress and anxiety high for all midwives; however, exclusively employed midwives revealed their sense of lower levels of autonomy, professional recognition, and empowerment. The researchers suggested that community case-loading midwives were less likely to experience stress and anxiety due to the nature of the caseload model, having supportive practice partners and a greater sense of autonomy and flexibility in their work. Interestingly, the researchers found that caseload midwives aligned with wāhine/women, whereas hospital midwives aligned with the institution. Furthermore, in the analysis of the data, midwives who work shift work identified higher anxiety levels because they could not provide wāhine/women-centred care (Dixon et al., 2017).

Welfare explored the experiences of midwives in Aotearoa/New Zealand who had transitioned between hospital and community case-loading midwifery in the previous two years (2018). Nine midwives were interviewed, with the main finding being that transitioning work settings was a way of sustaining their practice in the current maternity system in Aotearoa/New Zealand. Midwives also found positive relationships with the

wāhine/women, as well as support from family, colleagues, and managers in their work setting, important to remain sustained in the profession. The decision to change work settings was often motivated by lack of support, bullying in the workplace, poor renumeration and family commitments. Midwives transitioned to 'find the ideal way of working' (p.93), needing to juggle internal and external factors to remain sustainable. The researcher found transitioning workplaces allowed midwives to navigate their own stressors, to maintain physical and mental wellbeing (Welfare, 2018).

An unpublished thesis by Wynn-Williams in 2006 explored what it was like to be a hospital midwife in Aotearoa/New Zealand, and the relationships they develop with the wāhine/women they care for. The researcher was motivated by a lack of research into hospital midwifery. Four hospital midwives were interviewed using interpretative phenomenology to inform the findings. The study found hospital midwives in Aotearoa/New Zealand chose to work within an institution because it suited them and their families. Midwives developed three-way partnerships with wāhine/women and their community case-loading midwives, with an appreciation of when to step in or stand back, respecting and supporting the wahine/woman relationship with their chosen community case-loading midwife (Wynn-Williams, 2006).

In Aotearoa/New Zealand, it appears that hospital midwives who work within the institution are sustained in their work through developing skills valuable to their work and the pace of the job. The study by Gilkison (2017) that interviewed 22 hospital midwives working in various areas and workplace settings across Aotearoa/New Zealand focused on the skills required for their work's fast-paced and ever-changing nature. Being able to develop rapport quickly with wāhine/women and their families and the skills required to respond to changing situations were factors that hospital midwives found sustained them in their work on a day-to-day basis. However, these were also factors which challenged hospital midwives, claiming that there were limits to their flexibility. Having control over a consistent working environment also sustained the midwives in this study, rather than filling gaps in particular working areas where they may not enjoy or feel confident. Midwives taking leadership roles felt they could create the environment and influence the culture of the birthing unit, therefore not just sustaining themselves in their work but potentially influencing other employees. Gilkison et al. focused on the skills sustaining hospital midwives in their work. They did not explore external factors that studies in other countries

have explored, such as relationships outside of the workplace or remuneration (Gilkison et al., 2017).

2.5 Identification of gap in the literature

Research exploring why midwives leave the profession abounds internationally and within an Aotearoa/New Zealand context. There is significantly less literature regarding why midwives stay in the profession or what they find are positive aspects of their work.
This literature review identifies a gap in the literature around the strengths of hospital midwifery and the reasons midwives give for choosing to work in an institutional maternity facility. This research is designed to capture the strengths and motivations for staying in the profession in Aotearoa/New Zealand as a hospital midwife. The next chapter will consider the study's methodology and research design.

Chapter Three: Methodology and Research Design

3.0 Introduction

This chapter examines and justifies the choice of research methods and qualitative methodologies used. The decision to use qualitative descriptive with an appreciative inquiry lens and the process that led to this decision are examined. The research methods, including the recruitment, and the selection criteria of participants and data analysis are explained. Ethical considerations, including the principles of Te Ti Tiriti o Waitangi are acknowledged and the importance of these are discussed. The importance of acknowledging reflexivity and bias is discussed, and rigour is considered in relation to this research.

3.1 Methodology

A qualitative approach was considered the best approach to meet the aims of the research question. Qualitative research provides data that is rich with description, acknowledging the lived experiences of both participants and researchers. The outcome is not a single answer, but more detailed descriptions and interpretations of the chosen aspect of the research (Braun & Clarke, 2013). Qualitative research is based around the intention of generating knowledge which is grounded in human experience, described as providing a window to aspects of life that would have remained unknown to those who have no knowledge of the research topic, or a mirror in which to look back and reframe experiences to those who have personal experience of the topic (Sandelowski, 2004). This idea of reframing feels particularly pertinent in this research, as findings are not professing to be generalisable. Qualitative research needs to add insight, bringing new knowledge beyond what is known (Thorne, 2020). From these personal insights gained in qualitative research comes practice-based evidence, that is increasingly being used in healthcare policy and practice (Leeman & Sandelowski, 2012).

To guide the research process, a methodology directs the way a question is answered by defining the theoretical underpinnings (Anfara, 2008). The aim and scope of the study needs to be considered, and a methodology that will direct the strategy used to obtain knowledge-focussing on the phenomena initially, and matching this to a suitable methodology (Krauss,

2005). A qualitative descriptive methodology, to describe and interpret themes obtained from the data, was considered appropriate for this project. Qualitative descriptive methodology is suited to a master's project, giving the methodology a straightforward approach (Smythe, 2012). I incorporated this with another methodological stance, appreciative inquiry, as I will explain below.

I explored appreciative inquiry (AI) as a methodology, feeling this fit my research well at the time. Appreciative inquiry is a narrative-based process, which is based on the belief that focussing on positive aspects of a system to bring about change proliferates positivity, rather than the traditional approach of identifying problems to bring about change (Fitzgerald et al., 2003). Through using AI, the researcher recognises that focussing on problems within an organisation are unlikely to result in their reduction (Bellinger & Elliott, 2011).

Appreciative inquiry is seen to empower and motivate both researcher and participants. Embarking on a project with a positive mindset also appealed to me as a researcher. As the project progressed and interviews were conducted, it became clear that AI was difficult to use as a standalone methodology in this context. I will describe the methodological process of AI, and then follow with how I came to incorporate this into my research as a lens, rather than a standalone methodology.

AI is a cyclic methodology, which guides the research process, and the way participants are interviewed. There are four key stages in this process- discovery, dream, design, and destiny, or the '4-D cycle'. Using these alongside the principles, which provide an in-depth, theoretical view of AI, gives the researcher a guide from which to work with (Cooperrider, 2008). Figure 1. The 4-D cycle of appreciative inquiry (Cooperrider, 2005) provides visual representation of the 4-D cycle.

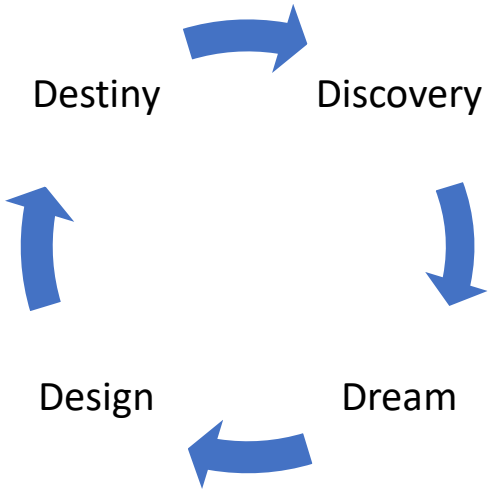

Figure 1. The 4-D cycle of appreciative inquiry (Cooperrider, 2005)

To begin with, in the discovery phase, researchers and participants appreciate and value the best of 'what is' (Cooperrider, 2008). In the 'discover' stage, emphasis is placed on the initial contact and opening enquiries, with this phase of the process drawing on the constructionist and simultaneity principles of AI. The constructionist principle acknowledges language, communication and relationships establish our meaning and identity, while the principle of simultaneity realises participants begin thinking of change and growth while discovering strengths (Whitney, 1998) . This phase began with the initial meeting of the midwives involved in the project, acknowledging the importance of the initial contact and first interview questions asked, emphasizing the need to set the tone for the rest of the process. In this context midwives described the influences that kept them in the profession, describing what have been highlights of their career so far, and the motivations that midwives have for staying in the profession.

The next phase, dream, envisions 'what might be'. Where AI diverges from other methodologies is that the researcher enables participants to look at past strengths and high points, to look forward to the future, creating positive potential from the past (Cooperrider, 2008). Here the interview turned to what could facilitate midwives to stay in midwifery- looking towards positive potential rather than problems to be fixed.

The design phase dialogues 'what should be'- being able to be expressed by realising the potentials created in the dream phase. Here the researcher and participant work together to co-construct a potential positive future (Cooperrider, 2008). Here during the interviews

midwives were asked what needs to be implemented to achieve the goals and dreams set out in the dream stage.

The next phase, destiny, leads on from this, asking 'what will be', and sustaining what was created in the design phase (Grant & Humphries, 2006). In context of these interviews, it was difficult to conduct this step, as it felt this was a step midwives would take after being interviewed.

I discussed my challenges incorporating this step into my interviews while attending a postgraduate research school at Victoria University of Wellington. It was suggested here that I consider using qualitative descriptive with an appreciative inquiry lens. I deliberated this with my supervisors, feeling that the suggestion made sense, but would also take away the essence of the project. It was becoming evident that the chosen methodology was not being held true, with methodological congruence becoming slightly confused (Smythe, 2012). Commencing analysis made the decision clear- there was an overwhelming feeling from midwives of dissatisfaction within the institution, which strayed from one of the main concepts of AI, focussing on problems unlikely to bring about change.

The interviews had been conducted, staying true to the principles of AI, however midwives discussed in depth their negative experiences as well, which, due to the semi-structured nature of the interviews, were not encouraged, but not cut short either.

Grant and Humphries found a potential limitation of AI was trying to steer participants away from any negative threads in their interviews. They stated that focussing only on the positive may have lost crucial elements in their research. Disallowing negative stories may also have reduced engagement and trust from participants (Grant & Humphries, 2006). To lessen the impact of this limitation, Bellinger and Elliot state negative stories need to be incorporated into the research, and that there may be some benefit to allowing participants to recall their worst experiences, along with their best (Bellinger & Elliott, 2011). This is the position taken in this research, acknowledging the whole of the midwives' experiences.

3.2 Research Design

This research was carried out, keeping in mind the process of qualitative descriptive AI. In this section I will discuss the setting, participants and justification for the selection criteria.

Details of the recruitment strategy is discussed. I will follow with the interview process, including details of the pilot interview and questions asked.

3.2.1 Setting

This research was carried out in Aotearoa/New Zealand. I have discussed in the introduction chapter the different settings midwives may work. Midwives were employed by, what was known then as District Health Boards (DHBs), but have changed since data collection to Te Whatu Ora, which has merged the functions of the DHBs to provide consistency and continuity of health service across the motu/country (Te Whatu Ora, 2022).

3.2.2 Participants

Participants were hospital midwives who were currently employed in a clinical role in a maternity unit in Aotearoa/New Zealand. The selection criterion for participants was that they were required to have been qualified at least eight years. This was decided on in order to interview 'experienced' midwives. The average length of service of a midwife in one hospital was 7.8 years (Technical Advisory Services, 2018), and as this was the only statistic available this became the evidence used to create the criteria for inclusion. Midwives were not required to have worked exclusively as a hospital midwife and may have taken time away from midwifery with maternity leave or sick leave. Six midwives were interviewed, with obvious recurring themes and data saturation was evident by this stage.

3.2.3 Sampling

Sampling in qualitative research is determined by methodological approach, rather than the need to achieve results that are generalisable to the population (Higginbottom, 2004). The emphasis in qualitative research is placed on obtaining information-rich data (Braun & Clarke, 2013). Boddy states that a sample size as low as one participant may be justified, and researchers may have all the data they require from one interview (2016). Sampling in qualitative research is purposive, selecting participants who will be able to provide the

information rich data required, and meet requirements of the research question (Young & Casey, 2019).

Purposive sampling was used to ensure participants met the requirements of this study. Inclusion criteria were- having been registered as a midwife for at least eight years, currently working clinically in a maternity unit. Purposive sampling is used rather than random sampling, where participants may not meet the criteria for the study. This also ensured participants who enrolled to be involved in the research were aware of the interview process and aware of the time involved.

3.2.4 Recruitment

Participants were initially recruited by posters in a secondary maternity unit in the lower North Island. They were also recruited via word of mouth, and then when the sample group was not large enough, more participants were obtained via referral from other participants. This enabled a cross section of midwives who worked in several maternity units in different localities in Aotearoa/New Zealand. Demographic data was not deliberately collected, as this was not seen to be detail that would enhance data collected. Six midwives were interviewed for this research.

3.2.5 Pilot interview

Data collection began with a pilot interview, and followed with further interviews, face to face or via Zoom. A pilot interview was conducted face-to-face prior to commencing the rest of the interviews. This was to practice my own interview skills and the suitability of the interview questions (Teijlingen & Hundley, 2002).

The pilot interview was carried out with the same ethical responsibilities as required for the subsequent interviews, with a midwife who met the criteria for the study. This was a valuable process, with the pilot interview taking less time than I had predicted. In addition, after the recording devices were turned off conversation continued, which may have been valuable data, which was not captured. From the learnings of this pilot interview, I introduced an opportunity for midwives to add further thoughts at the end of the interview. I also re-stated the research question at this point to bring the thought process back to the

research topic. The pilot interview also gave me an opportunity to become familiar with using recording devices and where note taking was appropriate.

3.2.6 Interviews

Face to face, one on one semi-structured interviews were used, and utilising AI in this context informed the type of questions used. AI requires the interviewer to ask prompt questions that are framed in a positive way, to obtain information about what is working well (Norum, 2008). Interviewing research participants face to face gives the potential to gather richer data, reducing the need for a larger sample size (Braun & Clarke, 2013).
The interviews were conducted in a private space agreed on by the participant and me. After the pilot interview, it was suggested to me that I conduct interviews via video conferencing if this suited the participants and would also protect the interview process if COVID-19 restrictions interfered. When this was offered as an option, all but one of the participants opted for interviews via video conferencing, using Zoom as the chosen platform. Zoom interviews have become more popular, and COVID-19 restrictions have amplified this. Advantages were accessibility and convenience- participants were able to more easily choose a time that suited them and not consider travel time. Accessibility for myself as researcher, living rurally with a family was an advantage. Disadvantages include the nuances of in-person interviews are lost, with potential to become distracted more easily. Technological issues are also a potential issue, although emerging research suggests participants often prefer this method of interview over face to face interviews (Archibald et al., 2019; Oliffe et al., 2021). I found one interview in particular a challenge, with an unplanned internet outage caused by construction works.
Interviews were planned to be 45 minutes, with one hour being allowed for extra time. Two recording devices were used, to provide reassurance in the case of any technical malfunctions. A Livescribe Echo® Smartpen was used to record all interviews, as well as a recording application on my phone, or in the case of Zoom interviews, the audio was recorded onto file. These were stored in password protected files on my personal password protected computer.

3.2.7 Interview Questions

Interview questions were based around the principles and 4-D cycle of appreciative inquiry. These took on a semi-structured approach, with five prompt questions to steer the interviews in the direction needed to answer the research question. Semi-structured interviews do not rigidly adhere to the order of questions asked, and wording of questions may differ, requiring the interviewer to flexible (Braun & Clarke, 2013).

The first question is often a broad inquiry, to build the participants' narrative (Galletta, 2013). Here I asked about the midwives' work history, as they had all been qualified at least eight years as I thought this would open the dialogue.

The information gathered here was not directly used in the data analysis, however it was drawn upon later in the interview when relevant. Qualitative research interviews are often progressive, with insights gained in previous interviews used to improve questions (Teijlingen & Hundley, 2002). Midwives interviewed often began discussing information that answered subsequent questions, which would negate the need to ask those particular questions later. I found it easier to follow the lead of the participant as I became more confident with interviews, and less likely to feel thrown off track when conversation took a different direction to that of my interview guide. As Rubin and Rubin state, an ideal qualitative interview is "on target while hanging loose" (1995, p.42).

3.3 Data Analysis

Data was analysed in steps, beginning with transcription, familiarisation with data, then coding data, searching for themes, reviewing these and going on name and define themes (Braun & Clarke, 2013). Here I will outline these steps with the relevance to this research.

Thematic analysis seeks to identify themes across a data set, looking at the data as a whole and the way the topic is talked about, rather than focussing on single items of data (Braun & Clarke, 2012). This allows links to be drawn between two or more different fragments of text where there is common ideas or phenomenon, rather than searching for the same wording (Fugard et al., 2020).

3.3.1 Familiarisation

Transcription is included in the data analysis phase, as there is not always a clear separation between data collection and data analysis. Qualitative researchers are able to notice emerging themes and draw deeply into the participant's experience when transcription is carried out after each interview (Braun & Clarke, 2013; Galletta, 2013). I began to take note of recurring themes and would take notes and highlight what I felt was relevant as I transcribed data.

Transcription was a time-consuming process, however I felt this allowed me to begin to become very familiar with the data. I then began familiarising myself with the transcripts, reading these though multiple times and taking notes as I went. Braun and Clarke describe this as immersion in the data and reflection on what you bring to the data as a researcher (2013).

3.3.2 Generating initial codes

Coding involves breaking down raw data into units, preparing for the next step of analysis (Steen & Roberts, 2011). Coding occurred during and following familiarisation with the data and note taking began to generate codes across the data. Coding was complete, across the entire dataset, identifying everything that was relevant to the research question (Braun & Clarke, 2013). Transcripts were printed out, and I highlighted these as I read them, taking notes in the margins, suggesting codes as I went.

3.3.3 Searching for themes

Searching for themes represents patterns emerging from the data, forming some shape in a analytic process (Braun & Clarke, 2012). Braun and Clarke describe searching for themes as an active process, with analysists making decisions on how to shape and craft what is found in the data, rather than a passive endeavour (2012). Categorising the codes generated from the raw data commences in this step (Steen & Roberts, 2011). Codes identified were printed out, with different coloured paper for each participant. These were then cut out, and

organised into broad initial themes, swapping, and changing multiple times as the themes were refined. This was a lengthy process and produced a number of themes which were refined as I reviewed themes in the next step.

3.3.4 Reviewing potential themes

Reviewing themes involves going back to the data set and checking themes against the set. This step involves quality checking the themes that have been generated and ensuring that what is contained within that theme is coherent and relevant to the research question (Braun & Clarke, 2012). An example of the data analysis process, from interview dialogue through to final themes, is shown in the table below.

Dialogue	**Code**	**Code grouping**	**Sub-theme**	**Theme**
I love helping the women *I just really like being with the women* *I'm there to help the women*	Helping women	Women	Nourishing for women and midwives	Midwife heart and soul

Table 1. Example of thematic analysis

This process was a continuation (as was the whole method of data analysis) from the last step, visually reorganising codes into themes, and going back and forth to the original transcripts for more clarity. At this stage I still had more sub-themes than overarching themes, which meant I needed some assistance from my supervisors going forward to further define my main themes.

3.3.5 Defining and naming themes

Defining themes sets out what is unique about each theme and set boundaries within that particular theme (Braun & Clarke, 2013). To clearly define themes, I met with my

supervisors as my data was still grouped into many sub themes with a lack of coherence between them. With three sets of eyes, we were able to name four main themes and group sub themes under these, adding and discarding some sub themes as we went. This also involved 'looping back' to the transcript, finding further meaning, recognising that qualitative data analysis is not a linear process (Galletta, 2013).

3.3.6 Producing the report

The final step of analysis- writing the report- links research findings to the literature (Braun & Clarke, 2012). This brings together the thesis, with the discussion centred on providing a clear story for the reader.

3.4 Te Tiriti o Waitangi

When considering Te Tiriti o Waitangi (Treaty of Waitangi) in research and health, the principles of partnership, participation, and protection have been traditionally used to guide protection of Māori rights (Hudson & Russell, 2009). These principles are useful as the basic guidelines, that can be expanded upon to incorporate the more relevant articles of Te Tiriti o Waitangi and provide a base from which researchers can use to ensure they are protecting Māori rights in research. Increased transparency and accountability provides greater autonomy between researcher and participant, in turn leading to heightened trust between both parties (Hudson et al., 2010). Here, the concept of whanaungatanga stands out- described as "the active process of building relationships through shared experiences and connections"(Berghan et al., p.19, 2017).Te Herenga Waka/The Victoria University of Wellington statute regarding the Te Tiriti o Waitangi applies to all members of staff and students at the university. The principles set out in this statute relate directly back to the articles of Te Tiriti o Waitangi, setting guidelines from which to work (2019). These principles ensure Māori collective rights are respected, recognised and protected, as well as involving Māori in the research process (Hudson & Russell, 2009). I consulted with my local District Health Board Māori Research Group and gained endorsement to commence recruitment and data collection with a recommendation that I had completed the

organisation's Tiriti o Waitangi education, which I had undertaken in 2019 (see Appendix E: Local Māori Research Review Group endorsement).

3.5 Ethical Considerations

Ethics approval was sought and granted from the Victoria University Ethics Committee (Appendix C: Ethical approval). I had also consulted with the Mid Central District Health Board Research Support Office and was approved to commence research within the DHB (Appendix D: Local District Health Board ethics approval). Protecting the participants' identity in this project was a significant matter, as is the case in any research, however, due to the small community of midwives in New Zealand, experiences discussed by midwives may be easily identified. Wynn-Williams discussed confusing demographic details of the midwives interviewed, to reduce the likelihood of identification of midwives in the study (2006). This is one option to preserve anonymity. Lathlean discusses the complex issue of attempting to preserve anonymity in qualitative research, and states at times it may even be inappropriate to guarantee this (1996).

Confidentiality was discussed with the participants throughout the research project, and participants were given the choice of whether they disclose they have been involved in the research or prefer not to be identified. Their information was not shared beyond discussing my research with my supervisors.

Because midwives work together regularly, it was anticipated that I would know some participants on a more personal level. Braun and Clarke discuss this issue, and state that information must be limited to what is shared in the interview (not using information already known from other sources), keeping information shared in the interview confidential to the interview only, and being sensitive to any possible power relationships that pre-exist (2013).

Clearly documenting these potential issues in the participant consent form and reiterating the concern of anonymity at the start of the interview ensured the participants were aware of these issues.

Other methods of protecting identity and preserving confidentiality include not discussing specifics of my work unless in a safe environment and using pseudonyms chosen by the

participants. All audio, interview notes and transcriptions were kept on a password-protected computer or locked cabinet.

Power imbalance during the interview process may present an issue. Braun and Clarke discuss the notion that the interviewer may be seen by the participant as an 'expert' on the subject, and therefore have a power-over relationship (2013). AI strives to balance this power imbalance, by liberating power and enhancing participants' confidence, empowering participants to confidently participate in the research and giving freedom to be heard (Cooperrider, 2008).

Other ethical considerations that need to be made are those of consent. Once participants registered their interest, they were given a consent form outlining the research process and be made aware they can withdraw at any time. Along with a consent form, a detailed information sheet was given, outlining the nature of the project, and how results will be used. Transcripts were offered for participants to read over, both for accuracy and to ensure the participants accept what may be published. One participant requested this, with the others happy to read the report once the research was complete.

When using AI principles to interview participants the questions are framed positively, to elicit a positive response. Therefore, I was not expecting to delve into any traumatic or negative experiences the midwives may have had, however, it must be acknowledged that it still may be an emotive topic for some. Therefore, I had available debrief options should the midwives require this.

A pilot interview was conducted with a volunteer, which informed me of potential problematic questions and enabled feedback. This was reviewed as the interviews progress, and assessment made after each interview. A personal record was kept throughout the process, reflecting as the interviews progressed.

3.6 Reflexivity and Bias

Reflection of the interviews formed an aspect of my self-awareness of my role in influencing the data. Reflexivity addresses this self-awareness, recognising that what is found in the research process is subjective to the researcher, and the importance of the researcher recognising this and how they may have influenced findings (Finlay, 2002). Reflexivity can be categorised into two forms- functional and personal reflexivity (Braun & Clarke, 2013).

Functional reflexivity acknowledges how research tools and processes may influence the research- this could be appreciating Zoom calls may provide data which differs to that collected in a face-to-face interview. Personal reflexivity is the acknowledgment and visibility of the researcher in the research (Braun & Clarke, 2013). I came to the interviews with pre-conceived ideas of what hospital midwives would think the strengths of working within an institution were, having worked my entire career as a midwife within an institution, which is an example of personal reflexivity.

I noticed some interviews were easier than others, sometimes unexpectedly. I found I may have formed a good rapport with a participant prior to the interview, but during the interview found the participants harder to draw information and struggled at times to keep conversation flowing. This may have affected the data obtained, with a reflection from one interview that felt challenging-

> *Just when I thought I'd become really good at interviews- this one grounded me! I think this was a combination of me feeling really rubbish that day and the participant not having the same 'dream big' mentality of the previous [interviewee].* (Personal reflection, 2021).

Reflecting on how I felt on those days is useful as well- my input had an impact on how the interview played out and outcome of the findings. Other interviews felt more relaxed, and even with technological difficulties during Zoom calls, were easy to pick back up and carry on.

Through reflective research, subjectivity becomes more evident. Researchers bring their own assumptions, perspectives, and mannerisms, as well as personal and cultural history, into their research. This generates subjective, rather than objective research (Braun & Clarke, 2013). This subjectivity may lead researchers to accept evidence that conforms to their hypothesis and prior beliefs, which could be seen as bias (Mantzoukas, 2005). As discussed throughout this chapter, this research introduced deliberate bias through the methodology, as AI strives to focus on the strengths of a research topic.

3.7 Rigor

Trustworthiness of qualitative research can be assessed through acknowledging the validity, reliability and generalizability of a particular study (Morse, 2015).

Braun and Clarke say the more rigorous the research process, the more trustworthy the findings, and in terms of qualitative research, the researcher must acknowledge that they influence the results (Braun & Clarke, 2013). The researcher can influence the research process, however exactly how this has happened may not be apparent until the research is complete. Keeping a personal research journal assisted in reflecting on the research process, as well as documenting methodological and ethical issues encountered in the research process which may not be apparent from the outset of the research (Annink, 2017).

Validity can be defined by asking "can the description be recognized by others who have had the experience, or appreciated by those who have not had the experience?" (Morse, 2015). The small population and limited area in which the research was carried out meant that results cannot be generalised across the population. However, the findings may resonate with other midwives in similar working environments.

This was combined with regular discussions with supervisors regarding coding and categorization into themes..

3.8 Summary

This chapter discusses how the research design and methodological approach was used to answer the question "what do New Zealand midwives say about working in maternity facilities?". The methodological approach used is examined, and how this was adjusted to accommodate findings as data collection progressed. The way appreciative inquiry was used as a lens, alongside qualitative descriptive is explained and the benefits and rationale behind this. Ti Tiriti o Waitangi is discussed, with ethical considerations and reflexivity, bias, and rigour. The following chapter details the findings and themes that emerged from the interviews.

Chapter four: Findings

4.0 Introduction

The four main themes and sub-themes that emerged after analysis of the interviews will be discussed in this chapter. Direct quotes from participants will be used to illustrate each theme.

The four main themes are **midwife heart and soul**, **advancing practice role**, **work-life balance** and **tension in the institution**. These four themes also contain a variety of related sub-themes, which emerged as data was analysed and organised into themes.

The first theme of **midwife heart and soul** has four sub-themes. These were *valuing moments of care*, where midwives valued the time spent with wāhine/women, regardless of the length of time; *nourishing for midwives and women*, exploring the idea midwives felt there was an element of reciprocity in caring, they gained a sense of satisfaction when they could support the wāhine/women; *bloom where you are planted*, which showed midwives felt they could grow through working in potentially difficult circumstances; and *a sense of agency*, midwives felt their work gave them a sense of satisfaction that also gave them the confidence to believe they were skilled in their work.

The second theme, **advancing practice role,** explored the ways midwives enjoyed the diversity and progression their chosen career brought them. The midwives appreciated their specialist midwifery knowledge, as well as skills they had gained through advanced practice roles. The four sub-themes were *learning and teaching*, *possibilities of extension*, *complexity clinical* and *teamwork in a skilled emergency response*.

Work-life balance was the third theme identified. Four sub-themes were as follows; *control over work-life balance*, midwives discussed how they found having a sense of control in various aspects of their lives helped their home lives; *boundary setting*, midwives felt setting boundaries in their work lives was essential to protect their lives outside of work; *choice*, midwives talked about having choice in their job sustained their midwifery career; *expectations of hospital midwifery*, midwives discussed what their expectations of hospital midwifery had been before becoming a midwife or working in a maternity unit, and how this had changed.

The fourth theme was **tension in the institution**. Midwives discussed where they felt their careers were being held back and how the institution contributed to these feelings. Three sub-themes emerged: *politics*, *powerlessness* and *limiting of autonomy and growth*.

4.1 Participants

Six midwives were interviewed for this research; all had been registered as midwives for a minimum of eight years and were currently practising as hospital midwives. Five midwives had graduated from Aotearoa/New Zealand academic institutions with a Bachelor of Midwifery, and one had qualified as a midwife through a postgraduate pathway with a nursing background. They all continue to practice as hospital midwives within their respective institutions. I will use the words of these midwives to illustrate the themes and subthemes found. Pseudonyms are used to protect the participants' identity.

4.2 Midwife heart and soul

Throughout the interviews, midwives expressed their connection to the midwifery profession and the wāhine/women and whānau/families they worked alongside. This is where midwives felt they valued themselves as knowledgeable practitioners. Their knowledge nourished wāhine/women and whānau through the effects of high-quality care. At the same time, the effective care reflected on and nourished the midwives. This is, in my opinion, the heart and soul of midwifery, the most deeply felt and joyous moments of connection for midwives. They felt empowered in their work and making a difference in wāhine/women's lives was a source of great satisfaction. Reciprocity was a factor in this theme of 'heart and soul': midwives found being able to form a connection and provide the care they felt was contributing positively to the wāhine/women's maternity experience gave them satisfaction. They described this satisfaction as a reason they enjoyed their work and something they would look forward to when coming to work.

> *I just try and, every now and then, remind myself that what is important is me and that woman. And all the other stuff, you know, once you're in the room with the woman, that other stuff doesn't matter. So that's what you need to focus on because it's the heart of it* (Barbara).

Midwives recognised the need to appreciate these moments and acknowledged that their care may only be for short periods of time, as discussed below.

4.2.1 Valuing moments of care

The midwives interviewed acknowledged they provided episodic care and not a continuous relationship with wāhine/women. Still, they expressed they could provide valuable care to the wāhine/women. When talking about what she found satisfying in her work, Donna enjoyed "*forming a trust relationship with somebody, be it however short or long that episode is for".* Barbara and Anna expressed satisfaction in moments of care were an important part of the wāhine/women's care *"I'm happiest when I'm in that moment… and providing whatever it is she needs"* (Barbara) *"just being there at the time of need"* (Anna). Midwives described more specific moments of care they valued, and Barbara articulated this by describing a change in her workplace that meant she provided more labour and birth care for wāhine/women, followed by a realisation:

> *I was quite excited initially because I thought, 'Oh, well, you know, I'll catch a baby'. And like that was going to fulfil something that was missing… so I did a few. And it wasn't amazing. I mean, no, it was amazing, but it wasn't more amazing. And I just realised; actually, there are so many moments that are amazing that I can make a difference that are relevant. And the birth is just another one of those moments*.

Julie reiterated this, describing a moment of connection that she valued *"You can make a massive influence on someone's life in ten minutes, and you can affect them more than their nine months with their midwife LMC[10] because you connect to them or say something that changes their life".*

The midwives felt these moments made their hospital midwifery role satisfying in a way that was different to community case-loading midwifery practice, recognising the importance of their input in wāhine/women's maternity experience. These valued moments were also opportunities to nourish midwives and wāhine/women, forming a reciprocal relationship, as outlined below.

[10] LMC refers to Lead Maternity Carer. This is a funding model, set out by Section 88, which may include midwives, General Practitioners or Obstetricians.

4.2.2 Nourishing for midwives and women

All the midwives interviewed felt midwifery was a satisfying career and working with wāhine/women to provide the best possible outcomes and support they can. *"I love helping the women", "I just really like being with the women", "I'm there to help the women"* "*focused on the women and making a difference for them"* (Sally, Ruby, Anna and Donna). This was at times clouded with interference from other needs on the ward, but midwives found that working with wāhine/women assisted them in bringing their focus onto what mattered. Ensuring wāhine/women felt comfortable and empowered in an environment that they may not be familiar with was a source of satisfaction for midwives:

> *I love to sit and chat and make people comfortable. I do not use medical terminology… I bring it down to normal English. So that people understand. I'm a huge advocate of people understanding what is going to happen for them* (Julie).

Julie goes on to talk about providing care that demands more from her but provides a greater level of satisfaction:

> *You're walking into someone you don't know in a high-stress situation when they need you the most. And that's the part I actually really enjoy. Secondary care level, secondary level care is because these women need double of us, not half of us, they need double the care, they're going through double the trauma, triple the trauma.*

Ruby continued this theme, appreciating the connection she made with those she provided care for:

> *Tailoring it to the person, engaging with the whanau, actually listening and trying to advocate for this woman you met 30 minutes ago, that's probably the most satisfying thing about being a core midwife, is that instant connection that I have an ability to make.*

These midwives appreciated being able to individualise care for wāhine/women within the institution and valued the quick rapport they could form. Midwives welcomed wāhine/women into the environment they were comfortable in, recognising a need from those who were not.

Nourishing indicates growth for the wāhine/women, their whānau/families and the midwives themselves. This could be assisting wāhine/women in labour *"she can birth her baby better… that would be really satisfying to me"* (Sally) or in the postnatal period, *"I find it really satisfying to help…they just start off so anxious"* (Anna).

Two midwives expressed satisfaction when wāhine/women and their whānau voiced appreciation for the midwives' care. Julie talked about finding a sense of fulfilment when caring for wahine/women experiencing foetal loss *"When you get feedback from those women, who take the time to write and thank you for being that person there, that day… what a difference it made just to hold someone and hug them without speaking".*

Ruby found her midwifery skills were appreciated by whānau/families in more acute settings, which she found a sense of pride in:

> *You feel like you've got knowledge that you can help someone, and especially in an emergency when family and whānau are sitting there going, 'wow, you guys are amazing'. And you're like, 'thanks; we've tried really hard to manage this really well'.*

This satisfaction in having good outcomes for wāhine/women supported the midwives' growth in the institution they worked in.

4.2.3 Bloom where you are planted

The midwives discussed appreciating their chosen career and enjoying their work in sometimes difficult circumstances. 'Blooming where you are planted' indicates midwives making the best of a situation they may not be able to control, but working within their capabilities to enjoy their work, and at times finding this may improve their midwifery skills. Hospital midwives enjoyed what continuity they could maintain with the wāhine/women they cared for, as this is not a given when working shift work and is often seen more as a quality in the community case-loading midwifery model of care. Donna appreciated following up on wāhine/women's care "*I enjoy it when there's women I've been looking after on the ward, and if they're still there, seeing how they've progressed".* Anna valued knowing wāhine/women she had cared for as well *"[It's] really great if you're back there for the next day, or a couple days later, and you know them".* These midwives didn't express a wish to carry on care beyond this point, appreciating their role in providing moments of care and valuing when these could be continued.

Midwives described situations where they had thrived or made the best in a situation that wasn't ideal. Julie and her colleagues coped by making light of these circumstances

> *Having a great day at work is maybe just having one win, baby on the breast or when it's manic... 'We've had a great day girls, cuz nobody died today'. I mean, that's a great day. When you are code red, that you actually get out of there and no one's died. It's dreadful to say, but that's the joke we have.*

Sally found that a busy workload had honed her skills and given her greater satisfaction in her work, even though she recognised it wasn't an ideal work situation. *"I got to the point where I was quite comfortable with that workload and just got into the rhythm of it. I got really work fit, where I could handle the high paced intensity of those jobs"* and goes on to say:

> *I kind of just accepted that, yes, this is bad. This isn't how it should be. But I just kind of started to thrive on working with that… I'd be skipping on my way out of there. I was so happy after my shifts.*

Donna appreciated the team around her when the ward was busy, making a potentially stressful workplace enjoyable "*they've got energy and resilience to cope with that, and they thrive on that, then that can be really fun".*

Going above and beyond what was expected of the midwives, despite dire staffing, supported this feeling of blooming, as well as giving midwives a sense of agency.

4.2.4 A sense of agency

Midwives felt their input to wāhine/women's care enabled them to have a sense of agency and recognised themselves as skilled practitioners in their own right. This came from being invested in skill and knowledge development and sharing. The midwives interviewed valued a sense of control over aspects of their working lives. Julie felt that hospital midwives might be underappreciated but said, as hospital midwives, "*we need to be very clear that we make an impact even in a short period of time".* Anna echoed the importance of hospital midwives' work *"the women in the hospital need good care"*. Ruby valued the specific skills hospital midwives had, elaborating on the feeling of being underappreciated "*to be constantly compared to nursing is a bit undermining because we do, in emergency cares and in delivery suite, a very, very specific role".* Midwives articulated feeling undervalued;

however, they knew the importance of their work and could see that they had a role they knew to be of enormous significance.

The midwives interviewed expressed value in the unique skill set they brought to the profession, which indicated a sense of self-confidence, continuing the theme. This was in a clinical sense, identifying what they brought to the profession individually. Julie articulated this feeling of self-worth *"I think it's very valuable what I bring to the table, and I value myself as a midwife".* Being a skilled practitioner was discussed further by two midwives, who had confidence in their midwifery experience *"we've all got our specialities, and I'm good at what I do"* (Anna). Donna had a role doing less clinical work but wanted to maintain it to a degree as she felt "*I'm quite good at it*".

Learning new skills and making change within an advanced practice role was discussed in terms of bolstering confidence. Anna talked about facilitating a breastfeeding support group "i*t was very fulfilling because it was my first experience in teaching in midwifery. And leading a group, it taught me about the value of a support group…it was empowering".* Supporting colleagues with the advanced practice roles provided a sense of control and empowerment over their working lives. Ruby articulates the point when talking about project work, "*it gives you a sense, when it goes right, that you are doing something and making change".* Donna appreciated assisting colleagues in her management role and recognised that smaller changes are important to facilitate development, *"seeing little steps that more, that make progress".* Barbara valued the support from her colleagues in her advanced practice role "*the majority of them are really appreciative of the time I put in and the changes that have occurred".*

Being empowered in their roles sometimes meant creating opportunities to make change. "*I've had to be creative, which has actually worked out really well"* (Sally). Getting frustrated with systems in place, Anna talks about her colleagues making changes "*I do find the younger ones just thinking, right, they'll go just do things anyway".* She went on to talk about having experience working on the floor as a midwife when collaborating with management:

That's empowering because I think, well actually, in a way, I do know, because I'm working with the women. That's given me a voice, in a way, because I used to be quite kind of quite in awe of those in management.

4.2.5 Summary

This section provided details around the 'midwife heart and soul' theme, where participants discussed their feelings about midwifery in a positive light. The idea of reciprocity came through. Midwives interviewed felt their job caring for wāhine/women and their whānau/families gave them a sense of satisfaction when they provided good care. This was evidenced through sub-themes of midwives valuing moments of care, feeling nourished through their care of wāhine/women, blooming where they were planted and feeling empowered by their work. Having variety in their work supported the midwives' heart and soul, feeling valued by being appreciated in roles outside of their clinical midwifery.

4.3 Advancing practice role

The midwives interviewed appreciated the opportunity for progression in their chosen careers. Four sub-themes emerged from advancing practice role: learning and teaching, the possibilities of extension, clinical complexity, and teamwork in a skilled emergency response. Participants spoke about how they enjoyed using and sharing their midwifery knowledge, wāhine/women they cared for, and the opportunities that midwifery could bring them. They also articulated their satisfaction from participating in a good team response in an emergency.

4.3.1 Learning and teaching

The sub-theme of 'learning and teaching' came through while interviewing the midwives in various ways. They were open to both sharing knowledge and learning from other midwives. Anna explicitly talked about being able to pass midwifery knowledge onto new whānau/families when facilitating a breastfeeding support group: "*they'd all walk out of the room and say 'thank you so much. And I can do this now. And I've learnt a lot', and it was*

really great". Teaching students was a valued endeavour for Julie, passing on clinical skills and the art of practising midwifery: *"if I've got a student and they're in the room bantering away, and I just go like that [mimes shutting mouth] because we are still allowed to sit in the corner and watch".* Anna felt she could also learn from students, which gave her some insight into her knowledge "*you learn from them, and you realise what you need to learn and brush up".*

Learning on the job was a sentiment echoed by Ruby, who valued brushing up on clinical skills "*one of the ACMs, on quiet shifts, she would just test me all the time, and it got me so excited about the weird and wonderful".* Donna felt that learning was one of the aspects of her job that she anticipated *"[I look] forward to some of the mental stimulation that comes".* She talks about helping colleagues in a managerial role *"I might have helped somebody understand something a little bit more".* Anna felt she had gained knowledge from an additional role and was now a resource for her colleagues *"it's really given me a boost in knowledge, and people often will say, look, you know about breastfeeding, can you help".* Sally felt working together and sharing knowledge went hand in hand, appreciating informal moments of teaching and learning, "*I would do any midwifery, I think if I could do it with another person. You can feed off ideas*".

This teaching and learning would potentially lead to an extension of the midwives' clinical roles, as considered below.

4.3.2 Possibilities of extension

While appreciating their work and the variety within that role, midwives explored the possibilities of extending, either within the role they were in, or the prospect of going down a different path whilst staying in midwifery.

Midwives enjoyed the additional advanced clinical practice roles they already had: all the midwives interviewed worked clinically but also had midwifery roles outside their clinical work. Ruby explains why she decided to take on another role "*I get bored very easily. So I was starting to get to the stage where it was like, 'okay, cool, check, what's next'".* Barbara echoes this sentiment "*sometimes.. you feel a bit stagnant on the ward, sometimes it can get a bit monotonous. So it was really good to have an additional role".* Sally found the

additional role suited her lifestyle "*being a casual, I was only getting offered night shifts and it was always really attractive to think of other things I could do as well".*

Midwives chose where they wanted to extend their careers, making sure this was a pathway they had a particular interest in *"when I saw the advertisement [I] thought, 'oh, maybe I could do something out of my comfort zone'. And I'm so glad I did"* (Sally). Barbara was also interested in her advanced practice role before she started *"when the role came up, I just felt that really talked to me".* Ruby had a sense of earning her advanced practice role "*I'm quite pleased that I applied for it, and I interviewed for it... I'd hate to just be gifted a role*". Anna felt reassured there were possibilities in her midwifery career that would develop "*I'd imagine in the next year, there might be a part-time thing that comes up one day or two days a week that I think, actually 'Yeah, I'd be interested in doing that'".* The midwives voiced their love of working with wāhine/women and the clinical skills they had but were seeking further skills and specialty roles.

The advanced practice roles gave midwives variety in their working lives and an opportunity to develop knowledge beyond their clinical midwifery skills. Barbara commented:

> *It was really good to have an additional role or something that I was interested in. And use some different skills. Because I feel like sometimes I've got a lot more to offer than just the day to day work.*

Ruby felt her role kept her in midwifery when she could not continue with clinical work regularly *"if I can do something else that makes my brain work, and it gives me that small sense of satisfaction, then I want to".*

Midwives interviewed felt there were benefits to extending their role and could see the potential for colleagues to be taking on advanced practice roles. Some felt giving opportunities to take on additional midwifery roles would keep midwives in the profession*: "I think, to retain the staff, and to really develop people, we almost need to start pushing them into these different project areas" (*Ruby). Ruby felt this development could *'open doors for you somewhere else'* and *'pique people into doing their further education'.* Donna reiterated that advanced practice roles *"keeps people interested in their work".*

Midwives felt possibilities of extension were ample, with two midwives discussing options in their extended roles. Donna talked about progression and the ability to switch roles in

career pathways when working in the DHB *"there is progression, but you can also jump from one to the other".* For example, Barbara found satisfaction in her current advanced practice role but felt she would like to try something new *"probably soon I'll need something else again".*

Advanced practice roles and the possibility of extension that accompanied these kept midwives interested in their work, and some felt it sustained midwives in their careers. While midwives appreciated extension beyond their clinical roles, they also valued variety when working clinically.

4.3.3 Clinical complexity

The sub-theme of clinical complexity emerged when midwives talked about appreciating the variety in their clinical environments. While they felt the possibility of extending their roles was important, they felt a varied clinical environment and workload mattered. Barbara talked about working on the floor and being open to a varied workload "*I don't mind doing anything, really. I don't like doing the same thing all the time"*. Anna also appreciated the range of clinical experience her large hospital had to offer *"the size actually has positives, [there's a] huge variety of women [and their clinical presentations] from absolutely normal to hugely complex"*. Midwives talked about enjoying moments of clinical complexity and varied workload but also reiterated they appreciated feeling like situations were under control. Barbara says: "*I quite like a busy shift, you've got a few things going on… as long as it's not too busy that you can't manage the workload*". Julie echoes this when talking about working on a busy birthing suite *"I love the buzz. I love the chaos, when it's organised chaos"*.

This theme of being under control continues, but midwives talk specifically about emergencies and their contribution to these. Sally talks about the satisfaction she feels in dealing with an emergency

> *I do quite like [a] routine emergency. And I feel like I've handled it quite well. And I feel like we've moved really fast and that's kind of when I feel that I thrive the most. That's probably what I get the most fulfilment out of, a non-traumatic emergency.*

Ruby appreciated her advanced practice role and how this contributed to her colleagues' knowledge and performance in an emergency: *"I love the thrill of an emergency but also a really well managed one. So when you can actually see that the training you've been giving is working and there's really good closed loop communication".*

Donna felt coming into work feeling prepared set her up well for a busy shift *"when you get to work and you feel like your brains firing and you've got one thing after another, after another, and it's an emergency... the chaos flies. Yeah it is great".* Anna prepared herself for the variety and complexity of birthing suite *" you never know what you're going to arrive to... so you just arrive feeling flexible"*.

Arriving feeeling ready for any clinical situation could mean anything, including emergency situations, the subtheme of this is discussed next.

4.3.4 Teamwork in a skilled emergency response

While midwives appreciated the complex clinical work they carried out, they felt working well within a team was a valuable aspect of their work. This was discussed predominantly within an emergency when midwives relied on their colleagues' skills and quick thinking. Feeling supported in a team was voiced by midwives- "*I love the support of the midwives around me when I am with a good team", "the thing I love the most about it is actually the teamwork. I love that it's me and another midwife", "we've got each other to bounce ideas off and to support each other"* (Julie, Sally and Barbara).

Ruby talks about a sense of satisfaction when teamwork goes well

> *Anyone can catch a baby. And we've seen that, you know, ambo staff, parents, anyone can catch baby. But when things go wrong, and it's well managed by a team of midwives, there's a real sense of pride and like we've come together and midwives can do it*.

Donna reiterates the feeling of facing challenges as a team:

> *Being able to go through whatever the day brings, but knowing at the end of it that we have supported each other, and even though there might be things that have been difficult or challenging or not what we expected to happen when we came to work, we've pulled together and working together as a team.*

The way midwives talked about team work in demanding clinical situations displayed their appreciation of a team that could cooperate, be flexible, and value the variety they would face regularly. Midwives relied on their colleagues to respond quickly as a team in an emergency and found satisfaction when they achieved good clinical outcomes.

4.3.5 Summary

Advancing their practice role was appreciated by all midwives interviewed in several different ways. Sharing knowledge in moments at work or in more formal teaching, which they could go on to see the positive outcomes in a clinical situation, provided a sense of satisfaction. Being aware of the possibilities and direction their career could take them was exciting and gave midwives opportunities to set goals. Midwives enjoyed complex clinical situations and felt supported by their team in an emergency.

4.4 Work-life balance

> *Why is it so frowned upon to be so honest, we're women, for crying out loud. We're supposed to cry. We're supposed to be moody. We're supposed to need coffee. We're supposed to go home and drink wine* (Julie).

Midwives talked about finding the balance between their working and home lives and how their hospital midwifery roles played a part in this. This theme covered why midwives decided to work in the institution, and how they set boundaries, feeling like they had control over their working lives to feel more present in their home lives. Their expectations of hospital midwifery was a sub-theme that emerged, bringing insight into where they started their midwifery careers and how this has developed.

4.4.1 Control over work-life balance

Midwives discussed choosing hospital midwifery and the structured hours it provided regarding the control it gave them, making time for family commitments. This was often compared to the on call nature of community case-loading midwifery work, which was

perceived by the participants as not family friendly. Some midwives had worked as community case-loading midwives and shifted to hospital midwifery, driven by need; as Donna states, *"my reasons for shifting to the core were about lifestyle"*. Barbara talks about how she came to work in a maternity unit, *"after maternity leave it just wasn't [going to work] to come back as an LMC [community case loading midwife]. So the option was core midwifery. And then that's where I've stayed"*. Ruby also talks about a similar situation, having worked as an community case-loading midwife until having children. "*I just couldn't see how it would fit our life if I was on call",* and she says, *"I needed the stability of core work"*. After having children, Anna changed her working hours *"after my second baby, I went back casually… which was great for work-life balance".* These midwives indicated they were primary caregivers for their children and prepared to change lifestyle and potential differences in pay and reduce work hours.

Midwives continued to balance their work with life commitments. Sally found she took on an advanced practice role which suited her lifestyle better than rostered shifts *"when I have childcare easily available".* Barbara worked more hours now, *but "when the kids were really little, I was just part time for a couple of years",* and Anna had followed a similar pattern *"my two days a week was great… and increasingly, as my kids got older, have increased that to three or four days".*

Having a life outside of work was necessary for the midwives, who felt they needed almost to justify why they might want to work in a maternity unit for the rostered hours. Julie says, *"things are happening outside work. Obviously I have a life, I have kids, I have a husband, I have family".* Anna talks about shifts working well because her husband travelled overseas for work regularly, and Barbara reiterates the importance of being present for her family *"I want to be available for my kids when I say I'm available. I don't want to be maybe available or maybe not".*

Planning their work lives enabled midwives to feel a sense of control, which Anna appreciates *"it's been an amazing work-life balance for me, that I just get my eight hour shifts planned"*. Julie echoes this *"it's an organised-ish life because you have a roster. And I can plan around it".*

Being about to control and plan their lives also enabled midwives to set boundaries, as discussed below.

4.4.2 Boundary setting

Finding the balance between work and home life often required midwives to set boundaries, which may have been limiting work hours, or intrinsically setting boundaries that they followed. Being able to manage home and work simultaneously was a challenge, as Julie was experiencing:

> *What I've found recently, is I could cope with home, and I could cope with work. But as soon as the two started going off together [problems emerging], I'd be sitting in the office, and someone would just come in and say one thing that annoyed me, and I would just burst into tears.*

Anna found she needed to separate home and work to give each the focus it required:

> *I feel like my mind has been on the job, on my midwifery, when I'm there. And as I've said, satisfying and interesting. But then when I'm home, it's just so much of the rest of life is just there… I just haven't had that space.*

Having 'space' and deciding to not extend themselves further at this moment in their careers was an idea that emerged, even though the same midwives had talked about possibilities of extension. Sally was content with her career "*I kind of just want to keep going steady at the moment, I don't want to bring anything new in".* Anna had a similar outlook "*I'm not in limbo, but kind of having a bit of space… no great aspirations right now".* Julie recognised the potential for growth but also acknowledged she needed to set boundaries "*the challenge of working full time and making a difference in this unit now… is really appealing. But I just can't do that at the minute*".

Limiting the number of shifts they worked and being able to turn extra shifts down when offered was acknowledged as challenging due to staffing shortages. However, two midwives felt this was important to keep their work-life balance adequate. Julie describes calls from colleagues: "'*please Julie, can you work tonight, please work tonight'. And I just really had to say, 'I would have leapt at that two months ago' and nailed myself whereas now, I'm not".* Sally also needed to recognise her limits in terms of shift work, *"just keep doing the same amount of shifts. Just the odd ones that I'm not there too much. Because if I'm there too much, then I don't enjoy going".* Sally develops this idea, compartmentalising work and

home life but acknowledging the joy she gets from her work "*I kind of just want to keep using midwifery to be something that supports my life, working to live. And it's a really big bonus that I can enjoy it while I do it".*

Julie goes on to talk about encouraging other staff members to set boundaries and recognise when they were struggling in their home and work lives *"I encourage the girls to, when they weren't in a good space to say so".*

Setting boundaries enabled midwives to enjoy their home and work lives in those respective spaces. Another aspect of advanced practice role was choice, as discussed below.

4.4.3 Choice

Having the choice to move between different roles whilst staying within the midwifery profession was something the midwives interviewed valued. Having options to work in other units or take extra shifts were ways midwives felt they had the choice to balance their work and life. Julie worked mainly at a secondary unit but felt *"lucky to have an option, in that I can work in [primary unit]"*. Anna enjoyed having the option to take on extra work if it suited *"always been plenty of work. And now, obviously, you could work full time. For a long time, they've needed more midwives".*

Participants valued having choices when clinical work needed to take a back seat, and self-care became important. Ruby and Anna talked about altering their roles due to injuries but still working in some capacity *"I do some clinical, but I don't like doing a lot of clinical because it hurts [long term injury]"* (Ruby). Anna had a short-term injury and *"had to do light duties for quite a few weeks"*.

Even though midwives appreciated having these choices that suited their lifestyle, they still acknowledged the importance they placed on clinical work and being with wāhine/women. Donna was at a moment of decision with her career and contemplated what she would miss *"am I ready to give up largely clinical practice? Is the timing right for that? Is that what I really want to do? Will I miss it too much and wanna come back?".* Other midwives echoed this sentiment when considering non-clinical roles: "*the thought of not doing clinical and then having to go into admin or retail or something, it would hurt too much"* (Ruby). Barbara had opportunities that had not suited her at the time

There have been a few other smaller things that have come along, and they haven't really suited me either… Because then I go back to, 'well, I could do this other role', but then it takes me away from the woman and that direct care.

Finding value in moments with wāhine/women in clinical work was a significant consideration when midwives faced choices regarding their work/life balance. Midwives were not always aware of the choices they would have available to them when commencing practice, as discussed below.

4.4.4 Expectations of hospital midwifery

Midwives came to hospital midwifery with preconceived ideas of what it would be like, either from their degree or looking in as a community case-loading midwife. Sally began her midwifery career in a busy hospital and felt discouraged at the start "*I didn't think midwifery would be like that. And it was so hard. And I almost sort of felt like giving up or going back to [hometown]"*. Trying to gain some work/life balance meant some midwives began working as hospital midwives when they had previously made the decision not to, as Ruby conveys; *"I always swore that I'd never come core. So it was a bit of a tail between my legs moment when I had to apply".* Julie had similar feelings about hospital midwifery *"when I qualified as a midwife, I swore I would never work in a hospital. But… it wasn't anywhere near as bad as I thought it would be".* She explains her reservations around coming to hospital midwifery "*there maybe was a reasonable presumption that it wasn't rewarding, and you just did your eight hours babysitting or doing half a labour".* Donna articulates what she appreciated about hospital midwifery after working as a community case-loading midwife *"there is certainly a diversity about working in an institution that I didn't even appreciate when I first went there. And I think that's, that is what is the attraction for me".* Diversity in hospital midwifery work and building on specialist skills was an idea echoed by Ruby

You hear about the toxic nature, and you hear about the shitty shifts, and you think, 'oh, I don't really want to do it' but learning the secondary, learning how to do mag sulph [magnesium sulphate] really quickly, how to do a GIK (insulin infusion) really quickly and thoroughly [was satisfying]".

Donna had initially been drawn to hospital midwifery for regular hours but felt there was much more the institution could offer:

> *For other people... the attraction about the organised institution is 'we like coming to work, we like knowing how long we're going to work for, and we like being able to go home at the end of it'. And I guess for me, that was part of it, but it's not now.*

Finally, the midwives were positive when discussing whether hospital midwifery had fulfilled their expectations of the job when they applied or graduated. *"I think it's gone over and above"* (Julie), *"the highs of the job and how amazing it feels to do what I do... probably exceeded what I thought it would be"* (Sally). Anna compared hospital midwifery to her earlier nursing career: "*midwifery has been a really exciting, new discovery, adventure, journey. And it's so positive, somehow. For me, it's more positive than nursing".*

4.4.5 Summary

The third theme identified the ways midwives found a balance between work and the rest of their lives. They found that they could control their working lives and, by doing so, maintain a balance in their home lives. Setting boundaries was important, but midwives also talked about the importance of preserving skills in clinical work to continue working with wāhine/women. Their expectations of hospital midwifery were often lower than what they found once they became hospital midwives, leading to an appreciation for midwifery in this context. These expectations were often informed by what midwives had heard from other midwives. This was often talk about a negative enviroment within the institution, which will be described next.

4.5 Tension in the institution

Interviews were conducted to find the positives in midwives' working lives and what they felt were strengths they could grow. A strong theme that came through was tension the midwives were feeling within the institution they worked. Due to the semi-structured nature of the interviews, these ideas were not focussed on and elaborated on, but we did not immediately change the topic. Many midwives felt unsupported in reaching their goals when asked about this in the interview, which led to further discussion around the institution. Midwives talked about frustration when working with management- 'management' was generally seen as colleagues within the institution who could make

decisions regarding protocols and accept or reject midwives' ideas for changes to the ward. This could potentially go on to affect midwives' career aspirations.

4.5.1 Politics

There is a theme I have called 'politics' that arose when midwives talked about the relationships they had with management. Whereas the midwives' face-to-face work with wāhine/women was satisfying and engaging, they didn't experience understanding or engagement from the management toward themselves as clinicians. Barbara felt this negatively affected her job: "*sometimes… all the politics take away from the job"*. She goes on to talk about times of stress in her workplace and being unsupported by management: *"there have been times at work where we've been going through change [imposed by management], and the ward's all unsettled, and morale is low. And so those are hard times"*. Julie felt that being unsupported in an advanced practice role had led to her not being able to continue with it

> *I said to (DHB management), I would have given you all of me if you had made this job a positive experience, I would have just taken this on but you've made it a shitty experience and I'm not going to do it.*

Anna had a similar experience, feeling unsupported by management in an advanced practice role, *"she was just so undervaluing of my involvement in [extra role] and coming in on days off, and she said 'well you chose to'"* and then goes on to say, *"I just thought, well, if this is what the management think about me coming in, basically giving a half day off, twice a week, I quit".*

Personality clashes were voiced by midwives, who felt this could affect their day-to-day work. Donna talks about her experience:

> *You still have to have the support of your leadership. And I think sometimes that is a little bit.. personality dominated, you know. So for example, if you've been in a position and you've pissed somebody off, you may be sitting there a little bit longer than what you thought you would be.*

Julie had decided not to work in a particular area "*I'm not working there because of that one person [in management]"*.

A feeling that those working in management had no perception of the reality of working clinically came through, as Anna explains; *"it's been quite an interesting realisation that they sit in their offices with these ideas, but actually, the reality on the floor is quite different".* Ruby echoed a similar sentiment *"I feel like, what's wrong, is that there's too many people sitting in the executive that have no clinical experience".* She goes on to explain how this motivated her to make a change to this *"so that's why I kind of deviated and went into leadership management"*.

While some midwives had made active choices to not work within particular roles because of the politics in the institution, there was a feeling of powerlessness, even when they had other options available.

4.5.2 Powerlessness

Midwives felt an element of powerlessness within the institution, whether on a clinical level, affecting the care they provided for wāhine/women, or at a personal/professional level.

Being too busy to provide care to the standard they wanted was a struggle for midwives. Sally talks about working in a busy ward; "*I felt like I wasn't giving the care that woman deserved. But I found ways to sort of get by with that in my head without feeling so guilty about it".* She goes on to explain how she would deal with these busy times; "'*If you feel that you need to complain, then here's the [feedback form]. I will do my best for you in the time I have', I could say things like that".* Julie feels care is compromised at times *"we miss so many things in maternity because it's too busy"*. She talks about rationing care to the point where expectations are low: *"day after day after day, just coming away going, 'nobody died today' is not actually a work environment that's healthy".* Donna felt powerless as a hospital midwife when she compared having more control over her work as a community case-loading midwife *"there's an infinite number of women [that could present]. There's a lot less control".* Ruby appreciated a day that she had time with the wāhine/women, comparing it to times when she felt the care wāhine/women received wasn't adequate- "*you could actually offer support and chat. And [help] them breastfeed instead of just jamming a boob in the mouth and leaving and thinking 'I wish I could have*

done more'". Anna was disappointed that she didn't always have time to share knowledge with the wāhine/women she cared for and felt overwhelmed with what she felt was expected of her role as a hospital midwife

> *There's just too much to tell them, too much for them to take in… often people take very little in and it feels like a huge responsibility, as a hospital midwife, to tell them everything they could possibly need to know.*

She goes on to explain how these high expectations may affect wāhine/womens' care, "*we're really finding the lack of midwifery experience passing onto the women disappointing for the women".*

Julie feels the system has contributed to what she feels is inadequate care: "*we just work in a horrible massive disgusting government department that treats people like numbers. Which is really sad, when you're dealing with mums and babies".* Powerlessness prevails in inadequately staffed maternity institutions and affects the quality-of-care midwives can provide. It negatively affects a sense of autonomy and professional development in those same midwives.

4.5.3 Limiting of autonomy and growth

Following on from the sub-theme of powerlessness, midwives felt there were limits placed on growth and autonomy at times. Some midwives considered not feeling valued by management as a limiting factor. Barbara talks about having specialist knowledge in her advanced practice role not being appreciated, "*I could be used more as a resource in some discussions and stuff that happen that are related to it. Whereas sometimes it's just, I'm not even considered".* Ruby felt there was little support for her career growth when she informed management of her plans for further study: *"they're not supportive at all, (charge midwife) really didn't give a shit when I told her what I had planned on doing".* She talks about the lack of support causing more stress for her, *"now to attend block courses and stuff, like I have to use leave, and I have to apply for it and maybe not get it. And then you can miss your block courses"*. Julie wanted to create visual resources for staff *"but did we ever have five minutes to do it? Do we ever have anyone that would support us to do it? No, nobody"*. Sally explains why she thinks she has little support from management in an

advanced practice role- *"the organisation resents that I do the other things. They want me to be more available. They want that to be my first priority".*

Midwives valued the opportunities for advanced practice roles but voiced concern that this growth was at the expense of providing clinical care. Julie expresses her thoughts on this: *"I'm not saying they're not important roles, but you're creating them when we're short staffed, well that seems to be shooting us in the foot".* She elaborates on this idea:

> *They've got brains and yes they maybe want to change it up, but do we do that when we're in a staffing crisis? Because of course they get an eight to four job and then they think, 'why would I ever go back to shift work?'.*

Donna has a similar outlook: "*you end up taking midwives off the floor, to do these other roles. Which keeps them in the profession and keeps them interested. But we still need midwives to do the midwifery work".* Ruby understands why growth may be limited to preserve clinical staff but still feels having other roles is important. "*I get why the executive don't want us all doing the audits and that sort of thing, because it is taking staff off the floor, but I think it gives people something else".*

Barbara and Ruby felt growth was essential in keeping interested in their work and staying in the profession *"I don't feel like there's much avenue to keep growing. And I need that"* (Barbara). Ruby echoes this, *"we can either develop you into another role that's still going to give, or we can lose you to boredom"*.

4.5.4 Summary

The final theme of 'tension in the institution' brought together sub-themes of midwives feeling frustration directed towards the institution they worked in. Feelings of powerlessness and limited professional development are perceived to be brought about by those in the institution who could control the final decisions that could be made. Midwives wanted to both advance in their roles, but felt some trepidation of advancement if this left fewer midwives working clinically. The politics of working within an institution were discussed, with midwives feeling these brought barriers to jobs.

4.6 Summary of Chapter

The interviews with midwives brought an understanding of what it meant to work within a maternity unit for them. Appreciative inquiry was used effectively throughout the interviews, and while this deviated from the plan of focussing only on strengths, giving midwives space to voice their feelings on tension in the institution gave a more balanced picture of midwives' work in a maternity unit. I have shown how the midwives' voices led to the development of the chosen themes and sub-themes.

In the next chapter, I will discuss how these findings are related to the research question and supported by the literature.

Chapter Five: Discussion

5.0 Introduction

This chapter will discuss the findings from chapter four, in the context of the research aim, methodology and the literature. This research sought to discover what hospital midwives said about their experience of working in an institutional maternity facility. Six hospital midwives were interviewed, and a qualitative descriptive approach was used with an appreciative inquiry (AI) lens. Interview questions were positioned around the 4-D's of AI: Discover, Dream, Design and Destiny. AI is a strength-based methodology, which provided midwives a sense of agency to discuss their chosen profession in affirmative terms, leading to the themes of *midwife heart and soul*, *advanced practice role* and *work-life balance.* However, as the individual interviews progressed, the midwives also voiced their dissatisfaction with the system they worked with, leading to the theme *tension in the institution*. These findings will be discussed in relation to the literature, firstly midwife heart and soul, looking at how hospital midwives develop relationships with wāhine/women and how they thrive in workplace settings that are not always conducive to growth. Secondly, the opportunities for advancing practice that hospital midwives appreciate in their roles is examined, focusing on the teaching and learning aspects and how these are developed. The third theme, work-life balance, is a feature of hospital midwifery, with midwives perceiving working rostered hours in a maternity unit to bring them better work-life balance. Typically midwives, as wāhine/women, often alter their work to better suit the needs of their whānau/families. Finally, the tension the midwives experienced working within an institution, and the limitations this placed on growth is examined. Following this a discussion of the implications for the workforce and research, limitations of this research and conclusion.

5.1 Discover

The discovery phase of the interviews sought to find the best of 'what is' for the hospital midwife participants. The key finding and overarching theme was 'midwife heart and soul'. This explored what midwives felt was working well in their midwifery lives, and where their

passion for working with wāhine/women became obvious. Their resilience and continued advocacy for wāhine/women continued despite the constraints of an institutional environment. Midwives feel nourished in their careers by providing good care, “to leave a woman satisfied with her experience is the greatest reward of being a midwife” (Lennox, 2002, p.160). Now begins with an exploration of the partnership model which defines this reciprocal relationship.

5.1.1 Partnership

In Aotearoa/New Zealand, the partnership model of care is a unique way of describing the relationship between the midwife and wāhine/woman and her whānau/family. The wāhine/woman is the centre of care, which is strongly reflected when midwives talk about working with wāhine/women in this research. The partnership model bases itself on being ‘with women’, which is also the Anglo-Saxon origin and meaning of the word ‘midwife’. Midwives bring their midwifery knowledge and skill to the partnership, contributing to the well-being of the wāhine/woman and her pepi/baby. The midwifery partnership model draws principles of the partnership model of Te Tiriti o Waitangi, through whanaungatanga, actively building relationships through shared experiences (Berghan et al., 2019). Mutual trust between the midwife and wahine/woman is developed through increased transparency and information sharing, as supported by the principles of Te Tiriti o Waitangi (Hudson et al, 2010). The partnership arrangement is reciprocal, echoing participants' sentiments when discussing midwifery both nourishing themselves and wāhine/women (Miller & Bear, 2018).

The partnership model is visible in the continuity of carer model, emphasising the role of the community-based case-loading midwife in walking alongside wāhine/women from booking through to the postnatal period (McAra-Couper et al., 2014). Hospital midwives work with wāhine/women and their whānau/families for much shorter episodes of care. The system in which hospital midwives work, where wāhine/women are allocated a midwife, or more frequently a nurse in postnatal wards, may appear to limit wāhine/women’s choice and concede some of the shared power in this relationship (Wynn-Williams, 2006). However, continuity of care can continue in a hospital setting, although the carer changes.

My research suggests the partnership model is applicable in the working relationship of hospital midwives. Research exploring the fleeting moments that hospital midwives find

valuable and sustaining them in their work has not previously been a feature of research in Aotearoa/New Zealand. Far more weight has been given to the relationships the community case-loading midwifery partnership model made possible. Conversely, Kreuzer et al. (2020) explored interactions between healthcare consumers and medical staff in North Macedonia and found that interpersonal interactions are seen as luxury. The researchers found healthcare consumers appreciated short-lived clinician interactions when the interactions involved the following three factors. These factors are: firstly, an authentic presence; secondly a balanced power relationship with joint decision making and lastly, emotional interconnectedness, with cohesiveness in actions between clinician and consumer (Kreuzer et al., 2020). Similarly in my research findings, midwives also valued being able to give high-quality care with those same three factors demonstrated in fleeting moments. Julie articulated this, *"You can make a massive influence on someone's life in ten minutes…because you connect to them or say something that changes their life".* Midwives did not feel that interpersonal interactions were a luxury but a fundamental part of their work. In research from the United Kingdom, making a difference in fleeting moments was also a factor that sustained midwives in their work (Kirkham et al., 2006). Authentic connection and shared decision making with wāhine/women appear to be important to midwives working in a hospital. This finding is important as it is at odds with other research findings.

Aotearoa/New Zealand research comparing midwives that work in hospitals to those who work in the community suggest hospital employed staff, or hospital midwives in this context, align with the institution, whereas community case-loading midwives align with the wahine/woman (Dixon et al., 2017). The argument is that job-focussed midwives support wāhine/women into motherhood in an evidence-based, task-focused manner, supported by guidelines and recommendations. In contrast, wāhine/women-focussed midwives work in an individualised way, focussing on wāhine/women's needs and valuing informed choice and decision-making (Van den Branden et al., 2022). These findings convey a notion of meaningful partnerships being available only to those midwives who provide continuity of care. While midwives in this research experience restrictions at times by the institution's boundaries, as discussed later, they believed they aligned with the wāhine/women and their

needs. This finding is significant; hospital midwives place great value on forming relationships with wāhine/women, which was for them the heart and soul of midwifery.

Midwives in Aotearoa/New Zealand must demonstrate how their practice meets standards, including those of partnership. Pre-existing literature and the findings of this research show midwives find the connections they make with wāhine/women as one of the key motivators in their work. Midwives campaigning for autonomy in the late 1980s in Aotearoa/New Zealand used the slogan "women need midwives need women" to highlight the importance of the reciprocal relationship between wāhine/women and midwives (Fleming, 1996). While this was centred around the promotion of homebirth and the strive for autonomy in community case-loading midwifery practice, the drive for reciprocal relationships is also flourishing in hospital midwifery. The relationship between wāhine /women and hospital midwives has not been covered extensively in the literature. Aotearoa/New Zealand research has explored the skill and sensitivity of forming a partnership quickly. Hospital midwives voiced frustration that they were not perceived to be practising 'real' midwifery by their community case-loading colleagues and other maternity professionals because of the nature of episodic care that they provided, as they believed partnership with wāhine/women was achievable, regardless of the length of time they provided care (Wynn-Williams, 2006). This research has not set out to compare midwives that work in different settings and has found that, no matter where they practice, midwives appreciate the connections they make with the wāhine/women they care for and provide wāhine/women-centred care. The interview data also shows that those midwives working in hospital find ways to flourish despite the constraints to practise that they experienced.

5.1.2 Bloom where you are planted

'Bloom where you are planted' describes the concept of midwives thriving in an environment. As I will discuss later, midwives may choose to work in an institution through need rather than choice and find that they can 'bloom' in this work setting. This indicates a level of resilience, defined as a positive adaptation to adversity (Hunter & Warren, 2014). Resilience in midwifery is a growing theme in research; however, this has not been explored in hospital midwifery in an Aotearoa/New Zealand context (Clohessy et al., 2019; Crowther

et al., 2016; Hunter & Warren, 2014). Factors that bolster resilience, considered an essential attribute in an emotionally demanding profession, can, according to international research, be categorised as internal and external. Internal factors like optimism, and having a sense of humour were evident in my research and depended entirely on the individual (Clohessy et al., 2019). Resilience may also be buoyed by peer support. As hospital midwives usually work within a team, peer support is an important external factor or attribute of working in this model (Hunter & Warren, 2014).

Participants in this research found that coping with and enjoying their workloads, whether acute situations or ongoing care, increased their job satisfaction and allowed them to 'bloom' in their chosen profession. Julie articulates this by appreciating small moments of positivity or 'wins', which have the power to make a whole day at work a good one. Midwives not only acknowledged the 'best of' what they experienced at work but began to appreciate 'what could be'- the dream phase of appreciate inquiry. Here midwives could look beyond the status quo and exercise their imaginations to envision a valued future (Cooperrider & Whitney, 2005). These dreams were not, in this case, extensive or unachievable- small moments of positivity were already happening, but midwives appreciated they could happen more frequently.

Having a sense of agency is a theme attributed to community case-loading midwives rather than hospital midwives in the Aotearoa/New Zealand context. Dixon et al. (2017) found that employed midwives experienced less autonomy, lower levels of empowerment and professional recognition than their self-employed counterparts. While hospital midwives may have these outcomes compared to community case-loading midwives, they still feel a sense of agency and professional responsibility, relating this to their unique skill set. Hospital midwives in Aotearoa/New Zealand value what they bring to the profession and the diversity of their skills, as I will discuss next (Gilkison et al., 2017).

5.1.3 Advancing practice role

Teaching and learning were appreciated by midwives, both on the job with colleagues or sharing knowledge with wāhine/women and their whānau/families. Obtaining and building on midwifery knowledge is an ongoing process throughout a midwife's career (Calvert et al., 2017). Storytelling and knowledge sharing support the art of midwifery practice. While

scientific ways of knowing have dominated the education of midwives, the significance of oral pedagogy is beginning to be recognised (Gould, 2017). This was valued as both education and a support role, with midwives feeling safe and knowing their peers' knowledge was available. In Aotearoa/New Zealand, this has been recognised as providing wāhine/women with the best possible birth experience and protecting midwifery knowledge (Earl, 2004). A study found midwives felt they had a professional responsibility to share the knowledge they may have obtained after taking part in courses or conferences (Bäck et al., 2017). Anna found that when her colleagues knew she had knowledge in a specialist area, colleagues would approach her for advice. They valued her knowledge, which also builds on the connection and trust between midwife colleagues.

5.1.4 Work-life balance

Midwives in this study had often chosen to work within an institution and move away from community case-loading midwifery practice. This was seen as a lifestyle choice that some midwives in this cohort attributed to starting a family. The midwives I interviewed believed an on-call lifestyle was not compatible with family life, and hospital midwifery provided more stability. Dixon et al. argue that caseload, or community case-loading midwifery, "is sustainable, but does require careful consideration of professional and family commitments" (Dixon et al., 2017, p.11). This careful consideration may be why midwives transition to the hospital from community case-loading midwifery. A 'tug of war' between home and work life, seen in wāhine/women-dominated professions, leads midwives, mainly wāhine/women, to alter their work life to suit family needs (Welfare, 2018).

The concept of a balance between work, home and family life is subjective, with individuals having different needs. An assumption can be made that 'balance' implies work and home life are separate, which is likely more achievable for midwives working in a hospital role than in an community case-loading midwifery role on call. One definition of balance is that "role effectiveness and role satisfaction are consistent with life priorities" (Casper et al., 2018, p. 183). During the interviews, midwives talked about priorities outside of their work, mainly whanau/family commitments, where they strived to find balance. This perceived 'balance' may have developed throughout their careers. Relationships with partners, whānau/family and friends were essential and supported midwives to stay in the workforce,

so this time out of work to socialise is key (Kirkham et al., 2006; Versaevel, 2011). Achieving work-life balance has many facets and benefits individual midwives' well-being and the institutions they work for.

Wāhine/women are more likely than men to choose work roles that fit their family lives (McDowall & Kinman, 2021). Work becomes less of a priority when women go through significant life changes, such as having small children or facing retirement, and takes precedence when children are older (McDowall & Kinman, 2021). Midwives interviewed were at varying life stages but tended to be the ones in their whānau/families making changes to their work patterns as their home lives changed. There was no mention of resentment due to being in this position however- Julie felt a sense of what it was to be female and what this meant for her: "*we're women, for crying out loud. We're supposed to cry. We're supposed to be moody. We're supposed to need coffee. We're supposed to go home and drink wine".* Work-life balance for these participants was achieved by being in control of the time one worked and the time one had for acting as a private individual. Boundaries could be drawn around work and home life and this was important to the midwife participants in this research for a variety of reasons.

5.1.5 Boundary setting

A feature of hospital midwifery was being able to set boundaries. Midwives could compartmentalise their home and work lives and focus on one or the other as needed. Working conditions can influence an individual's mental health (Dixon et al., 2017), and setting boundaries was a way for midwives to protect and preserve their mental health. Taking on roles still within the realm of midwifery but with fewer clinical hours often allowed midwives better working hours that suited their lifestyle. There is evidence that when healthcare workers let their work lives take precedence over their personal needs for work, personal relationships may be affected, as well as immune system dysfunction and even shortened life expectancy (Schwartz et al., 2019). This loss of self-care, in turn, is detrimental to patient care, and the midwives interviewed recognised when they needed to set work boundaries, before they became overwhelmed with work, and their life became unmanageable. While midwives gave reasons, such as needing to decline the invitation when offered extra shifts because they perceived they were needed more at home, they

may also have felt some guilt in setting boundaries. Still, the evidence indicates boundary setting benefits the service too, with higher turnover rates and reduced effectiveness of care in clinicians who are burnt out (Schwartz et al., 2019; Shanafelt & Noseworthy, 2017). While midwives chose to work in a maternity unit, often for whānau/family reasons, it was a transition they were pleased with and often surprised by how much they enjoyed the work. This was an interesting finding, as research that compares midwives who do shift work to those that provide continuity of care found the latter group had a better sense of job satisfaction and lower levels of stress and anxiety (Crowther et al., 2016; Dixon et al., 2017). Midwives had commenced hospital work with preconceived ideas that it would not provide the same levels of satisfaction in connection but found this wasn't the case. Sally articulates this well: *"the highs of the job and how amazing it feels to do what I do... probably exceeded what I thought it would be"*. The experience of working in the hospital setting were more positive than midwives expected however imagining a long term goal of any sort was more difficult, which is explored under the Dream or discovery phase.

5.2 Dream

The 'discovery' phase of the interviews found the best of 'what is' in hospital midwives working lives. To transition to the 'dream' phase, midwives were asked about 'what could be'. They were asked about their vision for their career in the future, and more specifically, how they envisioned their midwifery careers in five or ten years' time. The theme of career extension came from these discussions.

5.2.1 Career Extension

Midwives talked about extending their roles within their job, and then to career extension, which kept them interested in midwifery as a profession. The benefits of this extension were: a change from clinical work, more reasonable working hours and added diversity. They felt this was an area they had control over, where they could choose to extend into a specialty area or particular interest. The possibilities of extension could keep midwives in midwifery, with midwives wanting career development and feeling optimistic about

developing different skills. Finding a niche and working within a chosen area added to their job satisfaction (Kirkham et al., 2006).

Midwifery knowledge was used and expanded upon when working with wāhine/women with complex medical needs. Emergencies were talked about as the most dynamic expression of this knowledge. This finding has been mirrored in other Aotearoa/New Zealand research. Hospital midwives describe themselves as a 'Jill of all trades' when describing the skills of flexibility and adaptability required. Being prepared for unpredictable events requires mental preparation, which midwives enjoy (Gilkison et al., 2017). Attending appropriate training was an essential part of being well equipped for an emergency and doing this training with colleagues helped form a team bond.

Midwives values working as a team, particularly in a crisis (Gilkison et al., 2017), and they appreciated a 'well managed' emergency, and regularly referenced the training they had done in this team environment. Ruby talked about the benefits midwives gained from Practical Obstetric Multi-Professional Training (PROMPT), a scenario-based obstetric emergency training day, usually attended by multiple specialties, which all work with birthing wāhine/women (Shoushtarian et al., 2014). The satisfaction midwives gained by working in a team and enhanced by these training days was evident in my research.

Midwives interviewed felt they could reach a certain point of expertise in their careers, but then often felt their wings were clipped and could not visualise further extension. Some midwives had found aspects of the transition to working within an institution challenging, which brought about feelings of being unsupported by that institution. This was an important part of the findings identified by the midwife participants.

5.2.2 Tension in the institution

This research was sought to discover what sustained hospital midwives in their role, using AI as a strength-based methodology. As I have discussed in previous chapters, the significance of interview findings was not consistent with a strength-based, positive methodology and initiated a modification. Common themes repeatedly emerged through the data analysis,

which could not be overlooked. Midwives expressed concern about the tension within the institution.

The midwives talked about the politics of the workspace. The definition of politics in the workplace can be subjective, depending on the individual's perception and the area they work where usually a climate or culture also prevails. 'Workplace climate' or 'workplace culture' may be used interchangeably to convey the same idea. While not midwifery focussed, an article discussing workplace politics for pharmacists identifies that professionals are often assessed and skilled in the clinical aspects of their work, but attention is not paid to the soft skills of practice, such as navigating politics (Hecht et al., 2021). In the context of this research, organisational politics can be defined as individuals displaying self-serving behaviour at the expense of their colleagues. This may be most prominent at times of change when employees often see politics as a threat to their well-being (Basar & Basim, 2016). Midwives interviewed felt a strong sense of 'us and them' between those midwives working clinically and those in management, exacerbating the feeling of negative workplace politics.

Political behaviour (assuming this is negative, self-serving behaviour) promotes stress responses through a lack of control in the employee's environment and frequent episodes of conflict (Cropanzano & Li, 2006). Midwives feeling powerless within the institution was a sub-theme linked to the effects of politics in the workplace. When midwives do not control their working environment and how they work, it can lead to an unsustainable working environment (Gilkison et al., 2017). The institution was perceived to have contributed to powerlessness, with midwives reporting they felt undervalued. This was particularly evident when they were rotated to unfamiliar wards or placed in a clinical setting where they felt unsafe, often to meet organisational demands rather than suit the needs of wāhine/women or midwives' own needs (Hunter et al., 2019). The inner conflict midwives may feel when unable to provide the care to the standard they feel is appropriate can lead to moral distress. An article by the New Zealand College of Midwives examined feelings of moral distress in midwifery, suggesting repeated exposure to situations where midwives felt ethically conflicted exacerbated these feelings (New Zealand College of Midwives, 2022).

Midwives in this research project felt powerless when they felt they could not provide the standard of care they felt was optimal; not being able to provide the standard of care that midwives felt was appropriate contributes to midwives leaving the profession altogether (Curtis et al., 2006). In New Zealand, this may also lead to midwives reducing the hours they work to protect their careers (Dixon, 2019). When there are fewer midwives to provide care, the care needs to be rationed. This problem is then compounded when midwives feel unable to ask for help, if they are feeling their environment is not a supportive one. Feeling unsafe in a clinical environment leads health professionals to turn to support networks outside of their work environment, leading to barriers in speaking openly about workplace issues (Austin et al., 2014). This sense of powerlessness extends to a general sense of helplessness within an institution. The authority of senior midwifery staff was undisputed in a study of newly graduated midwives in the United Kingdom, even when midwives were directed to go against what they knew to be evidence-based practice (Hunter, 2005). Conforming to authority figures in this manner may lead to general disdain for management, and a lack of trust in authority.

When going through service reforms, midwives in Australia reported feeling powerless to effect change (Sidebotham et al., 2015). When midwives were faced with the possibility of changing their working model, from within an institution, to a continuity of care model, they struggled to visualise possibilities beyond their institution's limits. This study also used appreciative inquiry, to discover potential strengths of a change in working model but found participants unable to move through the 4-D cycle of appreciative inquiry. Discover and Dream were possible, but Design and Destiny were outside the reach of practitioners who felt limited by workplace culture. The feeling of powerlessness in the workforce, and feeling unheard by those who have power to change is a documented problem in Aoteaora/New Zealand (Eddy, 2022; New Zealand College of Midwives, 2022). The shortage of midwives, combined with the stresses of Covid-19 has exacerbated feelings of low morale in Aotearoa/New Zealand midwifery (Williams, 2020).

When midwives are feeling moral distress in their work, they are less likely to seek opportunities beyond their daily tasks (New Zealand College of Midwives, 2022). As I have discussed earlier, the midwives interviewed valued the possibilities of extension, which was an element of hospital midwifery. Midwives were asked about how they could bring these possibilities to reality, following the dream phase of AI into the design phase. This enabled

midwives to construct a potential future realised in the dream stage of the interview (Cooperrider, 2008). When asked regarding support for these career extensions, midwives felt their institution provided little or no support, omitting the possibility of the institution as a source of support. Significant staff shortages, combined with the pressure of Covid-19 meant midwives felt invisible in their institutions. This situation limited the creative thought required for the dream phase of AI and the vision needed to design their ideal future. Midwives were secure in describing the best of 'what is' in their work but were passively waiting for opportunities to arise when they discussed extension of their careers. Julie talked about taking initiative and actively being pushed back by her organisation in her interview:

> *I said to (DHB management), I would have given you all of me if you had made this job a positive experience, I would have just taken this on but you've made it a shitty experience and I'm not going to do it.*

The general disenchantment with the institution has been described in this section, stemming from a general lack of support and investment into midwives' futures.

5.3 Application of Appreciative Inquiry

Two of the four phases of AI have been explored in relation to the findings- Discover and Dream. Dream, where midwives talked about 'what could be' in terms of their future midwifery careers, turned to an exploration of midwives' struggles within the institution. When carrying out the process of AI, the dream phase informs the design phase of 'what could be', constructing a positive future from the ideals realised in the dream stage (Cooperrider, 2005). Because midwives grappled with envisioning their future careers, this stage was not realised in the findings. AI is not always successfully carried out completely, as documented by research with similar outcomes, where participants struggled to realise a positive future (Grant & Humphries, 2006; Sidebotham et al., 2015).

Despite AI not being utilised to the extent I imagined when the study commenced, using this methodology provided midwives an opportunity to realise the strengths of what they appreciated in their work. Both the strengths and limitations of working as a midwife within an institution are explored below, discussing implications for the workforce.

5.4 Implications for workforce

This research has several implications for hospital midwives, their colleagues, and the wider profession. While there is a temptation to first focus on the more negative findings and find solutions from these, this research was carried out with an AI lens, focusing on the strengths participants identified. Recognising and celebrating the connection hospital midwives have with wāhine/women and their whānau/families has been a key finding of this research. Acknowledging that all midwives, regardless of their work setting, are wāhine/women centred, is essential knowledge for everyone in the pregnancy, birthing and postnatal space. Wāhine/women and their whānau/families should know all midwives work from this partnership-based philosophy. This knowledge is beneficial for midwifery managers and workforce planners, who need to be cognisant of midwives' appreciation of having time to deepen relationships, and the quality of care that can be provided when the environment allowed for it.

Midwives are resilient, they 'bloom where they are planted'. This should be nurtured, by careful attention to aspects that sustain their growth. Resilience can be bolstered by peer support therefore effective team building strategies put in place by midwifery managers, may increase this resilience and growth. This can also bolster confidence, giving midwives better coping strategies when working in stressful situations. This has been recognised by the New Zealand College of Midwives (2022), and steps need to be taken to put this recognition into practice. Ensuring the environment that midwives are 'planted' is a workplace that is proactive, one that appreciates their workforce and is committed to their wellbeing will enable midwives to give their best (Jalilianhasanpour et al., 2021).

Midwives need opportunities for growth and expansion beyond their clinical roles and understanding from their leaders when they need space to focus on aspects of their personal lives. Hospital midwives often looked at a role within an institution as being able to give them those boundaries, and this needs to be recognised by those in managerial roles. Respect for midwives' home lives and how this may impact their working lives needs to be given. Hospital midwives need to have safe trusting relationships with their managerial team and when they cannot work extra shifts then there should be no need to feel they are letting the institution down. Midwives must not be pressured into working more hours than

they have contracted to be available. Regular forums where midwives can gather and communicate what is working well and what needs improvement may be part of a solution. Finally, acknowledging and working with midwives' feelings of disillusionment within the institution can achieve a more cohesive workplace. Teaching student midwives about the soft skills, such as effective communication with colleagues, would prepare them for working in an institutional hospital environment. These soft skills would enable less experienced midwives to work with their colleagues to achieve a workplace where midwives feel supported and confident.

Support for midwives wanting extension has been mentioned and work needs to go into the barriers midwives perceive as obstructing their professional development.

5.5 Further research

As I identified in the literature review, there is a lack of research into hospital midwifery internationally and in Aotearoa/New Zealand. Further research is warranted into aspects of hospital midwifery, especially by those who identify themselves as leaders. This will help workforce planners identify pathways to assist hospital midwives in achieving extension and improve access for others interested in leadership positions.

There is a need for further research into how hospital midwives integrate themselves into the workplace and the way they challenge internal values and those projected by the institution. Investigating a deeper understanding of what 'politics' in the workplace means to midwives within the institution may help leadership teams appreciate different ways of working if the institutional politics or culture are seen as detrimental to midwives' wellbeing.

5.6 Limitations of the study

The starting point for this research was to use an AI methodology. The reason was to focus on the strengths of the system within which hospital midwife research participants worked. AI would also enable midwives to look inwards at their own midwifery dreams and map out how they could be achieved. However, as the stories unfolded it was clear that midwives found it hard to focus on the positive aspects alone. Therefore the research pivoted to

become a qualitative descriptive study informed by AI but enabling the capture of negative aspects as well. The tensions of working within an institution was not a theme I was planning to acknowledge when I first started conducting interviews. While the midwives' negative experiences were not ignored, they were not sought as they may have been if this had been a study that was focused equally on both the positive and negative aspects of hospital midwifery.

The small number of participants mean the findings are unique to this group of midwives currently in practice. The aim is not for transferability, but for the potential to resonate with the reader. Hospital midwives will hopefully be able to recognise parts of this study's findings in the work they do.

5.7 Conclusion

Appreciative Inquiry sets out to discover the best of 'what is' at the initiation of the data gathering process. Hospital midwives value being able to practice what they feel is the heart and soul of midwifery, appreciating connections they make with wāhine/women and striving to give the wāhine/women the best experience possible with the tools they have. Midwives value balance, they want to work hard, which provides them with the satisfaction of staying competent and confident in their clinical skills. Still, they also need to find time to appreciate moments of connection with wāhine/women and their whānau.

Midwives seek balance in all areas of their lives, and at work are nourished by moments of connection with wāhine/women and colleagues at work. Midwives can bloom where they are planted, they seek growth in their work and find meaningful connections within their work environment with wāhine/women and their colleagues. They have often made the decision to work in a maternity unit out of necessity for a perceived work/life balance but have continued working within the institution even after a return to life on call would be possible.

Midwives desire support from their institutions to continue to grow and flourish in their work, and form meaningful connections with wāhine/women. When the opportunity is given for support, midwives can then go on to practice in a way that sustains the heart and soul of their work.

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Appendices

Appendix A: Consent to participate in research

What are the contributing factors that sustain core midwives in their practice?

CONSENT TO INTERVIEW

This consent form will be held for five years.

Researcher: Megan Hooper Smith, 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 1st November 2021, and any information that I have provided will be returned to me or destroyed.
- The identifiable information I have provided will be destroyed on 30th November 2021. De-identified information will be destroyed on 1st June 2026.
- Any information I provide will be kept confidential to the researcher and the supervisor.
- I understand that the findings may be used for a master's report and/or academic publications and/or presented to conferences.
- I understand that the recordings will be kept confidential to the researcher and the supervisor.
- I understand all video content will be deleted immediately after the interview (if conducted via Zoom).
- I understand that organisational consent has been provided and the organisation will not be named in any of the reports

- My name will not be used in reports and utmost care will be taken not to disclose any information that would identify me.

- I would like a copy of the recording of my interview: Yes ☐ No ☐
- I would like a copy of the transcript 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: _____

Appendix B: Research information sheet

Why do experienced New Zealand midwives choose to practice in hospital?

INFORMATION SHEET FOR PARTICIPANTS

You are invited to take part in this research. Please read this information before deciding whether or not to take part. If you decide to participate, thank you. If you decide not to participate, thank you for considering this request.

Who am I?

My name is Megan Hooper Smith and I am a master's student with the School of Nursing, Midwifery and Health at Victoria University of Wellington. I am also a core midwife, employed by Mid Central District Health Board, working at Palmerston North Hospital. This research project is work towards my thesis.

What is the aim of the project?

This project investigates the reasons core midwives give for staying in the profession.
Your participation will support this research by assisting me to look into why core midwives stay in the profession, using interviews to discuss what influences you to stay in practice, and what could sustain you to keep practicing as a core midwife in the future. This research has been approved by the Victoria University of Wellington Human Ethics Committee, ethics application number 0000029153.

How can you help?

You have been invited to participate because you are a core midwife, who has been practicing for at least 8 years. If you agree to take part, I will interview you at a time and location negotiated with you. This also includes options for online interviews via Zoom. The interview will take 45-60 minutes. I will audio record the interview with your permission and write it up later. You can choose to not answer any question or stop the interview at any time, without giving a reason. You can withdraw from the study by contacting me at any time before 1st November 2021. 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 researcher named below will be aware of your identity, but the research data will be combined, and your identity will not be revealed in any reports,

* Confidentiality will be preserved except where you disclose something that causes me to be concerned about a risk of harm to yourself and/or others.

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 read the notes or transcript of the interview. The interview transcripts, summaries and any recordings will be kept securely and destroyed on 1st June 2026.

What will the project produce?

The information from my research will be used in my master's report and may also be presented to midwifery colleagues and in journal format.

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 and/or recording of online interview to be turned off at any time during the interview;
- withdraw from the study before 1st November 2021;
- ask any questions about the study at any time;
- receive a copy of your interview recording;
- receive a copy of your full interview transcript;
- read over, comment on and keep 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?

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

Student:
Megan Hooper Smith
hoopermega@myvuw.ac.nz

Supervisors:
Dr Robyn Maude
robyn.maude@vuw.ac.nz
Dr Susan Lennox
susanmareelennox@gmail.com

Human Ethics Committee information

If you have any concerns about the ethical conduct of the research, you may contact the Victoria University of Wellington HEC Convenor: Associate Professor Judith Loveridge. Email hec@vuw.ac.nz or telephone +64-4-463 6028.

Appendix C: Ethical approval

VICTORIA UNIVERSITY OF WELLINGTON TE HERENGA WAKA

Phone 0-4-463 6134
Email rhonda.shaw@vuw.ac.nz

TO	Megan Scott
FROM	Associate Professor Rhonda Shaw, Convenor, Human Ethics Committee
DATE	15 April 2021
PAGES	1
SUBJECT	**Ethics Approval** **Number:** 29153 **Title:** Using appreciative inquiry to interview hospital employed midwives to discover their motivations for staying in midwifery.

Thank you for your application for ethical approval, which has now been considered by the Human Ethics Committee.

Your application has been approved from the above date and this approval is valid for three years. If your data collection is not completed by this date you should apply to the Human Ethics Committee for an extension to this approval.

Best wishes with the research.

Kind regards,

RMshaw

A/Prof Rhonda Shaw

Convenor, Te Herenga Waka—Victoria University of Wellington Human Ethics Committee

Appendix D: Local District Health Board ethics approval

[redacted]

11 March 2020

Institutional Approval

[redacted]

[redacted]

Dear Megan

Re: "Sustaining the core- why do core midwives stay?" What are the contributing factors that sustain core midwives in their practice?

[redacted] **Research ID: 2020.01.004**

The [redacted] DHB Research Support Office would like to thank you for the opportunity to review your study, and has given approval for your research.

Your Institutional approval is dependent on the Research Office having up-to-date information and documentation relating to your research and being kept informed of any changes to your study. It is your responsibility to ensure you have kept Ethics and the Research Office up to date and have the appropriate approvals.

[redacted] approval may be withdrawn for your study if you do not keep the Research Office informed of the following:

- Any communication from Ethics Committees, including confirmation of annual ethics renewal
- Any amendment to study documentation
- Study completion, suspension or cancellation

If you have any questions please do not hesitate to contact the Research Support Office.

Yours sincerely

[redacted]

Research Support Officer
[redacted] **District Health Board**

Chief Medical Officer's Department

[redacted]

[redacted]

Appendix E: Local Māori Research Review Group endorsement

[redacted]

[redacted]

Date: 24 February 2020

Megan Hooper Smith
[redacted]

Study Title: "Sustaining the core- why do core midwives stay?"
What are the contributing factors that sustain core midwives in their practice?

[redacted] Research ID: 2020.01.004

Tēnā koe Megan,

The [redacted] Māori Research Review Group met on 19 February to discuss your research proposal.

Thank you for providing the documentation relating to this project.

Comments:

- The Māori Research Review Group prefers for all individuals involved in participant recruitment and conduct of research at [redacted] to have completed Treaty of Waitangi and Cultural Responsiveness training provided by our organisation. In some cases, individuals involved in the conduct of the research may have completed alternative training in both Treaty of Waitangi and Cultural Responsiveness - it is the responsibility of the primary researcher to ensure that all people involved in the research team have completed suitable training so that recruitment and conduct of the research is culturally safe for Māori participants.
- The [redacted] Māori Research Review Group is willing to assist in the dissemination of your findings to the appropriate Māori organisations, Māori health professionals and Māori researchers in the [redacted] district as needed.

NB. The views expressed in this document are those of [redacted]

[redacted]

[redacted]

On behalf of the [redacted] Health Board Māori Research Review Group the study has been endorsed to commence at this DHB.

This endorsement by the Māori Research Review Group is dependent on the [redacted] Research Office having up-to-date information and documentation relating to your research and being kept informed of any changes to your study. It is your responsibility to ensure all relevant groups (e.g. ethics committees, [redacted] research office) have access to current and accurate information about the study and that all of the appropriate approvals are in place throughout the duration of your research.

We wish you well with your research.

Whaowhia te kete mātauranga
Fill the basket of knowledge.

Nāku noa, nā

[redacted]

On behalf of the Māori Research Review Group

[redacted]

NB. The views expressed in this document are those of [redacted]

Appendix F: Interview prompt questions

Interview Questions

Discovery

I want you to reflect on a typical day working as a core midwife- what do you particularly like doing? What do you look forward to about coming to work?

What brought you to midwifery? Why did you apply to become a midwife?

Reflecting on your time as a core midwife- when have you felt the happiest in your job? Why do you think you felt that way?

Dream

Reflecting on the most positive moments of working as a core midwife, what is your vision for your future as a core midwife?
Looking back on why you became a midwife, do you think you could achieve this vision?

Design

What needs to be implemented to help you achieve these goals? This could be personal workplace/institution-driven.