

Creating a better work-life balance

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ABSTRACT

Co-operative inquiry, an action research approach, was selected to investigate the work-life balance of 16 caseloading midwives living in Auckland. For some of the midwives the tension between their professional and personal commitments was at times hard to control, as they believed they needed always to be there for the women in their care. Thus burnout was a risk from the continuous on call nature of their role.

The participants met with the researcher in a series of focus groups for dialogue and inspiration as they evaluated their individual practice assumptions. Thus together they became co-participants and co-researchers in the study.

The midwives reflected on and re-evaluated their assumptions about their practice roles and in particular their relationships with women and with colleagues.

Resolutions to make and sustain change involved weighing up the options available and stepping out to create new relationships and new ways of working. Further, the findings in the study lead to the development of a work-life balance tool for midwives.

KEY WORDS

Caseloading, continuity of care, personal well-being, reflexivity, action change, work-life balance

INTRODUCTION

To be a caseloading midwife with sole responsibility for the primary pregnancy care of a woman - known in New Zealand as Lead Maternity Carer (LMC) - involves providing her antenatal, labour and postnatal care and that of her baby until six weeks after the birth (Ministry of Health, 2007). It involves being responsive around the clock to the maternity needs of the women in their care. The specifications for primary maternity care are set out in Section 88 of the New Zealand Public Health and Disability Act (Ministry of Health, 2007). Their contract requires that the LMCs or

their back-up "will be available 24 hours a day, 7 days a week to provide phone advice to the woman and community or hospital-based assessment for urgent problems, other than acute emergencies" (Ministry of Health, 2007, p. 1060). Midwife LMCs make up 41% of the midwifery workforce and care for an average of 47 women per midwife each year (Ministry of Health, 2010). The New Zealand College of Midwives promotes the philosophy of continuity of care recognising it as enhancing partnership with women (Guilliland & Pairman, 1995) – a philosophy confluent with the LMC model.

National satisfaction surveys show that women receiving continuity of care during childbirth report greater satisfaction (Ministry of Health, 2008). They also experience fewer interventions and have better outcomes ensuring the cost effectiveness of their care. (Ashton, 2005; Saultz & Albedaiwi, 2005; Saultz & Lochner, 2005; Waldenstrom, 1998). Thus, LMC midwives, as the primary care providers, appear to have achieved both the cost containment of maternity services and met the consumer demand for woman-centred care.

Although the provision of continuity of care improves the satisfaction for women, for some LMC midwives providing this service comes at a personal, emotional and physical cost (Caza, 2007; Young, 2011). Despite most midwives having effective strategies for sustainable practice (McAra-Couper et al.) changing circumstances can make it a struggle to maintain the balance between their work and their personal life. (Donald, 2012). What follows is the report on a research study that used cooperative inquiry methodology to explore how a group of Auckland LMC midwives could adjust their work to support an improved work-life balance. These midwives wanted to find a way to provide continuity of care while sustaining their own well-being. Through their experience of participating and sharing in this action research these LMC midwives were inspired and enabled to make changes. As co-researchers and co-participants they worked through cycles of reflection and individual action change in collaboration and dialogue with their colleagues (Heron, 1996).

RESEARCH DESIGN

Action research methodology is derived from critical social science and is used in many organisations and institutions as a vehicle to effect change. It is about practitioners investigating their own practice on the job, describing their interventions, and providing evidence of improvement (McNiff, 1988; McNiff & Whitehead, 2006). LMC midwives can choose how and when they work but must meet the requirements of the Section 88 contract and the Standards of Midwifery Practice (MOH 2007, NZCOM, 2008). Thus they can identify what needs to be changed in their practice and implement the resulting modification.

Cooperative inquiry comes under the umbrella of action research and was selected as the guiding methodology for this research. It is a term coined by Heron (1996) who developed this research approach to provide personal and social transformation through increased self-direction in living. It is also about wholeness, where everyone is part of the whole, where everyone participates through collaboration and dialogue working as co-subjects and co-researchers (Heron, 1996). Alongside cooperative inquiry, the principles of appreciative inquiry were used to enrich the project through the amassing positive accounts of what was working well and, by building on these strengths, enabling participants to envision and create a better future (Cooperrider & Whitney, 2005). These approaches were the foundation for the practical, philosophical, participatory and reflexive properties of the study and the democratic standpoint that addressed power and knowledge.

Ethical approval for this study (Number 08/11) was granted by the Auckland University of Technology Ethics Committee in April 2008.

The research was guided by a doctoral student (the lead researcher). As an LMC midwife she was also concerned about her work-life balance and able to be wholly engaged with the field of inquiry as a full co-subject and co-researcher (Heron & Reason, 2007). Fifteen other caseloading midwives joined the study after responding to an invitation distributed through the New Zealand College of Midwives Auckland region's global email list.

The participating LMC midwives came from both rural and urban areas. Midwifery practice experience ranged from those new to LMC practice, to those who had practised as LMCs since the early 1990s. Their ages ranged from 24 to 60 years with the average age being 48.4 which aligns with the current average age of the New Zealand midwifery workforce of 47.2 years (Midwifery Council of New Zealand, 2011). Māori and European ethnicity New Zealanders were represented alongside midwives who have emigrated here. As with their age, their nationalities also aligned with the latest midwifery workforce data (Midwifery Council of New Zealand, 2011).

Methodology and analysis

Over a period of 20 months the midwives completed four cycles of collaborative evaluation, reflection and subsequent action in their individual practices. Each midwife identified the issues affecting her work-life balance supported by collaboration and consultation with her focus group colleagues. In each cycle they implemented and reviewed changes they felt necessary in their individual practices.

Focus groups met once in each of the four cycles. Each session lasted two hours and the discussion was audio recorded. Where a midwife was unable to attend a focus group, the researcher made contact to update her on the ideas and topics discussed. Between the focus group sessions, the lead researcher kept in contact by phone or email with each participant to discuss the impact of changes in their individual work settings. The midwives kept journals to help them reflect on the changes they were putting in place.

Data sources for the study included the recorded focus group sessions, individual interviews with midwives not attending the focus groups, and hand written and electronic notes from the phone and email conversations. All audio recorded data were outsourced privately for transcribing following a signed confidentiality agreement with the private transcribers and consented by the participants.

The lead researcher immersed herself in the data by reading and re-reading the transcripts and listening to the audio recordings to ensure all that was being said, was heard. Information was manually grouped into different categories. Patterns of relationships within and between the categories were identified about the reasons why the midwives felt they needed to change their practice, and how they went about making the changes (Heron, 1996; Krueger & Casey, 2000). Changes were already in progress for some of the midwives at the time they joined the enquiry group. For others, change began during the research project.

A reflexive stance was adopted to address issues of rigour and validity. Lash (1993) states that for reflexivity to occur there needs to be a subject, an object, and a medium of reflection. In this study the reflecting subject was the individual midwife as she examined herself and her practice through the medium of action research. The objects of the reflection were the norms of the structures within which the midwives practised—for example, their philosophy and standards of care.

FINDINGS: The midwives and action change

The findings of an action research study are about the participation, the process and any change that may result. In this study the nature of the process and the change was particular to each midwife. Some midwives made radical changes to how they organised their time while others chose to maintain the status quo, albeit with a richer insight into their personal and practice habits. The findings therefore describe how each midwife

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responded, revealing the uniqueness and complexity of their individual situations. To protect the identity of the participants, pseudonyms have been used.

Three main themes were identified to show how change evolved: a tension between work and home commitments; changing assumptions about commitments; and sustaining practice change. A summary of the journey of each LMC midwife in the study is presented. The stories are grouped under the theme that best represents the effect cooperative inquiry had on their work and personal lives.

The first theme revealed a tension that arose between the allegiance the midwife believed she had to the woman and the need to meet her own personal commitments.

Tension between work and home commitments

Cherry worked as an employed caseloading team midwife. When Cherry's practice partner left the team, Cherry chose to work on call 24 hours/7 days a week (24/7) instead of having her usual two days off per week. She had thought this was a good way to provide care for women until she realised that her life had been over taken by the constancy of being 'on-call'. Change of mind-set: Discussions in the focus groups prompted Cherry to give herself permission to be released from certain ideals she had held about continuity of care and partnership. Realising it was acceptable and necessary to have time off she was no longer driven by, and was released from, a deep sense of guilt.

With her combination of work and family commitments **May** considered that she had a busy lifestyle but would like to manage it better. She worked 24/7 on call in a group having cover (using a back-up midwife) only for an important event or an occasional weekend off. Adopting strategies: May's focus during the research was to work at streamlining her practice to fit around her personal needs. Weighing these up and considering what she heard in the focus group discussion she decided that the beauty of being 'her own boss' rather than having set days off gave her the opportunity for spontaneity and flexibility in her day time activities. For now this suited her best.

Living in a rural area can mean less cover available to have regular time off. **Skye** was fortunate to have other LMC midwives in her area who were keen to share a caseload to enable more planned time off. There were times though when they were stretched to their limit as their booking numbers each month fluctuated and they had no control over when women birthed. Minimal change: The study involvement provoked Skye to consider sharing a caseload to get regular down time. However Skye felt

that the satisfaction she received from her on-call care provision would be diminished if she shared a client load. She chose to continue to provide 24/7 care using locum cover for arranged blocks of leave during the year. To assist with this she received assistance through the rural locum relief support fund available through the New Zealand College of Midwives (Health Workforce NZ, 2011).

An employed caseloading midwife, **Mariana**, joined the cooperative inquiry to get ideas for managing her practice life. At times her work load seemed unmanageable and she was unable to provide fully all of the aspects of care she felt the women needed. She often had high-risk clients in her caseload which placed a greater demand on her time. Listening to how others were thinking and making changes Mariana realised she needed to take control of change in her practice if she wanted to make a difference. A lowered caseload: Mariana collected and collated data to present to management that showed how high risk clients needed more frequent visits and longer sessions. Subsequently the caseloads were lowered for those who carried high risk women.

For **Kathryn** 'continuity of care' meant 'one midwife to one woman' and so stayed on-call with only occasional time off. Changes in her family life were coming up that could threaten her on-call availability. She had been considering whether she needed to move to a 'shift based' midwifery position with regular and predictable hours. Explored possibilities: The action research project opened up new possibilities for Kathryn to explore as she pondered how she could make her current practice more sustainable in the future.

Caught between a desire to be a LMC midwife and the need to be a mother and grandmother **Bronwyn** joined the group to try and find an answer to this dilemma. Relinquishing LMC practice: Bronwyn evaluated her philosophy about caseloading practice and chose to work with regular time off. She was unable to find a permanent midwifery partner or group for the backup she required and decided not to continue in LMC practice.

Changing assumptions about commitments

The second theme showed that for successful change to occur the midwife needed to change assumptions surrounding her commitments to the woman and to herself.

Being on-call 24/7 for **Evelyn** was not only about being with a woman any time during the day or night for a birth but also meant going to a woman's home in the middle of the night to help with breastfeeding. Evelyn's passion to be there for women had obsessed her. It had become unsustainable for her and tiredness was threatening to make her practice unsafe. Developing team philosophy: Evelyn formed a team and they worked on building continuity of care through a 'shared philosophy'. They

provided the same information to women and had the same approach to the midwifery care. When Evelyn was off call she knew the women in her caseload would receive the same level of support from her backup that she would have provided.

Life was losing its pleasure for **Joan** who had come to the point where her on call availability meant she was neglecting herself. She struggled to maintain personal activities in her life. Her participation in this research project opened up her thinking to pursue a change in the philosophy about how she had worked for many years. Getting regular days off: Joan was fortunate in the timing and two other midwives in her area coincidentally wanted to have regular time off.

An important consideration for **Rose** was not letting her midwifery practice dominate her life to a point where it prevented her from spending time with her family and friends. This was complicated though as she needed a regular income and in her rural area the number of women birthing was low. This tempted Rose to stay on call as her other colleagues often did. Empowering women: Rose identified that women needed to be empowered to rely on their own abilities and family support rather than be dependent on a particular midwife. Over time, as she stayed true to her ideals, she set an example to her practice colleagues as they slowly came to the same realisation that regular time off call was important for their well-being.

The project gave **Rachelle** the opportunity to observe the conflict that occurred in the lives of other midwives whose commitment to being on call for women put them at risk of neglecting their personal well-being. Achieving regular days off: Rachelle became aware of the importance of having regular and predictable time with her partner so that they did not develop separate lives and grow apart. She changed her on call philosophy of care 24/7 to one of providing continuity of care with regular days off call each week.

The focus group encounters provided a catalyst for the LMC midwives to re-evaluate their philosophy of practice and assumptions about how they managed their midwifery practice. **Janet** had a good off call arrangement with another midwife but still felt her workload could be managed more efficiently. Time management: Janet reduced the frequency of her antenatal and postnatal visits in line with recommended best practice which dramatically freed up her time.

Sustaining practice change

Finally, when the LMC made a practice change, a concerted effort was needed to adapt to the new ways of thinking and to sustain the practice change.

A commitment to family for **Robyn** superseded any consideration of working on call 24/7 for long periods of time. Fortunately Robyn knew two other caseloading midwives wanting to be in a structured team for regular time off call. However working in a group brought communication issues. Building team solidarity: Robyn learnt to raise any issues that were preventing her from being honest with other members. If disputes were not dealt with promptly, resentment could build up over time affecting colleague relationships.

After providing on call care 24/7 for several years **Margie** felt she had 'burnt out'. Her marriage suffered and she felt alienated from her children. After a year off she came back to LMC midwifery but needed to be able to say to her family regularly, "I'm off call tonight". Learning to be a team player: Margie commenced employment working in a team providing on call care with weekly structured time off. Being involved in the study gave her insight into many of the practice issues she faced. Margie no longer adhered to the 24/7 philosophy she had believed in and was now learning to work in a team, a 'letting go' of her previous way of doing things.

To work in a team with scheduled time off and only work two to three days on call at a time were ideal for **Ellie** while she had young children. However her team had a conflict of values that had profoundly affected team cohesion. Some midwives placed more emphasis on providing

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Tension between the midwife's professional and private life can affect her ability to sustain a practice long-term

'continuity of carer' rather than 'continuity of care'. Addressing group issues: Through the discussions and support in the focus groups Ellie felt confident to work on group dynamics in her practice. She realised that improved communication would achieve better relationships and the ability to align philosophies.

At the point of burnout **Mary** had to relook at joining a team for regular structured time off call. Becoming part of a team: An opportunity presented to work with two other midwives who also wanted to provide caseloading care with structured time off. She had worked in a team before but they had not been able to 'keep it together'. Participation in the research project gave Mary a platform to explore ideas to enable her to work on consolidating her team. Communication became an essential feature in the team. Regular meetings were held with an agenda and written records to reduce unnecessary conflict.

To work as a LMC midwife on call 24/7 was no longer sustainable for **Lorraine**. The constant periods of extreme tiredness after a birth and still being on call with unpredictable down time had become stressful. Adapting to a team approach: Lorraine changed to working in a group with regular days off. Yet she still did not achieve the satisfaction she thought she would. Lorraine experienced guilt when she was not available for her clients. The group discussions helped Lorraine realise she had created a dependent relationship with the women and not one of empowerment. If she was not at a client's birth she would feel disappointed which added to the guilt she experienced for not being there. Lorraine's focus of change during the project was to completely let go of her old way of thinking and to trust her colleagues more; the inspiration from others in the group enabling her to achieve this change.

This research demonstrates that the well-being of the LMC midwife can be affected in various ways. Tension between the midwife's professional and private life can affect her ability to sustain a practice long-term. Important factors threatening a balanced work-life arrangement were identified.

- the type and size of the caseload a midwife was carrying, e.g. low versus high risk clients
- being a rural LMC with a fluctuating caseload
- the robustness of the group structure for support and back-up
- how organised and self-aware the midwife was in the day-to-day running of her practice
- the quality of the interpersonal relationships in the midwifery team.

DISCUSSION

The LMC midwives in this study recognised how they struggled with managing their work-life balance. Some even talked about having experienced burnout. Their experiences reflected that of LMC midwives in other New Zealand research (Young, 2011) but these latter midwives had reached a point where they had felt powerless to get the support they needed. Their lives were put on hold and they felt incapacitated to work. In contrast, the midwives who participated in this current study had come to recognise their risk of burnout and were eager to find strategies to avoid it.

A common theme in this current study was the midwives' commitment to women's care; in particular they embraced the principle of continuity of care. Crossley (2005) suggests "society creates the social agent, who then recreates society" (p. 112). In a similar way the midwives were recreating what they believed was the only correct ethical way to provide continuity of care to women. The midwife participants sought to change their practice so as to be able to continue to provide continuity of care to meet the New Zealand College of Midwives Standards of Practice (NZCOM, 2008). The midwives who changed, from being on call 24/7 with only occasional time off, to having set days off, were mindful of their commitment to continuity of midwifery care. To the best of their ability they organised their practices so that the women in their caseload had an on-going relationship with the LMC and her back-up for the duration of their care. However, two midwives after reflection, decided that the flexibility of remaining on call suited them better than working in a team environment.

Some of the midwives who chose to work in a team providing continuity of care found that 'trusting relationships' with their colleagues were essential to achieving a better work-life balance. Team work provided newfound collegial support where previously, working with their individual caseload, they had felt isolated. In a recent Australian phenomenological study of a midwifery group model of practice, Moore (2009) interviewed midwives who set up team caseloading care that enabled women to be cared for by known midwives. Essential elements emerged which were similar to the findings of this study. These included attention to work-life balance, a shared group philosophy, the advantages of peer support, and a culture of trust.

Working in a team brought new challenges. Conflict arising between team members was often difficult to resolve and, where it was not dealt with early, could cause ongoing resentments. In his Canadian research, Bearden (2009), a registered nurse and health care manager, wanted to determine how training in constructive conflict resolution could benefit nurses. Using a naturalistic inquiry methodology Bearden interviewed ten nurses and three midwives to gain an understanding from their respective perspectives. The findings showed that unresolved conflict seriously hampers the relationships in a group and can even lead to burnout. Barriers that prevent effective resolution in times of dispute were identified by Gerardi (2004). He noted that these include: "time constraints, inadequate access to information, poor communication structures, unclear roles, conflicting policies, diversity of education/experience of clinicians, power imbalances, practice variations, high stakes, emotionally charged situations, and fatigue" (p. 183). The LMC midwives in this research project, who were faced with conflict in their practices, learnt from others in the research group how to address some of the factors cited by Gerardi. In particular addressing the time issues, group structures and communications strengthened them to face up to, and deal with, their particular conflict issue.

THE WORK-LIFE BALANCE TOOL

As a direct result of the cooperative inquiry, a work-life balance (WLB) tool has been developed. This is to assist a midwife to assess her well-being and recognise when she might need to make changes in her practice (Figure 1). This WLB tool is designed to make the caseloading midwife stop and 'think'. It is to help her measure how effective she is at integrating her personal needs around her on call work. It is then up to the individual midwife to decide if she needs to make changes. It could also be used

Work-life Balance (WLB) score for the LMC midwife

Name..... Date.....

ARE YOU IN THE RED, YELLOW OR GREEN ZONE?

Select the closest description or add your own to fit your situation

Points	0	1	2	Subtotal Choose a point from each criteria
Personal relationships	Not enough time for family No social life <i>Or.....</i>	Difficult to plan activities with family and friends <i>Or.....</i>	Enjoy planned time to spend with family and friends <i>Or.....</i>	
Time off call	Difficult to get cover <i>Or.....</i>	Some cover but not as often as I need it <i>Or.....</i>	Regular cover for days off <i>Or.....</i>	
Group/team work	Work on my own but struggle <i>Or.....</i>	Tension between members Some conflict difficult to resolve <i>Or.....</i>	Great team work and support Or Happy working on my own and have support if needed <i>Or.....</i>	
Physical wellbeing	Not enough sleep No recreation Poor eating habits <i>Or.....</i>	Struggle at times to catch up on sleep Irregular recreation Irregular eating pattern <i>Or.....</i>	Able to catch up on sleep Regular recreation Healthy eating <i>Or.....</i>	
Life satisfaction	Life is a constant struggle <i>Or.....</i>	Feel up and down Feel guilt if not available for women <i>Or.....</i>	Life feels great <i>Or.....</i>	
0-3: Red Zone	Life needs urgent attention! Intervene now before possible burnout.			Total Score
4 to 7: Yellow Zone	The work-life balance needs some attention. Life could be better. Continuing like this could make continuity of care difficult to sustain long term.			
8 to 10: Green Zone	Well done! A great work life balance. There is enough time for work and enough time to have a personal life and to enjoy both.			

Figure 1

as part of professional supervision, or within a group meeting, to assist midwives to recognise early indications of work and lifestyle stress.)

CREATING AN OPTIMAL WELL-BEING CULTURE

Many of the midwife participants began caseloading practice committed to the idea that the women came first and that they needed to be on call 24 hours, seven days a week. The cooperative inquiry research process enabled them to evaluate their assumptions about their practice and personal philosophies. They strategized to find a work-life balance that suited them in order to enhance their personal well-being, while still providing continuity of care for women.

LMC midwives have a professional responsibility to reflect on, and have strategies to care for, their own well-being. The Midwifery Standards Review (MSR) is a good starting place for this to occur as all LMC midwives are required to participate to maintain their practising certificates (Midwifery Council of New Zealand, 2012; Ministry of Health, 2003). The MSR is also well situated to provide reviewers with the opportunity to monitor and promote a culture of optimal self-care. This thinking is supported by Halldorsdottir and Karlsdottir (2011) in their research on professional caring which concluded by recommending that professional bodies should not just focus on cognitive and practical competences, but also on the evaluation of attitudes, interpersonal competence and self-care.

The midwives in this study have shown that LMC midwives can benefit from a structured reflective process to examine how they work and think. Using the principles of cooperative inquiry further peer review activities could be developed to support midwives needing to make practice changes to achieve a better work-life balance. Assessing personal well-being is ongoing. Awareness of the principle of establishing a sustainable life-work balance needs to start with midwifery students. Networking within and across geographical areas would provide opportunities for midwives to choose practice groups settings best suited for their needs. Most importantly, midwives need to develop good communication skills to negotiate and achieve effective practice change. Education sessions which encourage strategies for dealing with conflict, and skills for constructive conversations are desirable if midwives are to work within a culture that is self-preserving, not self-sacrificing.

CONCLUSION

This cooperative inquiry project was prompted by the desire of 16 New Zealand LMC midwives seeking a better work-life balance. The potential for being called out at any time impinged on their well-being and exposed them to the possibility of burnout. The tensions between their professional and personal commitments were at times hard to tolerate and some suffered from guilt if they could not 'be there', at all times, for the women in their care. To succeed in creating innovative ways to practise, the participants agreed that they needed to change their assumptions about how they provided care. This required adopting an empowering approach to care focussed on the woman's ability to cope rather than allowing the development of a dependent relationship between the woman and the midwife. The project has led to the design of a work-life balance score tool for midwives to self-monitor their well-being. All midwives, from the clinical practitioners themselves to the leaders and educators, need to act as change agents, to promote skills for work-life balance awareness so that everyone enjoy sustainable, safe midwifery practice while still honouring the principles of partnership and continuity of care.

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