

The work-life balance of the case-loading midwife:
A cooperative inquiry

Heather Donald

DHSc

2012

The work-life balance of a case-loading midwife:

A cooperative inquiry

Heather Donald

**A thesis submitted to Auckland University of
Technology in partial fulfilment of the requirements
for the degree of Doctor of Health Science**

Faculty of Health and Environmental Sciences

Primary Supervisor: Liz Smythe

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature 

Date..... 12 . 3 . 12

Abstract

Case-loading midwives have a demanding role with an unpredictable workday in which they juggle their professional, social, and personal demands. They often work long hours at a time and may choose to stay on-call without taking regular and frequent time off. These midwives are now the majority of Lead Maternity Carers (LMC) in the New Zealand maternity service contracted by the Ministry of Health to provide continuity of maternity care. The New Zealand College of Midwives' philosophy and standards of practice uphold a continuity of care ethic that is enhanced by midwives working in partnership with women. Cooperative inquiry, an action research approach, was selected as the best fit to investigate the concern some case-loading midwives had about the affect this on-call lifestyle had on their well-being. The tension between their professional and personal commitments was at times hard to control. Many suffered from guilt if they could not be there for the women in their care. They had an overwhelming commitment to always be there. Over 18 months 15 case-loading midwives investigated their practice in four cycles of reflection and action to make their work-life balance better. The participants became co-researchers and co-participants through collaboration and dialogue. The findings gave a range of practical ways of how they achieved change.

An influence of appreciative inquiry added a positive focus on what was good as participants envisioned and created a better future. To bring a deeper understanding to the change process the 'thinking tools' of the French social philosopher Pierre Bourdieu [1930-2002] were introduced. The important concepts of field, capital and habitus were used during the analysis and discussion of the findings. This had a core framework of reflexivity that illuminated the complex relationships between culture and power that confronts midwives in contemporary society. It was identified that the provision of continuity of care had come with personal, emotional and physical cost with a threat of burnout. To succeed in creating new or innovative ways to practice the participants needed to change their assumptions about how they provided care. This required an empowering approach to care focussed on the women's ability to cope rather than a dependency on the relationship between the woman and the midwife. An innovative tool to enable midwives to self-monitor their well-being was developed from this study. The study concludes with recommendations for leaders and educators on how to be change agents in promoting case-loading midwives self-care towards ensuring sustainable, safe midwifery practice, while still honouring the principles of continuity of care for the women they serve.

Acknowledgements

I want to express my sincere appreciation to the 15 co-participants and co-researchers who joined me on a journey of discovering how to make our work-life balance better. We had lots of laughter and serious contemplation as we analysed our work-life balance trying to put all we did into perspective. This study was only possible because of the willingness of these case-loading midwives who gave up precious time and to make the commitment to be part of the research.

I could not have achieved completion of this project without the step by step guidance and wisdom from my supervisors Liz Smythe and Judith McAra-Couper. Liz was always there if I needed her and gave timely advice that was just what I needed. Judith, who joined along the way, provided challenging insight on midwifery matters to keep the project in line with current thinking. Heartfelt thanks goes to them for their inspiration, reassurance and counsel.

Thanks to Julie Alesech who accompanied me on the way as she also worked on her doctoral thesis. The times we met to discuss our ups and downs always left me encouraged to carry on.

Thank you to the many midwifery colleagues and friends who provided encouraging interest in the project over the past six years.

My children have not only had to put up with having a case-loading midwife as a mother with her unpredictable hours and never knowing when she may be around but also put up with a mother who was studying. I look forward to being able to spend more time with each one and especially with my granddaughters Aliah and Mackenzie. To my husband Lindsay, who also had to share the sometimes impossible hours that both the research writing and my work brought, I give you the biggest thanks for your understanding and for your patience in waiting for me to finish.

TABLE OF CONTENTS

CHAPTER ONE: A desire for change.....	1
The emergence of continuity of care and a midwife-woman partnership	3
Justification of the study	4
Study context	5
Theoretical position	6
Position of researcher	7
Looking ahead	8
CHAPTER TWO: The place of midwives: the past to the present.....	9
The role of the midwife mid-1800s to 1930	9
The role of the midwife 1930 to 1950	12
The role of the midwife 1950 to 1990	13
The role of the midwife 1990 to 2000	16
The role of the midwife 2001 to 2011	21
Summary.....	25
CHAPTER THREE: The literature review	27
Woman-centred care	27
Continuity of care	29
Case-loading practices	32
Safety	37
Fatigue and burnout	40

The work-life balance	45
Summary.....	50
CHAPTER FOUR: Methodology	51
The choosing of a methodology in relation to the concern.....	52
Participatory paradigm.....	53
Reflective practice	56
Knowledge in action for action: Cooperative inquiry	56
Four forms of knowing and belief	58
Appreciative inquiry	60
Introducing Bourdieu	61
Summary.....	64
CHAPTER FIVE: The process.....	65
Gaining ethical approval.....	65
Accessing participants	66
The cooperative inquiry midwives (CI midwives)	67
Ethical considerations.....	68
Truthfulness.....	70
Validity procedures.....	70
Truth, rigour and validity through reflexivity	73
The action research cycle	74
An outline of the research stages	76

Timeline	77
Methods of gathering information	78
Focus groups.....	80
Journaling.....	82
Interviews.....	82
Making sense of the data	83
Reflections of the lead researcher.....	87
Summary.....	87
 CHAPTER SIX: Setting the scene	 89
Different approaches to practice arrangements.....	89
The midwife participants	92
The change process	100
 CHAPTER SEVEN: Initiating the change process	 103
Theme: Tension between commitment to women and commitment to self.....	103
Family	105
Financial security	106
Personal autonomy.....	109
Recreation and social needs	113
Physical and emotional well-being	115
Summary.....	120
 CHAPTER EIGHT: Action change	 122
Theme: Changing our assumptions.....	122
Stage One: A resolution to change	123

Making the decision	124
Sorting priorities	125
Stage Two: Weighing up the options.....	127
A deep seated commitment to 24/7 on-call continuity	127
Stage Three: Stepping out	130
Letting go	130
Empowered relationship	134
New attitude	138
CHAPTER NINE: Agents of change	145
Overcoming new challenges	145
Prerequisites for change	146
Changing old habits	146
Trust and respect	147
Perseverance and commitment	149
Flexibility	149
Communication	150
Conflict resolution	153
Sustaining change.....	155
Managing the unchangeable	155
Reflection, evaluation and adjustment	157
Being change agents	160
Developing our own theories of practice	160
Innovation	161
Leading culture change	161
CHAPTER TEN: The continuing journey	165
Bourdieu and case-loading midwifery	165
Habitus	165

Social field	167
Capital	169
The cooperative inquiry midwives' stories of action change	172
Summary	183
CHAPTER ELEVEN: Concluding chapter	185
The findings of the research.....	185
Relating findings to other research	188
Recommendations for practice	190
Acknowledging burnout.....	191
Identifying and monitoring well-being	192
Keeping the woman and the midwife safe	193
Access to professional supervision	197
Conflict resolution	197
Creating a well-being culture.....	199
Recommendations for research	199
Limitations of the study.....	201
Reflection on the past six years.....	203
Closing thoughts.....	204
APPENDICES	216
Appendix A: Ethics approval.....	216
Appendix B: Recruitment advertisement	218
Appendix C: Formal invitation to participate.....	219
Appendix D: Consent form	222
Appendix E: Confidentiality Agreement	223

GLOSSARY OF KEY TERMS	224
------------------------------------	------------

LIST OF TABLES

Table 1 Data collection methods.....	79
--------------------------------------	----

LIST OF FIGURES

Figure 1 Work-life balance mid-1800s to 1930.....	11
Figure 2 Work-life balance 1930 to 1950	13
Figure 3 Work-life balance 1950 to 1990	16
Figure 4 Work-life balance 1990 to 2000	21
Figure 5 Work-life balance 2001 to 2011	25
Figure 6 Four cognitive modes and stages of the inquiry cycle (Heron, 1996, p. 56).....	59
Figure 7 Timeline of the action research process	78
Figure 8 Practice approaches of the cooperative inquiry midwives (CI midwives)	91
Figure 9 The stages of change and the action research cycle	101
Figure 10 Tension between commitment to women and commitment to self.....	104
Figure 11 Changing our assumptions	123
Figure 12 The old and the new assumptions.....	143
Figure 13 Work-life balance score.....	194

CHAPTER ONE

A desire for change

I am a case-loading midwife who chose to embark on doctoral studies with the desire to keep my practice and my research closely linked. The research quest for this study came directly from my own practice concerns. Action research, through the integration of research and practice, was selected as a means to identify effective strategies to achieve a work-life balance for case-loading midwives. The methodology of participatory action research allowed me to be both a researcher and a participant in collaboration with other midwives as we engaged in a systematic inquiry to make our work-life balance better (Heron, 1996; McNiff & Whitehead, 2006a; Reason, 1994; Stringer, 2007; Whitehead & McNiff, 2006).

Fifteen midwives accepted an invitation to join me to investigate the issue of the work-life balance and to find ways to provide a better balance through action research. We desired to change our practice, still upholding the partnership and continuity of care ethic, but at the same time working in a way that was sustainable for our personal well-being. It was to be transformative of our practice experience as we learnt how we could make changes to improve our work-life balance. This thesis provides an informative outcome describing the experience which offers practical recommendations for the midwifery community to enhance practice (Heron & Reason, 2007).

Reasons behind undertaking the study

I am very passionate about my call in life to provide case-loading care to women in childbirth. In my enthusiasm to provide continuity of care I found I developed habits that 'fudged' the boundary of my work and personal life. Being on-call for long periods of time, usually weeks on end, was very hard to sustain long term. While some midwives choose to work like this without apparent effect on their personal lives, for many of us it made being a case-loading midwife either an impossible vocation to consider or something only done for a short period of time. In 2006, at a NZCOM conference, Carolyn Young spoke about the potential cost to midwives of burnout when providing case-loading care, stressing that we need to look after each other (Young, 2006). This received heartfelt response from some midwives who knew the experience of burnout. Dr Brianna Caza (2007) in her thesis on experiences of adversity at work, confirms that midwives providing continuity of care have the potential to burnout depending on their resilience and how they adapt to adversity. I

wanted to further investigate the work-life balance for the case-loading midwife as I felt there must be a way for midwives who struggle with this issue, to improve the balance between their personal life and work.

After my children had grown up, I started pursuing new interests like outdoor sports. Once I became involved in these activities I found my availability for women on a '24 hours a day, 7 days a week' (24/7) basis became difficult to manage. Answering the phone while I was paddling a kayak or riding a bike was an issue. Running in the bush would mean no cell phone cover. Furthermore, I was not in a position to attend to a woman urgently. I needed to have regular time off-call but this conflicted with my notion of providing continuity of care. I had the expectation I would always be available for women to the point where I would forfeit days off or taking time off-call.

This made me think about the last 14 years and my approach to continuity of care. Where has my life gone? What does my family think of me? What sort of mother was I to my children? What sort of wife was I? What do my friends think when they meet with me and we are interrupted with phone calls from my clients? Was this all justified by being on-call for women 24 hours a day for periods of months at a time? I seldom missed a birth but if I did I felt I was letting the woman down. This made me even more anxious to always be there so as not to fail in my commitment to women. What drove me to provide care in this way? Did the woman need this commitment to receive optimal care? Surely there was another way to provide case-loading care without this burden of responsibility to always be there?

While reconsidering how I practiced, I had also committed myself to doctoral study. I became excited to know that by using action research I could make a difference to what was close to my heart. I selected a 'same role' cooperative inquiry where I could participate with other midwives researching the work-life balance aspect of our practice, a co-researcher on the 'inside' (Heron & Reason, 2007). This participatory approach involved us offering descriptions and explanations about how we mutually experienced our world (Whitehead & McNiff, 2006). This 'insider' approach had two components. Firstly, it included findings from my own practice as my group worked through how we could provide care with regular time off while still meeting statutory and professional requirements. Secondly, I was involved with other midwives from their midwifery groups throughout the Auckland region and was an 'insider' as I was a fellow case-loading midwife working through similar issues.

A colleague asked me, “Is it ethical to research your own practice?” I was able to say that action research is about practitioners investigating their own practice, on the job, describing their interventions and showing evidence of improvement (McNiff, 1988; McNiff & Whitehead, 2006a). I was internal to the inquiry topic, being fully engaged with the field of inquiry as a full co-subject and co-researcher (Heron & Reason, 2007).

The emergence of continuity of care and a midwife-woman partnership

A partnership was forged between consumer groups and midwives in the 1980s to restore the power of childbirth back to the control of women from the medically dominated control that had emerged over the previous decades (Donley, 1998). This strong political action by women’s groups and midwives in New Zealand coincided with international health reform. Alongside other nations, the New Zealand government was looking at ways to contain escalating health costs (Ashton, 2005). The benefit of continuity of care for the client in health services showed a higher level of quality of care, improved outcome and higher consumer satisfaction and lower cost (Saultz & Albedaiwi, 2005; Saultz & Lochner, 2005). In 1990, New Zealand midwives gained authority to practice as autonomous primary maternity providers independent of the general practitioners and obstetricians (Guilliland & Pairman, 1994). Midwives as the main primary care providers appear to achieve both the cost containment of maternity services and meet the consumer demand for woman-centred care (Ministry of Health, 2008). Research has also identified that the provision of continuity of care provided by case-loading midwives has come with a personal, emotional and physical cost to the case-loading midwife (Young, 2006, 2011).

The New Zealand Ministry of Health and the New Zealand College of Midwives (NZCOM) sanction continuity of care (NZCOM, 2008b). The NZCOM promotes the philosophy of continuity of care recognising it as enhancing partnership with women (Guilliland & Pairman, 1995). The notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000 for a Lead Maternity Carer in New Zealand, mandates that the Lead Maternity Carer or 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). The Ministry of Health has conducted satisfaction surveys in 1999, 2002, and 2007 maintaining that women have a high satisfaction with their maternity care (Ministry of Health, 2008).

Such surveys are important but cannot be used as a sole indicator of satisfaction of care; “it may be that through either a lack of choice, or a lack of knowledge and experience of diverse choices, maternity consumer expectations can be low and as a result women report higher satisfaction” (Fitzpatrick, 2008, p. 3). However this information does help us as we create practices to meet both the women’s needs and our own. For example the following quote from the Health Services Consumer Research (Ministry of Health, 2008) from a woman dissatisfied that her known midwife was not available and the back-ups were too busy:

My midwife was on a day off, the back-up one was at dinner and the emergency midwife was looking after seven beepers. I got to the hospital and two other ladies were pushing and only two midwives were there. My partner was ready to deliver for me. (2008, p. 44)

The satisfaction and expectation of women is of concern to our project. It is important when we take time off that there is a reliable back-up service available to women and that they are well informed of this. We do not wish to compromise a woman’s care but we still need to take care of ourselves. Our concern is that we find a way to meet the continuity of care provision expected of us while at the same time create a balance between work and our personal life.

Justification of the study

The case-loading midwife strives to provide care that will give the women greater autonomy and self-determination through a partnership relationship (Guilliland & Pairman, 1994). In return the midwife who provides this continuity of care is thought to receive the benefit of a more fulfilling care provision experience, greater autonomy and relative flexibility in the way the care is provided (Guilliland & Pairman, 1994). Literature shows that the provision of continuity of care has a proven advantage to the women, however, it also shows that provision of continuity of care may not be sustainable long term for the midwife and may contribute to burnout (Brodie, Warwick, Hastie, Smythe, & Young, 2008; Cox & Smythe, 2011; Engel, 2003; S. Miller, 2002; Young, 2006, 2011).

No research in New Zealand has demonstrated practical ways that midwives can enhance the way they provide continuity of care for long-term sustainability. This research is an example of how midwives can examine their practices through action and reflection in collaboration with colleagues. It is about making changes to become more resilient to the pressure of continuity of care to sustain their case-loading practice long-term. Strategies were generated

to uphold the midwife and woman relationship of partnership while developing sustainable care provision which is likely to benefit society by maintaining midwives in the workforce.

There is increasing literature that the 'Millennials', often referred to as the Y generation, have an emphasis on maintaining a work-life balance (Lower, 2008; Smith, 2010). The Millennials are the generation following the baby boomers; Lower (2008) and Smith (2010) suggest they place priority on their personal relationships and lifestyle over work. Ways to keep Millennials practising case-loading midwifery when the baby boomers have gone needs consideration.

This research demonstrates a way to address adverse effects that continuity of care has on the case-loading midwife by identifying the issues and then how to put changes into action to overcome them for long-term practice sustainability. When the partnership model was formalised it was seen as an evolving model and there was an invitation made for further debate and research (Guilliland & Pairman, 1994). This research is important as it addresses how models of partnership and continuity of care can be examined and adapted for sustaining case-loading midwives in practice long term.

Study context

We were fifteen case-loading midwives motivated to create change in our practices to have a better work-life balance. The project needed to have realistic expectations to attract a sufficient number of us to participate and be prepared to put the time and effort into such a project. The action research cycle required individual reflection and action and group reflection. It demanded a time commitment for each individual to journal the changes they put in place and to travel to and participate in focus group meetings (some lived more than an hour away from the city). Our group needed to be large enough to produce rich data for reflection but small enough to provide good dynamics for sharing and trust (D. Hunter, Bailey, & Taylor, 1995; D. Morgan, 1997). We became co-researchers and co-subjects once our research was underway. In this context the nature of the stresses experienced by midwives in their work in relation to providing continuity of care for their clients was explored. Each midwife decided on her own action to make her work-life balance better. We generated practical solutions to provide a sustainable continuity of care service for the midwife while still meeting the care requirements for women.

Theoretical position

The partnership that underlies our practice and forms part of our midwifery culture is also the cultural style of action research. It is a consensual approach working on the assumption that cooperation and consensus are the primary orientation of any activity (Stringer, 2007). This important aspect of the collaborative approach drew together midwives facing similar practice issues around their work-life balance. This allowed for a supportive network that made the project workable keeping the momentum of the changes going over the extended period of time. We built a power base and fed off each other for information and support (Stringer, 2007). Krueger and Casey (2000) support this approach seeing the advantages of group interaction are imperative to help us form opinions about a topic. Listening to one another's opinions helps us to form our own opinions (Krueger & Casey, 2000). We all desired changes in our practice to make our work more sustainable long-term. A potential benefit is that we have learned how to engage in a systematic approach to learning that can be applied to other issues in other contexts (Stringer, 2007). We have learnt the importance of collaboration for support in learning about an issue important to us; putting a plan into action to create change; and to achieve sustained change.

This research was practitioner driven as we developed our own individual ways of addressing our work-life dilemma with collaborative support of our midwife colleagues. Action research allowed the creativity to explore the issues of the work-life balance for the midwife through the diversity of ideas and practice. Reason and Bradbury (2006) explain that ideas and practices are not always complimentary or in tune with one another but they share the same orientation toward inquiry which is to undertake enquiries with others, not on them or about them. This is not like the positivist perspective that separates the objective from the subjective experience and puts the researcher outside and separate from the subject of the research (Argyris & Schon, 1991). Putting theory into action as a research paradigm is crossing the disciplines between academic and vocational (Argyris & Schon, 1991). Cooperative inquiry, the chosen methodology, seeks collaboration and the researched become co-researchers (Heron & Reason, 2007). Heron (1996) describes cooperative inquiry as coming from the 'participative paradigm', a fifth paradigm, an addition to the paradigms of positivism, post positivism, critical theory and constructivism.

Participative reality is neither wholly subjective nor wholly objective neither wholly dependent of my mind nor wholly independent of my mind. It is always subjective-objective, inseparable from the creative, participative, engaged activity of my mind but never reducible to it, always transcending it. (Heron, 1996, p. 163)

All research shares common features from identifying a research issue through to the dissemination of findings and linking new knowledge with existing knowledge. The difference is in the underlying assumptions of the research traditions (McNiff & Whitehead, 2006b). The participative paradigm approach, which comes under the broad umbrella of action research, has unique features to make it stand apart from the other paradigms through its reflexive action that offers new understanding of the relationship between ideas and practice (Reason & Bradbury, 2006). There is agreement of an overlapping between the paradigms of action research and qualitative research especially constructivist and critical theory as each paradigm strives for social justice through empowerment of the research subjects (McNiff & Whitehead, 2006b; Reason & Bradbury, 2006).

The action research project was both informative and transformative in relation to our work-life balance. In this research we collaboratively worked together to develop our own ideas through a cooperative inquiry group approach seeing if these ideas made sense in our world. This action research was about revisioning our understanding of the world, as well as transforming the practice within it (Heron & Reason, 2007).

Position of researcher

I am mindful of the additional interests and responsibilities that I have carried in this study and made this explicit throughout the process. As the principal researcher I had a dual role. One role was as a facilitator and mentor of the midwives in the midwife inquiry group and the other of co-participant and co-researcher. I also conducted my own action research in my practice. In this way I experienced the process alongside my midwife colleagues from other practices in Auckland who had chosen to participate in this research process.

Action research allowed me to be an ‘insider’ to research alongside other co-researchers and co-participants to generate our own theories. It is research ‘with people’ not ‘on people’ (Heron & Reason, 2007). Practitioner research bridges the knowledge power base between the person (the subject) and the academic (Borda, 2006). The primary outcome of the research is for the practical knowing and the skills acquired and about how the situational and personal transformations are brought about. It has a secondary outcome as a propositional report (Heron & Reason, 2007) such as this thesis.

Often practitioners are too immersed in their day-to-day work that the formality of putting their lived theories into the public realm never transpires (Herr & Anderson, 2005). As the doctoral student I took the facilitation of the cooperative inquiry process further, putting the voice of the practitioner into the public arena. So not only did I support the midwives as they carried out and evaluated their action plans in an ongoing process of reflection and action, but on their behalf I have also put what they have said into written form. Furthermore, I have added my own layer of interpretation. The writing of Bourdieu has been drawn on in the process of discerning the shaping and reshaping of ways of practice.

Looking ahead

New Zealand's midwifery work culture from the mid-1800s is discussed in **chapter two** to provide an understanding of how history has played a part in shaping our current maternity care system.

The literature review presented in **chapter three** provides the context for the work-life balance research examining the impact of continuity of care on the life of the case-loading midwife.

Chapter four discusses the methodology of action research with attention to cooperative inquiry which is the main approach that guides the process.

In **chapter five** the process of the action research project is explained.

The participants as co-researchers and co-participants are introduced in **chapter six**.

Chapters seven to ten are about the journey the midwives made as they worked through their cycles of action and reflection investigating their work-life balance. The philosophical lens of Pierre Bourdieu was brought to the analysis of the data in **chapter ten**.

In **chapter eleven** I discuss the findings of the journey and make recommendations for further developments and research.

CHAPTER TWO

The place of midwives: The past to the present

This section looks at the position of the midwife in New Zealand and how the changes in the maternity care system have impacted on the midwife over the decades. These changes have been shaped by the economic, social and political forces of the time (Bunkle, 1994; Cooper, 1997; DeVore, 1997; Donley, 1986, 1998; Kitzinger, 1999, 2003; Mein Smith, 1986; Papps & Olssen, 1997; White, 1994). In the 1800s doctors were starting to be involved in births believing their science offered rational knowledge rather than the ignorance or tradition of midwife attendants (Papps & Olssen, 1997). In the early 1900s when midwifery became a regulated profession the state then had a preference for midwives to provide maternity care with births at home (Stojanovic, 2008).

However, as the century moved on, doctors gained the leading role in maternity care, midwives became their subordinates and births became hospitalised (Donley, 1986). In 1990 midwives became autonomous practitioners as a result of a women-led movement away from the medicalisation of birth (Donley, 1986). A maternity care system developed where midwives and women worked in a philosophy of partnership (Guilliland & Pairman, 1994). Increasing evidence shows the current system of continuity of care places an untenable tension on midwives between their work and their private lives (Cox & Smythe, 2011; Young, 2011). Approaches to continuity of care need to be examined and developed to meet the complexity of maternity care in today's world and into the future. This chapter examines the history of the midwife's work-life balance. It begins with the Colonial era. This is not to undervalue the history of Maori midwifery practices in pre-Colonial times but rather to recognise the shaping of the childbirth services that has come from a western worldview.

The role of the midwife mid-1800s to 1930

In the Colonial era the majority of the maternity care for women was focussed in the community with the care by a sole care provider, usually a traditional midwife (Stojanovic, 2008). Midwives were usually older women and often widows and needed the money to survive (Mein Smith, 1986). A woman took a midwife into her service often days before the birth and stayed on to run the household working long hours for little remuneration (Donley, 1986).

A relieved Sarah Greenwood wrote this letter to her physician husband, in 1845, on the birth of her 10th child:

I was first warned of the coming event about 6 on Tuesday evening and at 12 precisely the young lady made her appearance after giving me (if possible) still less trouble than her predecessors. I was very comfortably attended by Mesdames Hogan and Bere; the former lady remains with me ... She is delighted to be paid in old clothes, and I to save the cash. She is an active body with a most desirable passion for scrubbing and scouring... Of course I am longing to see you but thank God that I am so perfectly well that I do not require any assistance in the medical way. (Porter, Macdonald, & MacDonald, 1996, p. 348)

The midwife worked on-call. She did not know when she would be needed or how long she would need to work for. The woman hoped the birth would be straightforward and that she would not need any medical intervention. Having medical attendance would incur extra cost but also the woman had a fear of death whenever giving birth in this era (Enkin, 2006). The woman paid the birth attendant for her services on negotiated terms.

The traditional midwife's role began to change after the New South Wales Royal Commission investigated the dramatic fall in birth rate in New Zealand and Australia (Mein Smith, 1986). The report concluded the declining birth rate came from a high infant mortality rate combined with a conscious decision by families to have fewer children. In response, Parliament introduced the 1904 Midwives Act to address the concern of poor quality of maternity care (DeVore, 1997). It was seen that by improving birth conditions through greater regulation of the maternity services the high infant mortality rate could be reduced and the future population growth would be maintained (Mein Smith, 1986). Through until the 1920s most mothers still had home births or birthed in small, unlicensed one-bed homes (Mein Smith, 1986). The women were attended by a midwife or a maternity nurse with the help of a doctor if there were any difficulties.

Often the client's home was not the ideal place for the birth so the midwife used her own resources and capital outlay to establish 'lying-in' homes and small private hospitals (DeVore, 1997). Doctors also invested in small homes and hospitals to provide maternity care (DeVore, 1997). After public outcry in 1921 the Health Department investigated causes of maternal morbidity and mortality in New Zealand in which puerperal sepsis was seen as a major contribution (DeVore, 1997). The committee recommended upgrading of midwifery practice, making more inspections of licensed hospitals and the compulsory licensing of all 'lying-in' homes (DeVore, 1997). The licensee was required to submit quarterly reports to the

Health Department. The licensee-midwife had to pay increased attention to aseptic technique, sanitation and hygiene through the upgrading of equipment and the premises; and she had an increased demand for reports and records to be submitted to the inspectors (DeVore, 1997).

In 1925 the Nurses and Midwives Registration Act established uniformity of midwifery practice and midwifery training and the role of maternity nurse was also created by reclassifying the traditional midwife as a maternity nurse (DeVore, 1997). The majority of midwives were traditional midwives so after 1925 they were classified as maternity nurses and subsequently legally subservient to doctors (Mein Smith, 1986). In this period there was a transition from home to hospital births which made it more difficult for the traditional midwife who owned her own private hospital (Chick & Rodgers, 1997). By 1927 58 per cent of New Zealand births took place in maternity hospitals where women were cared for by midwives who worked long hours on rostered duties (Donley, 1986).

The 1904 Act had brought professionalisation to New Zealand midwives but with it opposition from doctors who feared loss of potential income because of a state-controlled maternity system led by midwives (Donley, 1986). In response to a perceived challenge from the Health Department reformers, the medical profession formed the Society for Obstetrics and Gynaecology in 1927 (Bryder, 1994). The medicalisation of birth in New Zealand was beginning.

Figure 1 Work-life balance mid-1800s to 1930

Manner in which the midwife worked:

The midwife worked long demanding days and nights of work with little predictable sleep. She worked on-call and as a sole practitioner. The midwife increasingly worked in competition with doctors and hospitals. Only registered midwives could work in the hospital. The midwife either went to the women's home or she had her own birthing room. She was paid by the women and this was often payment in kind.

Degree of autonomy of midwife:

The midwife had a high degree of autonomy which probably brought a large degree of satisfaction. She was either a traditional midwife or a registered midwife. She was the one, although employed by the women, who took charge of the situation and not only took responsibility for the birthing women but ran the household. After 1925 the traditional midwives could only work under medical supervision.

The midwife's likely perception of women's expectation of midwifery care:

The women recognised the midwife as the skilled attendant however she expected the midwife not only to help her in the act of childbirth but to be there before the birth and after the birth to look after her and the family.

Work-life balance:

Midwives were always on-call, and often needed to leave their own families to provide care for women. The manner of the relationship was negotiated depending on the context.

The role of the midwife 1930 to 1950

In the 1920s, doctors had stopped the Health Department achieving its full aim to reform the maternity system and heading into the 1930s they were again opposing the state interference (Bryder, 1994). Mein Smith (1986) discussed how Dr Doris Gordon believed that state control of maternity care would not be in the best interests of New Zealand women. Gordon had a motive for doctors to have the ability to give what pain relief they saw necessary for a woman in labour. With support of women's groups a nationwide campaign led by Gordon raised funds to establish a full-time professor of Obstetrics and Gynaecology in 1931 at the Dunedin Medical School (Donley, 1986). The power of the Obstetrical Society now transferred health initiatives from the Health Department to the medical profession (Mein Smith, 1986).

In this period doctors had gained a central place in maternity care (Donley, 1986). The midwife was placed under increasing constraints with regulations making her role less financially viable as she struggled to comply with regulations and care for women. As the midwife was often a widow working for a pittance (DeVore, 1997) she most likely did not have the financial or political resources to resist the changes. By 1935 to have a doctor at the birth and thus access to pain relief had become customary with 78 per cent of births in maternity hospitals (Mein Smith, 1986). Midwives at this time worked in their domiciliary practices, ran their own private hospitals or worked for the Health Department in the St Helens and public hospitals as district nurses or nurse inspectors. Further, Mein Smith (1986) informs us, that the St Helens hospitals were midwife-led until the late 1930s and maintained the lowest forceps and caesarean rates in the country. Midwifery training was like nursing training where single women were trained in hospitals through live-in apprenticeships (French, 2001). They were acculturated into hierarchical structures with strict dress codes, protocols and decision making processes.

The Abortion Inquiry of 1936–37 and the Maternity Services Inquiry of 1937–38 further distanced midwives from autonomy (Donley, 1986). Mein Smith (1986) relates how the shift in political power was evident at this time as doctors, rather than the Health Department, gained credit for reducing the maternal and perinatal mortality rate. The Health Department saw that childbirth was a normal physiological process but the medical profession was now defining pregnancy and childbirth as an illness. Childbirth became a medical event as puerperal sepsis and toxæmia began to be regarded as a disease. Women's groups had

demanded better maternity services and were successful in lobbying for these changes. Alongside this doctors had a united front in providing continuity of care (Mein Smith, 1986). The Social Security Act 1938 provided free maternity care for every woman under a doctor of her choice (Donley, 1986). The same egalitarian approach by the government brought about access to anaesthetics free of charge to all women (Mein Smith, 1986). Despite the government recognising the economics of retaining a midwifery workforce, the medicalisation of birth was established by the 1940s (Donley, 1986). The midwife's role was now mostly as an obstetric nurse (Donley, 1986).

Enkin (2006), a medical practitioner, reported how the maternal mortality rate sharply declined in the 1930s but a fear of childbirth remained. He recalled his entry into medicine in the late 1940s when birth was still 'tainted' with the fear of death:

...pregnancy was still seen as a time of danger, and maternity care was enmeshed in a tangle of enshrined do's and don'ts, prescriptions and proscriptions, dictated by medical tradition. Companions (witnesses?) were excluded from accompanying, helping, or even seeing labouring women. The pain of labour was controlled by massive narcosis and that of childbirth by general anaesthesia. But growing obstetrical expertise also brought great benefits. Care became more effective, childbirth both more comfortable and safer. It was a win-win situation. Women were pleased, and doctors gratified. It was a time of great, and justified, optimism. (p. 265)

However things were not resolved. There was to be conflict between the experts and the women's demands (Enkin, 2006).

Figure 2 Work-life balance 1930 to 1950

Manner in which the midwife worked:

Most midwives worked in hospitals on shift work working long hours. They had no voice. They were mostly single and powerless working in a hierarchical system.

Degree of autonomy of midwife:

Powerless. The lay midwife lost her autonomy and became a maternity nurse if she did not do further study. She was required to work under medical supervision. Most births were now in the hospital where midwives worked in an environment of increasing medicalisation. The midwife was becoming invisible to the woman.

The midwife's likely perception of women's expectation of midwifery care:

The women believed that the doctors knew what was best for them and their baby. The woman wanted free care, a known doctor in attendance at the birth and pain relief. However, the women were likely to see the midwife as someone who dictated what she could or could not do. Like the midwife, the woman had no voice.

Work-life balance:

Midwives were likely to be 'dedicated' to their profession, with little time for personal life.

The role of the midwife 1950 to 1990

The beginning of this period reflected the social view that marriage and family life were the proper fulfilment for women (Stojanovic, 2004). Very few married women worked outside the home. The public maternity system had become medicalised with a workforce dominated by single women who worked as nurses, rather than as midwives. The hospital midwife had become the obstetricians 'handmaiden' (Donley, 1986, p. 49). The majority of midwives now worked in the hospitals with the exception of a small number of domiciliary midwives who were still free to work autonomously as their contract remained with the Ministry of Health (Donley, 1986). In the post-war baby boom there was a severe shortage of nurses and midwives which was made worse by the introduction of the five-day week (Stojanovic, 2008).

From her own experience Stojanovic (2004) related how there was limited choice for women of where to have a baby; home birth was no longer an option and there were no small private maternity homes. Women gave accounts of the hospital experience of 'being alone', a 'lack of autonomy' and of 'uncaring attitudes' from the maternity staff (Stojanovic, 2004, p. 14). They were unable to make choices about their fertility and childbirth because they were uninformed. The hospital and medical care, however, was made attractive to women through the development of technology, asepsis and anaesthesia. The women's felt 'lack of empathy' may have been a reflection of the midwifery culture as midwives were carrying heavy workloads, often worked on-call and worked in a controlled and disciplined environment. One midwife related her memory of this period:

We had very long hours. We had to do all our own packing; we brought our own equipment, making swabs and things like that, which we stayed until two or three in the morning to do. We were on-call for days and days and days. Our conditions were very poor indeed and we worked extremely hard. (Stojanovic, 2004, p. 17)

The midwives had to do all the preparation for use in the stringent aseptic techniques that involved pubic shaving, enemas, swabbing of the perineum with antiseptics and the use of sterile drapes for the birth (Stojanovic, 2008). In the post-natal period women were kept in bed for up to ten days post-partum. The women were transferred from the admitting room to the labour room and then to the theatre for the birth where attendants were gowned and masked. Strict protocols, called the H.Mt 20 Regulations, were introduced in the 1930s to control puerperal sepsis and remained in practice until the early 1980s. These procedures made the labour care fragmented and task orientated. The midwives in this period became

specialised in hospital nursing and lost the skill and confidence to provide birth care outside the hospital setting (Stojanovic, 2004).

During this period consumer groups rose up to fight the medical control of the health services. Responding to social movements, such as feminism, women were empowered to regain the control of their birthing choices (Papps & Olssen, 1997). Women started rejecting the rigid asepsis protocols and demanding flexible routines with breast feeding (Donley, 1986). They rallied to support the home-birth midwives thus challenging the monopoly that obstetricians had over maternity care. There was a 32 per cent increase in home births in the early 1980s as this was a way women could have more control to make their own decisions (Donley, 1986). The 1971 Nurses Act was introduced, which required all midwives to work under the supervision of a doctor regardless of the situation (Donley, 1998). Doctors even needed to be present for home births. Records kept in hospitals showed that the vast number of births in this time were conducted by midwives but they were an invisible workforce as doctors were legally in charge (Guilliland, 1999b).

A change to the Nurses Act in 1983 allowed non-midwife nurses to provide maternity care which precipitated a conflict between midwives and nurses (Tully, 1993). The midwives now recognised that their profession might not survive (Tully, 1993). Midwives joined with women in their fight to regain their control of birth. In the 1980s the Save the Midwives Association was established in response to a crisis in midwifery (Strid, 1991). It was an association of health professionals and parents who worked to achieve the highest quality of maternity care compatible with freedom of choice in childbirth. The association was concerned with the quality of maternity care provided in New Zealand both from the perspective of the midwife and the mother. By 1988 midwives and consumers formed a working party to form the New Zealand College of Midwives to take a proactive stance to address issues for midwives and women (Tully, 1993).

Women recognised they had a loss of power and dispossession of childbirth and motherhood (Guilliland & Pairman, 1995). This alienation from the experience was thought to increase their anxiety and guilt with a loss of self-confidence, loss of identity, dependency and ignorance and loss of control over their bodies (Guilliland & Pairman, 1995). Midwives chose a 'new professionalism' that reinforced the notion that professional-client relationships needed to move away from the medical model (Tully & Mortlock, 1999). This would be a

challenge against the societal views that welcomed medical invention seeing childbirth as something that happens to women rather than something women do naturally (Davis, 2005).

Figure 3 Work-life balance 1950 to 1990

Manner in which the midwife worked:

Most midwives were young single women who lived in a nurse's home and many remained unmarried. An invisible workforce. They worked with highly regimented protocols. They were short-staffed and overworked.

Degree of autonomy of midwife:

No autonomy from doctors unless a domiciliary midwife (only a few midwives practiced in the community and those who did do home births still needed a doctor in attendance at the birth).

The midwife's likely perception of women's expectation of midwifery care:

The woman was socialised into the medical belief that she was safer in hospital ([Stojanovic, 2004](#)). The women would do as they were told just like the midwives were.

Work-life balance:

Although often worked overtime, was free on her days off especially toward the end of this period.

The role of the midwife 1990 to 2000

A new era for midwives was born as the century drew to a close. In 1990 the Nurses Amendment Act brought autonomy from the nursing and medical profession back to midwives. The midwives and the consumers challenge to the medical control of maternity care met with a favourable response from Government policy makers who were endeavouring to make health services more competitive, flexible and cost-effective (Tully, 1993). The Hon. Helen Clark, in her speech to parliament in 1990 introducing the Nurses Amendment Bill, said:

Having a baby is not an illness. It is a normal physiological process that for generations was viewed as such. With the advent of medical technology, there has been a trend towards treating pregnancy and labour as an illness. This has resulted in an increasing amount of medical intervention in the management of normal pregnancy which has led to the erosion of the midwives' role. This has proved to be both costly and in many cases inappropriate. Medical practitioners are trained to diagnose and treat people with illnesses and abnormalities. In the area of pregnancy and childbirth, their expertise is necessary with the high risk, complicated, and abnormal pregnancy and childbirth. The focus of the midwife's expertise, however, is the low risk, uncomplicated, normal pregnancy and childbirth. (Clark, 1990, p. 9)

Leading up to this momentous time for midwives was much discussion about what it would mean. Pelvin (1990) gives her viewpoint:

There is tremendous scope for midwives to offer continuity of care once the Bill becomes law. This can be achieved by: the individual midwife, domiciliary midwives, midwives partnership sharing clients, midwives in collectives, or midwives in teams, where the woman gets to know each midwife throughout her pregnancy with the goal of the woman in mind that she is being attended by a midwife she knows when she goes through labour and gives birth to her baby. (p. 7)

The change allowed a registered midwife to again undertake sole responsibility for the care of women throughout the pregnancy, childbirth and post-natal period. The way was open for continuity of care “which would be the cornerstone by which midwifery stands or falls” (Pelvin, 1990, p. 6). Midwives could make their place in the provision of maternity care as main maternity care providers (Pelvin, 1990).

The New Zealand College of Midwives was established in 1988 (Tully, 1993). In 1990 through a combined effort of midwives and consumer representatives the College’s philosophy and standards for practice was written. An independent professional identity was constructed based on partnership with the aim to provide women with equity, access and choices. The first responsibility to the client was for the midwife to work in partnership with the woman. Tully (1993) said:

...by involving consumers at a national, regional and community level of College activity, they demonstrated their commitment to working in partnership with women. In joining forces with consumers they succeeded in making the re-establishment of the midwifery tradition synonymous with reclaiming women’s control over the birth process. (p. 12)

The leader of the newly formed New Zealand College of Midwives, Karen Guilliland, proposed that the partnership model would keep the care in the control of the woman and to set it apart from a patriarchal medical approach (Tully, 1993). Guilliland and Pairman (1994) discussed how the consumer networking is seen as invaluable support and energy-giving and the consumers will not give up on issues until there is some resolve. The women-centred care, as in the partnership model, is seen as making the midwife’s practice different to the medical model (Guilliland & Pairman, 1994). In the NZCOM Handbook of Practice (2008b) the role of partnership and continuity of care is described:

Midwifery care takes place in partnership with women. Continuity of midwifery care enhances and protects the normal process of childbirth (p. 3).

The midwife works in partnership with women, on her 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 (p. 4).

The theoretical model of midwifery as articulated by Guilliland and Pairman (1995) is a partnership between the woman and the midwife. The aim of 'partnership' is for the woman to be at the centre of the experience with the midwife confident and strong in enabling the woman to meet her expectations (Guilliland & Pairman, 1995). Pairman (1998a) further endorsed an extended notion of the midwifery partnership to work at all levels in the organisation. "Partnership enables emancipatory change and is political at both a personal and an organisational level" (p. 14). Strid (1994), a consumer representative, saw the potential for the partnership relationship to put the power into the hand of the consumer rather than giving the midwife professional dominance, which would have the ability to be disabling and disempowering.

After the 1990 law-change, the midwives who began providing self-employed case-loading care received their payment from the Maternity Benefit Schedule at the same uncapped rate as the general practitioners (Pairman, 2006). This was a substantial increase for domiciliary midwives who had been working with no time off to generate enough income (Young, 2011). These midwives however, despite increased remuneration, did not change their practice to take days off. They continued to work in the same practice structures working the same hours being on-call for women in their care (Becker et al., 2000). In 1993 the Maternity Benefits Tribunal increased the set fees for service but the labour and birth and mileage fees were reduced (Guilliland, 1997). This impacted mostly on the midwives with a 30 per cent drop in their income (Guilliland, 1997).

Also in 1993 the hospitals became Crown Health Enterprises and in line with health reforms financial competition was introduced between public and private providers (Guilliland, 1999a). The independent midwives, general practitioners and obstetricians became the private sector competing against each other and the hospital. It was hard to have cooperation and teamwork in this environment with midwife against midwife and midwife against doctor. Until then many midwives had been working in shared care arrangements with general practitioners but midwives were becoming dissatisfied. They felt that this way of working, with doctors dominating the care, seemed to provide poorer birth outcomes for women. (Guilliland & Pairman, 2010b).

In 1996 a notice pursuant to Section 51 of the Health and Disability Services Act, prescribed the way maternity services would subsequently be provided and paid for (Northern Regional Health Authority, 1996). Section 51 introduced a Lead Maternity Care model to address funding arrangements by removing duplication of services and to improve continuity of the caregiver (Northern Regional Health Authority, 1996). Women were required to choose a single Lead Maternity Carer (LMC) who would budget-hold for the modules of service a woman and her baby received during the childbearing cycle. The LMC (an obstetrician, a general practitioner, or a midwife) would now carry the risk for women who might require more than the services paid for in the contract (Guilliland, 1997). The new maternity scheme involved giving midwives and doctors a fixed sum or budget to look after a pregnant woman no matter how much care and support she actually needed. The previous system paid doctors and midwives for the actual care they provided.

Consumers were concerned that financial considerations would come into the caregiving relationship, that it would restrict women's choice, as providers could decline patients who would cost more money (Hinton, 1999). General practitioners were quick to exit obstetrics under the new scheme and women who still wanted a doctor or could not find a midwife were forced to have their care through their local hospital (Women's Health Watch, 1996). There was provision for the LMC to subcontract but the payment came out of the LMCs own budget (Northern Regional Health Authority, 1996). This created difficulty for case-loading midwives to achieve down-time or to call in a colleague during a long birth as they had to share funding (Young, 2011).

Midwives set high expectations of the service they wished to provide for women. They desired to meet the needs of women and set up expectations to fulfil their continuity of care provision that may not have been in their own best interests. There was an expectation of being 'expected to cope' even when their exhaustion could be affecting their ability to make rational decisions to provide safe care (S. Miller, 2002). Rolston (1999) observed that while many case-loading midwives loved the lifestyle, some found that the expectation of 'never-ending availability' put stress on their personal relationships because often they were not there for their own family. They came with a passion and commitment to provide continuity of care, with an expectation to see the woman through; there was (and still is) no time limit (S. Miller, 2002).

Case-loading midwives worked in a variety of ways to maintain some semblance in their lives (Rolston, 1999). Rolston (1999) explained how some worked alone, others in pairs or small groups. Some midwives worked in a team with rostered routines and days off; others had a combination of team work and carrying their own case-load to allow flexibility; while others were constantly modifying their practice to find a good balance for work and personal life. I worked in both employed and self-employed case-loading practices in this period. I recall how many self-employed case-loading midwives provided care in small groups with their own case-load with a partner available for back-up when the unforeseen occurred. Most would be on-call for 24 hours a day every day of the week and take perhaps every alternate weekend off. Although having days off-call was often the exception to the rule unless it was your planned annual leave. This created an expectation in the women that her midwife would always be there for her. A woman describes this expectation:

I was confident in my body's ability to give birth naturally so my biggest fear was that she (the midwife) would not be there to get me through it. It was really important for her to be there – we had built up a really good relationship. (Rolston, 1999, p. 7)

There were mainly self-employed case-loading midwives but some were employed by the public hospitals or private enterprises. Those who were employed had opportunity for more scheduled days off than the self-employed as they had a formal contract with the employer negotiated by a trade union and were paid for days off. It seemed that many midwives at this time interpreted that the Ministry of Health requirement of the Lead Maternity Carer excluded team care and rostered duties so very few midwives did practice as a team. It was also thought to conflict with the ideology of the New Zealand College of Midwives partnership philosophy. Team work also brought tension with personality clashes and for the self-employed case-loading midwife was fraught with financial issues (Rolston, 1999).

Despite the demands of case-loading care, in 10 years New Zealand had a midwifery-led workforce with 50 per cent of midwives in case-loading practice and 60 per cent of New Zealand women were choosing a midwife as her LMC (Guilliland, 1999c). Midwives were realising the need to have good strategies in place for coping with the demands of the lifestyle but they were bound by their own expectations when providing continuity of care.

Figure 4 Work-life balance 1990 to 2000**Manner in which the midwife worked:**

The midwife could work as a self-employed case-loading midwife providing continuity of care. Or the midwife could choose to work in a hospital setting on shift work. The midwife could choose to provide home births or hospital births or both.

Degree of autonomy of midwife:

The midwife could work autonomously of doctors or nurses. She was contracted directly to the Ministry of Health or employed by a hospital. Becoming autonomous practitioners as case-loading midwives and establishing small practices was a feature of this period.

The midwife's likely perception of women's expectation of midwifery care:

Women who chose a midwife Lead Maternity Carer expected the known midwife would be available 24 hours a day, 7 days a week.

Work-life balance:

In the LMC role the midwife was often continuously on-call; no restriction on length of hours worked at one time, sometimes difficult to arrange cover. Work-life balance challenging.

The role of the midwife 2001 to 2011

The New Zealand maternity service is again midwifery-led as it was at the beginning of the 20th century. There is partnership with women and midwives have professional autonomy but society's anxiety around childbirth and the medical model of birth remain dominant (Pairman & Guilliland, 2003). The health environment is increasing in complexity. Societal influences with a culture of birth have come to see intervention as normal which places midwifery's body of knowledge under threat (McAra-Couper, 2006). International literature tells us there is insufficient scientific evidence to support current practices regarding the use of caesarean section, epidural analgesia during labour and routine ultrasound screening in pregnancy (Waldenstrom, 2007) yet the medical domination of maternity care persists. Normal vaginal birth outcomes have been shown to decrease once medical intervention is introduced during the normal birthing process (Tracey, Sullivan, Wang, Black, & Tracey, 2007).

Evidence-based practice is one way to reduce the increasing technology to promote the decision for normal birth (Waldenstrom, 2007). The New Zealand midwifery system is guided by evidence-based practice and is recognised as a world leader with its midwifery-led maternity model of care (New Zealand College of Midwives, 2011). Despite this the caesarean section rate in New Zealand is increasing (Ministry of Health, 2003). The caesarean section rate is particularly high for the well-educated European women (Cole, 2006). Cole

(2006) expresses the opinion that consumers in their desire to have control are handing over their health care to practitioners believing that medicine and technology will provide a better outcome than trusting their own bodies. From a consumers' point of view, Clarke (2007) posits the main reasons for the soaring intervention rate to include: the choosing of comfort, convenience, and control; a focus on the LMC; a lack of true informed choice; and the birthing environment. More recognition in this era is given to the place of birth as significant to decrease the global trend for medicalisation of childbirth (Pairman & Guilliland, 2003).

Consumers, midwives and doctors have a different definition of what constitutes both the normal and the abnormal of pregnancy and birth but the issue is not just the definition but also ethically establishing a solid evidence-based practice that everyone agrees on (Davis, 2005). The midwife strives to 'keep birth normal' weighed up against the woman's feelings and the advice and recommendation of the obstetrician when it has been sought. Davis (2005) concludes that "midwives daily field the pressure to follow risk-averse practice in the current medico-legal atmosphere, and contemporary public expectations of 'quick-fix' solutions" (p. 18). The topics and kinds of questions asked by the medical profession are different to the midwifery profession and most likely differ again to the consumer. To try and blend the different interpretations the Cochrane Collaboration and the New Zealand Guidelines Group encourage the collaboration between consumers and various health and research professionals in the development of evidence-based, best practice guidelines (Davis, 2005).

The way research data is collected, collated and disseminated has an impact on evidence-based practice and informed consent (Davis, 2005). The Hannah trial advocated caesarean sections for all breech births, even before all findings were collated, as the evidence was so strong to say that a breech was too high a risk to birth vaginally (Hannah et al., 2000). This study was refuted by many critics and is an example of how medicine in research has used its own discourse to base a global decision on intervention practices (Davis, 2005). Nevertheless it has become obstetric practice now to offer caesarean to all woman with a breech presentation (Dixon, 2008).

Interventions in labour have also been shown to increase the rates of operative birth (Tracey et al., 2007). Studies show that the natural approach to childbirth has been undermined by medicalisation and better outcomes are shown when the woman is in control and cared for by a known caregiver. The midwife's mandate under the partnership model is to give the women

informed choice and consent (Guilliland & Pairman, 1995). The difficulty for the midwife is that she remains in a dominant medical model and culture where alternative ways of knowing are often not understood or valued (L. Hunter, 2008).

Midwives gain satisfaction from providing case-loading care, however, further concerns were now beginning to surface about being able to sustain long-term care provision (Wakelin & Skinner, 2007). In Wakelin and Skinner's (2007) research forty-five of the ninety-five case-loading midwives interviewed stayed on-call on their structured time off. Dixon (2007) interviewed three practices in response to this study by Wakelin and Skinner and found alternatively that many case-loading midwives do practice in a sustainable way. One group worked as a team of three, another had a practice of eight and worked in pairs and another had four members and worked in pairs. These examples made case-loading practice appear to be a very ordered way to work. It did not reveal the tension that midwives experience in deciding their work and personal boundaries and maintaining continuity with their clients. It did not demonstrate the struggle they may have in juggling their day-to-day workload against the unpredictable birth call-outs.

Smythe et al. (2009) provide a glimpse into sustainability for case-loading midwives. They found that where a community has a primary birthing unit and all the providers and the women share the same ethos of non-interventional normal childbirth then they can work together in seamless continuity of care and support each other. This provides sustainability to the midwife on-call. Not all case-loading midwives and women are fortunate to have the opportunity for such a community approach to their maternity care.

Cox & Smythe (2011) interviewed three midwives to gain knowledge of their experience of the need to leave case-loading practice. Each midwife was passionate about the care and relationships they had with women in their role as the Lead Maternity Carer. However for different reasons they each had feelings of betrayal which came from being let down by unsupportive colleagues or by women in their care who did not respect their personal boundaries. The midwives found that the burden of being responsible for a good outcome affected how they practiced. They often felt outraged when other health professionals or family members did not share the same care, trust and respect as they had toward the woman. The final straw seemed to be the exhaustion they constantly battled both emotionally and physically. This research recognises the fulfilling aspects of the case-loading care model but recognises more strategies are needed to support ongoing practice for some midwives. It

asserts a need for further research to describe the experiences of case-loading midwives to understand sustainability which this research project has addressed.

Evidence-based care that has produced protocols and standardised formulas may address the complicated care but is no longer enough in addressing the complexity of care (Enkin, 2006). Enkin (2006) affirms:

Our growing understanding of the nature of complex systems, from the physical to the social, can help us understand the changes that are taking place in maternity care. The strength and acceptance of family-centred over practitioner-centred care, the resurgence of midwifery as an honoured profession, all speak to the power of self-organisation within complex systems. (p. 268)

Cole (2006) puts the onus back onto the midwifery partnership to be one of strength so a woman can regain belief in normal birth free of unnecessary intervention. Midwives are seen to be in a strong position to 'create changes in assumptions, beliefs and expectations' (Dixon, 2008, p. 33). This can be done at the practice level when working with women sharing information on their decision making, and at the academic level to provide research to support a midwifery perspective on childbirth (Dixon, 2008). Like the core midwife in the tertiary setting, despite the strong midwifery philosophy and belief in the normal birth, the case-loading midwife is also in 'a daily battle trying to keep birth normal' (Earl & Hunter, 2006, p. 23). Midwives have to identify and manage risk at the same time as keeping birth normal (J. Skinner, 2011). This adds to the struggle from the pressure of providing on-call continuity of care and the provision of emotional labour as the midwife deals with others' feelings in the midwife-woman relationship (Kirkham, 2000). Further, for the person involved in people-work, emotional labour is thought to be more than just being emotionally taxing but also predictor for burnout (Brotheridge & Grandey, 2002).

Midwifery practice over the past decade has continued to evolve and change as issues for case-loading midwives are being discussed and researched. In one New Zealand survey the concepts of continuity of care and the close relationship with women that drew the midwives to case-load work were the very factors that drove them away again (Wakelin & Skinner, 2007). Skinner (1999) noted that there have been remarkable advances in the collaboration with consumers to advance both midwifery and the care for women, and called for a re-examination of the relationship with women on the practice level for the next step in our development. The theme of the New Zealand College of Midwives 10th Biennial National conference in 2008 was choices, challenges and diversity. Pertinent to the 'enormous

diversity' midwives currently face the presentations ranged from midwives being called on to reduce the caesarean rate, to promoting primary birthing units, to burnout, to midwives finding sustainable ways to work as case-loading midwives (NZCOM, 2008a). Research is seen as a medium to challenge existing ideologies; a powerful agent for change (Dixon, 2009).

Figure 5 Work-life balance 2001 to 2011

Manner in which the midwife worked:

Clinical midwives work either as core midwives for a DHB or a private hospital; or they work as a self-employed or employed LMC case loading midwife. The recommended case load is 40 to 50 women per year ([New Zealand College of Midwives, 2008b](#)).

Degree of autonomy of midwife:

The LMC midwife works autonomously. The self-employed case-loading midwife chooses the colleagues she works with and decides if and/or when she takes time off call. There are no rules as to how long she can work at one time or how many hours in a week.

The midwife's likely perception of women's expectation of midwifery care:

Many women would like to have the same midwife LMC available 24 hours a day, 7 days a week. Each woman can have a different expectation of the midwifery care and the midwife needs to find what her expectation is. Some women want to be led and some want to lead.

Work-life balance:

Has become an issue for case-loading midwives; they seek new ways of arranging their practices to achieve more sustainable life styles

Summary

Since the beginning of the 20th century midwives moved from a position of autonomy, to becoming an invisible workforce, to come back to being autonomous health professionals in 1990. Midwives experienced what it was like to be business women and run their practice as independent practitioners; they then experienced being subservient to the medical profession. Since 1990 they again have the opportunity to be self-employed midwives holding their own case-load and enjoying the flexibility this type of work brings. Women have driven changes in maternity care influenced by the societal beliefs of the time. Midwives now work with women in partnership to achieve women-centred care. Midwives today have a professional organisation that gives leadership and professional representation with the advantage of being self-regulating to give control of various aspects of its work (Pairman, 2006). Midwives are a

predominantly female workforce and each midwife can choose the setting in which she practices, be it employed or self-employed. A midwife can work shift work in a primary, secondary or tertiary unit. The case-loading midwife can choose where, how and with whom she practices having autonomy not just in her clinical decision making but autonomy in how she works. She can choose to access a hospital for births and also provide home birth care.

Providing this overview of midwifery practice has given a sense of the way midwives have adapted to changes in maternity care. Midwives are part of society and their work-life balance reflects the expectation of the time. Midwives joined with women to bring back women-centred care. Pelvin (1990) foresaw that midwives would work with women in the community in different practice arrangements with continuity of care at the core. Indeed case-loading midwifery comes with a fulfilling style of work providing great satisfaction to the woman and the midwife but if not kept in check it can lead to burnout. In the last few years, as maternity provision and societal demands have increased, the care provision has become more complex. More emphasis has recently been placed on the need for the case-loading midwife to manage the balance between work and life to retain midwives in the case-loading midwifery workforce.

CHAPTER THREE

The literature review

Work-life balance is the individual perception that work and non-work activities are compatible and promote growth in accordance with an individual's current life priorities.
(Kalliath & Brough, 2008, p. 324)

This thesis is about case-loading midwives finding ways to create a better balance between their professional and personal life. In chapter one the idea of the on-call nature of continuity of care provision placing the midwives at the risk of 'burn out' was introduced. An historical context of New Zealand midwifery is provided in chapter two outlining how for almost 90 years midwifery had been an invisible work force fighting for its survival. Then in 1990 a change in legislation revitalised the world of independent midwifery but brought with it an unseen burden of professional obligation to provide continuity of care (Young, 2011). Literature related to the impact of providing continuity of care on the case-loading midwife is now examined drawing from a wide body of work, beyond midwifery.

This literature review sets out to identify completed as well as ongoing research, on the case-loading midwife, her well-being and sustainability of providing continuity of care. The intention was to find gaps in the existing research to show the relevance for investigating the work-life balance (Morris, 2010). It draws on information about how other occupations deal with on-call work, shift work and long hours of work to see how such a potentially stressful lifestyle can be managed. The theme of the work-life balance is woven throughout this chapter with a closer examination in the final section. To facilitate the literature search the Auckland University of Technology search tool Summon was used which provided information from books, eBooks, journal and newspaper articles and scholarly commons items.

Woman-centred care

In the late 1980s feminist protagonists had a large impact on the New Zealand midwifery scene promoting a 'with woman' ideology (Flint, 1986; Kitzinger, 1988). Midwives were able to offer a different paradigm, a different way to see birth than the dominant medicalised healthcare system where experts are in control (Donley, 1991; Guilliland & Pairman, 1994). Birth was seen to be over-medicalised with routine and unnecessary technological intervention and inadequate support for the labouring mother (Rothman, 1983). The dominant medical model treated childbirth as a disease and a medical emergency as opposed to a

holistic approach that midwives could offer. Flint (1986) emphasised the empathy provided by the midwife in a close relationship in this holistic approach:

To be a midwife is to be with women – sharing their travail and their suffering, their joys and their delights. To be a midwife is to engage in a close and intimate relationship. (Preface)

Flint (1986) goes on further to say that not only does the midwife have an effect on the whole birth experience for the woman but helps the man to feel strong and competent. Flint describes the midwife as “the cornerstone of the emotional health of the whole community” (p. 1).

New Zealand midwives wholeheartedly embraced this woman-centred holistic ideology reflected by the NZCOM Standards of Practice and the philosophy of partnership with women (Guilliland & Pairman, 1994). The fundamental features of the construction of New Zealand midwifery are continuity and woman-centred care which drives the midwives’ passion to be on-call for women (Davis & Walker, 2011). It remains based in a feminist ideology where the language used is empowering and gender sensitive; value is placed on the female experience to empower women to be freed from oppressive ideologies (Cragin, 2004). Midwives make a space for the birthing woman to “reconstruct the maternal body as a competent body, reposition the woman at the centre of care, disrupt the obstetric gaze, and create an oasis of privacy, calm and 'woman-centeredness' within the birthing room” (Davis & Walker, 2011, p. 606). It is seen that midwives need to negotiate competing discourses to keep women and themselves safe (J. Skinner, 2003; Surtees, 2010).

The LMC midwife is driven by a commitment and passion to be there for women that can be at a cost to herself (Cox & Smythe, 2011; Wakelin & Skinner, 2007). Domiciliary midwife Sian Burgess spoke about her passion at the advent of midwifery autonomy in late 1989 acknowledging the sacrifice midwives were prepared to make (Roberts, 1989). Burgess (1989) said: “It totally disrupts my private life, but that is what you take on. It is just great” (p. 7). The midwives in this action research project, over 20 years later, still carry this passion to provide woman-centred continuity of care but were not prepared to continue to place their work-life balance at risk. When this research project was commenced, a telephone survey of 74 case-loading midwives that explored the sustainability of LMC practice was just completed (Wakelin & Skinner, 2007). The study revealed that many midwives work in an unsustainable way. It was identified that a better balance was required between the needs of the women and their own needs if they are to continue providing continuity of care long-term.

Despite the immense satisfaction of providing case-loading care it can create the potential to affect the midwife's well-being.

Continuity of care

The LMC practitioner is required by the Primary Maternity Services Notice 2007 (Ministry of Health, 2007) to provide continuity of care. Continuity of care is a fundamental element of the midwifery partnership model (NZCOM, 2008b). "Continuity of care refers to the ongoing relationship between the woman and her primary midwife, including the midwife's back-up, throughout the woman's total maternity experience" (p. 14). Primary medical care holds a similar definition with the same sentiments of a trusting relationship formed by seeing the same person or back-up over a period of time. (Jatrana, Crampton, & Richardson, 2011)

Continuity of care presupposes the existence of a regular source of care over time, regardless of the presence or absence of disease or injury. It is intended to help the provider and the patient build a long-term relationship in order to foster mutual trust between provider and patient, and knowledge of both parties' expectations and needs. (Jatrana et al., 2011, p. 16)

Freeman and Hjortdahl (1997) describe these definitions as longitudinal continuity as they imply a personal ongoing relationship. In New Zealand the longitudinal and the personal continuity coexist in primary services and are found at the interface between primary and secondary maternity care (Ministry of Health, 2006). Freeman and Hjortdahl (1997) also describe another category of continuity of care as 'personal continuity' where the responsibility lies not in the relationship but with the patient/client in consultation with all the practitioners that the person will be involved with. However personal continuity raises the concern of fragmentation of care as the client is being seen by various practitioners (Haggerty et al., 2003). In the New Zealand maternity care system if the client is transferred to secondary or tertiary services it is usually only an interim measure until care is able to be handed back to the LMC. This may reduce the chance of fragmentation of care.

Continuity of care can be described in a variety of ways with no united consensus of the definition often being used synonymously with continuum of care, coordination of care, discharge planning, case management, integration of services, and seamless care (Haggerty et al., 2003, p. 1219). Haggerty et al. (2003) evaluated a wide range of academic and policy literature from 1966 to 2001 on continuity of care used across all health disciplines identifying three types of continuity.

The first two descriptions are similar to Freeman and Hjortdahl's (1997) description but add a third dimension of management continuity:

- Relational continuity: an ongoing therapeutic relationship between a patient and one or more providers
- Informational continuity: the use of information on past events and personal circumstances to make current care appropriate for each individual
- Management continuity: a consistent and coherent approach to the management of a health condition that is responsive to a patient's changing needs (p. 1220)

These forms of continuity are useful for describing New Zealand maternity care. The relational continuity, or longitudinal as described earlier, is fundamental to the LMC concept where the woman chooses her LMC and will have an ongoing relationship with that LMC or the back-up provider/s. Informational continuity, described earlier as personal continuity, is required when referring a client to another service such as ultrasound scanning, laboratory services, an obstetrician or the well-child services. The woman is seeing other care providers but the information shared is relevant to her ongoing care. The third type of continuity Haggerty et al. (2003) identified as management continuity which also describes part of the role of the LMC when care often needs to be coordinated with other services, for example, the LMC may refer a client to the diabetes service or other specialist services. The LMC would usually stay as the primary provider to provide the ongoing relationship. Saultz (2003) in his review of the literature had a similar conclusion to Haggerty, however disputed that the management of continuity was one more of coordination of care not continuity of care. What is of importance is that the essential element of relational continuity is not lost from the equation of continuity of care (Saultz, 2003).

Some say that findings from research comparing continuity of care with other types of maternity care are not consistent enough to be able to say that better outcomes are achieved with continuity of care provision (Green, Renfrew, & Curtis, 2000; McLachlan et al., 2008; Waldenstrom & Turnbull, 1998). In a literature review, Green et al. (2000) considered definitions of continuity of care internationally to see what matters to women. No firm definition of continuity of care was found but it usually referred to fewer caregivers with a known caregiver in labour. For satisfaction of care to be achieved most women wanted to have trust in a caregiver. Continuity in itself was not valued. A Randomised Control Trial (RCT) in Melbourne, Australia, has been set up to compare standard maternity care with one-on-one midwifery care with a known midwife to see if it reduces intervention for women, addresses the attrition rate for midwives and is cost effective (McLachlan et al., 2008). It was

prompted by results of other RCTs in the United Kingdom and in Australia that reported reduced caesareans and other labour interventions with increased maternal satisfaction. However these studies had not specifically compared continuity from a known caregiver with other midwifery team models of care or medical care. The results of the RCT are still to be released. In a systematic review of seven trials to compare continuity of midwifery care with standard maternity care involving a total of 9148 women, it was concluded that the continuity of care was associated with lower intervention rates but no statistical difference was found for the maternal and infant outcomes (Waldenstrom & Turnbull, 1998).

In an Auckland setting 100 women and 104 midwives were surveyed comparing continuity of care and hospital midwifery and it found that the birthplace setting actually had more influence on the labour care outcome than the type of midwifery care provided (L. Freeman, Adair, Timperley, & West, 2006). A British study compared care from a team midwifery approach and a personal case-load approach to determine the women's preference and satisfaction with their care (M. Morgan, Fenwick, McKenzie, & Wolfe, 1998). There was a high response rate from 247 women antenatally and 222 post-natally. It was found that personal continuity was not a clear predictor of women's satisfaction; the women's expectations, their relations with midwives, communication and involvement in decision making were of greater importance. Another literature review was undertaken comparing midwife-models of care (not necessarily care by a known midwife) with other models of care from 11 trials to include 12,276 women concluding that midwife-led models of care provide women and babies with better outcomes (Hatem, Sandall, Devane, Soltani, & Gates, 2008).

Yet other research shows that continuity of care provides the client with satisfaction of care and improved clinical outcomes alongside lowering of health cost (Dorling, Munro, Freeman, & Oxley, 2006; Page, 2003). In a UK hospital a retrospective analysis of 612 women who had one-on-one midwifery care were compared to 14,332 women receiving standard midwifery care showing reduced intervention with higher rates of home-birth and breastfeeding (Dorling et al., 2006). A prospective comparative cohort study using both quantitative and qualitative methods to evaluate clinical outcomes of continuity of care to 800 women was carried out in the United Kingdom (Page, 2003). When comparing the women who received continuity of care with those who received standard care it was demonstrated that a lower intervention rate, a higher vaginal birth rate, a lower caesarean birth rate, and a higher intact perineum rate were achieved for women receiving continuity of care.

Waldenstrom and Turnbull (1998) suggested that more research is necessary to determine conclusions about safety when comparing different models of maternity care. McLachlan et al. (2008) agreed there remains some doubt if it is the midwifery woman-focussed care that makes the significant difference or continuity of care from a known caregiver (McLachlan et al., 2008). What seems to be a key factor in the care provision for better outcomes and greater satisfaction is not about the model of care but the philosophy of ‘woman-centred care’ that appears to provide the woman with increased choice and control (M. Morgan et al., 1998; Tinkler & Quinney, 1998). There needs to be more research to determine what the most significant features of care are for women. Perhaps there is an unnecessary onus on continuity of care from the known caregiver when the focus should be on the birth place or just providing woman-centred care regardless of the model of provision. This may provide relief to the midwife who feels that she is failing her professional call if she cannot always be available.

Alternatively in a phenomenological study ten first time New Zealand mothers were interviewed about their birth experiences; it was found that for these women taking personal responsibility for their well-being increased their birth satisfaction (Howarth, Swain, & Treharne, 2011). Their neoliberalist ideal led them to take personal responsibility, to be well informed and prepared and to be accountable for their own birth journey (Howarth et al., 2011). Perhaps we need to focus more on empowering the women to take the lead in their care so that regardless of whether it is a known caregiver or not the woman is able to own her birth experience and gain satisfaction in her own abilities.

Case-loading practices

The self-employed case-loading midwife manages her own hours and case-loading to determine what works for her and what she realistically thinks she can manage professionally and personally (Guilliland, 2007). In New Zealand there is no governing body that sets out conditions of hours of work for the self-employed case-loading midwife. There is no prescribed way a midwife needs to practice and many midwives find a group or develop a group to suit both their own needs and those of the women in their care. The Midwifery Standards of Practice produced by the New Zealand College of Midwives guide the midwife in how she chooses to practice (NZCOM, 2008b). Case loading midwives usually work in small groups so that the women in their care have a known back-up should it be needed. The

midwife is contracted directly to the Ministry of Health or employed by a District Health Board or a private institution.

Previous to 1990 there were only small numbers of midwives providing community care so setting up groups to practice was new territory for many midwives (Donley, 1986). Davies (1994) shared her experience of starting a 'Know Your Midwife' (KYM) service, a form of continuity of midwifery care, in 1992 at Queen Mary Maternity Centre in Dunedin. After some initial rearranging three midwives took turns working three days first on-call, three days second on-call and three days off. They were provided with equipment, pagers and a car from the hospital and had a hospital receptionist to do their business paperwork. They worked for as long as they individually felt safe – usually about 12 to 15 hours before handing over to the back-up midwife after consultation with the woman. The inspiration for the service came from Caroline Flint: a midwife, birth activist, and author who published research on a continuity of care scheme at St George's hospital in London. Similar types of KYM or Domino teams were simultaneously set up around the country.

Kowalewicz (2000) spoke at a NZCOM conference of a KYM scheme that had been running at the Waikato Hospital since 1988. It evolved over the years. The team started with three midwives providing low-risk care to having twelve midwives working in pairs. The initial team had two days off a week with one weekend in three. The team had its own administrative support person and the midwives worked out of different locations both on-site at the hospital and in the community. An administrator was appointed to arrange cover for sick leave, to budget and market, but as autonomous practitioners they felt they did not need a leader. Although Kowalewicz worked as a midwife in an organised team she still found it difficult to juggle her personal and work life because of the unpredictability of call-outs. She related how working in a group brought times of disagreement, disharmony and heated discussion between members. When the team of twelve reduced to two groups of six it helped to work issues out. In all, Kowalewicz found it was a lonely job on the road all day despite contact with the women. She talked about nearly having a car accident from being on the road so much at night. Despite a good system in place Kowalewicz highlighted the issues she faced; from the isolation from other colleagues, to the demands of working in a team to coping with the exhaustion that comes from long hours of continuous work and the unpredictability of being on-call.

Coyle (1992), a midwife who practiced in London with another midwife providing home births, was also stretched by the demands of the on-call lifestyle. Coyle enjoyed the job satisfaction working independent of the National Health System but discovered many challenges with relationships both professional and personal. Coyle, like Kowalewicz, experienced the isolation from other midwives. She had a secretary for office work to free her up for downtime and learnt to do routine work only Monday to Friday. Because of the unpredictability of call-outs childcare was always a major concern as she found it was hard to manage the unknown.

Other groups describe how they worked to sustain themselves in case-loading practice. The Hutt Union and Community Health Service provided a range of health services including a team of four LMC case-loading midwives (Nicholl, Vano, Griffiths, & Skinner, 2000). The midwives were salaried and had regular weekends off with eight weeks paid leave, study leave and sick leave. Two midwives would attend every birth. A midwife who had been up all night would be relieved in the morning and would be off-call the following night. Each woman had her own named LMC who carried the overall coordination of care role and who would undertake the majority of the care with a named back-up.

The Midwives Collective commenced in 1987 and by 2000 had eight midwives although many members in the group changed over this time (Becker et al., 2000). This group felt that feminist values guided their direction which included nurturing, democracy, cooperation, empowerment, inclusion, transformation, maximising rewards to all, and ending oppression. They supported each other to have time off, holidays, and sick leave to minimise financial loss. If a birth was provided by a back-up a proportion of the fee would go to both the LMC and the back-up. They had a set price to pay each other for antenatal and post-natal visits done by a back-up. They had weekly meetings, seconded each other for a home birth and provided back-up for every second weekend off. They socialised together for fun building relationships, and getting to know each other on a wider level than midwifery. They had a team building weekend away together every year. They felt the way they worked suited their needs.

Over the years, in New Zealand and elsewhere, case-loading midwives have demonstrated how they work together in groups to support each other. Each group or team is different as they take on their own distinct character to meet the particular needs of the midwives and women in their care. Some midwives, however, still found that case-loading practice was

hard to sustain no matter how good their group infrastructure was. For some midwives the benefit of continuity of care seems to be outweighed by the disadvantage of the unpredictable nature of the role and the demand this places on their personal well-being.

Sustaining continuity of care

At the inception of this study there was no published research exploring how midwives provided continuity of care and managed their work-life balance. A recent Australian qualitative study has sought to gain insight into how case-loading midwives can achieve such a balance (Fereday & Oster, 2010). The study highlighted the importance of flexibility at the organisational level, within the team, and at the individual level. The necessity was seen for an industrial agreement or such to provide the midwife with clear boundaries for work time.

Evidence suggests that the practitioner who provides continuity of care receives satisfaction (Engel, 2003; G. Freeman & Hjortdahl, 1997; Page, 2003). A review of case-loading midwifery in the United Kingdom recognised that being on-call is stressful but a group of researchers reported that the advantage of knowing your clients and the autonomy of how the midwife works relieves this tension (Andrews, Brown, Bowman, Price, & Taylor, 2006). Yet others say that the tension of being on-call can be greater than the perceived advantages which affects the case-loading midwife's ability to maintain a balance between work and personal life needs (Fereday & Oster, 2010). McLachlan et al. (2008) were aware of the possible disadvantages to case-loading midwives when they set up a Randomised Control Trial (RCT) to investigate the effect of one-on-one midwifery care on the birth outcome for women. Part of their study was to also investigate midwife job satisfaction, recruitment and retention in light of emerging evidence suggesting that case-loading midwifery has high personal costs, burnout and stress. McLachlan et al. (2008) noted that other institutions in Australia had moved from case-loading midwifery back to midwifery teams because of the perceived disadvantages of continuity of care provision. There is no published data on the outcome to date.

It has been recognised for many years that the case-loading midwife sacrifices a lot of personal freedom to offer continuity of care to women as all her activities are based on her immediate availability for an urgent call-out (Flint, 1986). Flint (1986) urged midwives to have a support system in place reminding them that it is the midwife's passion that drives her to provide care in this way. "Despite others saying 'don't get involved in other people's lives', it is the very reason a midwife is a midwife; she wants to be involved in other people's

lives” (p. 2). Increasing evidence shows that the impact of work-life balance may crossover to partners and other family members creating a negative or positive psychological effect depending on how commitments are managed (F. Jones, Burke, & Westman, 2006). For continuity of care to be sustainable it needs to be provided with the best interests not only for the women but for the midwives as well (Brodie et al., 2008).

Skinner et al. (2011) engaged in two qualitative studies involving telephone surveys and in-depth interviews of 49 nurses and midwives in an Australian hospital setting, investigating the challenges to the work-life balance of the 24/7 nature of health work. Although this study was looking at the sustainability of the work-life interaction for hospital workers rather than midwives working on-call, it provides valuable insight into the perceptions and understandings of what the work-life balance can mean to case-loading midwives. “The significant investment of meaning and commitment to their work seemed to be a ‘double edged sword’ for many participants, leaving them more vulnerable to negative spill-over of work-related worries and concerns during non-work time” (p. 219). Their work commitments often left the participants working on days off or unable to take leave when needed because of poor staffing levels. The findings highlighted the need to build and maintain a supportive organisational culture to retain workers.

McLardy (2002) found that if midwives cannot find a balance then they will opt out of continuity of care. Although caring for the same clients increases job satisfaction it requires a high personal commitment and availability making work and home boundaries difficult to define (McLardy, 2002). Engel’s (2003) research in a qualitative study of five midwives showed that the setting of boundaries between the midwifery practice and the home helped maintain some midwives in continuity of care but for others, despite the setting of boundaries, being on-call was still disruptive for leading a balanced life. Engel (2003) sees the relationship as a “romantic notion to become everything to other people. Becoming an important part of a woman’s life makes it ‘easy to lose your own life’ and long-term it is not sustainable” (p. 14).

The NZCOM continuity of care model remains an important key to the success of the New Zealand maternity system (NZCOM, 2006a) yet researchers agree that many case-loading midwives have had to grapple with the challenge of balancing professional responsibility against personal needs (Brodie et al., 2008; Cox & Smythe, 2011; Rolston, 1999; Wakelin & Skinner, 2007). Continuity of care comes with a high chance of professional burnout that

could lead to a reduced workforce if steps are not taken to protect midwives (Young, 2011). Continuity of care is something that perhaps can only be managed for a select amount of time (Wakelin & Skinner, 2007). What is of importance to the LMC practitioner is that she finds a way to practice continuity to meet the continuity of care requirements and the satisfaction she desires but at the same time achieve a work-life balance (Brodie et al., 2008; Fleming, 2006; Rolston, 1999). It has been identified that the work-life balance is an issue for case-loading midwives but there is a gap in New Zealand literature about what sustains case-loading midwives in practice. McAra-Couper (personal communication, September 4, 2011) advised that the AUT midwifery school is in the middle of a project as a beginning to address this gap.

Safety

The implication of continuity of care for many case-loading midwives is that the midwife will be with the woman to the end, no matter what, no time limit (S. Miller, 2002). However the midwives' standards of practice clearly states that "Midwifery actions are prioritised and implemented appropriately with no midwifery action or omission placing the woman at risk" (NZCOM, 2008b, p. 20). Midwives speak of 'a call' to midwifery which can inspire and override self-interest driving the midwife to carry on (Young, 2011). Sharon Cole at the NZCOM 9th Biennial National Conference reiterated this intensity of the midwife woman relationship by saying:

The nature of the profession is that it attracts women who are passionate, compassionate, and want to give women the best midwifery care possible. Unfortunately too many give of themselves. Not to set boundaries...will inevitably lead to burnout but it can also lead to not a healthy partnership between midwife and the woman but to a co-dependency which is healthy for neither. (Cole, 2006, p. 9)

The responsibility for protecting the work-life balance it seems lies with the midwife and how she structures her practice to provide safe care for women. Young (2011) notes though how a midwife suffering from burnout can realise too late. A midwife in Young's study had already entered into burnout before realising her interpretation of partnership was unsustainable. She stated:

I was well indoctrinated in my training that the partnership model was the gold standard; that my job as a case-loading midwife was to uphold the partnership model and work with the woman so that she received the best possible care on her terms throughout. I have a different view on partnership these days! (Laugh's loudly). It was

just an idea. I would like to think it wasn't expected to be the panacea that it has become. (p. 181)

This case-loading midwife saw all around her other midwives that believed the selfless giving to create a partnership model would be the only way to meet the needs of women (Young, 2011).

The midwife who works tirelessly in the care for women in her case-loading can become exhausted and even struggle with knowing when she is impaired to make the right decisions because of her sleep deprivation (S. Miller, 2002). There is no stated time period of how long is too long for a midwife to be with a woman continuously; it is left up to the individual to make her judgment of each situation (Guilliland, 2007). Some midwives may handover care to secondary services after two hours and yet some will stay on for fifteen to twenty hours. Some women do not think to consider that midwives could be 'too tired' to perform their tasks well during their long labours so can feel 'let down' by the midwife when her care is handed over to another (S. Miller, 2002). The expectation from the woman to have her midwife there can cause a case-loading midwife to soldier on in an exhausted state. This state of exhaustion can lead to burnout (Paterson & Adams, 2011).

Miller (2002) reminds us that some of the most disastrous environmental and social calamities of the late twentieth century were caused through poor decision making due to sleep deprivation. The former Health and Disability commissioner Dr Ron Paterson recognises that health providers who suffer burnout will either leave their profession as they cannot cope or they will carry on in an exhausted state being more likely to make a mistake that could harm a patient (Paterson & Adams, 2011). Young (2011), in her thesis on the experience of case-loading midwives, reveals the potential for clinical errors. She quoted a participant who described how she was unsafe when she was fatigued: "I took my epidural top-up and went to attach it to the woman's IV luer, pulled back and thought whoops! It was only then that I realised that I was too tired" (p. 137).

The midwife can feel very guilty for not being 'with women' even though another competent practitioner can take her place (Rolston, 1999). Some case-loading midwives have the expectation to be there for women 24 hours of every day and no one can really say why this expectation has been taken so literally (Wakelin & Skinner, 2007). In the past midwives and nurses both worked under the same 'nursing' umbrella. Ingrained in nursing training is the expectation to cope with long hours and exhaustion with the obligation of the nurse to put

others before herself. Improvement in working hours was introduced in the early 1900s to protect nurses from exhaustion. There was however an underlying theme of thought that “nurses would get no training in endurance. A good nurse, they said, should not want to make life easier: long hours and hard work were part of this chosen vocation” (M. Brown, Masters, & Smith, 1994, p. 30). It seems that this notion lingers on in our day with the calling to be there for women. The midwife is compelled to be there, despite exhaustion, neglecting parameters of safety.

Wakelin and Skinner (2007) found that exhaustion was the main reason given by midwives in their research for leaving LMC care. These midwives stayed on-call and worked twenty four hours at a time before taking a break. The Midwifery Council sends a survey form to all midwives who choose not to renew their practising certificate; only 42% responded so the findings can only be seen as indicative. However, in the years 2005 to 2010 the combined number of those who left the workforce stating the reason of stress/burnout/responsibility were the largest group to leave (Midwifery Council of New Zealand, 2011). *The Workforce Report 2010* (Midwifery Council of New Zealand, 2011) showed that some midwives had very high hours, although it is not known how the hours were calculated, particularly in the case of self-employed midwives. When a midwife stays on-call seven days a week it is difficult to calculate the actual hours worked as these are spread throughout the day dispersed with down-time interrupted with phone calls.

LMC midwives in New Zealand in 2010 cared for an average case-load of 45.2 women; a small decrease from 2009 when the average was 46.6 women (Midwifery Council of New Zealand, 2011). Based on the *2009 Workforce Report*, the figure of caring for five women a month, the case-loading midwife’s income after work related expenses and GST was calculated to be similar to that of a senior core midwife with only three years of experience (Mansfield, 2011). Mansfield (2011) concludes:

It seems to me that, having regard for the different nature of the independent and staff roles and the differing levels of responsibility employed (core) midwives currently enjoy a financial advantage over their independent colleagues, especially considering the different demands of the two roles. (p. 4)

Financial reasons can cause self-employed midwives to work long hours providing birth care and staying on-call without a break (Young, 2011). Case-loading midwives employed by a DHB have the protection of the DHB/MERAS Multi-employer Collective Agreement to receive a set salary of \$82,083.00 per annum for a 40-50 women case-load, a number

recommended by the NZCOM (MERAS, 2010). These employed midwives are also entitled to have 24 hours off, in every two-week period and are not required to work longer than 12 consecutive hours unless the midwife chooses to do this. If the midwife works 16 or more consecutive hours intermittently over a 24-hour period she is entitled to an eight-hour break.

The self-employed midwife is paid for three separate care modules to include the antenatal care, the birth care and the post-natal care (Ministry of Health, 2007). The module of payment for the birth care can be earned in a matter of hours and is approximately one half of the overall funding. If a midwife loses this fee it significantly impacts on her income. On the other hand if the self-employed midwife needs to call in a colleague for relief while working long hours at a birth she is responsible for the payment reimbursement to the colleague (Ministry of Health, 2007). The funding in this situation is not adequate to cover both the long hours worked and a reimbursement to a colleague. Despite the NZCOM making a submission to the Ministry of Health for increased funding for a long labour this was not granted in the Section 88 Notice released in 2007 (NZCOM, 2006b).

Fatigue and burnout

It is no longer “save the midwife from extinction” as previously claimed but “save the midwife from exhaustion” (Rolston, 1999). Lack of sleep is a concern for on-call practitioners (Wakelin & Skinner, 2007). There is no established amount of time a person needs to sleep but the US National Institute of Health (NIH) suggests that most average adults need about seven to nine hours of sleep each night (National Institute of Health (NIH), 2003). Unfortunately for some LMC midwives due to their on-call availability they may have to work all night after having worked a full day. A study of 94 LMC midwives, who worked on-call, showed that most of them would work 24 hours before calling in back-up (Wakelin & Skinner, 2007). Maslach (1982), a pioneering researcher on job burnout, describes the nature of being on-call:

The provider’s personal life is also interrupted when he or she is “on-call”. Not knowing when (or if) an emergency will arise, but having to be ready to respond to it, the provider cannot fully relax and unwind after a hard day’s work. Even one’s sleep may be interrupted. Leisure activities are limited, or even curtailed. (p. 83)

The National Institute of Health (2003) suggest there are many misconceptions about sleep.

Two important misconceptions are:

- getting just one hour less sleep per night than needed will not have any effect on daytime functioning
- the body adjusts quickly to different sleep schedules (p. 1)

If midwives took on board just these two important misconceptions it may prevent many from driving their bodies to work such excessive hours. A sleep debt can develop without the midwife realising it and when the sleep debt becomes too great it leads to problem sleepiness (National Institute of Health (NIH), 2003). “The biological clock that times and controls a person’s sleep/wake cycle will attempt to function according to a normal day/night schedule even when that person tries to change it” (National Institute of Health (NIH), 2003, p. 1). This sleep debt can have powerful effects on the daytime performance, thinking, and mood. Sleep is a required activity, not an option. The lifestyle of the case-loading midwife means that some midwives at times do not get enough sleep (Wakelin & Skinner, 2007). The NIH (2003) suggests that problem sleepiness, being sleepy at times when a person expects to be awake, can be associated with difficulty concentrating, memory lapses, a loss of energy, fatigue, lethargy, difficulty with relationships and emotional instability. Studies show that multiple physical and mental disorders are considered to be associated with sleep deprivation (Alhola & Polo-Kantola, 2007; Burke & Cooper, 2008).

In 2009 fatigue was identified as a contributing factor in 44 fatal crashes, 140 serious injury crashes and 456 minor injury crashes (Ministry of Transport, 2010). In the US approximately 100,000 automobile crashes each year result from drivers who were ‘asleep at the wheel’ (National Institute of Health (NIH), 2003). A recent fatality of a midwife was linked to driver fatigue (Otago Daily Times, 2011). The Ministry of Transport reports that fatigue occurs long before a person falls asleep at the wheel. Fatigue affects reaction time and ability to concentrate and to understand generally what is going on around them. The Ministry reports the three main causes of fatigue are: sleep loss, disrupted circadian rhythms (dictates the time of day that we are most tired) and time spent driving and/or working. The *Land Transport rule: Work Time and Logbooks 2007* sets the limit for a driver in a transport service to increase safety by managing driver fatigue (Land Transport New Zealand, 2007). All the work the driver undertakes needs to be recorded, including other employment. The driver

must work no more than 13 hours in any 24 hours with a 10 hour break between days and no more than 70 hours before taking a 24 hour break.

In the *Air Nelson Pilot's Collective Agreement* the duty times are clearly stated and adhered to. For example, if a pilot has been on duty longer than 12 hours or flown more than 8½ hours a rest period of not less than 24 hours is required (Air Nelson, 2008). Human factors incorporating aviation medicine, aviation psychology and aviation ergonomics are taught to trainee pilots to ensure pilot safety (Ardmore Flying School, 2002). The aviation psychology gives an in-depth look at pilot personality, including personality traits, sleeping patterns, visual illusions and decision making. If a pilot has exceeded flying hours and there are no other pilots to carry on, the next flight is cancelled. A midwife may have some control over her routine work but, unlike a pilot or a transport driver, her on-call work gives no guarantee as to when she will work or for how long or if she will get any sleep that night. This was a concern raised by some of the midwives in this action research project. They were sometimes faced with their back-up partner not being available because she was also at a birth or the maternity facility not having staff available to take over the care. This same issue of unavailable back-up was raised in recent New Zealand midwifery research on burnout (Young, 2011).

There has been an expectation of the general practitioners in the past to always be available for their patients, which brought with it the chance of sleep deprivation (L. Brown, 2008).

...in years past 'physician' and 'sleep deprivation' were descriptors joined at the hip. Career advisers, parents and grandparents, physician mentors, and medical school admissions personnel stressed the nature of medical practice as requiring an overwhelming commitment to working as long as was necessary to preserve and protect patient health, as all other concerns were subsidiary. (L. Brown, p. 1)

As it was for physicians, midwives have accepted that sleep deprivation is part of the package of being on-call. The working environment for physicians has changed over the past 25 years with regulations to safeguard student hours and legislation of work hours for employed doctors (L. Brown, 2008). Backed by numerable research studies Brown (2008) confidently says:

It is incontrovertible that sleep deprivation, not only one night of total sleeplessness but also a series of nights with too little sleep or a night with multiple interruptions, leads to decrements in performance and function in a wide variety of areas. (p. 2)

How much sleep deprivation a person can cope with and how they can adjust to changing their sleeping times, as in shift work, can vary person to person and a person can become sleep loss resistant (L. Brown, 2008). The complexity of health care and the variability of the practitioners' work schedules and workloads makes studies of sleep deprivation extremely difficult to conduct (Weinger & Ancoli-Israel, 2002). Pilots, transport drivers and employed medical staff have legislation to govern their working hours but self-employed health professionals do not. There is concern that the health industry puts public safety at risk when there is no restriction on working hours of private practitioners (Weinger & Ancoli-Israel, 2002). Sleep deprivation for the LMC midwife could be compounded by her age and sex. The majority of LMC midwives is female (99.4%) and the midwifery workforce is aging with the average age at 47 (Ministry of Health, 2010). Although sleep problems increase with age in both sexes, women are more susceptible (Polo-Kantola, 2010).

The extensive research since the 1930s of the long hours and the shift work of truck drivers and the resulting accumulation of fatigue increasing the risk of accidents demonstrates the long process of introducing policy change (Wylie, 2005). The same stressors that occur in drivers have been demonstrated in shift work of medical interns and Wylie (2005) hopes that this will impact on future policy guidelines for health professionals. However this needs to be weighed up against the quality of care provided through client continuity (O'Grady et al., 2010), the economic and potential staffing shortages and any actual improvement by controlling the working day (L. Brown, 2008; Weinger & Ancoli-Israel, 2002). The impact on the quality of care and patient satisfaction gained through continuity of care needs to be measured up against the disadvantage of the sleep deprivation to the practitioners. Those who work providing continuity of care may actually be those very people who have self-selected to work this way and do cope well with the extreme variability of their working hours. For example, for the LMC, the autonomy of their role and work satisfaction gained from her/his role may outweigh any perceived disadvantage of sleep deprivation.

Miller and McGowan (2010) reviewed literature on professional burnout and summarised the findings defining burnout as:

Burnout is a work-related syndrome distinct from depression. In the professional literature, burnout is characterised by three adverse characteristics: emotional exhaustion, depersonalisation (or cynicism), and a sense of personal inefficiency or impeded accomplishment. These characteristics manifest as loss of enthusiasm for work and feeling that one has nothing to contribute; developing negative attitudes toward work; treating others, including patients, as if they were objects; and feelings

of incompetence or inadequacy. In terms that capture more of the actual subjective experience of burnout, some have referred to "compassion fatigue"; deterioration of dignity, values, spirit, and will; an "erosion of the soul"(p. 25).

There are various tools used to evaluate burnout. In two recent New Zealand studies investigating the morale in general practice on medical practitioners one used a Likert scale (Dowell, Coster, & Maffey, 2002). This postal survey of a random sample of GPs in New Zealand with a response rate of 448/ 658 (68%) assessed levels of morale and psychological distress. The potent causes of work stress were excessive paperwork, bureaucracy, multiple problem consultations, time pressures and combining work with family life. In the other study the Maslach Burnout Inventory was used as a psychometric measure to assess burnout in hospital-based medical consultants in a large tertiary hospital in Christchurch (Surgenor et al., 2009). Utilising the standardised measures of burnout (Maslach Burnout Inventory) and job satisfaction (Job Satisfaction Scale) this cross-sectional study of 267 recruited consultants found that of those experiencing high burnout, by severity or dimension, working long hours and low job satisfaction appear to be particularly contributory factors. Resolving burnout once identified is not easy and the above two studies suggested that prevention through self-awareness is required alongside counselling and addressing environmental causes.

In the *Sunday Star Times* in 2011 the public were alerted to the fact that suicide is a risk for health professionals due to the demands of their role:

The ability of health professionals to cope with the demands of their jobs is under the spotlight with doctors being warned about burnout and a little-known study that shows New Zealand nurses have a higher than normal risk of suicide. (Pepperell, 2011)

Young (2011) identified that suicidal thoughts occurred in a participant in her research on burnout among case-loading midwives. Burnout can happen to any of us and if the warning signs are spotted early then it can be avoided (Head, 2006). However, Young (2011) found that burnout was not easily identified by those affected by it. Burnout is recognised as a work-related syndrome rather than depression (M. Miller & McGowen, 2010). Young (2011) proposes that graduate midwives need to understand the reality of burnout. It is important that midwives focus on woman-centred care without the ideology of a selfless priority to the woman. Ways to make case-loading practice more sustainable need to be developed.

The work-life balance

The concept of work-life balance is generally agreed to be about an understanding of priorities between commitment to career and ambition as opposed to leisure time, family commitments and nurturing of the emotional and spiritual aspect of self (Tolhurst, 2007). Globally governments promote flexible autonomous working conditions with the dual aim to achieve competitive performance alongside an improved work-life balance (Fleetwood, 2007). The State Services Commission (2005) defines work-life balance as:

Work-life balance is about creating a productive work culture where the potential for tensions between work and other parts of people's lives is minimised. This means having appropriate employment provisions in place, and organisational systems and supportive management underpinning them.

Work-life balance for any one person is having the 'right' combination of participation in paid work (defined by hours and working conditions), and other aspects of their lives. This combination will not remain fixed, but may change over time. (p. 1)

Fleetwood (2007) suggests there are serious underlying problems to the enactment of work-life balance policies and practices if it divides work and life into two distinct spheres of activity which in fact are part of each other and cannot be made into a comparison of either or, good or bad, paid or unpaid. The work-life balance could be more aptly described as work-life integration so it does not give the idea of a 50:50 investment or allocation (F. Jones et al., 2006). It appears the concept of work-life balance is an ambiguous term having many meanings:

An objective state of affairs; a subjective experience, perception or feeling; an actuality or an aspiration; a discourse or a practice; a metaphor for flexible working; a metaphor for the gendered dividing of labour; or a metaphor for some other political agenda. (Fleetwood, 2007, p. 352)

Kalliath and Brough (2008) tell us that a number of conceptualisations of work-family balance occur in the literature “yet there is no direct well developed measure of the construct, which constrains our ability to investigate the phenomenon fully” (p. 323). This can make empirical assessment of work-life balance interventions problematic and inter-organisational comparisons ineffectual (Kalliath & Brough, 2008). Reiter (2007), however, has categorised definitions of work-life balance according to a framework of ethical ideologies that can be used for a comparative analysis of work-life balance programmes. Reiter acknowledges how many current definitions are absolutist in nature meaning that they require the person to get the balance right. Instead Reiter promotes a situationalist perspective as being more valuable

for academics and practitioners. The situationalist perspective gives opportunities to groups of people to explore what factors contribute to the attainment of work-life balance for them and pertaining to midwives is a gap in the international literature (N. Skinner et al., 2011).

Marks and MacDermid (1996) have a situationalist perspective and hypothesised that better indicators for well-being can be achieved when people balance their roles and identities across their entire systems of activities rather than in a hierarchical pattern which denotes certain areas have more importance than others. This definition can be taken further to define work-life balance as a fulfilment of role salience between multiple roles (Kalliath & Brough, 2008). The person sees roles in work and life activities working together, complementing each other, varying in importance in a compatible way depending on life's priorities at the time. In this definition it is important that one's expectations about work and life roles are met (Kalliath & Brough, 2008).

Rothbard and Dumas (2006) found that role conflict is a central concern to work-life research. A person experiences role conflict when an expectation from one sphere of commitment interferes with that of another (Rothbard & Dumas, 2006). In Young's (2011) research on burnout an interviewee remarked:

If I was advising a friend whose wife was going to be a case-loading midwife, I would make him aware he had to have no expectations. Don't try and plan anything or expect her home at a certain time because it is not going to happen. (p. 205)

Here the husband is on the receiving end of the role conflict and has had to accept that he cannot have any expectation about when he would like to have his partner at home. On the work-home interface this 'work family conflict' construct has the basic premise that the role demands from either domain are sometimes incompatible and interfere with full participation in both roles (Tetrick & Buffardi, 2006). The midwife's on-call nature of the role is not so much that she does not have time for her family rather than she just does not know when she will have that time, or how long she will be working at that time, she can give no guarantee.

An essential element of work-life balance is that the individual has a high level of discretion and control over the conditions of work (F. Jones et al., 2006). While this is true for the case-loading midwife, in the sense that she can choose her case-load and how she works, she cannot choose when she works as this is dependent on the urgent call-outs. In an Australian study the experience of 17 case-loading midwives was explored to see how they achieved a work-life balance (Fereday & Oster, 2010). The midwives soon learned that although they

initially wanted to be everything to everyone they also needed to offer a service that met their own needs as well. They struggled to free themselves from the relationships with women on their days off but were supported to do this by their industrial agreement that allowed two days off each week and to work no longer than twelve hours consecutively. The occupational health literature concludes that choice of work hours is a key factor in promoting well-being (Major & Germano, 2006). This can be an issue for the case-loading midwife as she has a lack of control of not only when she is going to work but the hours and time of day or night involved in caring for a woman in labour. Balancing work and life can be like a 'survival perspective' as noted by Fereday and Oster (2010) when the case-loading midwife can interpret the work-life balance as "feeling on top of things and not feeling overwhelmed" (p. 317).

Literature showed that alternative work schedules and flexibility do not necessarily contribute to a control of work hours (Major & Germano, 2006). Like midwifery other professions also experience potential burnout when work takes over and time for a personal life is diminished. Four freelance writers were interviewed about their experiences and what they have learned about keeping a work-life balance (Morell, 2010). The writers discussed a life consumed by writing having given up time that they felt should have been spent with family or for self. Like the midwife these writers were driven by a passion for their work but unlike the midwife these writers were able to create divisions between time writing and time to leave the house or to do other activities. It is also seen that those with careers in financial services are subject to getting their lives out of balance (Parry, 2009). They love the work they do as they have the freedom to work their own businesses and help people with their financial futures but this passion for their work makes them subject to getting their lives out of balance. Parry (2009), a business coach, advises his clients to prioritise the following nine areas in their lives and to programme into a calendar the time to be spent in each area. These include: finances, physical health, spiritual health, self-improvement, fun and recreation, and relationship to spouse, family, friends and community. Using such a tool could help the midwife to be aware of the time she spends with work activities and non-work activities but it still does not allow for the unknown call-out that she has no control over.

It is recognised how demanding the lifestyle of continuity of care provision is and measures need to be put in place to sustain this style of practice (Association of Ontario Midwives, 2007; Brodie et al., 2008; Cox & Smythe, 2011). When a midwife considers LMC practice it is important to weigh up how it may affect her personal well-being. Quality of life or

wellness models are theoretical constructs used within the literature. The terms 'quality of life' and 'well-being' are often used interchangeably in research in a limited colloquial manner rather than theoretically based with a holistic approach (Langlois & Anderson, 2002). Langlois and Anderson (2002) suggest that research on quality of life/well-being requires both a subjective and objective dimension. They developed an integrated model fusing the concepts of quality of life/well-being together. Jones (1994) previously had developed a conceptual model of quality of life and also combined the objective and subjective experiences into a single framework. These concepts are useful for patient well-being but not so easily transferable to measure the balance in a professional's work and personal life.

In the nursing profession maintaining quality of life is seen by some as an ethical obligation where nurses need to care for themselves through the practice of wellness (Uno & Ruthman, 2006). Uno and Ruthman (2006) propose that various wellness models have similar dimensions including: "physical fitness, nutritional awareness, stress management, environmental sensitivity, and self-responsibility" (p. 4). They say that by practicing wellness it serves to enable the nurse to be more resilient and passionate embracing new visions and direction as the healthcare industry continues to change. This approach to well-being places all the responsibility on the individual. Guilliland (2007) the NZCOM CEO, discussed the difference in midwifery roles, and takes this same view that midwives are responsible for how they choose to practice. Guilliland (2007) comments that:

Self-employed midwives are more personally responsible for the way in which they practice. The profession provides guidelines but the hours, case-loading numbers, the leave, and the time-out decisions are the midwives'; and no one else's. It is up to the case-loading midwife to manage being on-call. (p. 6)

When I set out to investigate the work-life balance there was little written on how midwives manage their role and maintain a work-life balance. Gerkovich (2006) found the same noting that there was "no research on how these change efforts were planned, introduced, implemented and evaluated (that is what worked well and what did not work) and what was learned from these experiments" (p. 293). This review has revealed that there is keen interest in the area of the work-life balance of the case-loading midwife. It shows the need to actively pursue changes at both the individual and the organisational level to create a sustainable way of working to keep midwives in the workforce. This needs to be done in careful consideration of how feasible it may be for the LMC midwife to create a better work-life balance. Not just because of the unpredictability of call-outs but also the power of the relationships between

her commitment to the women in her care and to her family and her other roles in life (Caproni, 1997).

In writing about the work-life balance I am mindful of another consideration. Focusing on the 'balance' of the work-life balance may undermine the midwife's attempt at having a more fulfilling life (Caproni, 1997). Drawing from a feminist and critical perspective Caproni (1997) discussed how "the work-life discourse reflects the individualism, achievement orientation, and instrumental rationality that is fundamental to modern bureaucratic thought and action". She fears that "such a discourse may further entrench people in the work-life balance that they are trying to escape" (p. 46). Whyte (2009) also contests that it is not about balance but a dynamic interplay of three important spheres in life between our self, our relationships and our work in a quest for meaning rather than achieving ease and contentment in life. Perhaps in Whyte's terms this study is too simplistic, but the work-life balance for the case-loading midwives in this research set out to see how they juggle their multiple roles to achieve both a fulfilment in their role as a case-loading midwife and the meeting of personal life commitments. Caproni (1997) suggests we do not want to be following a systematic, goal-oriented approach to life and over-plan our lives rather than just 'living'. Caproni (1997) urges us to ask ourselves "is balance or juggling really our goal or is it living life to the full?"

The Department of Labour designed a project aimed to find out how New Zealanders, both employees and employers, viewed work-life balance issues that involved over 700 responses from individuals and organisations (Department of Labour, 2004). New Zealanders are aware of needing a good work-life balance and it is primarily seen as a matter of individual responsibility (Department of Labour, 2004). Midwifery research is still being produced about the work-life balance and how to protect ourselves from burnout as we see midwives continue to struggle with the on-call nature of their role (Cox & Smythe, 2011; Young, 2011). Have we ignored the advice to change the culture of the expectation to be there to the very end (Smythe, 2000)? Some of us though do want to change this and agreed to set about changing our practices through a cooperative inquiry approach. By doing so we hope not only to make change to improve our own work-life balance but we hope to contribute to changing the culture of expectation which expects us to cope even when tiredness puts us beyond our limit of safety. There needs to be more openness to the fact that burnout occurs in the midwifery community and appropriate supportive intervention is seen as the solution rather than losing midwives from the profession (Young, 2011).

Summary

From the examples of literature there is clear evidence to suggest that providing on-call care and working long periods of time without a break may not be in the best interest of the case-loading midwife. Hospital-employed doctors, pilots and transport drivers all have clear parameters of when they work and how long they have off between shifts. The self-employed case-loading midwife uses her own judgement of what she deems as safe care. She has no statutory requirements to govern when or for how long she works. Case-loading midwives strive to attain a level of continuity of care for women provided in a relationship of friendship and trust. The midwife gains great satisfaction from this type of care and the woman is able to receive holistic care with a potentially safer outcome. However, exhaustion may undermine such safety. It is up to the individual midwife to decide her parameters of safety for herself and for her professional accountability to the client.

The expectation of always being available places the midwife at odds with reality. Although there is a lot of literature on the effect of long hours, on-call work and night work there is little said about how the midwife can actually negotiate her way of working to have some sort of work-life balance. It is not expected that a midwife is to be on-call perpetually for her clients, yet some midwives still strive to attain this when providing continuity of care. Finding a balance can be a struggle. The law requires that the LMC (or the back-up) is available 24/7. Yet there appears to be an 'unwritten rule' that fuels a drive for some midwives to be there 'no matter what' for their own clients. In chapters five to ten the journey of the midwives who set out to achieve a work-life balance while providing continuity of care is captured. Can the on-call midwife find a way to work that meets her strong professional desire to be 'with woman' without crowding out her personal life? Can the demands of on-call practice be organised in a manner that makes long-term practice sustainable? The 15 LMC midwife co-practitioners and co-participants in this study chose to embark on an 18 month project to explore how they could change their practices to create a better balance of their work and life needs.

CHAPTER FOUR

Methodology

Action research is a participatory, democratic process concerned with developing practical knowing in the pursuit of worthwhile human purposes, grounded in a participatory worldview...It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people. (Reason & Bradbury, 2006, p. 1)

The purpose of this inquiry is the investigation of how midwives can make their work-life balance better by making changes in their practice arena. A philosophical stance was needed that could address the complexity of the multiple dimensions that surround their practice issues. This was achieved through an action research methodology. As the lead researcher and a fellow case-loading midwife, I also had a passion to address my work-life balance. I was able to join with the others as an ‘insider’ to make a difference in my own midwifery setting (Herr & Anderson, 2005). This chapter establishes the relationship between the purpose of the inquiry and the chosen methodology. The umbrella of action research shelters a diverse range of forms to conduct such an inquiry (Herr & Anderson, 2005). For this project two complementary action research approaches have been weaved into the research process. Cooperative inquiry is the main approach used which is supported by appreciative inquiry.

Cooperative inquiry is about wholeness and requires participation where everyone is part of the whole, everyone partakes through collaboration and dialogue working as co-researchers and co-subjects (Heron, 1996). The principles of appreciative inquiry enriched the project through the creation of positive accounts of what was good; enabling us to envision and create a better future (Cooperrider & Whitney, 2005). Bourdieu’s conceptual terms are used as ‘thinking tools’ in highlighting and explaining the social processes exposed in the empirical data for the analysis stage and in the discussion of the findings (Grenfell, 2008). I illustrate how this research combination is appropriate to address the issue at hand by discussing the practical philosophy, participatory and reflexive properties of these approaches and the democratic standpoint that addresses power and knowledge.

For the purpose of this thesis each participant in this inquiry, a co-participant and co-researcher, will now be referred to as the ‘cooperative inquiry midwife’ (CI midwife).

The choosing of a methodology in relation to the concern

To undertake research in order to ‘make the work-life balance better’ a methodology was needed that could achieve a practical outcome. I was seeking an approach that would develop knowledge to guide midwifery practice both of those involved in the study and a wider audience. This fitted with an action research approach as it allowed us to create knowledge based on our values and assumptions and what we, the CI midwives, wanted to achieve (Greenwood & Levin, 2005). Action research is the broad name given for a variety of inquiry traditions that come from distinct scientific communities (Herr & Anderson, 2005). It is a methodology therefore that allows creativity in one’s approach as not only is there a range of teachings and practices contributing to action research but also an array of underpinning theories. These approaches include: a pragmatic philosophy, critical thinking, the practice of democracy, liberationist thought, humanistic and transpersonal psychology, constructionist theory, systems thinking and complexity theory (Reason & Bradbury, 2006).

There are certain movements and people in particular that have been shown to contribute to the evolving forms of action research. Most commonly mentioned are the social experiments of Kurt Lewin in the 1940s as the founding of the action research we have today. The philosophy of pragmatism grounds the approach of action research by linking theory and practice (Greenwood & Levin, 2005). Reason and Bradbury (2006) discuss the multiple forms of action research as all having five common attributes which give them their identity with action research. These encompass: an evolving inquiry that remains open to all possibilities; the combining of theory and action; the making sense of practical problems through participation and democracy; and an outcome to promote human flourishing. The theory of action research was used to guide our journey as we uncovered our assumptions and made change. We created our own theory to test our ideas and create new associations between our thoughts and actions (Gustavsen, 2006).

My midwifery practice is informed by the formal knowledge of both nursing and midwifery. This is shaped by the resources of my tacit knowledge that is continually built on by the influences of others (Greenwood & Levin, 2005). All that I do is intertwined with other people’s lives and through this I have come to realise the value of a participatory approach to knowledge creation. In this project we generated knowledge by democratic collaboration through purposeful action following reflection and planning to achieve the goal (Heron,

1996). “We were involved in mutual relationships of influence” (McNiff & Whitehead, 2006b, p. 23).

In the preparation stage of the action research project when I was learning about the process I realised that one particular approach may not be enough to craft the research in a way to meet the need of the topic under study and to suit each of the CI midwives involved. I anticipated that the midwives would come with a range of concerns about how to make their work-life balance better. Each one represented different practice situations even though we were all case-loading midwives. I was relieved to read that it is not only suggested but even encouraged that more than one method can not only enhance but also make the project more robust (Reason & Bradbury, 2006). Reason (1994) relays how different approaches of participatory inquiry can be complementary to each other and used together to form a robust paradigm of research with people. From the family of participatory action research we used cooperative inquiry as the base with the innovative approach of appreciative inquiry to explore what was working well.

Together these forms of action research helped in the creation of the process to meet our need. They both fully embraced the participatory and democratic aspects of action research while allowing flexibility and creativity in the process (Reason, 1988a). The participative reality is signified by three important and interrelated properties to include: participatory and holistic knowing; critical subjectivity; and knowledge in action (Reason, 1988a, p. 10). Participatory and holistic knowing is about wholeness acquired through participating in empathy and taking responsibility for our actions. Critical subjectivity is about the quality of awareness of our subjective experience of the world. Even though it may be distorted because of the things that personally influence us, it is “alive, involved, committed, it is a very important part of our humanity” (Reason, 1988a, p. 11). Reason (1988a) says that “knowledge is formed in and for action rather than in and for reflection” (p. 13).

Participatory paradigm

The participatory paradigm joins the knower and the known. It does not sit within the positivist worldview that separates everyday life from the researcher’s subjective experience to seek objective truth (Reason & Bradbury, 2006). Neither is it situated in a postmodern/post structural perspective as it believes in an emergent worldview drawing from both paradigms (Reason & Bradbury, 2006). During the 17th century humanist insight was lost as rational and absolute truth began to emerge. The humanistic approach wrestled for a place again in the

20th century making it possible for us to draw from both approaches (Reason & Bradbury, 2006). Heron and Reason (1997) frame their argument for a participatory worldview:

A participative worldview is based on subjective-objective ontology; an extended epistemology of experiential, presentational, propositional and practical ways of knowing; a methodology based on cooperative relations between co-researchers; and an axiology which affirms the primary value of practical knowing in the service of human flourishing. (p. 1)

The subjective-objective position is explained as “the experiential encounter with the presence of the world is the ground of our being and knowing” and “*cannot* be confused with our symbolic constructs” (Heron & Reason, 1997, p. 3). As put by Heron (1996) “worlds and people are what we meet, but the meeting is shaped by our own terms of reference” (p. 11). However “any subjective-objective reality articulated by any one person is done so within an intersubjective field, a context of both linguistic cultural and experiential shared meanings” (Heron & Reason, 1997, p. 11).

The paradigm of cooperative inquiry sits in the participatory reality which Heron (1996) frames as the ‘fifth’ paradigm. It is a paradigm shift from positivism with its objective approach bringing together the objective and subjective (Heron, 1996). Putting theory into action as a research paradigm is crossing the disciplines between academic and vocational and has been a great area of contention for philosophers and the scientific world (Argyris & Schon, 1991). Heron (1996) felt that positivism fragmented knowledge neglecting the needs of humanity, the ecology and spirituality. The scientific perspective separates the objective from the subjective experience putting the researcher outside and separate from the subject of the research (Heron, 1996). Heron saw the need for a return to a knowing based on “a participative and dialogical relationship with the world” (p. 10).

Participative reality is neither wholly subjective nor wholly objective, neither wholly dependent on my mind nor wholly independent of my mind. It is always subjective-objective, inseparable from the creative, participative, engaged activity of my mind but never reducible to it, always transcending it. (Heron, 1996, p. 163)

The individual experience is paramount in cooperative inquiry, as knowledge in action offers practical skills and abilities, to offer solutions to practical human concerns (Heron, 1996).

Reason and Bradbury (2006) describe the participatory worldview not as a separation of mind and matter but of relationships where we participate in our world as we co-create it.

A participatory perspective asks us to be both situated and reflexive, to be explicit about the perspective from which knowledge is created, to see inquiry as a process of coming to know, serving the democratic, practical ethos of action research. (p. 7)

The participatory approach is a political statement because of its democratic approach through peer relationships as well as a theory of knowledge (Reason & Bradbury, 2006). The political principal provides the CI midwives with a basic human right to participate fully in designing research that intends to gather knowledge about them (Heron & Reason, 1997). Following from the epistemic principle of participation the researchers are co-subjects. From the political position they are co-participants. The research is done by people with each other, not by researchers on other people or about them (Heron, 1996). This research goes beyond the orthodox empirical and rational Western views of knowing. Through a participative worldview diverse forms of knowing are drawn on as we encounter action in our world (Reason & Bradbury, 2006).

The philosophical stance of the NZCOM is an organisation based on relationships of partnerships (NZCOM, 2008b). This partnership approach sits comfortably with the participatory worldview. The midwives in the research project formed a partnership with their co-participants and co-researchers which allowed them to develop a deeper understanding of their practices to make effective change in a trusting and supportive group setting. This research does not set out to disprove any concepts of a midwife-woman partnership but rather reveal ways of creatively using it, refashioning it to suit the purpose of the current climate of midwifery care. The CI midwives are beheld to provide continuity of care and extolled to provide this care in a relationship of partnership (Guilliland & Pairman, 1995). The partnership concept also promotes partnership between midwives and other health professions and extends beyond the practice level. It is often used in the context of the body of consumers and the organisation of the NZCOM (NZCOM, 2008b). The participants worked together to examine their practices and through cycles of action and reflection made their work-life balance better with these mandates in mind.

The action research cycle is in conflict with traditional social research where not only do the researchers have to research to create valid knowledge about practice but they also have to test them through intervention experiments (Abercrombie, Hill, & Turner, 1994). In action research it is the practitioners themselves coming up with a theory and then testing it and refining it in a participatory reflection-action spiral. It is a pragmatic approach to changing

one's practice with evidence to support the rationale. It is seen as necessary to have collaboration with others to ensure a democratic outcome (Abercrombie et al., 1994).

Reflective practice

In this study it was important that each CI midwife engaged in reflexivity: the process of reflecting critically on the self as researcher (Guba & Lincoln). Reflective practice is part of New Zealand midwifery culture (Waller, 2004). I continually contemplate an array of aspects of my practice as to how it can be better for the women, for me and for practitioners in general. I am always seeking new knowledge to gain a deeper understanding and appreciation of why I think the way I do. Heron and Reason (2007) term this reflexive approach as applying 'critical subjectivity' by building on our personal and living knowledge. "We can develop a high-quality and valid individual perspective on what there is, in collaboration with others who are doing the same" (Heron & Reason, 2007, p. 149). The notion of reflexivity is of utmost importance in a society that has diverse worldviews and unequal access to resources and power (Abercrombie et al., 1994).

The action research methodology has challenged the CI midwives to reflect and put changes into action in collaboration with their colleagues. Midwives undertake a biannual professional review process, the Midwifery Standards Review (MSR), as part of their annual practicing certificate requirements. The MSR has a component where the midwife reflects on her practice and with reviewers makes an assessment of her midwifery practice (NZCOM, 2007). This process encourages an attitude of reflection but does not have the validation of the participatory approach of acting on what they learn in a cycle of knowledge generation (Kemmis & McTaggart, 2005). Through the action and reflection cycle the co-participants have gained fresh insights into practices that they may have been 'trapped' into through their individual way of thinking. Through cooperative inquiry they are able to develop new strategies to face old or recurring problems. The reflexive property of participatory action research aims to help the CI midwives to investigate reality in order to change it in a cycle of critical and self-critical action and reflection (Kemmis & McTaggart, 2005).

Knowledge in action for action: Cooperative inquiry

Heron (1996) commenced his development of cooperative inquiry in 1968 when he began an experiential research method of reflection on experience, intentional action, observing phenomena and trying out new behaviours. Heron (1996) later added the importance of

applying peer experiential research. This has led to today where he sees research as a society with members in a continuous process of cooperative learning and development. He sees it as an inquiry methodology that can counter forms of social oppression and disempowerment. The participants are consciously adopting change through collaboration and periodically reviewing and altering changes in light of their experience through reflection and deeper vision. This was an important dimension for the CI midwives who not only needed to be empowered in their caregiver role but needed to have the ability to foster the woman's empowerment as she navigates the birth journey.

Cooperative inquiry is about a group of people working together as co-researchers and co-subjects exploring their world and changing it. It is research in action for action (Heron, 1996) where the practitioners can be creative and integrate their own ideas in their practice, develop a method that fits their personality and inquiry need (Reason, 1988a). This paradigm or paradigm shift allows for the voice of the practitioner to be heard. It echoes the sentiments of the New Zealand midwives philosophy of holistic care (NZCOM, 2008b). It incorporates the combined understanding of the social, emotional, cultural, spiritual, psychological and physical dimensions of the CI midwives' lives into the inquiry process. Midwifery care is to be given in a manner that is flexible, creative, empowering and supportive (NZCOM, 2008b). These same qualities are expectations of the cooperative inquiry approach.

Cooperative inquiry is an all-purpose inquiry that has a broad approach and specific validity procedures that can encompass transformative and informative outcomes (Heron, 1996). The primary outcome was manifest in the transformative change in our lives as we worked on our work-life balance in our midwifery practices. This has already occurred and has been experienced by us in our day-to-day lives. The secondary outcome is an informative one, this report, in which I strive to represent our experiences by painting a picture through words of our action and experience as co-researchers and co-participants investigating our practices and putting in place changes in a cyclical process of individual and group reflection. The inquiry followed validity processes to achieve these transformative and informational outcomes.

The action reflection phase as described by Heron (1996) takes place in four stages. Both propositional and presentational beliefs are required for the first stage of reflection and planning in order for the co-researchers to choose their inquiry focus and plan their first action phase of the cycle. The second stage, involving practical belief, is the action phase of

putting the ideas for change into practice and recording and observing outcomes. The third stage is using experiential belief in the initial part of the inquiry which becomes experiential knowledge deeper into the inquiry process as changes are taking place and are being experienced. The fourth stage brings us back to further reflection as sense is made of the data that was generated in the first stage. This is a meshing of the presentational and propositional beliefs with knowledge now grounded in prior experience and practice. As this cycle is repeated the practical, propositional, presentational, and experiential knowledge is further grounded. It forms “well-founded outcomes, with a well-formed warrant to lay claim to knowledge” (Heron, 1996, p. 55). Heron and Reason (2007) discussed how there is no prescribed way of how methods are used or how they are to be applied to the process.

Four forms of knowing and belief

Action research is inquiry that is done by or with the insiders rather than ‘to’ or ‘on’ them (Abercrombie et al., 1994). Cooperative inquiry more fully embraces the doing ‘with’ and involves the co-practitioners and co-researchers as self-directed, involving them in different forms of knowing (Heron, 1996). Heron (1996) discusses these four forms of knowing as an extended epistemology: the interdependence of experiential, presentational, propositional, and practical knowledge.

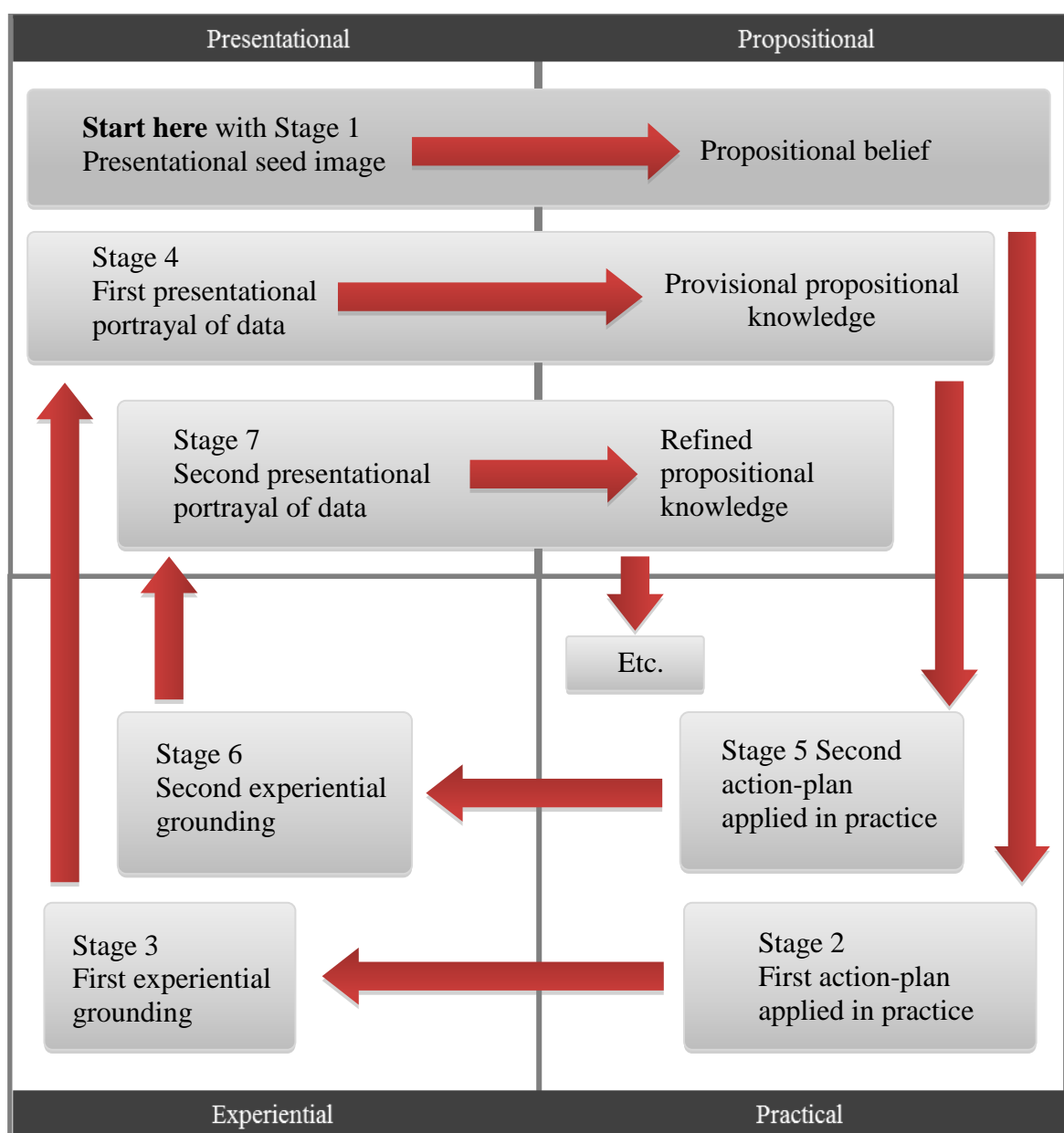
Critical subjectivity involves an awareness of the four ways of knowing, of how they are currently interacting, and of ways of changing the relations between them so that they articulate a reality that is unclouded by a restrictive and ill-disciplined subjectivity (Heron & Reason, 1997, p. 278).

They include knowledge about the subject, knowledge of how to do it and knowledge through the experience of the encounter. These forms of knowing are grounded on each other with experiential knowing at the base, “a pyramid of four-fold knowing” (Heron, 1996, p. 53). This knowledge is personal to each midwife who has her own pyramid of knowing in relation to the other co-practitioners.

Heron (1996) refers to experiential knowledge as the grounding instrument of empirical inquiry. It is the person fully participating in all there is to know about their lived experience. Only the person can fully know their own experience through direct encounter with people, or places and things. It cannot be done by someone else. The presentational knowing is “an intuitive grasp of the significance of patterns” (Heron, 1996, p. 52), a “process by which we first order our tacit experiential knowledge into pattern” and then can be expressed in art, in

poetry, in dance and even storytelling (Reason, 1994, p. 3). Propositional knowledge goes beyond the intuition of the presentational knowledge and becomes a conscious reasoning by transforming the lived experience into concepts to state what the case is through uncovering and revealing the knowledge (Heron, 1996). The practical is the knowing how to exercise the skill (Heron, 1996). The co-practitioners are not required to have an agreed representation of practices but rather display varied perspectives and behaviours which illuminate an area of inquiry (Heron, 1996).

Figure 6 Four cognitive modes and stages of the inquiry cycle (Heron, 1996, p. 56)



As well as four kinds of knowing there are four kinds of belief which precede the knowing (Heron, 1996). It is a process of converting belief into knowledge as the co-researchers work through the cycles of action and reflection. This is captured by Heron (1996) in his four cognitive modes and stages of the inquiry cycle (see fig. 6). The belief is preliminary to the knowledge. An experiential belief is the leading up to the development of knowledge of the experience. Presentational belief is the intuitive feeling about the knowledge rather than a complete intuitive understanding. A propositional belief is belief that something is probably the case but it still needs to be shown to be such. This becomes propositional knowledge and is refined with each action cycle.

Appreciative inquiry

Appreciative inquiry was applied as a method of organisational intervention as it is able to produce alternative realities through language to foster constructional change (Ludema, Cooperrider, & Barrett, 2006). Ludema et al. (2006) see that appreciative inquiry “can unleash a positive revolution of conversation and change in organisations by unseating existing reified patterns of discourse, creating space for new voices and new discoveries, and expanding circles of dialogue to provide a community of support for innovative action” (p. 155). The CI midwives knew that their lives had become unbalanced or had the potential to be unbalanced because of the way they thought about continuity of care. The concept had become a concrete notion rather than remaining abstract and fluid: open to change. They needed a positive way to make their work-life balance better. For this purpose appreciative inquiry was weaved into the action and reflection cycles of the cooperative inquiry process.

The qualities of appreciative inquiry lead us to identify the very things that give life to our organisation and to capitalise on this potential for innovation change (Ludema et al., 2006). We can become so focussed on the problems we experience within an organisation that we do not see the potential to build on what is already good. We particularly feature on the very things that make us falter so that we can turn these around to be a positive aspect of our work. The philosophies of partnership and continuity of care that as midwives we strive to encompass in our care can prove to be both a negative and a positive force in our work environment (J. Skinner, 2011). We saw that it was the opportunity to take what was positive and expand the meaning for application in our lived experience.

Berger and Luckmann (1966), with the belief that reality is socially constructed, say “the language used in everyday life continuously provides me with the necessary objectifications

and posits the order within which these make sense and within which everyday life has meaning for me” (p. 22). For the CI midwife her world of midwifery is part of her reality of everyday life. She has been socialised through language into her identity as a case-loading midwife and acts out her role accordingly (Berger & Luckmann, 1966).

The key data collection innovation of appreciative inquiry is the collection of people’s stories of something at its best that lead to new ideas and images of how to change the way things are for now (Argyris & Schon, 1991). The CI midwives were able to use appreciative inquiry to assist in the process of change through creating new theories or ideas or images (Reason, 1994). We met and collectively discussed the issue of the work-life balance. Each of us chose an area in our case-loading practice that needed to be worked on. The process was based on collaboration through appreciation of what midwives have already. Through a socio-rationalist approach, valid knowledge was developed and the ‘nature of things’ were determined through communal creation rather than discovered through detached, value free, observational methods (Reason, 1994).

The changes that were to be put in place needed to be applicable to government mandates for practice and NZCOM midwifery philosophy but at the same time to be proactive to facilitate change. Although this research is not thought to be taking a postmodern stance per se we do live in a post-modernist climate where we have a multitude of approaches to knowing and telling surrounding us (Richardson, 2000). However, Bushe (2001) does place the dominant theoretical rational for appreciative inquiry in a category of post-modernist European philosophy. Bushe (2001) explains: “From this point of view there is nothing inherently real or true about any social form. All social organisation is an arbitrary social construction” (p. 118).

Introducing Bourdieu

This inquiry was transformative in nature with the primary outcome of being practical and transformational. This was demonstrated by the midwives as they worked at changing their practices to create a better work-life balance. The CI midwives consented to the lead researcher using the data that emerged through the action cycles, secondary to this, to produce a propositional report for the purpose of a doctoral thesis. To gain greater understanding of the midwives’ motivation, their way of working and the complexity involved in making change, the philosophical framework of Pierre Bourdieu, a critical

theorist, was brought to the analysis of data. This was done subsequent to the action research process as a means of articulating the complex tensions involved in making change.

The pragmatic approach of Bourdieu (Aboulafia, 1999) fitted with the application of cooperative inquiry. It linked problem solving behaviour to reflection grounded in experiential knowing. Both Heron (1996) and Bourdieu (1990) work at overcoming the subjective/objective dualism by producing ways the researcher can be embodied in the data, as close to the agents' thinking as possible, to discover their lived reality. Heron (1996) uses a participatory approach so that the researcher and the researched share the same lived experience. Bourdieu developed a theoretical approach to formulate a scientific theory of social meaning with the aim to locate and secure a social space that could bridge the academic disciplines. Bourdieu felt that neither objectivism nor subjectivism alone could adequately grasp social life. He bridged the internal/external separation between the participant and researcher in a reflexive approach using three fundamental concepts of habitus, capital and field (Calhoun, LiPuma, & Postone, 1993). This gives a subjective feel for the situation or 'game' and allows his philosophical tools to analyse a complicated reality (Mahar, Harker, & Wilkes, 1990). They both shared a desire of emancipation by enabling the agents to grasp the meaning of their actions to reveal the disempowered and disadvantaged in their social settings in order to transform the social structure (Calhoun et al., 1993; Heron, 1999).

Bourdieu described the social field as a competition for life and security, a site of struggle, a game, a race of all against all for both material and symbolic advantage (Dreyfus & Rabinow, 1993). The field provides a frame for a multidimensional analysis of all that goes on in the agents' social arena accounting for the relationships between habitus and the position in the field as indicated by the accumulation of the necessary forms of capital (Calhoun et al., 1993). Grenfell (2008) describes four semi-autonomous levels of social fields as proposed by Bourdieu. The first level is the field of power. The New Zealand maternity care system fits this description and can be likened to a science fiction force field with a mother ship and fleet. At this level there is hierarchical order with some levels more dominant with decision making power over the ways the smaller social worlds function. The second level could be that of the broad field under consideration which encompasses all the practicing midwives in New Zealand. A third level could be all the practices that the CI midwives represent. The fourth level could be described as the social agents, the individual CI midwives. People

groups can occupy more than one social field at a time but all belong to a common social space, the field of power.

The habitus is the link that brings the experience of the agent in the field together with the existing social conventions (Grenfell, 2008). It is a thinking that looks at the relationships between them measured by varying degrees of fit or mismatch. Within the social space, the habitus is the mediator of the agents' choices: a product of social conditioning (Bourdieu, 1998). The habitus is a product of its position, but also has generative principles of distinct and distinctive practices (Grenfell, 2008). Habitus is an ongoing and active process bringing together our past and present, to make the choices we make, to feel and act the way we do and about 'being' in our world. For example, in general, a woman and how she lives and views life and her opinions of childbirth are systematically different from an obstetrician's corresponding activities. What the obstetrician sees is right for the woman is not necessarily what she sees as right for herself. The habitus provides the agents with classificatory schemes, a distinction between what is right and wrong; it provides rules for vision and division but these can be different distinctions for different agents. To analyse practice we need to understand the evolving fields and the effects of the evolving habitus on practices and belief that the agents bring to the field (Grenfell, 2008).

Bourdieu (1998) gives a formula to analyse the relation between social positions, the habitus, and position takings within a social space. This is based on two dimensions of capital: the closer the agents are to one another in the two dimensions the more they have in common. The first dimension is categorised through the overall volume of the different kinds of capital they possess and the second identified according to the structure of their capital. The differences associated with the different positions of agents in each social field are seen as symbolic differences which amount to symbolic capital (Bourdieu, 1998). Different fields have different forms of important capital, for example, in the most advanced societies in the world Bourdieu (1998) found that the most efficient forms of capital are economic and cultural capital. In a paper by Firkin (2004) on New Zealand midwifery the capitals of priority were given to human, social, and cultural capital, above economic and physical resources. Capital is a form of wealth which yields power so that by having the right type of capital it can be used to exercise control over the future and that of others. Also an accumulation of capital maximises position and potential in the field (Calhoun et al., 1993). It is necessary to understand that the habitus, field and capital are equally important as neither is more dominant than another: they are interdependent and co-constructed (Grenfell, 2008).

Summary

The cooperative inquiry sits in the participatory paradigm allowing the cooperative inquiry midwife (CI midwife) to investigate her own practice concerns and to make action change. The inquiry was a democratic process with the CI midwives as fully involved as possible in all the research decisions concerning content and method. The CI midwives were to investigate their own practices applying collaborative, democratic and reflexive research methods. Aspects of appreciative inquiry were shown to benefit the inquiry. Appreciative inquiry inspires innovation as it can uncover language that has created tension between the different worlds of the CI midwives. The cooperative inquiry action cycles are able to take this further.

As the CI midwife works through the action research cycles she can uncover assumptions that may be holding her back. The CI midwife is able to create new theories about her approach to practice as she reflects and refines her action in the research cycle. Concepts of Bourdieu were introduced for the analysis of data. This critical approach compliments the cooperative inquiry approach providing another way to understand the experience of the CI midwives with emancipatory undertones. Cooperative inquiry sought knowledge in action and for action and so created potential for practical knowledge and transformational change in the area of the CI midwife's work-life balance.

CHAPTER FIVE

The process

As participants engage in inquiry, they are invited to challenge prior beliefs and understandings and reframe what they know. This new knowledge fosters action to bring social reality into alignment with what is understood.
(Martin, 2006, p. 168)

This chapter presents how the methodological process guided the research project with explanation of the data generation and analysis. Attention is paid to ethical and scholarly integrity. As the principle researcher and a case-loading midwife I joined with the other fifteen case-loading midwives in an action research project. As described in chapter four this research was underpinned by a cooperative inquiry approach. We worked collaboratively to develop our own ideas to make changes in our practice settings (Stringer, 2007). The project became a ‘work of art’ as it was created to fit the situation (Reason & Bradbury, 2006).

The cooperative inquiry cycles passed through stages of reflection and action to achieve a practical resolve of issues (Heron, 1996). The participants become co-researchers and co-subjects: the expectation of participative inquiry methods (Heron & Reason, 2007). The data analysis occurred at two levels. One level was of ‘reflection in action’ by the case-loading midwives for making action change. The other, ‘reflection on action’ by the lead researcher to provide this written report (Greenwood & Levin, 2007). Themes were identified and fed back to the cooperative inquiry midwives (CI midwives) at all stages of the research for further reflection and clarification.

Gaining ethical approval

In March 2006 I entered the Doctor of Health Science programme at the Auckland University of Technology as a part-time student. Since embarking on this journey my desire remained to discover how the case-loading midwife could improve her practice environment to sustain a healthy work and personal life. I wanted to gain a greater understanding of the philosophical underpinnings of the midwifery profession and their application to practice. I continued to work as a case-loading midwife alongside my doctoral study. The first two years of the doctoral programme involved participation in three papers at the university. The topics included: Health Systems Analysis; Practice and Philosophies; and Practice and Methodology. This provided access to knowledge about a broad range of possibilities for not only exploring the methodological approach but for confirming that I was pursuing a current

relevant topic of research within my profession. I refined my topic choice to ‘identifying effective strategies to make the work-life balance better for the case-loading midwife’. After much deliberation the methodology of action research was selected.

Due to issues of size and time constraints this study did not involve consumers, health professionals other than the case-loading midwives, or persons significant to each CI midwife. We each sought our own feedback from consumers, colleagues, and significant others, for reflection on our individual changes and to measure the success of the interventions we had made in our practices. Of initial concern to me was not including involvement from midwives’ clients in the project. New Zealand midwifery is underpinned by a relationship of partnership between the midwife and the woman in her care. However it was felt that new mothers would have limited time to give to such a project. Also possible tensions may have arisen if midwives were to talk about specific women and vice versa. Perhaps this could have been avoided because the problem solving approach adopted in the research was focussed on issues rather than personalities. I often naturally take the lead and with this comes being ready to take initiative. This posed a possible concern to the achievement of an equal power-sharing approach. The CI midwives, however, shared this same attribute of initiative which made lively and proactive focus group encounters.

Accessing participants

In February 2008 ethics approval from the Auckland University of Technology was granted (see Appendix A). Immediately, advertising, to invite case-loading midwives to participate in the cooperative research inquiry, was sent out (see Appendix B). Two separate midwifery networks were used, one placing an advertisement in a local newsletter and the other via global email. In consultation with my primary supervisor I had estimated that a group size of eight to sixteen would be an ideal number of participants to make the project manageable and to provide a good variety of experiences. It is suggested that a study where one is trying to understand the essence of experience, that at least six participants are required to make a qualitative study worthwhile (Ryan & Bernard, 2000). I had planned for further advertising for participants, if required, and had also chosen how to select the potential participants if more than required had applied. Neither of these two actions were necessary as, fortunately, there were neither too many participants nor too few that applied. The advertising generated an immediate response from fourteen case-loading midwives keen to learn more about the

research project. Most of these midwives I had not met before. This added to the three midwives I had already personally invited.

I immediately followed the initial contact with a phone call to provide a verbal explanation of the research. Two of these midwives felt they were not suitable and declined to participate as they were not going to continue in case-loading midwifery. I provided the other prospective participants with a formal invitation to participate (see Appendix C). Next I arranged to meet with each potential CI midwife before our initial focus group to explain further about the research, how they would be involved, and how much time they would be committing to. If the midwife wanted to participate she signed the consent form (see Appendix D). There were two options given to the midwives: they could sign it at this meeting or if requiring further time to think it through they could bring their signed form with them to the first focus group. Due to the on-call nature of the midwives' work two midwives were not able to meet with me before the first focus group. I discussed the project with them on the phone and was in email contact, and they signed their forms before the commencement of the first focus group. This gave us a total of sixteen CI midwives, including myself, who participated in the research.

The cooperative inquiry midwives (CI midwives)

The CI midwives represented rural, semi-rural, and city practices. The experience of midwives ranged from those new to case-loading practice to those who had practiced since the early 1990s. The ages ranged from 24 to 60 years with the average age of 48.4 which is similar to the average age of the entire midwifery workforce at 47.2 years (Midwifery Council of New Zealand, 2011). The CI midwives represented Maori and European-born New Zealanders alongside midwives who emigrated from other continents. As with their age, their nationalities provided a good representation of midwives in New Zealand according to the latest workforce data (Midwifery Council of New Zealand, 2011). Some were registered nurses before they undertook a Diploma of Midwifery course to become a registered midwife. Others trained in a Bachelor of Midwifery degree programme (a degree programme that does not require the person to be a registered nurse before undertaking the course). Some midwives trained in New Zealand and some trained overseas. As I have participated as a CI midwife I also have taken on a pseudonym presenting myself just as I have presented the data from the other participants. Chapter six provides further information of the CI midwives in the 'setting of the scene' of the research.

Ethical considerations

Collaborative decision making is required for a cooperative inquiry (Heron, 1996). This was upheld throughout the inquiry process within the constraints of doctoral research. The interest, intent, and the potential outcomes of the research were openly discussed with the CI midwives (Heron, 1996). They were well informed of their involvement in the research so that everyone had equal opportunity for participation. At any stage a CI midwife could choose to leave the project. The process gave them free choice and they were not coerced to participate. Two CI midwives, due to changed circumstances, withdrew after the action research process was underway. With their consent they have still been included in the total number as their involvement, although not completing the full time of the action research study, did have an impact on their practice and contributed to the findings. Another CI midwife was out of the country at the time of the first action cycle but joined the project on her return. The CI midwives agreed that I could use the information gained from the AR project for the purpose of writing this thesis for a doctoral degree.

With the consent of the CI midwives the transcribing was outsourced. The transcriber signed a Confidentiality Agreement (See Appendix E). Two separate audio recordings were taken at each focus group encounter. Should one recorder fail the other provided a back-up. The data was downloaded electronically and emailed to the transcriber. The transcriber returned the conversations in a Word document by email. The transcriber then securely deleted the electronic data. I kept a copy of both the electronic recordings and the transcribed Word documents on an external hard drive stored in a locked cabinet for the duration of the research project. The final storage of data will be at AUT on completion of this project. The data and the consent forms will be stored in separate locations. In line with AUTECS guidelines the consent forms are presently kept in a locked cabinet at AUT under the care of the Principal Supervisor. The data will be destroyed after six years.

At the first focus group there was agreement to keep all personal discussions confidential within the group. We decided that members could discuss with others outside the study in general terms about their involvement in the project. Summarised reports of each focus group were provided to the CI midwives as soon as possible following each focus group encounter. These reports remained confidential to them. Pseudonyms have been used to protect the participants from identification. Any place names, institutions or other identifying data has been changed around or removed from narratives to provide further anonymity.

The cost for the CI midwives was kept to a minimum, both money and time. They were provided with exercise books and pens to journal their thoughts and action changes and given petrol vouchers to go toward their travel costs. Food was provided at the focus group venues which not only provided sustenance for midwives who were ‘on the go’ but also created a relaxed social atmosphere to allow trusting relationships to develop. The involvement in this research provided a challenge to time. They needed to be prepared to participate in the project knowing this. The CI midwife already has enough to do, maintaining her case-load without conducting her own research which involved extra work of the recording of data in a journal and finding the time to meet with colleagues for group reflection. Despite having to make more time for the research project the result for each one was worthwhile. The methodology provided an opportunity for the CI midwives to make new personal connections with colleagues who were concerned about similar issues: this alliance cemented the resolve to make a difference in their practice.

I have used action research as the broad umbrella for the research design mainly drawing on cooperative inquiry. Advocates of action research support the adaptation of an inquiry suggesting how they are shaped by each one’s situation as it presents itself (Heron, 1996; McNiff & Whitehead, 2006b; Reason, 1988b). The doctoral research has put constraints on the research as there needed to be some pre-planning to have the research approved by the academic institution and secondly for the ethics approval. The participants are case-loading midwives who work fulltime with a demanding on-call role. They did not have the time to be involved in the planning of the research process and learning in-depth about the methodology of action research. With their consent this was undertaken by me, the lead researcher.

The aim of this research is both informative and transformative (Heron, 1996). I had a desire to find out more about why we as midwives are so captivated by our relationship with women. This provides a passion that drives us to work a demanding on-call life that is often at a cost to ourselves. The primary purpose of this project has been the discovery and application of how we can all make changes in our practice arenas to achieve a better work-life balance. Heron (1996) discusses how a report is secondary to the “primacy of the practical” (p. 48), it is like “the programme notes without the performance” (p. 35). In this regard the writing of this thesis has been a secondary outcome of the action research project.

Yet the project has involved being practical, transformative and informational throughout the entire process. In order to provide feedback to the CI midwives as the project progressed I

kept them up-to-date with the findings. This assisted them with decisions in their own practice changes and provided validation of the report findings. During the time of the project some CI midwives did conference presentations about their practice changes, others wrote up reports for possible publication. As principal researcher I likewise presented at conferences giving reports of the overall findings as they were developing. These were informational reports which were secondary to the primary, which were practical and transformative. Informational reports being secondary are no less important. The primary transformative outcome provides new forms of practice but they both have “important political purpose of empowering others to revision their experience and practice” (Heron, 1996, p. 101).

Truthfulness

In the participatory paradigm the claim is to know the world from your own practice: an inside perspective (McNiff & Whitehead, 2009). Each CI midwife made their own claims about what they were doing and generated their personal theories about practice. These theories are not a set of propositions about the way things are but rather ‘living theories’. “You do and live theory through your practice” (McNiff & Whitehead, 2009, p. 21). I was involved in the research process as a co-practitioner and a co-researcher alongside the other CI midwives in a self-study research. In consultation my fellow co-participants agreed to my role as the lead researcher to document this process. McNiff and Whitehead (2009) phrase this as “an epistemological shift from ‘I study you’ to ‘I study me, in company with you’” (p. 17). To ensure that this work is not simply my opinion I have used the validity procedures as proposed by Heron (1996). My hope was to represent accurately the views of all the CI midwives and to have represented their action changes as accurately as I could.

Validity procedures

The practical outcomes or theoretical concepts that arise from the cooperative inquiry are said to rest on the collaborative encounter with experience which legitimises its approach to research with persons (Reason, 1994). Reason (1994) suggests that what makes this encounter valid is the quality of the critical, self-aware, discriminating and informed judgements of the co-practitioners. There are various validity procedures that Heron (1996) recommends planning for, or that are applied, during the inquiry process to ensure the study is sound and well-grounded. These, Heron (1996) suggests, may not all be selected but a range are available for selection of the appropriate ones to meet the particular research need to resolve uncritical subjectivity. Of those suggested I have chosen: research cycling;

divergence and convergence; reflection and action; aspects of reflection; challenging uncritical subjectivity; and authentic collaboration (Heron, 1996, pp. 58-59).

Research cycling causes a refinement of experiential and reflective forms of knowing through two-way negative and positive feedback (Heron, 1996). It simply either deepens the knowledge around the focus of the research or eliminates the unnecessary information. First it required a group of midwives to meet to discuss what it was that they thought needed to change to improve their work-life balance. As the lead researcher I initiated the process by calling for midwives to join the group with the general question of making their work-life balance better. Heron (1996) suggests that this is the most common way for a cooperative inquiry to be launched which is followed by the group jointly deciding a more focussed aspect of the topic. We then needed to work out how we could support one another in our changes and when to meet on a regular basis. This meeting was a sounding board for reflection and deciding on further action. We were to research our own experiences and needed to come up with our own answers to put them into practice to improve our work-life balance.

Divergence and convergence allows for differences in and blending of what and how the action of the topic under study is performed. In this way it creates a more thorough investigation (Heron, 1996). In our project there was a good variety of divergence and convergence as each midwife was at different stages in her goal to have a better work-life balance. Some joined the project already having achieved a new group set-up with set days off each week, another was wanting to make her day more time efficient so she could have downtime to make up for the unexpected call-outs. Others were just starting to investigate what sort of practice arrangements they felt would be possible to make and would meet their needs. Yet others needed to make their group set-up even better. Although we all worked to achieve a better work-life balance we all worked to do this in different aspects in our own practice setting. This produced rich data to describe our total experience.

Reflection and action is about finding the right balance required so that the reflective and experiential forms of knowing can be refined, that is, not too much or too little of either the reflection or the action (Heron, 1996). We came together with the group for collaboration to further refine our individual plans completing four cycles from March 2008 until December 2009. We were participating with others in collaboration in a cycle of reflection and sharing of experiences (Heron, 1996). We were able to maximise a fourfold effect. Heron (1996) says

“an inquiry is most potent and effective, if it can maximize this fourfold interaction: both the distinct individual effect and the collective reciprocal effect of the mutual influence between reflection and action” (p. 134). We had sufficient divergence and convergence in our experiences so that when we came together our different individual perspectives converged to illuminate the common ground (Heron, 1996). The balance of moving from one cycle to the next with the correct amount of time between each focus group meeting was important. It improved the validity of the research cycling to refine the topic under study. We all needed time between each focus group to action our change and observe outcomes. A focus group meeting was held every three to four months. This was long enough between meetings to gather material for group reflection and to not overburden the midwife by meeting too frequently.

During the reflection phase there needed to be a balance between the presentational ways of making sense and the propositional meaning. In the latter there needed to be a balance between description, evaluation of the descriptions, building theory and the application of what is learnt to be applied to the next action phase (Heron, 1996). Four important aspects of the reflection phase were applied in this project. These included description, evaluation, explanation and application. Heron (1996) explains that in an Apollonian approach it is never merely descriptive reflection, but also needs to include evaluation and explanation. An Apollonian perspective takes a more “rational, linear, systematic, controlling and explicit approach to the process of cycling between reflection and action” (p. 45). The descriptive reflection was phenomenological in its application as we each conveyed to each other as much as possible the content of the action phase. The evaluation occurred at two levels. Firstly, each one needed to provide an evaluation of their progress and achievements. Secondly, I provided an overall evaluation bringing everyone’s descriptions together in a coherent whole. The explanation stage of the reflection builds on theory. This theory building contributes to the application in the final part of the reflection phase when we were proposing what content we needed to explore in the next action phase.

Challenging uncritical subjectivity is a questioning of the process. We needed to ask if critical subjectivity was being achieved. This was an important part of our process. We loved to chat and come up with ideas of how we would take on the midwifery world and change it. We needed to know which ideas were realistic, were within our midwifery philosophy of practice and met the requirements of the Ministry of Health to achieve continuity of care. We did not need to have someone come into our group to provide the service of a ‘devil’s

advocate' as Heron (1996) suggests. We were a diverse group and were able to challenge each other's ideas. We also discussed changes we would like to put in place with colleagues outside the group as any new ideas needed to be accepted by those we worked with if we were to action them.

Authentic collaboration requires each member to be fully immersed in the inquiry by being fully engaged in each action and reflection phase, each one on an equal basis fully heard and fully participating in the decision making (Heron, 1996). It was not possible to involve the CI midwives in all decisions about the content and method but they were included as fully as possible to this end. A full blown cooperative inquiry would see all participants involved in democratic decision making about the content and the method (Heron, 1996). Instead I gained consent from the CI midwives to select the methods to be used to achieve this. Some consent was given retrospectively as the operational plan and overall topic of research was pre-existent. This was required for consent from the academic institution and the ethics committee. Although full authentic collaboration was hindered for these practical issues, there was full democratic decision making in how the project proceeded. The midwives did not have the time to become involved in the organising of the overall project as well as researching their own experience. Any modification of the plan during the process was to be through consensus. The action research project, however, went according to plan and no significant modification was required.

Truth, rigour and validity through reflexivity

Bourdieu's sociological reflective critique makes truth and validity more secure (Lash, 1993). Lash (1993) mentions that for reflexivity to occur there needs to be a subject, an object and a medium of reflection. In this study the reflecting subject involved the individual midwife as she examined herself and her practice as well as the lead researcher who further developed the data for the thesis writing. The objects of the reflection were the norms of the structure that the midwives worked in. For example, this involved the CI midwives considering the philosophy and standards of care in relation to their midwifery practices. Lash (1993) discusses Bourdieu's type of reflexivity being about classifying the classifiers. This reflexivity refers to the CI midwives who are the producers of knowledge. They are understood through their habitus and through their individual and collective struggles. Through self-reflexivity they sensed their situation in their social field in three different ways. Firstly, they looked at their own position in their social fields in both a subjective and

objective way. Secondly, they made an objective reflection on how they related to the women in their care and others in their social world and where this was leading them. Thirdly, they identified their position in the struggle between the well-established norms of continuity of care and partnership and diverging ways to practice. This is a struggle between orthodoxy and heterodoxy (Lash, 1993).

This research has been conducted to the best of my ability and to truthfully present the journey of the CI midwives. I am not able to apply rigour as I would if working within a positive paradigm where there is an objective truth to be identified with certainty and precision (Crotty, 1998). This research presents the subjective and the objective construction of meaning as understood by the CI midwives to reveal their relationships in their worlds. The midwives, in the action research, and the lead researcher were full participants in the changes they each created in their practices. It required them to be reflexive in their thinking to be able to objectively understand the relationships between themselves and their clients. Although this study focussed on the work-life issue of the CI midwife it was necessary for them to be able to understand and monitor any effect this would have on the client and not prejudice the women through actions that had not been objectively scrutinised by the midwife. The CI midwives needed to realise their own biases in the change process so that they still upheld the woman's best interests in the care she received.

The action research cycle

The first cycle began with informal interviews. I travelled to the south and north of the city to meet with participants. The initial interviews covered discussion of how they worked in relation to their work-life balance and in what areas they felt they wanted to make changes. We discussed the extent of involvement of the midwife for both her time and duration of the study. Her time was voluntary and it was estimated she would need a minimum of two hours for each of the four action cycle focus group meetings as well as time for her to journal her own action changes and reflections. At the first interview the midwife was also encouraged to begin the reflection, if she had not already started this. This reflection was about 'the positive things in her practice and what it was in her practice life that she felt may need to change'. The midwives' involvement in the project would contribute toward their professional development required for annual recertification. They would be able to provide their own written report of their experience and learning for their portfolio. At the first group meeting

and the final focus group we discussed the possibility of writing an article for publication but this is still to be realised.

The CI midwives came together to explore an agreed area of human activity, which in this instance was their work-life balance. I facilitated the initial workshop to introduce the topic and for the inquiry group members to gain an understanding of action research. We then decided together how we would investigate the work-life balance. The CI midwives agreed that I continue to facilitate our meetings: to decide what was to be looked at, the methods to be used, and to make sense of all that we discovered. Although they were capable to achieve the creative thinking required they allowed me to undertake the facilitation of the project and undertake the data analysis of the overall project. Each CI midwife was responsible for her own research in her practice arena deciding on what she wished to achieve and how. It was up to her to journal her own thoughts, actions and outcomes as she created her own individual action change in her practice setting. The group needed to get to the point where everyone was a co-researcher and co-participant (Reason, 1988b). Each one of us chose our own way of gathering and recording data. We observed and recorded the process and outcomes of our own action; then we shared in discussion, as a co-participant, our action and experience as a co-researcher.

The research was an 'open boundary inquiry' for the purpose of generating data and feedback from people who were not part of the inquiry group (Heron, 1996). For example, consumers or other interested parties could be invited into the meetings of the whole group, to participate in the reflection process to give feedback. This would add new perspectives to refresh the group's thinking, contribute to the design of the study, and challenge the limitations of the inquiry (Heron & Reason, 2007). Not all the midwives who volunteered for the research project were able to complete the cooperative inquiry process, yet all had valuable information about their work-life balance reflection, action and experience. As an open boundary inquiry we were able to include their voices. Their contributions were weaved into the process in a style of participatory research involvement which could be described as an action science approach which again overlaps into cooperative inquiry (Heron, 1996). These midwives' voices were useful for building and testing theories in practice. It also provided fresh insight such as a 'devil's advocate' to keep the co-practitioners from possible collusion (Heron, 1988).

To provide an innovative approach to our research the concepts of appreciative inquiry were introduced to the reflective stage of the cooperative inquiry cycle. Ludema et al. (2006) suggest that in line with appreciative inquiry in the initial stage a positive topic needs to be selected. This is the core of the cycle and the most important part (Cooperrider & Whitney, 2005). The midwives joined the project knowing that they had a positive research topic of investigating how to make their 'work-life balance better'. Not all considered they had a 'poor' work-life balance but they knew that the integration of their work and private worlds could be better. When I made my first contacts with the co-practitioners I asked them for their response to the questions: What am I doing about my work-life balance? What do I enjoy best about my work? What do I need to improve? How do I improve it? Their accounts of practice showed how they were trying to improve their own learning, and influence the learning of others (McNiff & Whitehead, 2006a).

Each reflection stage was based on four phases using appreciative inquiry. These included: discovery, dream, design, and destiny (Cooperrider & Whitney, 2005). The discovery phase focussed on what was good in the work arena and examined the forces and factors that achieved this. The dream stage provided opportunity for the CI midwives to share their experiences and learn from each other allowing new ideas and new understandings to emerge as they dreamed about what they wanted. The design stage was where the midwives were debating and discussing in the focus groups as they negotiated new ideals and visions. The destiny, the innovation and action phase, occurred as the midwives tested their new theories for change in their work places. By focussing on what was good about how we work we were soon able to create "enough uncertainty about the dominance of deficit vocabularies to allow organisational members to consider new possibilities" (Ludema et al., 2006, p. 158).

An outline of the research stages

To guide the action research process to be able to investigate and evaluate our work we used the following stages developed by Heron (1996).

Stage 1

The first reflection phase for the inquirers to choose:

- the focus of the inquiry
- a launching statement of the inquiry topic
- a plan of action for the first action phase to explore some aspect of the inquiry topic

- a method of recording experiences during the first action phase

Stage 2

The first action phase when the inquirers are:

- exploring in experience and action some aspect of the inquiry topic
- applying an integrated range of inquiry skills
- making records of the experiential data generated

Stage 3

Full immersion in Stage 2 with great openness to experience: the inquirers may,

- break through to new awareness
- lose their way
- transcend the inquiry format

Stage 4

The second reflection phase, the inquirers share data from the action phase and:

- review and modify the inquiry topic in the light of how they developed or reframed it
- choose a plan for the second action phase to explore the same or a different aspect of the inquiry topic
- review the method of recording data used in the first action phase, and amend it for use in the second

Subsequent stages will:

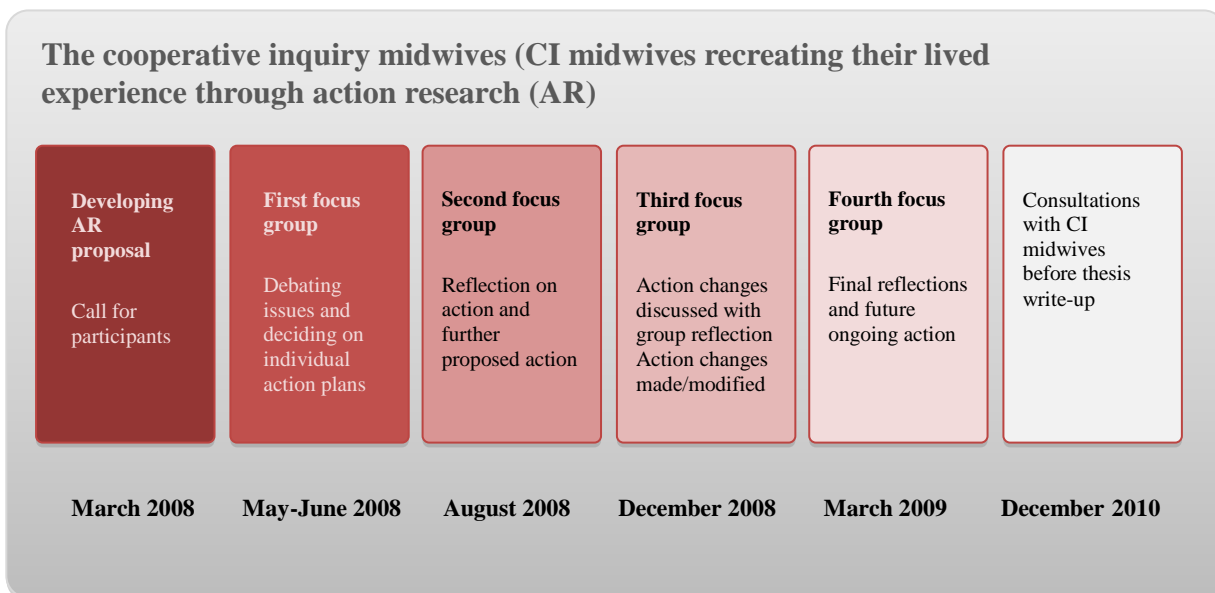
- involve, including the first, four full cycles of reflection and action, with varying patterns of divergence and convergence, in the action phases
- include a variety of intentional procedures in the reflection phases, and special skills in the action phases, to enhance the validity of the process
- end with a major reflection phase for pulling the threads together, clarifying outcomes, and deciding whether to write a cooperative report

Timeline

I have produced a timeline to show how our action research flowed (see fig. 7). In March 2008, we met for our first of four focus group encounters. This had been preceded by a call to be involved in the research project. Following this were conversations between myself and the CI midwives to introduce them to the concept of action research. With three to four months between each group encounter the CI midwives had time to focus on implementing changes in their practice and recording the process. The second and third focus group encounters provided reflection on action and further proposed action. The final focus group

was a celebration of the journey we were on. It provided opportunity for final reflections and thoughts for future ongoing action. The research process concluded just after a year and a half in December 2010 with final consultations with individual CI midwives, before the thesis write up.

Figure 7 Timeline of the action research process



Methods of gathering information

Data was collected from participants through focus group encounters, interviews, telephone conversations, informal conversations and emails (see Table 1 below). The initial focus group set the stage for the following 21 months of the action research study. At this meeting we brainstormed and confirmed the issues surrounding the work-life balance as it affected each one of us. In collaboration with each other we were able to formulate how we would individually make changes. This was followed by three more focus groups for collaborative evaluation and reflection over 12 months. Each group session lasted two hours. Between focus group sessions the midwives recorded journals or I would contact them by phone or email to discuss the impact of changes in their work setting. The amount of time each CI midwife committed to the study was determined by each one individually. The research time taken was of benefit to each one as they developed techniques to improve the way they practised. They had considered the time it would involve before undertaking a commitment to the study.

Heron (1996) discusses the transformational and informational type of cooperative inquiries. This research incorporates both. The data collection was used to serve both these purposes. The transformational research brought about change in the participants' lives and was demonstrated in their changing awareness of their practice issues and how they resolved them. Each time we came together in our focus group meetings we would share our stories. Some had recorded this through journal writing. The informational aspect of this project required me to capture the stories of the transformational changes and present them (a propositional report) at public presentations or in this case as a thesis.

The action research project was both transformative and informative in relation to the work-life balance of the CI midwives. It was necessary that the data analysis occurred at two levels. This involved reflection-in-action by the CI midwives and as lead researcher I provided reflection-on-action (Greenwood & Levin, 2007). I continually reflected on the midwives' cycles of experiences and their actions mapping and recording the process. This reflection-on-action made sense of the knowledge-generation created through the action research cycles. The written findings provided an important and powerful tool with regards to the experiences and resulting actions. Due to the amount of time required for the midwives to analyse the data in-depth the co-practitioners agreed that this would be my responsibility. In line with the participatory nature of the inquiry the concepts were fed back to the CI midwives for their consideration and discussion. This was done during the process of the inquiry. The CI midwives gained transformational change in their practice and allowed me to write about their experiences.

Table 1 Data collection methods

Collection method	Number	Length	When
focus group	seven recorded and transcribed	two hours	throughout the research period
semi-formal interviews	six recorded and transcribed 13 with note-taking only	one to two hours	
telephone conversations	20 with note-taking	varying in length from five to 30 minutes	
email	15	a few sentences in length except two with attached notes of two pages in length	
informal conversations	four with note-taking	one hour	

Focus groups

The CI midwife was to research her own practice experience and then come together with others in a focus group meeting to participate in shared reflection, as part of the cycle of reflection and action. One CI midwife was going to be overseas when the initial focus group was to take place so she consented to a recorded interview. An option of going to one of two focus groups in each cycle was created. There were two reasons for this: firstly, a manageable size for a focus group to provide opportunity for each member to share is about six to ten participants (Morgan, 1997). Secondly, not everyone could come at the same time of day nor was the same geographical location convenient for everyone. For each of the two focus groups during the four action cycles there was a choice of place and time to meet, a week apart: either at the home of the principal researcher on a Friday evening from 7 to 9 pm or in a comfortable meeting room provided by a maternity facility, from 5 to 7 pm on a Thursday in a central city location. The final focus group was combined.

The focus group was the place where important exchange was shared about where each midwife felt how she was situated in regards to achieving a better work-life balance. The initial focus groups were commenced with introductions. In my role as the lead researcher I again shared the aim of the cooperative inquiry process and commenced by briefly introducing my story. Over the years I have had opportunity to run workshops and small groups so facilitating such an encounter was not an onerous task. I had not taken any chances though and had read up on how to facilitate for research purposes. We each agreed that we needed to discuss how we understood continuity of care and partnership and how we perceived the impact, both negative and positive, on our personal well-being. From here each of the participants shared their experiences as to why they had chosen to be a part of the study and what they hoped to achieve. After each one had an opportunity to share their story others were invited to ask questions or share thoughts that had come to them as the other participant was speaking. Conversations flowed well and participants were respectful of others and allowed the opportunity for everyone to be heard.

Hearing the initial stories from the CI midwives confirmed that this research was meeting a need in our midwifery community. These midwives knew they wanted to provide continuity of care but had concerns about how care could be provided in a sustainable way. In one of the initial focus groups a CI midwife talked about how “the academics have set the rules for us to follow but in the lived experience the theory doesn’t work”. It excited the CI midwives that

they could be co-participants and co-researchers to find a sustainable way to practice by testing their own theories of how to achieve this. Literature supports the approach of the practitioners themselves doing the research at the grass roots level rather than being done by academia (Borda, 2006). It is seen as being an accurate and realistic way of determining what is going on in our lives with each one choosing how to resolve it.

The group came together for the reflection phases to share data, make sense of it, and revise our thinking. After careful consideration we planned the next action phase. It was a place where collective conversations liberated the co-participants from former ways of thinking to be able to transform their practice thinking (Kemmis & McTaggart, 2005). It provided a democratic form of knowledge discovery and produced data from group synergy for interpretive inquiry that individual interviews could not produce (Kamberelis & Dimitriadis, 2005). The focus groups were pivotal for the ongoing action as they were the place for collaborative and collective processing of thoughts and actions and deepening the level of understanding of the change process. Due to the on-call nature of our work it was envisioned that it would be difficult to arrange meetings that would allow all participants to attend so the number of inquiry focus groups was limited to four cycles. Of importance for action research is the number of action and reflection cycles rather than the number of participants. The recommendation by Heron (1996) is that a minimum of four cycles should be achieved. Heron also suggests that he has not given a set of rules for others to follow but rather each cooperative inquiry group needs to build a process that is flexible in the way they apply the inquiry criteria to meet their needs.

Each focus group became a place for the midwife to tell her story and for us each to learn from each other and get new ideas to consider for our own practice. We each had been considering how balanced our work and personal lives were. We considered what we enjoyed best about our work and with that came what disadvantaged us the most. We looked at how we could improve our own situation. To provide further opportunity for the midwives to reflect I met with co-participants for informal interviews and communicated via email and telephone conversations. As the facilitator of the project it was up to me to keep the momentum going and these contacts provided extra avenues for reflection, support, encouragement and reporting back. The recorded data came from the focus group meetings, informal interviews, email contact, informal telephone conversations and spontaneous face-to-face conversations that occurred in a work place setting. The focus groups were pivotal for the on-going action and reflection cycle as they were the place for collaborative and

collective processing of thoughts and actions and deepening the level of understanding of the change process (Heron, 1996).

Journaling

Journaling or taking notes of our experience was used as a method to record what was occurring in our individual lives (in our personal and work situation), to trace our responses to change and to note how it affected significant others in our lives i.e. family, friends and clients. Journaling was a paramount method for me to record the inquiry process. I monitored the progress noting the positive and the negative issues that I encountered. I recorded my thinking and responses as I evaluated the findings throughout the process and I used it to record my own journey of discovery. It gave me both a historical record and a record of my feelings as the research evolved which became a method of discovery and analysis (Richardson, 2000). From the notes written in each one's journals the CI midwives could recall the changes they had made and report this back through shared stories at the focus group meetings or directly to me.

Journal writing is seen as an essential tool for keeping researchers focussed on their task and in describing their role (Janesick, 1994). The journal writing provided the co-practitioners with written material that they could reflect on. By coming together in the focus group it provided a platform for them to learn from and empathise with each other and see similar and different patterns of experience emerging. This challenged them and comforted them as they made further decisions about the directions they would next take in the following action stage of their research cycle. This data collected was also used for the secondary purpose of the writing of this report to give the overview of the study in its entirety.

Interviews

Informal conversational interviews took place through face-to-face encounters, telephone and email contact. This open-ended approach to interviewing offered maximum flexibility to allow the CI midwives to explore what was appropriate for them (Patton, 2002). Some midwives were already known to me but for others the interview process was also useful to get to know each other and introduce the cooperative inquiry process. The interviews were a starting point for the first action cycle and for some an interview also finalised the formal inquiry process if they were unable to make the final focus group. Some interviews were

recorded with the CI midwives' consent and transcribed producing valuable data to add to the focus group discussions.

Making sense of the data

As previously mentioned the primary outcome of the action research project was the transformative nature of the practice for the individual co-practitioners. The secondary function was that of being informative through propositional reports to the midwifery community and through the formal academic writing of the thesis. The broad questions asked throughout the project were: What information assists us in change? What changes were achieved? How was the information used to bring about the changes? Each of us individually challenged ourselves with these questions as we conducted our own inquiry in our practices. These same questions were applied to the data that arose from the focus groups and during informal interviews that had arisen from the communal sharing. In this situation we gained strength, and solidarity, empathy and shared insights and we were inspired to continue in our change process. It was here that insights from appreciative inquiry were to be applied to the data collected from the interviews and groups to serve this purpose.

Five different ways of thinking from the appreciative inquiry approach have contributed to making sense of the data (Bushe, 2001). These include the social construction of reality, heliotropic hypothesis, the organisational inner dialogue, paradoxical dilemmas, and appreciative process theories of change.

1. Socially constructed reality

Our imagination and collective will was needed to create a better work-life balance. Postmodernists see language as an active agent in the creation of meaning. At the group meetings as we talked about 'our' world we were also constructing the world we think and talk about. As we changed how we talked, we were changing that world.

2. The heliotropic hypothesis

The heliotropic hypothesis is based on the idea that life forms gravitate toward light i.e. toward images that are affirming and life-giving. The co-practitioners explored the best of what is and has been in order to generate a collective image of

what could be. Through group consensus they had the confidence to change their practices in line with their new way of thinking.

3. The organisation's inner dialogue

This is being mindful of the layers of awareness in the organisation. In formal meetings we use our conscious, rational part of the organisational mind. In informal settings we say things that we do not discuss in official settings. It was here where the CI midwife's real thoughts and feelings were articulated and communicated. We told it to each other in stories that justified our interpretation of the events and decisions. This research project took such stories about practice change and put them in the conscious mind. The stories ideally would have more impact if they were not anonymous but this is not possible for this research report. The participants though had been encouraged to write their stories for publication or for conference presentation so that this impact can be achieved in full. In this thesis I use quotes in a way to maintain anonymity but reveal the thinking of the midwives. This is to show how midwives have become aware of their need to change and how they are crafting new ways to practise in meeting their work-life balance.

4. Resolving paradoxical dilemmas

The data was examined for paradoxical dilemmas facing the midwives and how they emerged out of, or not, a feeling of being 'stuck' with the unconscious or undiscussible paradox. It looked at repeated failing patterns where the CI midwives had addressed the same issues over and over, never seeming to get them resolved.

5. Appreciative process

The appreciative process can be thought of as a change agent technique. We achieved change through paying attention to what we wanted rather than what our problems were or what we thought we could not have. This process is described as *tracking and fanning*. We were good at talking about what we wanted more of and this fit well with the research objective of a better work-life balance. We were able to identify when this was good and how to improve it. Next we had to apply the process of fanning. Through this process we looked at every action that would amplify, encourage and help us to get more of our sought after work-life balance.

This required the midwives to use their imagination and widen their vision of new possibilities to achieve change in their practice. As an example some CI midwives trialled different ways to provide antenatal and post-natal care, trying to think outside the box (pp. 117-127).

By bringing different ways of thinking it can shed light on the examination of the raw data as it was collected throughout the research period (Argyris & Schon, 1991). In making sense of the data my approach was initially pragmatic. There was not a prescribed way that I went about analysis but rather the above principles of appreciative inquiry led me as I worked with the data. Much of this has been through a tacit knowledge rather than one I am able to write down for others to follow. Indeed Argyris, Putman, and McLain Smith (1985) argue that for action science there is a great deal of artistry and skilful application that involves both explicit and tacit rules in how something may be done.

Once I received the transcripts back from the transcriber after a focus group or an interview I started a process of immersing myself in the conversations anew. It was an enjoyable time as I was able to relive the moments of lively interaction that repeatedly occurred and the laughter and warmth that was shared amongst us. I read and re-read the transcripts and listened to the audio recordings to ensure I was hearing all that was being said. I had to sort out how I was going to organise the information into different categories or themes. I looked for patterns of relationships within and between the categories that would show how the participants changed the way they practised (Heron, 1996; Krueger & Casey, 2000). Throughout this process I kept asking questions about change. Why did we want to change? What was making us want to change? What was stopping us to make change? How were we making change? Once we decided on change how did we go about it? Did we all achieve change?

When I considered the data I was mindful of my own stance of reflexive thinking which allowed me to be able to recognise the same type of thinking that was occurring in the discussion of the other CI midwives as they related their experiences. For example, whenever I receive feedback from my clients I always try to imagine how it was for them rather than take a defensive stance. I ask myself why they did not see my care the way that I thought I had provided it. For instance, if a client complained that I was not there for the birth I needed to examine why she had the expectation that I would indeed be there. Even though I had thought I had explained that I did have time off-call in fact I may still have been encouraging

the woman to have a dependency on me by retaining an inference that I would be there. This can be described as having an espoused theory but being actually governed by a theory-in-use (Argyris & Schon, 1991). The data was placed in the context of the practicalities of change as I questioned the reasons why the midwives wanted to make change, how they chose to go about it and what they needed to do to action the change.

Patterns were identified, which often framed the issues we were encountering, and then concept mapping was used to reconceptualise the categories (Ryan & Bernard, 2000; Stringer, 2007). This was done to identify the interrelationships of the problems surrounding each issue so that this could be fed back to each CI midwife to assist them as they made changes in their practice and to provide further reflection in the next focus group. As the data unfolded over the 21 months, three main stages or themes emerged that showed how the change process had involved. Firstly it revealed recognition of the tension present between the commitment a midwife has to women and the commitment to her personal life. Secondly it showed that to action change she needed to change her assumptions about her commitments. Finally she needed to learn and adapt to new ways to sustain change in her practice. Once these broad themes were recognised I was able to assemble other data findings that broadened them out. Data from each stage in the cooperative inquiry process kept building on each of the main themes.

Having established the broad themes of what led the CI midwives to decide they needed to achieve a better balance in their lives, and the various means they went about this, I recognised that there were deeper layers of complexity that went beyond the individual midwife. The thinking tools from Bourdieu framed the data to expose the complexity of the wider social field. It was one thing to talk about making change; it was quite another thing to always achieve that due to factors beyond the midwife's control. Bourdieu offered insights into why change was not easy. In chapter four the concepts of habitus, field and capital were introduced. Using these ideas helped me to understand the CI midwife and to situate her within the broader context of her immediate experience. The concepts provided the means to examine the data to find an explanation of each CI midwife's reasoning and actions and how change came about. It directed me to ask about how the past had shaped her thinking and what has led her to make the choices she had made. I looked for what individuals and social groups were important to each CI midwife and how these may have influenced her. This process revealed what the CI midwives valued in their work and in their personal lives and

their motivation for change. There was a lot of packing and unpacking of data findings until I settled on what stood out as giving the best representation in telling the story of the CI midwives.

Reflections of the lead researcher

I was mindful of the additional interests and responsibilities I carried in this study and made this explicit throughout the process. Throughout this project I have had five important roles which included: a doctoral student who is responsible for the research project; a lead researcher; a facilitator of the process; a mentor of the CI midwives; and as a co-researcher and co-participant conducting my own action research in my practice. I experienced the process alongside the midwife colleagues from other practices in the greater Auckland area who chose to also be involved in the research process. I use the pronoun 'we' as I write up the data as I am an 'insider', a co-participant and co-researcher in the action research project. Action research has many positions on a continuum from being an outsider to an insider to the setting under study (Abercrombie, Hill, & Turner, 1994). As the lead researcher I have worked as an insider: this means I have been doing research alongside my colleagues who have been co-participants and co-researchers (Heron, 1996).

I had the responsibility to ensure that this cooperative inquiry met the research position it espoused yet still was a design tailored to meet the everyday needs of the co-practitioners and co-researchers. The midwives chose to keep a journal and/or give me a verbal report of their action and experience as well as coming to the focus groups. The focus group meeting times and any interviews taken were flexible and at times that best suited the midwives. The focus group meetings were kept to a minimum of four over the length of the project so that participants were able to make the commitment to attend. I also organised two meeting times in each cycle to allow the midwives to have a choice of which day, what time of day and which location was most convenient for them. Our action focus was toward creating change to making practice better for midwives while at the same time ensuring the quality of care stayed high for women. I hoped that the 'coming together' of the midwives in the focus groups would provide a time of celebration about the journey we were on.

Summary

For the purpose of this project the methodology of cooperative inquiry was selected to guide the cycle of action and reflection. Each one of us, sixteen co-practitioners and co-researchers,

had the same underlying desire to have a better work-life balance in our midwifery case-loading practices. We jointly agreed on how the process of the inquiry was to be conducted. We each chose the area to be researched in our practice in collaboration with the other co-researchers and co-practitioners. Focus group meetings provided the avenue for joint reflection of the cooperative inquiry midwives (CI midwives) experiences and planning for the next action stage as we worked through four cycles of action and reflection. We came with different time frames, needs, expectations and assumptions about what we would like to achieve. Creativity was needed in the research process to find a unique way to make the right fit to meet our needs. Aspects of appreciative inquiry and the sociological tools of Bourdieu were brought to the data generation and analysis to achieve greater flexibility.

The assumption was that through reflection-in-action the midwives would be able to make transformative change in their practices to make their work-life balance better. As the lead researcher I reflected on the midwives' cycles of experience and action to make sense of the knowledge generation. With the consent of the other CI midwives I mapped and recorded the overall experience and resulting actions. This data was fed back into the focus groups during the process and also used for the writing of this thesis. The research contained two outcomes: one of the transformative changes in the midwives' lives and the other an informative report, this thesis. The aim of this project has been to seek ways to strive for balance in our lives in a participatory holistic learning process. This chapter also presented the conscientious process to achieve ethical and scholarly integrity where every attempt was made to respect and protect the CI midwives. The next chapter gives detailed information about each of the CI midwives and why each one desired change. Then the following four chapters describe the impact that being on-call has had on our lives and what it required to make change.

CHAPTER SIX

Setting the scene

Action research...its purpose is to build collaboratively constructed descriptions and interpretations of events that enable groups of people to formulate mutually acceptable solutions to their problems. (Stringer, 2007, p. 189)

This chapter introduces us, the co-researchers and co-participants of this cooperative inquiry: the CI midwives. The findings represent our interpretations of events that we built on collaboratively, reflecting individually on our practice, and then discussing together in focus groups in four cycles, over twenty-one months. Our group was composed of sixteen case-loading midwives from different areas of the greater Auckland region representing city to rural midwifery practices. We were at different ages and stages in our lives and practice experience. We were drawn together by the shared empathy of the felt need to make our work-life balance better.

Some CI midwives worked as the only midwife in their practice and others worked in a structured group practice arrangement, ranging from cosmopolitan practice environments to country practices covering wide geographical areas. Despite our different practice experiences and settings we all identified that working on-call, often days and weeks on end for some, was not sustainable. We were all looking for ways to make our work-life balance better with acceptable solutions that met the continuity of care requirements of the Ministry of Health and the philosophy and standards of care of the New Zealand College of Midwives. This was a cooperative inquiry about revisioning our understanding of the world, as well as transforming the practice within it (Heron & Reason, 2007).

Different approaches to practice arrangements

The CI midwives represented four approaches in their practice arrangements as Lead Maternity Carers (see fig. 8).

Approach1: Individual practice (1)

The Lead Maternity Care (LMC) midwife provided 24/7 on-call availability which meant she was on-call for the woman in her care twenty four hours a day seven days a week. She had an affiliation with a group for support and back-up. The woman does not always meet the LMC's back-up. The midwife only takes time off occasionally for important events in her life. She would, however, have a colleague who would be available for back-up for sleep if

she felt she could not carry on. Her personal life would be juggled around her work-life. This LMC midwife was responsible for payment to the colleague for any cover provided at a previously negotiated rate. She made her own business and practice decisions. Some had lower case-loads than others but this was not always by choice but rather by availability of clients. These midwives had a case-load of four to eight women per month but each one tended to have varying numbers month to month.

Approach 2: Individual practice (2)

The midwife LMC had an arrangement with a colleague for every second to third weekend off. She also had an association with an affiliated group for support and back-up. Usually the women would have met the LMC's back-up. The rest of the time the LMC would be on-call 24/7 only calling in back-up when she felt she could not cope or needed cover for sleep after being up all night. The LMC was responsible for payment to the back-up for any cover provided. She also made her own business and practice decisions but needed to work in with the back-up person to provide reciprocal cover. As with the previous group, case-load numbers varied from four to eight women per month.

Approach 3: Team practice (1)

The LMC midwife worked in a team of three to four members. They each had at least two days off-call each week and knew their days off in advance. They had an individual case-load. To keep a good level of continuity of care when not on days off each member in the group would mostly see their own clients. They would however see clients of another midwife who they were covering for. They had a defined time limit about how long they would provide continuous care to a client. They would call in a colleague for back-up when required. Back-up for each other did not affect income as payments were pooled and evenly dispersed. Business and practice decisions required democratic decision making. Teams chose a case-load of five to eight women each per month. If they were salaried the case-load numbers were determined by their contractual agreement with their employer.

Approach 4: Team practice (2)

A group of midwives, about three to four, shared the client base equally and provided team continuity of care. This care was based on the women meeting the team of midwives. They understood that they could have any one of the midwives attend to them at any stage for their maternity care. The midwives had set hours to be on-call for urgent call-outs, off-call but still

working to provide routine care, and days off. Back-up for each other did not affect income as payments were pooled and evenly dispersed. Business and practice decisions required democratic decision making.

Figure 8 Practice approaches of the cooperative inquiry midwives (CI midwives)

Approach 1	Approach 2	Approach 3	Approach 4
Individual practice (1) Affiliated to a group of LMC midwives	Individual practice (2) Affiliated to a group of LMC midwives	Team practice (1) A group of LMC midwives	Team practice (2) A group of LMC midwives
No structured time off	1 weekend off every 2 to 3 weeks	2 days off per week	2 days off per week
Own case-load	Own case-load	Own case-load	Shared case-load
Works 24/7 on-call	Works 24/7 on-call when not on days off	Works 24/7 on-call when not on days off	Take turns at being first on-call
Urgent back-up only	Back-up for days off and when need back-up	Back-up for days off and when need urgent back-up	Back-up for days off and when need urgent back-up
Women usually only meet LMC	Women meet the back-up midwife	Women meet the other midwives in the group or at least the back-up partner	Women usually seen equally by each midwife
Loss of income if cover required Reimburse backup	Loss of income if cover required Reimburse backup	No loss of income if cover required Pooled income	No loss of income if cover required Pooled income
The CI midwives			
Bronwyn Rachelle Kathryn May Joan Skye	Rose Janet	Cherry Ellie Evelyn Mariana	Robyn Mary Lorraine

The self-employed CI midwives received their income directly from the Ministry of Health (Ministry of Health, 2007). It has set modules of payment spread over the antenatal care, birth and post-natal care and paid at completion of each of three modules of care. These modules include: the first and second trimester; third trimester and birth; and the post-natal module. The employed CI midwives were salaried and represented public and private maternity organisations.

The midwife participants

This section introduces the 16 participants.

Cherry

Cherry worked as an employed case-loading team midwife. When one of the team members moved on Cherry was left without a back-up partner so she chose to work on-call 24/7 instead of having her usual two days off per week. Initially she had thought this was a good way to work until she realised that her life had been taken over by constantly being 'on-call'. Slowly over time her social life was lessening. She was feeling exhausted after long hours of work and guilty if she could not be available for her clients. One day she was very embarrassed during an appointment with her doctor when she had a phone call from a client. She answered it apologising to the doctor explaining she was 'on-call'. She realised at that point how her on-call life was now governing everything she did or did not do. Cherry needed to have set time off to do things like visit the doctor, catch up with friends, go bush walking and spend off-call time with her husband. The action research for Cherry provided a platform to explore her thinking about her on-call work and how she could work to meet her own needs as well as the women in her care. The study offered her confidence to change what needed changing.

May

May considered that she had a busy lifestyle with her combination of work and family life. Her husband's work commitments put great demands on the family. There were expectations for her to also spend time in her husband's business which made it difficult if she had an urgent call-out. There were periods of time when her husband was out of the country leaving her with the full responsibility of managing the household on her own. May had only recently come back into case-loading midwifery after a period of time working as a core midwife in a

tertiary hospital. What concerned her most was getting cover for time off; knowing what an acceptable case-load level was for her; and working out her preferred practice setting i.e. working from her home, paying rent for clinic rooms or doing antenatal home visits. She had a loose working relationship with other midwives and could arrange cover for time off with them and would cover for them as well. She did not consider this a long-term set up.

May worked mostly 24/7 on-call with days off only when there was some particular activity coming up that would take her out of the city. For example, if her son had a sports tournament she wanted to be able to go with him. Another concern, which weighed heavily on her mind, was her inability to visit her elderly parents regularly as they lived in another town. Time is passing by so quickly. She feels she is not meeting her family obligations because of her casual and infrequent off-call arrangements.

Impacting on her work-life balance was bullying that she experienced from staff in the facility she had access to. This affected May's confidence. Not only did she need confidence to be the woman's advocate she also needed to advocate for her own rights, for example, when she was working long hours and needed relief for a break. May's participation in the action research was to gain ideas and support about how she could develop her practice to be 'safe'. Ideally she wanted to have a small group of supportive colleagues to work with to give her guaranteed back-up cover with regular days off.

Skye

Skye and her partner live in a rural area with their children. There are only a few midwives who serve the community where she lives. Some of the women choose to have home births. The remainder of the women travel some distance to a hospital or birthing unit of their choice. The midwives work with an individual case-load but they rely on each other for back-up cover. The dilemma for Skye was that the other midwives mainly practiced home births. This could mean continuous periods of months at a time being on-call 24/7 as she did not have alternative back-up cover for the hospital births.

Her case-load numbers varied greatly each month. She could not control the numbers as they were the only midwives available to provide the maternity care. It averaged out at about four births per month over a twelve month period but some months could be very busy and others quiet. When the number of women in care varies from too few in a month to too many, causing very busy periods of work, it is difficult to maintain a balance between work and

home-life. At the time of the first focus group Skye and her midwifery partner had just had fifteen births between them in the previous fortnight. She said she felt 'pretty wasted'.

The challenge for Skye was to find a way to work to meet the inconsistent work load and to have some down time that was completely off-call. She wanted to spend off-call time with the family and enjoy leisure activities. Skye loves sailing but it could only be done when she was on annual leave. The opportunity was there for sharing a case-load so she could have planned days off. This was a dilemma for Skye as she also wanted to provide one-on-one care for her clients. She felt her satisfaction in her care provision would be diminished if she shared a client load.

Mary

Mary had been an independent midwife for many years. She had usually worked with her own case-load and had tried various back-up arrangements. These arrangements had changed over the years as circumstances in her life around her changed. Mary felt she was at the point of burnout. An opportunity presented to work with two other midwives who also wanted to provide case-loading care with structured time off. In the past year Mary had changed from working with her own case-load with only occasional time off to working in a group with structured days off. She had worked in a group before but they had not been able to 'keep it together'. She is keen to work on consolidating her current practice structure to withstand any conflict that could arise between group members.

Joan

Joan has had many years of experience in working with people. Joan had worked in many different places as a midwife in different practice arrangements. Life moved on and Joan eventually moved from a well-structured city practice to the country and worked with her own case-load, only occasionally calling on another midwife for cover. Now she has come to the point where she needs to have regular cover for time off as she feels she is neglecting herself. Even getting to the hair dresser had become a mission. She just felt that she never knew when she was going to be called out so she put things off. If she had an appointment but was called out she just did not get around to remaking the appointment. Then she realised that she was not doing anything for herself and life was losing its pleasure. Joan has a range of leisure time activities and likes to keep in touch with friends and her family. Joan also loves to go tramping. She struggled to maintain the extra activities in her life when she was

on-call 24/7. She hoped to find a better way to practice to meet her needs and those of her clients.

Mariana

Mariana and her husband enjoy a quiet but industrious life. Mariana works as a case-loading midwife with the hopes to retire from midwifery to be involved in business with her husband. The idea of being able to work alongside her husband and have a good income without being on-call appealed to Mariana. Mariana has opportunity to enjoy her leisure activities as she works with set days off. Outside of work she feels she has a good life.

Mariana is an experienced midwife. Just recently she commenced working as an employed case-loading midwife. She still wrestled with the on-call nature of the job but accepted that was how she had chosen to work. What drew Mariana to the study was the hope to find ways to make her workload more manageable. Although she worked within a team and had regular time off she identified practices that she could change to reduce areas of stress in her working life. Her main concern was the high-risk clients that she cared for. The time needed to be with them was more than she had available. She wanted to accommodate these clients but not feel unduly pressured as it affected her work in a negative way. By meeting with the other CI midwives Mariana felt this would help her to reflect on her practice to see how she could make changes.

Rose

Rose commenced a self-employed case-loading practice recently. She was in the process of building up her case-load but this was taking time as there were other new midwives in her area as well. She was aware of the dedication that midwives have to their work that was often at the expense of their own personal well-being. She did not want her midwifery practice to become a dominating factor in her life to a point where it prevented her from spending time with her family and friends. Rose wanted to use the action research process to reflect as she shaped and consolidated her practice. She wanted her practice to be one where all the midwives in her group had adequate time off from being on-call. She wanted the women to be in a place where they were confident with whichever back-up midwife they had.

Robyn

Robyn returned to the midwifery workforce some time ago after a long break to raise her children. Robyn had been working as an employed midwife in a private midwifery practice Monday to Friday with regular hours. After an initial period of mentoring to update her midwifery skills Robyn was practicing midwifery across the scope of practice. Her confidence was built over this time to the point where she felt she would like to have her own case-load. As her children became less dependent on her, Robyn could look at being a self-employed case-loading midwife. To work on-call concerned Robyn but she knew she would experience greater satisfaction and earn a better income than if she continued in her employed situation.

Robyn, however, could not rationalise the 24/7 on-call concept of caring for women. Her commitment to family superseded any consideration of working on-call 24/7 for long periods of time with no guaranteed time off. She decided she would need to be in a structured team setting to allow for set on-call and off-call time and days off. Fortunately Robin knew two other case-loading midwives wanting the same. Working in a group brought communication issues that needed to be addressed. Robyn recognised the need for her to keep a 'clean slate'. She learnt to raise any issues that she felt was preventing her from being honest with other members and not harbouring any grudges. She found that if issues were not resolved they would build up and be more difficult to deal with. Her action research project was to work on her group's communication.

Evelyn

Evelyn like others in the group had worked overseas and in New Zealand. Providing case-loading midwifery was the way Evelyn liked to practice best. She liked the autonomy it provided to be able to develop a practice around her needs and those of her clients. She talked about how we were a 'woman profession'. We needed to be able to choose how we work to suit our needs. When Evelyn first started providing case-loading care it was in a team and she often found that when they had days off the back-up midwives would get the burden of caring for the extra women as well as their own. This workload became too heavy so Evelyn chose to set herself up in self-employed practice. This too had its draw backs.

The passion to be there for women obsessed her to being available 24/7 without a break. Not only did she have to get up for births in the night but she would often find herself going to a

woman's home in the middle of the night to help with breast feeding. It became unsustainable. She was always tired and felt she made her practice unsafe. Evelyn stood back and evaluated this and realised that she was pushing herself too much and not leaving any time for herself. From here she created a group practice where the midwives could work in together to provide cover for each other for days off without burdening each other. Evelyn's goal over the time of the action research project was to work on aligning the same 'shared philosophy' and building the new practice.

Margie

Margie loves to care for women and be on-call for their births but when she previously worked as an LMC midwife on-call 24/7 she 'burnt out'. She felt her relationship with her husband was suffering and that she was neglecting her son. After many years of having her own practice she 'packed it in'. After time off work to have another baby and rebuild family relationships it was time to come back to midwifery. Margie knew that she could not work on her own again. She needed to be able to say to her family 'I'm off-call tonight'. The opportunity came up for Margie to be employed and work in a team providing on-call care with structured time off. This appealed to Margie as it met her desire to care for women the way she loved to but enabled her to 'put the brakes on' when it came to having time off. It reinforced her ability to say no.

Margie felt that since 1990 independent midwives (LMC midwives) had set up a hard act to follow. The expectation for women has become to have the same provider to be there for them on-call 24/7 and midwives have been keen to provide this. Margie quite happily now explains to women that they have 'not one midwife but four!' She said the women think this is great. What Margie does find is difficult is to entrust care of her clients to the other team members. She found herself going in to work on her days off to review charts. Margie needed to trust her colleagues recognising that there are, as she said, 'different ways to skin a cat'. She had to trust the other midwives that they will recognise what is important. Margie used the action research project as a means to work through this transition period as she adjusted to case-loading in a team setting. 'Letting go' of clients was her focus for the action research. Some other midwives in the action research project also identified with Margie: they wrestled with this concept of 'letting go'.

Rachelle

Rachelle is a relative newcomer to midwifery practice. The project gave her the opportunity to see the issues that experienced midwives have faced in their practices. These ranged from being on-call 24/7 and the perceived advantages they gained from this to the advantages of working in a team setting having regular time off. At this point in her career Rachelle saw that it was important to consolidate her midwifery skills by working with clients she had total responsibility for and with whom she had a close relationship. The 24/7 on-call concept in this respect worked well for her. She was also aware of the need to have regular time with her partner so that they did not develop separate lives and grow apart. Rachelle chose to work on how she could have cover and still enjoy the satisfaction of having a high continuity of care by being there for her clients when they were in labour. However, she was now realising the disadvantage of only having occasional time off so joined the research project for ideas to get around this.

Ellie

Ellie was an experienced midwife having worked overseas in both hospital and community settings. In New Zealand she was working as an employed case-loading midwife but identified that there was more emphasis on providing 'continuity of *carer*' rather than 'continuity of *care*'. The continuity of carer she terms as exclusive availability: the same midwife to one woman. This causes conflicting values in her team. Ellie has identified that it was important that she worked in a team where she had scheduled time off and only worked two to three days on-call at a time.

Ellie was attracted to the action research project as she needed to develop ways to cope with the changes in her group structure. Ellie had worked in the same team for several years but in a short space of time the team decreased to three. This had profound effects on how they worked. Firstly, it meant less midwives to cover for sick leave and annual leave but also a change in group dynamics. This involved the communication between the three midwives. Two of them had a similar work philosophy but the third would question the others' decision making which caused tension. These ranged from having different ideas about how they selected women they cared for to what stage in labour they would meet a woman at the hospital. Ellie felt she needed to work on the communication of the group to get better cohesion in their practice.

Janet

Janet had a good on-call and off-call arrangement with another midwife. They were both experienced case-loading midwives and worked with a larger group to have support whenever it may have been required. She had worked as an independent midwife since the early 1990s and it had fitted in with family life. Janet worked on-call 24/7 with every third weekend off. Janet looked at her practice to see what could be modified and what made excess or unnecessary work in order to streamline how she worked. Janet felt she could use her time more wisely freeing it up for other clients or to have more down time. She joined the action research study to help her identify and eliminate unnecessary time spent on tasks that were no longer providing advantages to the women or to her. The focus group discussions were a means for her to evaluate her philosophy of practice and to examine her assumptions about how she did things.

Kathryn

Being an experienced midwife for many years and working as a self-employed midwife caring for about four to six women per month had brought a lot of pleasure to Kathryn. She was now considering whether she needed to move on to a midwifery position with regular and predictable hours. Some other colleagues had changed to midwifery roles with set hours when they required regular hours. Kathryn was not ready to leave her case-loading practice but neither did she imagine she could work in a team setting to provide case-loading care. She believed that 'continuity of care', was 'one midwife to one woman' care. It would not be ethical for her to change. Involvement in the project was to explore new possibilities for how she could continue in her current practice.

Lorraine

Lorraine knew that she no longer wanted to work as a self-employed midwife if it meant working 24/7 on-call. It was hard though to find other midwives to work with and who thought the same. So many midwives felt that you could only do case-loading practice if you worked on-call 24/7. Lorraine began working with two other midwives after a year of preparation. There was still a lot of work to be done to work through the changes. It was very different to how she had been practicing. Having her own case-load that only she was on-call for meant she could make her own work decisions. Now she needed to consult with the other

midwives in the practice. In a lot of ways it was easier to work independently as she did not have to consider the others. The time you had free, apart from a call-out, was your own time.

Many return clients were used to having just Lorraine to care for them. They also had to adjust to having others involved in their care. Most understood Lorraine now worked like this but a few wanted just Lorraine, placing pressure on her. She needed to constantly reflect on why she felt she had needed to change. She had to work through the guilt she experienced when she had her days off and was not on-call. Regular time off-call allowed Lorraine to achieve other commitments in her life that she had been previously prevented from doing. The action research project was a chance for Lorraine to reflect on why she chose to work in a group; to learn to trust her colleagues; and to develop her team work skills.

Bronwyn

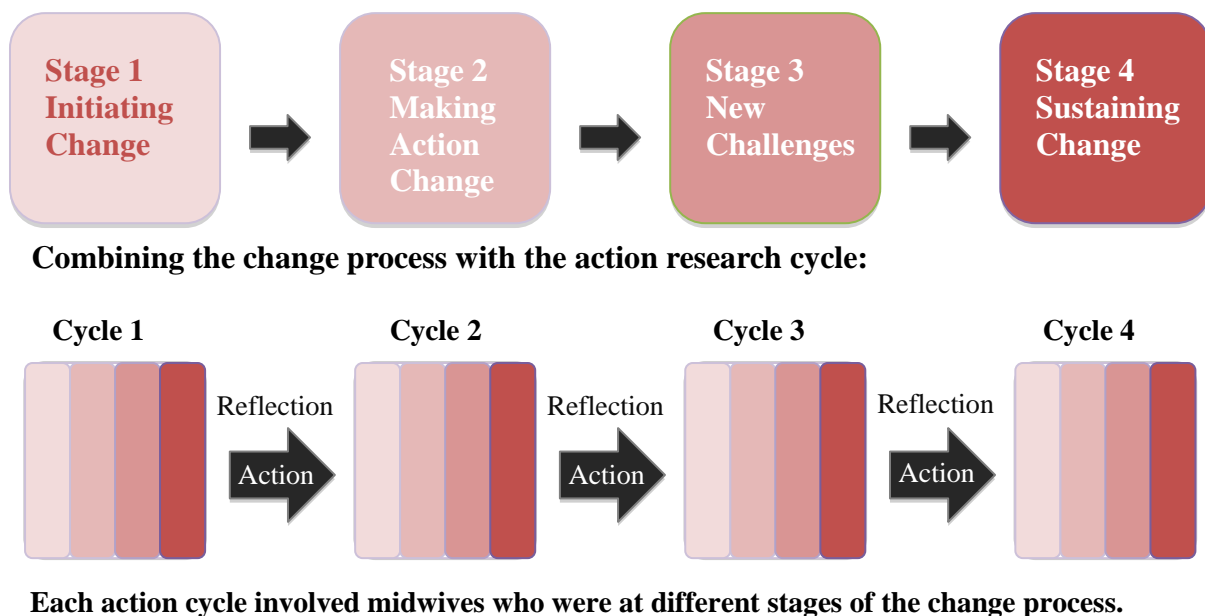
Bronwyn was an experienced midwife and had worked in a variety of midwifery settings since the mid-1970s. She had seen a lot of changes in how midwives practiced. Bronwyn provided locum support for case-loading midwives and was involved in other midwifery services. She yearned to work as a case-loading midwife in a supportive team with regular time off. She was caught between a desire to be a case-loading midwife and the need to be a mother and grandmother. Bronwyn was proud that over the years of being a midwife she had been able to preserve time for her family and felt that she had always been there for them. She knew she would be sacrificing her ideals if she were to be a case-loading midwife without being in a well-structured team with organised time off. In her role as a staff midwife Bronwyn had observed that when a woman's LMC did not make it in time for a birth the women seemed happy to have another midwife attend them. They said that they did not mind who the midwife was as long as they felt safe and that the midwife was kind. This reassured Bronwyn that the idea of having one midwife 24/7 on-call was not a priority or necessity for some women in receiving the care they wanted. With the support of the inquiry group Bronwyn was keen to discover how she was going to practice.

The change process

The planned process was for each of us to work through four action research cycles of reflection and action (see fig. 9). We proposed our action change in the first cycle and then we reflected and modified the action in the subsequent three cycles. It was evident in the first focus group encounter that each one of us represented four different stages in the change

process. Some were just becoming aware that they needed to make their work-life balance better. Others were already putting change into action. For others they had made changes but were challenged by issues brought about by the change. Some were fine-tuning changes they had already made. There were some who used the entire time to work through how they were going to change and others who made a complete change in their practice over the 18 months. The focus groups and interviews in each of the four action research cycles produced a combination of data as everyone was at different stages in the change process. Because of this, the findings have been written up to reflect the change process, not what actually occurred in each of the action cycles.

Figure 9 The stages of change and the action research cycle



The data revealed a four-stage process of change:

- **Initiating change:** The CI midwives recognised they needed to make changes in how they worked as they felt their personal well-being was being affected by how they worked. (Chapter seven)
- **Making action change:** The CI midwives started making a change and had to work through their assumptions about how they practiced. Not only to make practical practice changes but to change their thinking. (Chapter eight)

- *New challenges:* The CI midwives found that change could bring new practice issues that needed to be resolved. (Chapter nine)
- *Sustaining change:* To sustain change the CI midwives needed to fine-tune how they were now practicing to make the change even better. (Chapter ten)

Summary

Some of us felt that we already had a diminished balance between our work and our private lives. Others had recognised the potential of this occurring. Some of us had the realisation, or an already realised notion, to take regular weekly days off and needed to work through how we were going to achieve this. Some CI midwives felt they had good boundaries between their work and personal lives but sought to make changes in their work structure to make better use of their time. Some had this almost irresistible compulsion to be always on-call. Even the midwives who were working with regular days off were still faced with days in a row of being on-call 24 hours a day, working long hours often without a break. Safe practice was an issue for all of us. We all needed to maintain personal and social relationships and respect our physical and emotional health, balancing this against the need of the women in our care. We sought to balance this tension in our lives. There was a ‘tug of war’ between upholding a continuity of care ethic against the risk of a negative impact on our personal well-being. The following chapters give the story of how the midwives’ thinking developed and how they made ongoing changes in their practice settings through the cooperative inquiry process. Chapter ten provides a summary and conclusion of the ongoing change process. In this chapter the concepts of Bourdieu have been introduced to provide further insight into the midwives’ journey.

CHAPTER SEVEN

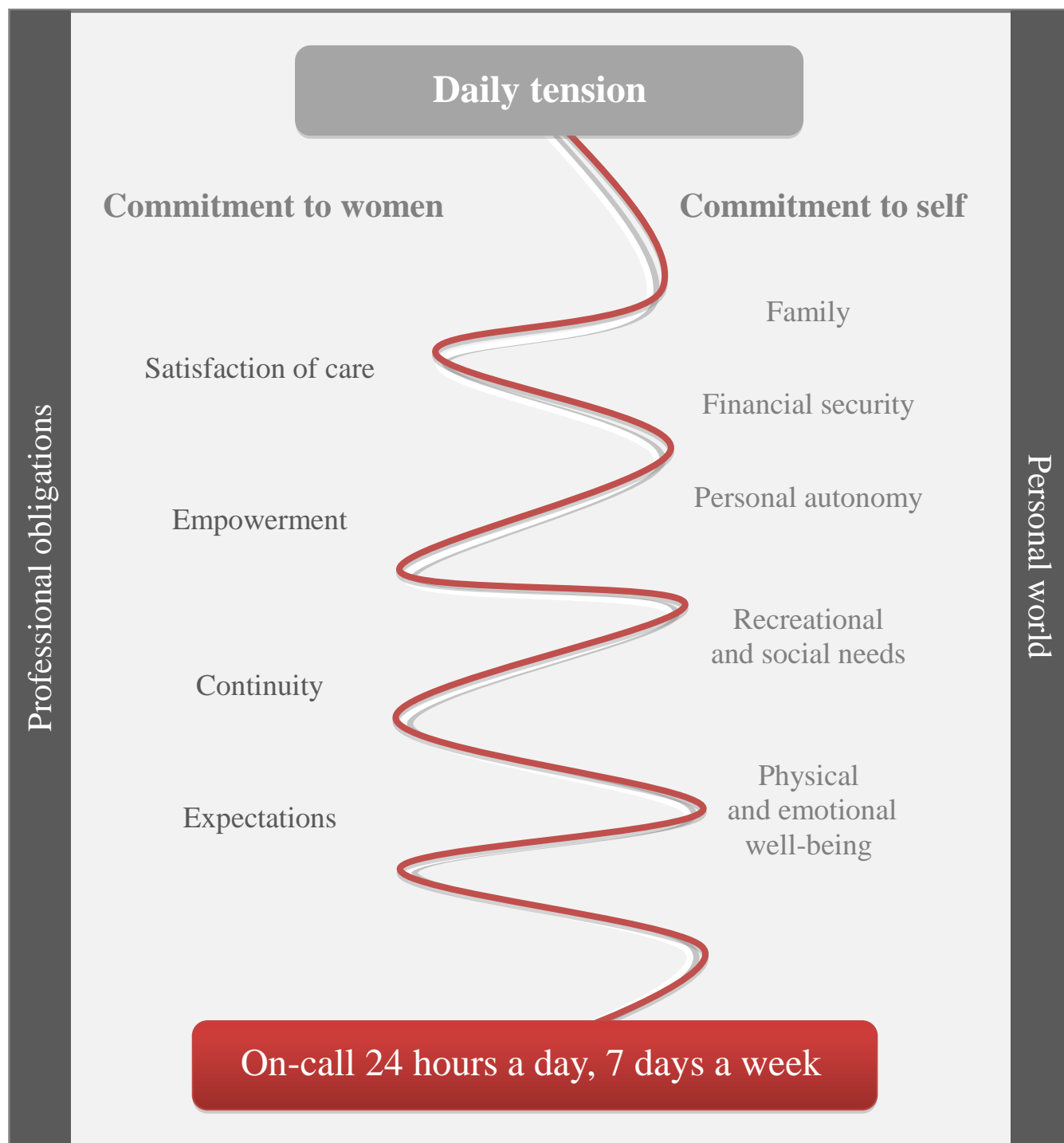
Initiating the change process

Inquiry and change are not separate moments, but are simultaneous. Inquiry is intervention.
(Cooperrider & Whitney, 2005, p. 50)

This action research revealed a power struggle between our professional obligations and our personal world. A tension existed between a commitment to women and a commitment to self: a tension always present but with the potential to become out of balance. We each sought to develop trusting relationships with child-bearing women who chose us to be their Lead Maternity Carer. The immense satisfaction we derived from this relationship kept us motivated as we strove to meet our own and the women's expectations of care. Together we reflected on what we found positive about our work and what we felt needed to be changed. We exchanged our views on our philosophical underpinnings of partnership and the meaning of continuity of care and how we applied these notions in our practice. We looked at the real, as opposed to the ideal, situations that we found ourselves in. We reflected on areas in our lives that we felt were under threat because of our long periods at a time, being on-call. We discussed ways we could sustain the continuity of care provision and meet our commitment to family and other personal life needs. The following data shows the tension that existed in our daily experience that had to be acknowledged to begin the change process.

Theme: Tension between commitment to women and commitment to self

Each day we experienced tension between meeting our professional obligations and our commitments in our personal world (see fig 10). Some CI midwives had already put changes in place to try and overcome this sometimes seemingly overbearing tension. Others who had recognised the conflict of their day-to-day struggle were still deciding how best to address their situation. We perceived our well-being was being affected by the demands of our on-call work. As case-loading midwives we strove to provide women with satisfaction of care, to be empowered, to meet their expectations of care, and to provide safe care. We talked of our passion to provide continuity of care but also discussed the areas in our lives we perceived were at risk because of this type of care provision. These dimensions of our lives included: family, financial security, personal autonomy, recreation and social activities, physical and emotional well-being.

Figure 10 Tension between commitment to women and commitment to self

Family

Most of us found that juggling our on-call life around family commitments was demanding. Margie shared with us about how she was consumed with a passion to be on-call for women but this got in the way of her and her family needs. She gained immense satisfaction from her midwifery work but the commitment to be on-call showed a tension in her life that she could not ignore:

But I had to do something. My husband was getting a divorce; my child was looking at photos of me on the fridge to remember what I looked like! You know it was getting pretty rough back home.

Every day Margie had a constant battle of having to somehow balance her love and desire to meet her family needs against her professional obligation to women. Her passion for women was consuming her life. Margie seemed compelled to place the woman's need above that of her children and her husband. Working on-call required understanding from her family and friends. Margie's family could no longer maintain this generosity of spirit. They were feeling deserted. Her work was having a negative impact on their lives. Life was starting to crumble around her. She knew she had to do something.

Rachelle could never guarantee if she would be home or not in the evening. It was a consequence of how she practiced. Here is a conversation she had with her partner:

No, he's not negative, he isn't really positive either. But I talked to him the other night, and he's actually doing things like playing rugby, and goes to training twice a week with rugby on Saturday. And I said to him 'Rugby takes up a lot of your time that you could be spending with me'. And he said, 'Well, how do I know that you're going to be home? Why should I sit at home hoping that you're going to come home and see me when you possibly couldn't?' So, it's pretty much like he does what he wants to do and I go home and sleep. And if we're home together then that's nice.

Rachelle did not have any certainty about when she would be home. She hoped her partner would wait at home for her but he told her that this was not a realistic expectation. He could not live his life around her work: around her passion. One of them had to have a life. The midwife call for Rachelle meant she sacrificed time with her partner for her relationship with women. Any planned activity she would miss if she was called out. Her commitment to women came with the 'on-call' status. She had expected her partner would want to stay 'on-call' for her.

Lorraine believed in providing around the clock availability to provide continuity of care for women. However, over the years life circumstances changed forcing Lorraine to reconsider the extent of this commitment:

My husband and children have always been really great. You know, they've never complained, because that's how I worked. I loved the close relationship with women and being 'in charge' of my work. I always tried to be available but sometimes I had a birth when we had a special family activity planned. My husband was always good, dropped the kids off and picked them up for out of school activities if I was unable to. We worked in together well. We both had flexible work schedules so we could catch up during the day if I wasn't home in the evening. But then the kids grew up and it wasn't until now that I realised that I don't have time for myself, and I'm thinking, what really did my family think?

Lorraine just got on with life. She worked hard and drew great satisfaction from case-loading care. She believed in the care provision she provided. She felt fulfilled. Her family supported her as they knew that women could not plan when they went in to labour. Yet did her family get a fair deal? Lorraine was so sold on the idea that women came first that she would even miss special family times so she could be 'with women'. Then after years of working this way she asked 'At what cost?' Was she so tied up in her own desire to fulfil her commitment to women that she negated her responsibility to her family or to herself?

Margie talked of how midwives had created an expectation to always be there for women:

The continuity of care thing has happened and with that it has created this picture of where women come first, and we have trouble putting ourselves or our families first or recognising that we have needs. It has become a life of putting the women first. I think that's what a lot of women expect, or have done, over the last few years...since when midwives first started being independent midwives, that's what women expected wasn't it, that they would be available like that 24/7?

Margie was working through why she had let herself get into this situation of being controlled by her desire to fulfil the women's needs before her own needs. She now knew she needed time out for herself. Margie had recognised that the demands she had put on her life working on-call 24/7 was not working out for her. The thought that continuity of care necessitated putting the needs of the women before her own or her family now concerned her.

Financial security

The financial side of life could add an extra tension to the work-life balance of the CI midwife. The self-employed case-loading midwife is autonomous in how she structures her practice (Guilliland, 2007). She has to set herself up in practice. She needs to find clients, arrange her back-up support and sort out her business arrangements. There is no prescribed

way for her to organise her practice. Many CI midwives who worked in their individual practices were affected by fluctuating case-loads. This sometimes meant too many clients in a month or too few. When there were too many clients it had the potential to make up for the quiet months. However, this irregular work load affected time off. In the quiet months the midwife could not afford to miss a birth and when it was busy it increased the chance the midwife could miss a birth. Either way it affected her income.

Rachelle was establishing her case-load. She recognised she needed planned time off but if she missed a birth she would also miss a payment:

I found that having four or six women was not really that much difference, because I'm always on-call for them anyway...but I can't go away because I'm on-call. You really can't go away because if you miss one, then financially you're at a disadvantage.

Rachelle felt it was a financial risk to take time off-call. She would lose the birth payment if she was not able to provide the care.

May arranged urgent cover if it was needed but did not have a specific midwife partner to back her up so she could have regular days off:

Um, I still feel like I'm on a rollercoaster and I can't get off. So, um, a little bit of my own making, because I usually book about four to five women a month. And I don't have a full-time partner, but I'm part of a wider group, about seven or eight of us, but I don't have a financial partner yet so I don't actually get weekends off.

May wanted to take more time off but in her current arrangement she would miss the birth fee if she missed a birth. May was describing her experience as being on a 'rollercoaster'. As it gained more momentum she could not seem to slow it down or alter her course. She wanted to work in with another midwife for regular days off to reciprocate birth payments but life kept careering on. She just did not seem to have a chance to organise something.

Janet was aware of needing to take time off-call but wanted to be there for her clients. She also had a financial tie to be there:

I still don't think that one weekend a month is enough to have off. I don't. So, but it's kind of like, because of the way that I'm working, I want to be there for all of them, and also the other part of it, which is absolutely horrible, is that I don't want to miss out on the money, that's absolutely horrible to think like that, but you do. And so it's kind of like well you either have two weekends off a month (Saturday, Sunday and Monday), which would be fine, but then that's six days where I'm risking losing money, and people having babies that I'm going to miss out on.

Janet held an expectation to be there for the women in her care. Yet she knew she needed more than one weekend off a month for her personal well-being. Not only did Janet have the intense desire to be there for all the women in her care but she also needed to be at the birth to get paid. The more time she took off the greater chance of missing a birth and the payment.

Rose worked 24/7 on-call and liked to have one weekend off each three weeks. Unfortunately some months she did not have enough clients so she could not afford to always take her days off:

An example is that I'm scheduled at the moment to have one in every three weekends off. Now one of my weekends off in April I lost two deliveries, and I only had three booked for the whole month. Financially that was very difficult. And another one of my colleagues who was actually out with me at the weekend, that same weekend, she lost two as well, and she also, I think she also has the same number. Just because of the timing of it. I'm one of the newest in the area and where I work has not a lot of people booking. I aim for four. And some months I've got four; sometimes I've got six booked. I had eight booked in March.

Providing LMC care on-call 24/7 allowing flexibility for Rose to choose when and how she provided care did not always work out. Often how she worked was determined by when bookings were available. She found some months she could have enough women, other months too many and sometimes not enough. For any births Rose missed she lost the payment to the midwife who covered. There was no guarantee that she would be able to reciprocate a birth to make up for the payment she lost.

Rose valued taking time off but like Janet she missed the continuity of care and the income if she missed a birth. Taking time off was a dilemma for Rose:

But I can see a lot of difficulties with taking regular time off. So it actually makes a difference, not just to the midwife, like the continuity and the care and the relationship. But it also has an effect on your livelihood, and you can't afford certain types of time off if you don't actually have an income to support it.

Rose felt the impact on her income if she missed a birth. Rose wanted time off but wondered if it was worth having time off if she could not afford to enjoy it.

Having two women in labour at once can threaten the case-loading midwife's income which almost happened to Rose:

It's happened with some others (missing a birth). I'd recently though just finished being up in the night caring for a client who just had her baby at one hospital and as I was doing paperwork I had a call from a woman. I thought I would have to call in my back-up. The woman thought she might be in labour and we chatted. She called me back, and I had to race over. And I got there in time. She arrived there just after I did.

Rose just made it in time to a second birth in another hospital. She had been with a woman in one hospital most the night and then rushed over to the other facility with no time to eat or freshen up. Rose worked 24/7 on-call. She wanted to provide continuity of care to all her clients. She also needed to receive the birth fee.

The CI midwives saw the need for regular and frequent time off yet they felt they could not miss a birth. Although receiving a payment for a birth was important it was not the only reason they did not want to miss a birth. The CI midwives were committed to being there for their clients as they had developed a relationship with them. They wanted to be there. Missing a birth fee is just part of the story in the daily tension in the CI midwife's life.

Personal autonomy

The CI midwives were finding that the constant availability placed a threat on their personal autonomy. We each had started case-loading care with great enthusiasm enjoying the close relationships with women. Then some felt that their on-call availability was affecting how they lived their lives to an extent that they were having less and less control. Taking rostered days off in the past had been seen as going against the continuity of care ethic. Mary recalled that a group in South Auckland were challenged about working a rostered system. It was seen that a midwife's role was to provide woman-focussed care through continuity to ensure quality of care for women.

On Bronwyn's return to case-loading practice she was reminded of the forgotten demands that this care provision placed on her personal freedom:

I'm doing a locum at the moment and suddenly it's all dawning back on me. You know I realise that perhaps I'm just not right for the job, that sort of thing. I mean I do love it, but I'm thinking already now the phone is going to go for one of these women. So basically I value my private life a little bit.

Bronwyn thought of her commitment to midwifery, to women, as a lifestyle. Work and personal needs she hoped would work together. She knew the importance of nurturing her private life. Yet she loved to provide continuity of care. She had forgotten the demands that it made on her life. It felt like it was going to rob her of her private life.

Many of us experienced a loss of personal freedom. Margie felt under pressure as women seemed to expect they could call her any time even if not urgent:

I think that's exactly what people think (we are supposed to be available anytime not just in an emergency), but you wouldn't expect that of a doctor, who rings up doctors surgeries and says can I have an appointment at 7 o'clock at night? But I have people

who ring me and ask for appointments; oh can we do it after 5.30 pm? And all I think is when am I meant to go home?

Margie was on-call for women. She could be called out anytime urgently so tried to get her non-urgent visits done during day time hours. She wanted to leave some time free in the evening for herself and her family. If women did not expect the general practitioner to be available after hours for non-urgent consultations why was it that they expected the midwife to be available she asked. Margie was aware of fulfilling her philosophical obligation that 'midwifery care is delivered in a manner that is flexible, creative, empowering and supportive' (NZCOM, 2008b, p. 3). She tried to be flexible but had her own life to live as well. She had to work out how she could gain back some control not only for some relief from call-outs that could occur at any time but to get some space for uninterrupted down time.

Kathryn tried to define clear boundaries about her availability for non-urgent calls and clearly communicated this to women. Sometimes setting boundaries did not always work which frustrated Kathryn. She explained: "*I got a text the other night at 10.30pm. It was just about an appointment. Ahh! I tell them not to text or phone after 5pm if it's not urgent*". It was important to Kathryn to be on-call 24/7. She set herself boundaries about when women could call her to provide some down time. This text could have woken Kathryn and broken her precious sleep. It was disappointing to Kathryn that this woman did not respect her need for privacy or sleep.

Lorraine had been committed to providing 24/7 on-call midwifery care to the point where her commitment had prevented her from taking days off:

When I first started case-loading I stayed on-call for births on my days off because I wanted to. So the women just saw me or sometimes my back-up. And I never missed really any births. You know just about 100% continuity. Then some years later I started working with another midwife, and we shared the case-load, taking alternate weekends off, and had two days off during the week as well. It wasn't long before I had women that were dissatisfied, and it wasn't that the other midwife wasn't any good, it's just that it wasn't me, I'd looked after them before, or they expected me. So more and more I was saying I'll be on-call for you, and before I knew it, I was on-call again. I couldn't find a good compromise between continuity and the right amount of time off-call.

Lorraine knew she needed time off but could not say 'no' to the women. She had good cover arrangement in place to have regular days off each week but gave up this arrangement and went back to being on-call 24/7.

Evelyn also identified that her life had become unbalanced. Her midwifery work started controlling everything she did:

I used to go out to help with breast feeding at all hours...and then I realised that I'm not going to be somebody's only possession and their territory because I realised that I've got to have a life...for me I need to do things for me outside of midwifery.

Evelyn had got so tied up in what she was doing that she had felt that she was no longer in control of her life and felt that she was 'owned' by the women she cared for. She felt she had no life outside of work. Evelyn had allowed women to think that she was at their 'beck and call' any time day or night.

Like Evelyn, May felt that some women thought they had ownership of the midwife. She shared: "*The downside of course is the fact that the women kind of own you. I think you have to get that balance. And that's what we need to explore*". For May this 'ownership of the midwife' was a negative side of having your own case-load. It seemed that midwives could be trapped into becoming the woman's possession. May was keen to find out more about how to maintain a balance between availability for women without having them dependent on her being there. May, Lorraine and Evelyn could not say 'no'. Their lives were controlled by their 'on-call' status. They found it difficult to define a boundary between work and their personal life. They did not have personal autonomy. Their midwifery culture had shaped their thinking to be one of always being available.

In partnership the woman brings the knowledge of her body and her needs and the midwife provides the professional knowledge to meet the agreed care provision (Guilliland & Pairman, 1995). We discussed how we understood partnership as a relationship: a two-way sharing between the midwife and the woman. Evelyn felt that some women were not ready to take a shared responsibility for their care:

But we have a lot of women who, if we are to reflect on the partnership model for instance, that we have a lot of people that aren't at the point where they could work in a partnership model. That's not their thing. They're not used to sharing that responsibility, not used to having to think about the care, but they want it to be handed to them. So when they're given the opportunity of having a midwife 24/7 I think that's where a lot of midwives run into problems, is that they don't know how to respect those hours, and if that midwife does need some time off, they don't understand why she's not available.

Evelyn expressed that to work in a partnership model both parties needed to have an understanding of what was expected of the other and fulfil the criteria. Evelyn knew that it was the midwife's responsibility to negotiate this arrangement. One of the four competencies

for entry to the Register of Midwives is that the midwife promotes each woman's right to empowerment. "The onus is on the midwife to create a functional partnership" (NZCOM, 2008b, p. 5). However, she found at times she could not achieve a working partnership relationship.

We talked about how we struggled to work in partnership with women to meet our understanding of partnership and the woman's expectation of care. Many times Janet has had women say to her: *'yes it's fine that you have days off but just not when I'm due'*. We needed to negotiate a partnership around each woman and her particular needs and life experiences. Some partnerships were highly functional in our practices and some were limited. Skinner (1999) referred to the midwife as a 'paradigm broker'. When providing midwifery care the midwife negotiates different ways of knowing and understanding. Pairman et al. (2006) acknowledges the complexity of midwifery. Pairman discusses how there is a need to understand that power relations do exist and the midwife is to "work to keep her own power" (p. 76). Despite knowing this for Evelyn and others of us we fell into the trap of allowing the women to feel they had ownership of us.

Kathryn found that as the pregnancy advanced and the relationship with a woman deepened it was harder for her to take time off-call:

In that we do, um, kind of want to be there for them to some extent, as much as... 'cause that's the problem when you have smaller numbers, you, the midwife also has a relationship. You do want to be there to follow it through for the job satisfaction.

Kathryn developed a close bond with her clients and wanted to be there to protect them:

We try to have a weekend off a month each, but again we are a little bit flexible. And as I said unfortunately I think we are a little bit, well, protective is probably one word I'd use of clients.

Kathryn was protective of her clients. She had formed such a close bound with them that she was willing to give up a day off to provide their birth care.

Rachelle felt that women placed unrealistic demands on her:

So it seems like not much time off (one weekend a month). It's not really. But then if you're not here this weekend and you're not here this weekend, then you know, people just say, oh you're always having time off...I get angry when they say that but don't say anything. Like if you're only seeing them monthly and you've just had a weekend off when you saw them last time, and you're having a weekend off when you saw them again next time, then they think it's quite often.

Rachelle tried to take about one weekend off a month. The women seemed to think that this was a lot of time off. Rachelle became angry about this as she did not understand why the women could not understand that she needed to have some time off-call. She despaired:

I think it's quite funny because they look at the midwife as if you should be doing what they want, when they want. Or you tell someone that you're going to be seeing them a certain day and you're delivering a baby, and they expect you to be there. But you can't be. Well, like when I was delivering one day and a woman rang me at two in the afternoon and said you were meant to come today, I'm having trouble breast feeding. And I said, well I'm at the hospital delivering a baby, and she got really angry about that. And I just thought, I was with her for 17 hours in the hospital as well, surely she should know (how it is). I don't know, maybe respect for other women who are also having babies, but they just think they're the sole person that you are focussed on and that should be how it is.

Rachelle's clients mostly saw her. They became dependent on Rachelle and expected her to be always available. They seemed not to realise a midwife had other people to care for and her own life to live as well. Although Rachelle would have offered for another midwife to visit this was not what the women wanted. The women wanted Rachelle to be there.

In trying to meet the ideals of partnership we needed to recognise that a woman's choice is shaped by her social and cultural values and beliefs (McAra-Couper, 2007). Women and midwives live in a society influenced by a culture of consumerism, neoliberalism, and individualism. Choice, the central ethical tenant of feminist movements in the 1960s and 1970s, merged with a neoliberal promotion of consumer identity of the 1980s and 1990s (Craven, 2010). An era of consumer rights as opposed to women's rights emerged. A society where women had a choice and that choice was always the right choice. Women considered that services were there for her convenience and ease. In this light some women may have interpreted partnership as a possessive relationship: as an individual contractual agreement rather than the intended social contract of negotiation (J. Skinner, 1999).

Recreation and social needs

Most of us usually did get cover for important social or recreational events. But on a day-to-day basis those who did not have access to regular and planned cover just hoped they could achieve both work and non-work activities. Lorraine just accepted the fact that when she arranged to meet friends she still needed to answer her phone. It was something she had to do. She said: *"When I meet with my friends for coffee I often have a phone call and texts during the time. It must be annoying for them as I have to answer the calls in case it is urgent"*. Lorraine wondered if her friends thought she was being inconsiderate when their

conversations were interrupted by a phone call from a client. Lorraine was always available for women to contact her. Section 88 (Ministry of Health, 2007) requires that the midwife or her arranged back-up will be available at all times. She lived her life always being available. Lorraine felt she had no choice but to answer the phone.

Bronwyn discovered her passion for continuity conflicted with enjoyment of outdoor recreation. She explained: *"I have outdoor sports I want to do now so that's sort of a priority. But I do love the continuity of care"*. Bronwyn was at the point of deciding what was most important in life for her. Providing on-call care or having employment with regular work hours.

Others of us were placed in a similar position of choosing between our perceived work expectations and meeting our need for social and recreational activity. We talked about the dilemmas we faced choosing between work and private life, we wanted to try and work out what we could do to reduce this conflict. We constantly faced a threat of disappointment if we missed a planned event. We were committed to providing continuity of care to women. To be spared disappointment some chose recreational activities that were more compatible with on-call work. We had no 'normal work hours' or 'predictable' time off when we were on-call 24/7. We all wanted to get some order into our lives to manage our 'on-call' lives better.

Cherry realised that a work-life balance was just not happening for her. Her social life was suffering. Cherry talked about how her limited social life was starting to overshadow the satisfaction she gained from caring for women: *"I started declining invitations to go out. I get less invites now. I find I don't travel far from home because I'm expected to be near the hospital for an urgent call-out"*. Cherry had isolated herself from friends and the opportunity to have fun and relax. She stayed close to home because of her need to be able to attend women whenever they may call. She seldom arranged for someone else to cover her. She knew they had their own work to do and their own personal lives to work around. Besides she felt that she should be there for the women in her care. She decided she was not willing to take the risk to go too far from home. She adjusted her life around her work and this made her unhappy.

Prior to the 2007 Section 88 amendment the LMC was required to be available within 20 minutes of the woman arriving at a birthing facility (Ministry of Health, 1993). This was changed to read “the LMC must make every effort to attend, as necessary, during labour and to attend the birth, including making every effort to attend a woman as soon as practicable” (Ministry of Health, 2007, p. 1067). May recalled a complaint made against her by the core staff because she was not at the birthing unit within 20 minutes. Although the time frame of 20 minutes had been removed from the contract this type of bullying attitude remained. We were all very aware of our responsibility to be at the facility as soon as possible. This impacted on how we went about our social and recreational activities and what activities we could choose to do.

Physical and emotional well-being

The on-call nature of our work was affecting us physically and emotionally. For many of us a day off-call was infrequent. At times we would work long hours providing birth care pushing ourselves to the limit physically. We could become totally exhausted. Often we ate irregular meals with fast food sometimes the only option. Some midwives spoke of weight gain and others were unable to have regular exercise. Others felt they had already reached the point of burnout. Burnout had insidiously appeared in some of the CI midwives lives.

Skye was exhausted. She stated how she was burning out: *So I haven't had any cover for the six years that I've been doing it... And yeah I'm pretty burnt out... Yeah I'm pretty wasted.* Skye was committed to caring for women on-call 24/7 and for six years she had stayed on-call. She worked in a practice where back-up was not always available. So at times had no option but to stay on-call for her case-load. Skye recognised she was at the point where she would have nothing more to offer if she did not do something soon. She wanted though to provide one-on-one continuity of care.

We read earlier of Lorraine's inability to sustain taking regular days off because she had clung to the belief that she should be there for women. Lorraine felt she was disappointing women if she was not there for them: *So it becomes unbalanced when we feel we're indispensable, in the sense that we feel that we have to be there. Or we feel guilt because we're not there.* Lorraine had felt that women were disappointed when she was not available so she stayed on-call 24/7. She was trying to meet her own expectations and those she

thought her clients held. Lorraine talked about the guilt she experienced if she was not there for a birth.

Margie also punished herself with guilt:

You know when you work on your own, and it's your weekend off, and you get to the end of the weekend and the phone rings, and you think, how many women are in labour that I've got to go and look after? How many women have given birth over the weekend and are now cross at me because I wasn't there? And the guilt. I feel like one of those women with a thing that they flog themselves with. I wasn't attending her birth, I'm a bad midwife. I've got to be a mum and a wife as well as a midwife. There's got to be more room in my life than just one role.

Having a weekend off was great to have but Margie dreaded turning her phone back on anticipating guilt for having deserted the women in her care. Being a midwife on-call for women had overtaken Margie's life.

Margie thought the case-loading midwife's ego could be part of the problem:

And I also think a lot of midwifery is ego based as well. That we are the ones, we're there, we look after these women, they're 'my clients', they're 'my women' you know. But we are 'oh look, I'm indispensable'.

Margie suggested case-loading midwives like to think they are the special person that made all the difference.

Cherry had her own case-load but worked in a group for cover if she needed it but seldom asked for help. She loved the autonomous way she could practise. This was a workable arrangement as she provided most of the care for her clients in a way that suited her. Cherry soon realised her vulnerability when she was faced with a health need: *"I needed to have a surgical procedure. So I'm thinking, well, who am I going to ask to cover me, because everyone in my group, they are all so flat out?"* Cherry's commitment to 24/7 on-call care had meant she had isolated herself from her group. She just got on with the needs of her own case-load day-to-day. Then when she did need back-up she hesitated in asking for help. Everyone, she thought, was too busy.

Driven by guilt Cherry kept on being available 24/7:

...all that year I never handed over because I had the feeling of guilt, I didn't want to. I felt protective for my women, you know, I felt like I had to be there for their births. But in a difficult moment, it must have been a burnout; I couldn't manage any more emotionally. Looking back on it now, I did feel that I was being irresponsible, but I felt an even stronger need to protect my case-load.

Cherry wanted to protect women. Cherry was working excessive hours at one time because guilt made her reluctant to handover care. Then she suffered guilt from feeling she had not met the woman's expectation if she did handover care. Cherry explained she had guilt because she felt she was deserting the woman; guilt because the unit was already under staffed and it burdened them; and guilt because the woman would have someone caring for her that she did not have a relationship with. Her personal life was threatened and her practise unsafe. Cherry's obsession to be there for women had led her to believe that women depended on her alone for their emotional support and knowledge for decision making. Cherry believed she was the only midwife who could best meet their needs. Guilt compelled Cherry to work long hours with women and never handover care. In her effort to shelter the women from harm she pushed herself to the point of burnout. Cherry had a growing realisation that the way she was working was crowding out her personal life. Some of us shared this same experience and were in a downward spiral, working harder until we would have nothing left to give. Work was getting our full focus. We were emotionally drained.

Margie was concerned by what she saw. She felt that women placed unreasonable expectations on her:

I mean I couldn't have continued in midwifery. It was doing my head in. I just couldn't do it anymore. And I don't think the women realise the demands on us. They've only got one midwife and we've got 50 of them. And to try and remember everybody, and then they get upset cause you don't remember who they are when they ring you, and they don't say who they are, you're supposed to recognise their voice.

Margie could not carry on. She was becoming antagonistic toward the women in her care. Young (2011) found that a negative attitude toward women could signal burnout. Margie displayed feelings of being trapped in a care provision she no longer enjoyed.

Exhaustion created an issue of safety. It destroyed the pleasure of Lorraine's work. Yet Lorraine remained driven by her commitment to provide continuity of care. She just carried on hour after hour. Lorraine related the unpredictable nature of the work and how long the hours of attending a woman in labour can be:

I was called by the hospital, as the woman who was being induced was now in labour. It was 10 pm and I had managed to get an hour of sleep. It was a Saturday evening so going to bed early was pretty boring but I wanted to get some sleep in case I was up all night. At 1.30 am I had a call from another woman who was in early labour. She wasn't ready to come in yet. At 3 am she turns up at the hospital. Although not in established labour she stayed in the hospital to use the bath to help her relax as she didn't want to go home. The first woman had her baby at 6.30 am and I was able to finish caring for her by the time the second woman needed one-on-one care. She was

progressing slowly so an epidural was sited and her labour was to be augmented. I was feeling extremely tired but there was no back-up midwife available. One colleague had the weekend off and the other had also been up in the night, but at another hospital. I had discussed the need to handover care to the core midwives. They had no staff available until 1.30 pm.

Lorraine spent the whole day anticipating being called into the hospital to care for the woman being induced. Everything she did in that day would have been determined by this. She would not have been unable to make any solid plans. There would have been no outings that took her too far out of her area. She went to bed early on a Saturday evening, probably reluctantly, instead of enjoying her Saturday night. She was called in. Another woman also went into labour. Lorraine's practice back-up midwives were not available. There were no core staff midwives available to take over the care. Lorraine had no choice other than to push on until a staff midwife was available. She worked nonstop over the 15 hours she was at the hospital even though she was exhausted and feeling unsafe. Lorraine was dedicated to providing continuity of care but the support systems had failed her. She was left in an unsafe situation.

This exhaustion could carry over into the following days:

I think of the times that I've worked all night, and I've done a clinic all day, because it's too hard to cancel the clinic or get someone else in. They all expect to see me. And they're all so thoroughly disappointed if you phone them and change the clinic, and then where do you find another time to see them. And I felt so exhausted. And I guess it's that feeling of continually feeling exhausted. And sometimes I've had a busy case-load, but usually I've had about say six women a month, which is a manageable case-load.

The perpetual exhaustion and working when she should have been asleep was something that Lorraine no longer wanted to carry on with. Her constant tiredness was creating an unsafe environment. There is no regulation from the NZCOM about how long a midwife should work without a break or when she should have time off. It is left to the individual midwives (Guilliland, 2007). The *Health and Safety in Employment Act 1992* (Department of Labour, 2011) and the associated regulations have no maximum working hours specified for self-employed workers. There is no specified length of shift, no specified length of rest time between shifts, and no specified length of time before a case-loading midwife must have a break. It is up to the midwife to decide when she is no longer able to work safely due to fatigue. Literature informs us that New Zealand midwives risk burnout when they are committed to being on-call working unpredictable and sometimes long hours at a time (Brodie et al., 2008).

Tiredness affected Lorraine's safety when driving in the community to do visits:

What I find hard is the continual feeling of being tired. When I'm driving around doing home visits I sometimes have to 'will' myself to stay awake. I'm like a robot going through the actions. I can't think straight when I'm like this.

Lorraine even if exhausted would visit for the sake of continuity of care rather than calling another midwife in. Where does continuity of care finish and safety begin? Not just safety for the woman but safety for the midwife.

The CI midwives not only talked about being sleep deprived but some struggled to keep up regular fitness and healthy eating patterns. Rachelle had all the best intentions in the world and wanted to exercise and eat well to control her weight and feel healthy:

Before I started being on-call for women I was doing regular exercise. Now I hardly ever get to the gym. Not only that, last week I had to buy take-away food five nights in a row because of the weird hours I'd worked.

Before case-loading midwifery Rachelle had been able to have a regular exercise routine but now she found that almost impossible. She lived a life where there was no guarantee that she could attend the gym when she hoped to. Being home each evening to have a meal with her partner was not guaranteed. She was not saying that she was really busy but rather that her hours were irregular. They were unpredictable, for example, one day she may have been at the hospital from the early hours of the morning and then another day called out in the late afternoon after doing home visits all day. Rachelle was not only unable to get to the gym because of her work hours but had to settle for fast food the previous week. She worked at times that made it impractical to prepare food. Even if she did cook a meal there was no guarantee that she would get to eat it. Even basic requirements in life, like eating, sleeping and exercising, could be a challenge.

Rachelle had a fear of losing clients. She was afraid she would let them down if she was not there for them:

And in my dream it was the fact that I hadn't seen her for her last visit, so she'd rung someone else to deliver the baby. She expected me to be there (for all her visits) and I wasn't, so she ditched me. That's what my dreams are like.

It played on Rachelle's mind. What if she disappointed her clients? Would they leave her care if she was not always there for them? Rachelle and other CI midwives were denying their right to healthy living and a sound mind for the sake of continuity of care. While Rachelle wanted to provide woman-centred care she thought that it appeared women wanted 'woman self-centred care'.

Rachelle was also losing sleep worrying about when she was going to get called out:

I think it's quite hard. Even though like some weekends and after work I don't have to do anything, like there's no work to do, but I'm still on-call and I'm still anticipating that something might happen, so I've not been sleeping the best.

It was not about just working long hours and being up all night at a birth preventing Rachelle getting enough sleep. Rachelle lived in a constant state of anticipation not knowing when she would be called out. She stayed on-call 24 hours a day for long periods at a time with only occasional time off-call. The 'not knowing' when she was going to be called was stressful for Rachelle. This state of uncertainty disturbed Rachelle's sleeping pattern.

We realised the impact that being on-call had on our lives. Sharing our day-to-day experiences reinforced our need to make change and helped us realise what was important in our lives. We started a negotiation process about what we would be willing to change or modify in our work so we had more guaranteed time for self-care. Some CI midwives realised that their commitment to work was driving them to the point of burnout. Some already knew that they could not provide continuity of care unless they had regular time off-call. Others still could not imagine providing LMC provision without being on-call every day of the week for weeks on end. We were all faced with the possibility of working long hours without a break. A continuity of care ethic of working on-call was so embedded in our thinking that some experienced guilt when taking time off-call. We knew 'self-care' was important yet we still struggled to handover care to a colleague when we had worked long hours. We needed to recharge emotionally and physically to stay safe. As we reflected and talked we were beginning to make change. By questioning our practice we were beginning a process of intervention: of bringing a better balance into how we provided continuity of care.

Summary

The ethic of being continually on-call exerted an insidious power over our lives that prevented us from producing safe boundaries. We relished the positive aspect of our professional responsibility to continuity of care but realised that being on-call created a tension in our lives. We struggled to maintain a balance between our work commitment and our personal lives. The relationship we built with a woman was an important feature in our work. Yet the way we provided on-call care to achieve this relationship could also work against us affecting our well-being. We had reached a point where we needed to make changes in our practice to create a better balance in our lives.

The following chapter looks at the change process. We needed to examine our assumptions about our motivations of how we provided continuity of care. We chose to take action to define the boundary between work and life with a focus on how women could be empowered to take ownership of their care.

CHAPTER EIGHT

Action change

If I am to have a sense of belonging in a social reality, then it is not enough for me merely to have a 'place' within it: I must also myself be able to play an unrestrained part in constituting and sustaining it as my own kind of 'social reality', as not 'their' reality, but as of me and my kind, as 'our' reality. (Shotter, 1993, p. 15)

Chapter seven highlighted the commitment we had to providing continuity of care. Despite the fulfilment in our work through the relationships we developed with women, we struggled to achieve a balance between our personal and work-life. We wanted to make this better. We wanted to make changes to provide continuity of care in a way that provided us with clear boundaries between work and our personal lives. Our aim was to retain the positive features of continuity of care: the enriched experience for the woman and the midwife but with an improved balance between work demands and our personal lives. This chapter describes what the cooperative inquiry process enabled us to achieve in working toward this goal.

We discovered the beginnings of a positive revolution of change which was enhanced by using aspects of appreciative inquiry (Cooperrider & Whitney, 2005). In the reflective stages of our action research cycles, using the appreciative inquiry tools of discovery, dreaming, design, and destiny (see chapter five) we collaboratively debated and built on the positive aspects of our practice. We acknowledged the satisfaction we got from the relationship we formed with women. Working on-call had created a negative effect on our personal lives. We began to dream and design how we could make a difference. We wanted to take control of our destiny. We addressed our assumptions about how we practiced to make it work.

Theme: Changing our assumptions

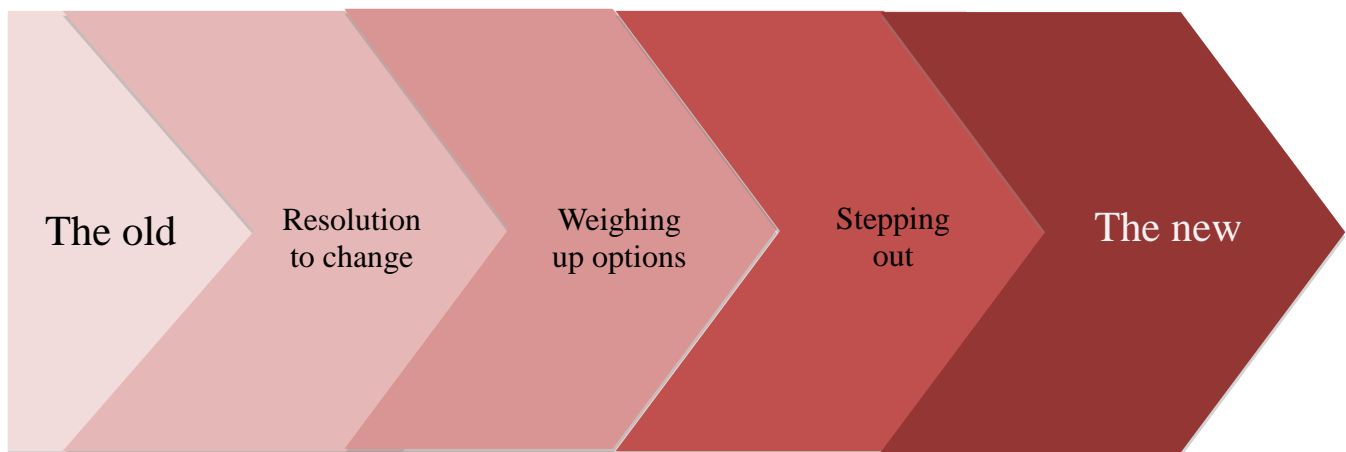
The data in this chapter has the underlying theme 'changing our assumptions'. It is supported by three stages (see fig. 11):

- a resolution to change
- a weighing up of options
- stepping out

Making action change involved changing our assumptions about our midwifery care. We found remodelling our assumptions was imperative to achieve change. From our past experience we discovered if we did not make a shift in the premise on which we practiced then we ran the risk of not being successful in our change. The first step for taking action was

to make a firm resolution to begin the process, no half-hearted decision. Some of us were suddenly halted in our tracks realising we needed to change how we were working. Others of us had been working incessantly on-call and came to a slow realisation. Yet others just knew that they could not work on-call for long indefinite periods of time. For some of us to sustain working on-call we felt the need to have planned and regular cover off-call. The remainder of us sought ways to streamline how we were working to create more down time. Before we could step out to make change we all needed to sort out our priorities and weigh up the options about the best action for us to take. By asking questions about how and why we worked and what we think would be better we had begun our change process.

Figure 11 Changing our assumptions



Stage One: A resolution to change

We examined our assumptions about our care for women as we worked through our resolution to make action change. This was a fluid process open to adjustments along the way. It was like venturing into unknown territory. This reflective process meant leaving a secure but also precarious way of thinking to find a more balanced way to practice. Some made changes within their current group structure and others totally changed from being a 24/7 individual case-load practitioner to practice in a team providing continuity of care with a shared case-load. Our resolution to change involved the initial decision to change and a sorting of our priorities.

Making the decision

Some of us had an epiphany moment that turned us around in our thinking. We read in chapter six how it took a visit to the doctor for Cherry to realise her life was out of order. It was not the diagnosis but the realisation that she had an out of control compulsion to stay on-call for women no matter what she was doing:

I even found it difficult to attend a doctor's appointment for myself as I have always put my workload first and often had to cancel it as I could not predict what could happen on a regular basis. During a spot check at the doctors which I finally put on my priority list, my mobile phone went off. I felt so embarrassed that I had to interrupt the doctor who was concentrating with his magnifying glass over my eyebrow and apologising to him by justifying that I am a midwife.

Cherry was driven by such a strong passion to provide continuity of care and gained such great personal reward and personal satisfaction that it left her with nothing else. No life and poor health. Cherry had allowed her commitment to women to overtake her drive to have any personal space. She no longer took time off-call to do things that she needed to do.

Lorraine had been unwavering from the outset in her belief of 24/7 on-call continuity of care as the ultimate care provision. She had been practising like this for many years. Then one day Lorraine had an 'aha' moment. She was jolted into getting her life into perspective:

I was overseas telling my midwife friends about how I worked. Their reaction was of complete, well almost, of horror. Their mouths dropped open. They said 'why would you want to work like that?' I thought everyone would share our passion. They told me they were passionate about being on-call but they also respected that they needed time for a personal life as well. Their reaction made me really think about how I practised.

When overseas, Lorraine met with a group of midwives and proudly she told them of the amazing care provision in New Zealand and how she worked on-call for women in her care. The other midwives were confounded at what they thought was an 'over the top' way to work. Lorraine had thought that people did not work 24/7 on-call because they did not have the infrastructure to support working like that. No, she found out they did not work like that because they chose not to. Lorraine had assumed everyone would think like her. It made her consider what was of importance in life. She began to reconsider her premise for continuity of care. This counted toward setting new priorities in her life.

Margie had no choice but to make the decision that working 24/7 on-call without regular days off was not suitable for her. Margie suffered burnout. She could not balance the pressure of home-life with the demands of being on-call in this manner:

I had a 'burn out' and time off. And I needed to do something so that I could say this week I'm not on-call. This week we can go out for drinks with friends. This weekend we can go away because the phone is not going to ring every two minutes. So we came up with a structure where we work alternatively, first on-call, second on-call, and we have the third week off completely. And that's how we work.

Robyn wanted to provide LMC care but knew she could not be on-call 24/7 without regular time off:

So I just happened to be thinking the same as two other midwives that I knew. One of them said that I could do that (be an LMC), but I knew I wasn't going to be continuously on-call 24/7, I don't want to do that, but if I can do something where I know I've got regular time off, I'll do it. And another midwife was ready to throw it out the window.

It worked out well for Robyn. She was working day shifts and felt she would like to provide LMC on-call care but on the proviso that she had regular days off-call. She was in a situation where she knew other midwives who wanted to change how they were working. They decided to work out a way they could work in together.

Rose also knew she did not want to do LMC work without regular days off:

And I've seen a lot and experienced a lot of people with burnout. And in those situations it's very much like 100% commitment 24/7. And I've seen enough and experienced enough personally to know that I can't sustain 24/7 sort of, on a permanent basis, and that I need to have time out.

Rose had decided to take on a case-load but knew she needed regular time off-call. She knew the value of time for herself, time spent with her family and time to emotionally recover from the demands of providing midwifery care at such a critical point in the life of a family.

Janet, however, was resigned to work long periods of days and weeks on end on-call but felt there must be a better way to manage her routine day-to-day activities:

...so my ambition is to not see women as often antenatally. I've always done visits religiously every four weeks, until 28 weeks, fortnightly from 28 to 36, weekly from 36 until they have the baby. And somehow I got to wondering why I do this.

Janet had been following routines as she had always done. It finally occurred to her that this did not mean it was the right way to do it now. She realised that she could improve her daily routines to free up more of her time and still meet the woman's needs.

Sorting priorities

Margie was certain that firstly we needed to get our priorities sorted:

We actually need to say, no, I'm looking after myself, or no, I'm being a mum today. And there's nothing wrong with that. And also the other thing is that we need to

model to a lot of women how to be a good mum. And if being a good mum involves taking half a day off cause your kids are sick, that's what you do. That's what I'm finding.

It concerned Margie that we were not setting a good example to the very people we cared for. If we did not care for ourselves there was no one else who was going to do it. If we did not define our own boundaries we would lose our balance. Protecting our private lives was a priority if we were working on-call. We needed to know what our boundaries were and find a way for work to fit in with our personal needs and not make the on-call nature of our work the priority.

Working 24/7 on-call had robbed Margie of her family and them of her. Margie was setting this right. She was making new priorities in life:

My husband's already finding the benefits of that (having regular weekly time off-call). My son certainly is and my youngest doesn't know any difference. This is going to be his life, but it's nice to know this day I can actually take him out of crèche and be at home with him because nobody's going to call me. And it's the most liberating experience.

The only way for Margie to return to her passion of LMC work was to work in a team. She could not sustain working 24/7 on-call with her own individual case-load. She had to reshape her thinking of continuity of care. Margie was able to start afresh. She was revelling in the freedom. She was liberated from a way of working that had imprisoned her.

Lorraine finally realised she needed to change her priorities if she was going to take regular time off. *"It wasn't until I came to a complete change in my thinking: just realising that it just wasn't good for me to be always on-call. Then I was able to take regular time off and not feel guilty"*. Lorraine found she could not take days off until she had a complete turnaround in her thinking. She had to stop feeling indispensable with the need to be always on-call. Having regular days off meant she could catch up on sleep and her home responsibilities. It meant she was refreshed when she was working. Once Lorraine changed her expectations about her availability she could clearly communicate this to the women in her care. She no longer experienced guilt if she was not there. Change did not come about simply by recognising her work-life balance was at risk. It required making a decision that was supported by new beliefs of how she could practise. These new assumptions gave her new priorities that guided her change.

Joan was forced into making a change in how she practised when she realised her practise was unsafe:

I was practising on my own really and one January I was extremely busy. It gave me a fright especially when I couldn't manage. I had some unexpected birth events and had to call in others to help. I was not safe.

Joan called on others for help when disaster struck but she learnt from that. She decided that safety was more important than her feeling she had to always be available. “*I now take regular time off each week; I work in with another midwife. I have a smaller case-load. I even have time to go to the gym and have time to get a haircut*”. Joan learnt to say ‘no’ instead of just taking on more clients. Joan was not doing anybody a favour by working beyond her physical capabilities. She put safety as a first priority.

Stage Two: Weighing up the options

A deep seated commitment to 24/7 on-call continuity

We weighed up our options of what changes we could make in our practices to meet our changing beliefs about care provision. We sought a way to combine continuity of care with suitable time off-call arrangements. We wished to provide continuity of care to meet our professional obligations (NZCOM, 2008b) but also protect our personal well-being. We had to consider the effects on the woman's satisfaction, our personal satisfaction and on our professional requirements. This stage was like a bargaining process. If the midwife chose to do something one way or another, what would she gain or lose?

For Skye there seemed no ground for negotiation. She believed that the LMC midwife works seven days a week on-call. It was a belief in a vocation, like being in a religious order: she had a special calling to work in this way. Skye had developed a practice that reflected who she was. It gave her status. She feared losing this special status:

I feel really torn about it. I don't particularly want to share a case-load. I really enjoy that. I get a lot from that one-on-one relationship. My role is my identity. I'm sure that's how it is, whether it's good or not, I don't know.

Skye described her feelings of being ‘torn’. She was torn between the need to have down time for herself but at the risk of losing her identity. Somehow her identity was tied up with being a midwife providing one-on-one care. She thrived on the relationships she developed with women over the months. The sharing of the intense joy of the new-born cry, the moment of new life, not only as the health professional but as the trusted mentor, friend and companion who has shared the journey. She derived great satisfaction from her commitment

to women and the one-on-one care she provided. How could she work any other way? It would destroy what is so special to her. Skye wanted the close relationship, a mutual sharing of the experience, a deepening of a relationship to bring a richness to life that can only be gained from being 'with women' when it really matters. She does not want to share her case-load with another midwife. She perceives it would dilute the relationship. Maybe another midwife might have different views, a different standard of practice. Maybe she even feared the woman might prefer the other midwife. 'Her' women remind her again and again of who she is. To change her mode of practice brought her a fear that she would lose something of 'self'. Skye faced a dilemma about what she should do.

Bronwyn was unsure about continuing with a case-load:

I've got to think really carefully, yes, I want to have a small case-load, but again I'll be on-call so I need group cover. Now if I'm minding my grandchild, you know, I'm going to have to have someone on-call to cover if I'm called to a birth. So it's quite a hard one because you want to keep your practice up, plus you want to be a grandma. But I do love the continuity and taking a very small case-load.

Bronwyn felt she had to make a choice between being on-call for women or to be there for her grandchildren. The call to midwifery continuity of care was a strong passion that she was drawn to. She despaired that she had to make a choice between the two.

Kathryn had worked 24/7 on-call with no regular time off. Soon she felt she would need time off on a regular basis:

I am really looking at the lifestyle now with weekends to spend with the grandchildren. One of the part-timers in our practice, was full-time, that's why she cut it back part-time, and went on teaching, because she wants to be more available (to her family).

The uncertainty in life for Kathryn was now becoming too much. She knew she had to start planning for a lifestyle where she would be available for grandchildren. She could not see case-loading practice to be compatible with her on-call midwifery work and family commitments. Her colleague found a teaching job to get regular hours. Kathryn's philosophy of continuity of care demanded her to be available on-call for the women any time, day or night.

Kathryn shared how she felt working in a group and taking regular time off would be too much of a compromise to her commitment to women:

When I can't stay on-call for women 24/7 any more I will work in the hospital. People have come to me the first time, and had expected me there the whole time.

And then, the second time, I would kind of want to be there because that's the way it was the first time.

Kathryn considered that providing continuity of care prevented her from having frequent and regular days off-call. Kathryn only had one option. If she were to have regular weekly days off then she would need to return to hospital work. What compels midwives like Kathryn to work incessantly 24/7 on-call putting the woman's needs before their own? Is it something from the midwives' inner core? A 'calling' that is from deep within? It has been said that man exists essentially for the sake of others (King, 1964): so is it simply about a call to being-in-the-world-with-others?

Rachelle considered what it would be like working in the hospital setting:

Well, I don't think I'd like to work in the hospital, because that's not really continuity of care, and I don't think, when I did stints in the hospital, it was kind of like you'd meet people you'd never met before, playing some sort of role in them and their babies lives, which is quite a special time, but then all of a sudden, you know, you just disappear and somebody else comes along...I think some women get upset about this.

Rachelle did not like the disjointed and impersonal care the women received in the hospital setting. She did not like providing care in this context. Returning to the hospital setting was not an option for Rachelle.

Choosing healthier ways to provide continuity

Mary feels a release both emotionally and financially. She took the option of working in a team. She could not sustain working 24/7 on-call any longer:

We've been doing that since August (6 months). And it is so good. We share everything: pay comes in, a third to each bank account. We work through issues as we come to them. We know when we're off. I know when I'm off next year! Our annual leave, we plan. We did a little bit of jostling over that, and 'to-ing and fro-ing' and deciding when we're going to do it. We meet all the women and take turns at being on-call for their births. We have six weeks each off each year; we take them in two, three-week blocks. We just block out six weeks, usually around February/March, six weeks around August/September, and we take turns at taking three weeks off at that time, so there's always someone for antenatal and post-natal visits. We don't technically book anyone at that time. And so we're making that very structured, so we each know when, we've got time off. And it's just so amazing!

Mary no longer had to work for long periods of time on-call. She could get cover for sleep. What a joy not to cancel and reschedule clinics or do community visits after being at a birth all night. She had no financial concern as they equally shared their income. She was enjoying her contact with women and enjoying her time off. Now she was in a group she was able to

‘catch her breath’. The three midwives in the group met and got to know all the women in their care. She had become a safe practitioner.

Cherry was not able to set boundaries until she had a dramatic change in her thinking. She made her decision to change and immediately she felt the benefit of her decision:

I felt like I had to be there, and I felt fantastic satisfaction, if I delivered them you know, but I didn't have a life. I did not have a life. No social life. I wasn't invited to parties. I couldn't go out of the city. I couldn't drink. Now I'm starting to handover the care. I feel like it's better for the women as well, because they can trust their body more, rather than trust the midwife.

Cherry's situation now was quite different despite it taking a long time before she recognised the limits it had placed on her life. Life was back under her control. Cherry was taking two days off each week and handing care to her colleagues in the team.

Others, like Robyn, always knew they could not provide continuity of care without taking regular days off:

I love what I do but I can only provide LMC care if I know I have regular days off each week to spend with my family. My family need to know when I can be available for them.

Personal autonomy was important to Robyn. She was quite clear about needing time off and would not work 24/7 on-call. Like Kathryn, Skye and others she was driven by a strong belief, not her commitment to midwifery but her commitment to self and to family. That was what drove her, not her tie ‘with women’. Robyn was applying continuity of care principles to her practice, negotiating it around her family commitment. The women were well informed of who her back-up was and women were satisfied with her care. Robyn found her days off allowed her to catch up on lost sleep and put some order into her life. To get enough sleep and to get sleep when it is needed was an issue in all our lives.

Stage Three: Stepping out

Stepping out to make an action change has three key elements to describe this process: letting go; empowered relationship; new attitude.

Letting go

To make a change the CI midwife had to ‘let go’ of the old ways. It was a letting go of how she used to think and do things:

I'm still working on letting go. Got to turn my phone off when I'm off-call, that is a real downfall, just turning the phone off at night. But I've started to do it.

Margie changed from having her individual case-load to working in a team. She had to 'let go' of the way she used to work. It was difficult just to turn off her phone. She knew she was still harbouring old feelings of being indispensable. If she continued to think like this then the feelings of guilt would come back. She had to trust her colleagues to be able to do the job as well as her. Going back to how she previously worked was not an option.

Janet 'let go' of some old ways which had released precious time that could be spent in other more useful ways:

In a subtle kind of way I'm now spacing them out a bit (antenatal visits). I'm following the NICE guidelines. A few of my mother's that I've looked after before, I could see them at five or six weeks and they don't want to come back until after they've had their nuchal scan, and it's like, wow, two months. I've always had this thing about wanting to hear the foetal heart as soon as possible but I'm learning to let go of that, and it hasn't been as hard as I thought it would be. It has already freed up my time which is good as I've had some extra visits to do for my midwifery partner who is on leave.

Janet was looking at her practice to find ways she could use her time more wisely. It was hard to change from the same routine for antenatal visits that she had been using for the last 20 years. Through discussion with the women Janet tailored her visits to suit each woman in her care. She was guided by the six decision points in pregnancy as recommended by our professional body (NZCOM, 2008b) and she researched the NICE (National Institute for Health and Clinical Excellence) guidelines for antenatal care. When Janet started practicing in the early 1990s not all women would have a scan even at 20 weeks gestation. Now most women are having a scan at 12 weeks as part of screening for Down's syndrome. To add to this they often had already had a dating scan. They had seen the baby on the screen and it was enough reassurance for them. Janet was pleasantly surprised that the women did not want to see her as much as she thought they would.

Rose knew she needed regular time off-call and had colleagues who were available to provide back-up cover. Even so Rose still felt compelled to be with women in labour. She admitted having trouble 'letting go':

I did have a situation where my perhaps most needy client so far this year, I had arranged for her to meet my back-up, cause I knew that I was going to have a weekend off. And she didn't get on with her. In the end it was that midwife who was on-call the weekend she did go into labour, which is such a shame cause I think that's one situation where it could have been really different had I been there.

Over time Rose had formed a relationship with the woman in her care. She understood the woman and her life's circumstances which is seen as important for providing safe care (Brodie et al., 2008). This woman had formed a trusting relationship with Rose. Rose felt it was important for her to be there as she knew the woman well. She was disappointed that she was away the weekend this woman went into labour. She was experiencing how hard it was to 'let go'. The back-up midwife had met the woman and was aware of her needs.

Rose knew from past experience that an LMC can feel indispensable:

And I think, I think about, like with seeing colleagues working overseas and in developing countries, I see people seeing themselves as indispensable and I'm at risk of doing that as well, and my colleagues as well. But this particular example reminded me that you might be very involved with people, but don't forget you're not indispensable and you can't be everything to everybody all the time.

To take regular time off-call Rose needed to overcome the feeling of being indispensable. In reflection she realised that the outcome worked out better for them both that she was not there.

Rose felt that the close relationship she had with the woman would have made it harder to be firm with her in labour and she would not have been able to take an objective stance:

But on the other hand, looking back, perhaps having become so involved in her emotional and physical needs, and her family, all sorts of things. Maybe that was really positive for me to be able to care for her better in her post-natal times, because there are times she may have been really grumpy at me, for a start, especially when she had such a bad experience, and it might have been a case where I would not be able to be so supportive because I would feel, oh no, she's had a hard time, and lots of feelings in that, emotions and guilt feelings, and feelings of pity but just perhaps I might have been a bit incapacitated to care for her well, if I had been at the birth as well. Do you know what I mean?

Rose found that when she had a close bond with women, as a professional friend (Pairman, 1998b), it was hard not to be on-call for her. Changing her thinking about the midwife-women relationship from a friendship basis to a professional basis i.e. 'professional to woman' not 'friend to friend' could work as a way to provide her with a boundary. From this experience she realised that if her care is solely on a professional basis it allowed more room in the relationship to provide the professional care required. It provided a greater distance from the client and she could be more objective, not only in her care but about having time off-call.

Kathryn spoke of the risk of the compulsion of always being there for others:

It's something that the nursing profession and perhaps the midwifery profession, the sort of people that go into it are maybe people who like to give and like to care. And there is a risk that, one of my colleagues from down country suggested that you have to be careful that your work and your care for people in pregnancy and birth doesn't become the only joy you have. If you don't have other joy in your life, or positive feedback then it's really hard to let go for a weekend off, or for letting someone else take care of one of your clients.

Kathryn knew she could not let her midwifery work dominate her life to the extent that she could not 'let go' to have time for her personal life. She felt that people who work in a caring profession are at risk of letting work take over their life. To work and have regular days off each week we needed to change our assumptions about continuity of care. One of these assumptions is that we are indispensable. 'Letting go' of thinking that we are indispensable helped us to overcome guilt.

Margie talked of how midwives can 'need to be needed':

Yeah, probably, I mean who doesn't enjoy being relied on to a certain extent, and having the answers when someone asks you. Maybe parents can identify with that, actually it's a nice feeling to be able to show kids how to do something. It's a bit of a wrench when they actually go off and do it on their own initiative and do it themselves. You don't have to do anything for them anymore. They don't need you anymore.

Margie drew comparisons of the midwife role being like a parenting role. We love to feel needed. We love to be the ones to supply the answers. We like the feeling of having others dependent on us. Margie felt that we had convinced ourselves we needed to be there for women.

Marie saw that our ego was taking our midwifery role too far. It was making it too hard to 'let go':

And it's quite a shift to go thinking they'll be fine with whoever looks after them. And I think that's a big issue as well for a lot of midwives. Especially when you've done it for a long time, because I think you get used to that sort of, oh yes you're wonderful, I couldn't have done it without you. It's a load of bollocks: of course they could have done it without that particular midwife. I think that's part of the problem too, we carry this ego with us.

Margie was saying that we needed to work under a different set of assumptions but that it was not easy to change. We could not continue to think we were indispensable to each woman in our case-load.

Empowered relationship

New Zealand midwifery has developed a philosophy of partnership, “a relationship of ‘sharing’ between the woman and the midwife, involving trust, shared control and responsibility and shared meaning through mutual understanding” (Guilliland & Pairman, 1995, p. 7). Rose experienced that at times it was difficult to work within a partnership model. She explains:

People like to be led. There's a few that don't know any different. In other countries it's 'cause they haven't been taught that they can question. Here, it's probably more I think that people want formulas. They want things to be reasonably easy and they don't want to have to sort it out for themselves. They want a formula to go by. And most people like an easy life really.

Rose found that people wanted to be led, not work in a partnership. If midwives are to work in partnership with women providing holistic woman-focussed care how can this occur when women want to be led?

Ellie agreed with Rose about the difficulty of working in partnership with women. She found that women relied on the medical profession and now they rely on midwives to lead the care:

But that's part of it. We have disempowered these women. Because they are now relying on us, like they were relying on the medical profession, to tell them what they should be doing.

Ellie felt that the one-on-one relationship had fostered a dependence rather than empowerment. A woman could become dependent on the midwife instead of being empowered. Ellie felt that we had led the women to this position of dependency.

As we reflected we realised the challenge of changing this dependency to empowerment to provide midwifery care as it was intended to be. We were to find ways to enable women to take responsibility for their own birth journey. Rose shared:

But I just wonder whether we shouldn't be teaching a lot more of women to rely on their own abilities in labour. And know their own body, and knowing that you expect this and this and this, but there are variations. To go much more with what you are feeling than what people are telling you to do. If you feel you want to move, you say so. If you want to, yeah, you do that. I think we've fallen into a bit of a restrictive mode, I'll tell you what to do mode. What to do at the time. Just trust me, and once you've got that trust relationship then everything will be fine.

Empowerment of women was for women to be able to take control over what happens to them (Robertson, 1994). We knew that it was our responsibility as the LMCs to facilitate empowerment of women. The more we talked the more we saw that being on-call 24/7 to provide one-on-one care to empower women can in fact create a negative impact on women.

Not only did continuous on-call availability affect our personal lives it also could impact negatively on the way we were delivering the care.

One of the reasons May came to this project was to explore ideas about how to empower women in their birth experience:

But yeah, I would like some ideas really, because, I guess what I was trying to convey, that if women were empowered, with both the information and the confidence before they actually hit the time of delivery, then I sense they might still miss the trusting relationship with their midwife, but if they've got the goods, they can get on and do it themselves.

May was saying she needed a new way to empower women in her absence. The way she had been providing continuity of care had been to create the women to be dependent on her rather than facilitating empowerment. She felt that her presence had been crucial for the woman to feel safe. She wanted to change this dependency status that she has created.

Our group conversation was centred on how many of us had fostered the expectation that we would be the midwife at the birth. Now we realised we needed to equip the women to be reliant on their own resources rather than be dependent on a single caregiver. Rose shared: *"I think that does happen. I think I did exactly that. I actually couldn't be there for the birth. And then post-natally, she was off. I made her too dependent on me"*. Rose had a vivid memory of allowing a woman to be so dependent on her that the woman felt deserted. This woman was disempowered. She was not able to cope without *her* midwife.

Kathryn related how she had met women who had great difficulty ending the relationship: *"I've come across women who have needed counselling after they ended the midwifery relationship because they've been so dependent on that one particular midwife"*. To have become so dependent on your midwife during the childbirth journey, emphasised to us, the danger of an unhealthy midwife-woman relationship. Was this the expectation the women had about how the midwife provided care? Was it a relationship where the midwife needed to have women dependent on her to fulfil her own needs? The midwife was there to empower the women and support her through the childbearing process. Instead of this the midwife seemed to be disempowering the women and fostering a reciprocal dependence where both needed each other to feel fulfilled by the experience.

Margie had also recognised how women had become dependent on her but did not think it was just the fault of the midwife:

You see I think it's the women as much as the midwife. They think they can't do it without you. That type of intelligence...we are actually not encouraging women to stand on their own feet, and birth their babies.

Perhaps we had fitted into a culture to meet a woman's expectation to be led. Margie recognises the importance for women to be responsible for their childbirth choices.

Rose expressed that she felt a key to planning change was the empowerment of women:

I think that's one of the key things, empowering women to first take responsibility, that actually, it's their bodies and their baby, and if they don't know what's happening with them, fair enough we can give our opinions as midwives, and knowing clinical things, but there comes a point where you have to make your own decisions. They're the ones that actually have to go through labour.

Rose identified the importance to empower a woman to build on her own strength and resources for the journey. She saw that it was up to the midwife to facilitate this process in achieving a safe outcome.

Ellie felt that we had a lot to learn about empowering women:

I think there's a lot more that we can learn on how women can be empowered to go for it themselves, in terms of labour and childbirth and beyond. Rather than the woman just thinking I need someone to tell me what to do, or to give me a prescription or to take the pain away or to take the responsibility away, but life is not like that really. We need to see that people are empowered to get on and do it themselves.

Kathryn agreed. It was hard to find the balance between dependence and empowerment. She said: *"I can think of a senior midwife who's now retired who always said, yeah, you're there to empower the woman, she should not be dependent on the caregiver. Um, but it is difficult to find the balance"*. Kathryn still hears the voice of her colleague advising her that women should not be dependent on her, to feel they could not cope unless she was with them. Yet knowing this she still struggled with taking time off-call. She shared with the group how she experienced that women want *her* to be there when they are in labour. She wants to be there as well.

Evelyn wanted the women to take more responsibility. She saw that midwives take over the responsibility rather than allowing the women to make the decisions:

It's the woman's choice. I've got a new grad working with me, and all the time she says what shall I do now, what shall I do now? And I say, don't take on the responsibility, it's not your choice. Say to her, this is what the medical profession

recommend. You don't have to do it. These are the things you could do if you chose not to. As long as it's all clear, and it's documented, it's the person's responsibility.

Evelyn knew it was her role to empower women rather than taking responsibility away from them. It was not up to the midwife to decide or to tell the woman what to do but her role to ensure that the woman was informed of her choices and to be her advocate if it was needed.

Margie said we needed to trust women to take responsibility for their pregnancy:

Yeah. Women have become too dependent on us. We need to actually get them off their tushes and back on their feet, and back in charge of their own lives and their own pregnancy. It's even things like wee sticks. They come into clinic and some of the midwives will make them wee on the stick and bring the stick back out to show them. Well, I say look women, you can look at it, has it changed colour? No. Throw it away. Tell me it hasn't changed colour and that's fine.

Even in the simple things midwives could exercise power over women. Margie used an example of the woman testing her own urine to illustrate how we needed to give responsibility back to women. It is about demystifying the 'expert' aspect of care and to put care into the woman's hands.

To foster self-responsibility was a change that Rose had put into action. She talked of how she was encouraging women to be resourceful and to think for themselves:

I've been doing lots of thinking, and I think probably the only thing that I've done different so far is to actually talk a lot more, with the women, about more sort of asking specifically. Like in a lot of situations if you don't ask you don't get. Asking, you look worried, what is it you are worried about?

Rose knew that women needed to be equipped with knowledge so they could make their own informed decisions. By asking questions she was hoping the women would be more aware of what they think and feel. She wanted women to take ownership of their bodies and take an active role in the decisions about their choices in pregnancy and birth.

By making a strong emphasis on empowerment Rose hoped to change the culture she had observed where women became dependent on their midwife:

I think that's one of the things I've been thinking through over the last year, is the importance of being really vocal about doing that. One of the things I'm always saying is, like pregnancy's a chance to get to know, to listen to your body and really emphasising about, people's own abilities, encouraging them about their own responsibility. Finding their own resources, in early labour for example, and what do you usually do if you've got an ache in the back or whatever. And it's a really big concept (empowerment), I'm trying to push that the whole way through, you know, it's your pregnancy and birth, you take responsibility for it. You decide what you want, and we will work with that structure.

Rose encouraged the women in her care to learn about their bodies during pregnancy. When the woman takes responsibility and knows more about herself, then the midwife can work alongside her to help her to birth in the way that best meets her needs. Then it was not Rose creating a situation where the woman could become dependent on her.

In the clamour of life and the business of our work it was like we had forgotten the basics. ‘Rose declared’: “*Birth their babies. That’s the key thing*”. There was a new wave of energy in the group as the midwives were excited by the prospect of encouraging the woman to be emotionally strong for the birth experience. By knowing her body and having her own support network the woman can be empowered ‘to birth her baby’ rather than having her hand held by the midwife. This new group synergy was achieving the aim of appreciative inquiry. Cooperrider and Whitney (2005) said: “building and sustaining momentum for change requires large amounts of positive affect and social bonding-things like hope, excitement, inspiration, caring, camaraderie, sense of urgent purpose, and sheer joy in creating something meaningful together” (p. 53).

We needed to step up and empower women to develop their own resources and trust in their own ability to birth. This would free us from the feeling that they needed us there or we needed to be there. The woman would be empowered for her birth, a pivotal time of her childbirth journey, even if her LMC was not present.

New attitude

Lorraine had made a change in her practice. To do this she had to change the way she thought. In the past it would have been too hard not to stay on-call for a client that she had cared for before. It was especially hard to go off-call when Lorraine had cared for a woman before: not just for one previous birth but for five other births. Lorraine relates her story:

I have had to leave her and she’s in labour. I’ve changed the way I work so that I do get some time off. It’s hard to leave a woman in labour when I’ve looked after her before for her five other babies but I’ve had to leave her. I missed the birth but I had to draw the line, because no longer can I sustain it 24/7.

Lorraine had chosen to take regular weekly time off-call. Another colleague had taken over the care of her client so she could have her scheduled days off. It was not easy to leave the woman. There was still a desire to be with her but Lorraine knew that if she was to sustain case-loading midwifery she needed to have regular time off-call. There would be no

favourites, no exceptions to the rule. Her days off were to become an important part of how she now practiced.

When Rachelle commenced LMC practice she had just expected she would be on-call 24/7 with minimal time off:

We pretty much got taught that continuity of care from the same midwife was the best thing for women. And that the midwife should provide this, like antenatal, delivery and post-natal care as much as she could. They never really talked to us about how to balance between personal stuff and work. It was just all about women, and we should be available for them as much as possible, 24/7.

It was not until Rachelle started practising that she realised that there would be a conflict between caring for women and her personal needs. Her midwifery training had focussed on the on-call availability without preparation for the impact on the midwife's personal life. The culture she learnt about was one where she was to be on-call without regular time off-call. The way Lorraine used to work.

Janet worked her individual case-load within a wider group for urgent back-up cover. She talked with her colleagues about a small group of midwives having regular time off and sharing the client load. She tells us: *"Only one in our group of eight said that she would like to try that. The rest of them said that was not continuity of care"*. Most the midwives in Janet's group saw that the 'ideal' for continuity of care was for the same midwife to be there 24/7 and not calling in a back-up unless there is just no option. If they had two women in labour or had worked just too many hours without a break only then would they consider calling in their back-up. Working as a team for regular time off was not seen as congruent with continuity of care provision.

Rose would like to have thought that she could always be on-call: *"It would be nice if we could have the ideal and be there, but it's almost like we're giving up our lives"*. Rose had felt that the ideal was to always be there for women so that she could provide the optimal care for the woman but to do this it would be like giving up her life. If she continued to believe that the ideal was to have the same midwife available 24/7 on-call then she would not be able to take regular time off. If she did it, would come with a sense of betrayal to the women and to herself. Rose had observed other midwives around her that had the belief that upholds continuity of care as one midwife to one woman care with only occasional time off-call. She knew that she did not want midwifery to rule her life as it did for them.

Rose had been considering why it appeared difficult for some midwives to take time off-call:

I was talking with one of my colleagues a few hours ago, how, in a way it can be a culture that our clients build up because of other people who have come to a midwife here or because of what we do or don't tell them at the beginning of the time. Or what we do or don't reinforce.

Rose found that some women had an expectation that the same midwife would always be there for them. She observed three main reasons for this. Firstly, the culture of continuity of care had the expectation that the same midwife would always be available. Only as recently as 2007 was the concept of 'continuity of carer' removed from the Primary Maternity Services Notice (Ministry of Health, 2007) and was rephrased as 'continuity of care'. This relieved the implication of the same caregiver always being available. Secondly, midwives needed to be specific with each woman in their care about their on-call availability. This meant if the midwife did not state otherwise, at the beginning of the care, the midwives were obliged to be available for the birth. Thirdly, midwives needed to remind the women that they had regular time off-call. Often in the antenatal period they may be the only midwife the woman meets and she becomes reliant on seeing the same midwife. The midwife needed to make provision for the woman to meet the back-up midwives.

Kathryn had observed that introducing the back-up midwives early on in the care created less dependence on one midwife:

I've certainly noticed the more midwives a woman sees in the early stages, that's better. If she sees one person for several visits early on, that's the relationship, and it's very hard for her to adapt. She tends to compare everybody else with that, and certainly our group has got to work on meeting people earlier. But when you only do monthly visits in the beginning, yeah, it's not easy to do.

Kathryn had tried to take more time off but found it difficult for the women in her care to meet the other midwives. Mostly it was the LMC who saw the women before the birth even if she did take time off-call. It was easy for the women to develop the reliance on one midwife because of this.

Rose was aware of the possibility of burnout from when she started her 24/7 on-call practice:

In the various different places overseas where I've worked there have been rules in the organisations I've worked for, like you have to have a week off for example every three months, out of the situation. Or you have to have a weekend off every six weeks. In those sorts of situations people can sustain that level of activity but only if they have that, sort of, not really a work-life balance, but you break out of the situation. It's time to physically recover and time to mentally process all that you've experienced.

Rose knew she needed regular time out to maintain a work-life balance. Rose had observed what happens to workers who feel compelled to work incessantly being left drained mentally and physically exhausted. She did not wish for that to happen to her or her colleagues. If the colleagues she worked with did not all take regular time off then it would be difficult to arrange an effective cover arrangement. She saw that a midwife needed time out to be a better person. Days off would give a midwife time to recover physically and mentally and to put her life back into perspective.

We were saying that we needed to change the 'always being available' thinking if we were to survive. Rose explained why she felt we were slow to change:

Resistance to change is a bit of doing what we've always done and not questioning it, personality a little. In some organisations you do nothing. You make no changes unless you get on with the person at the top. You do everything by the book and to the letter, unless you've got the courage and the informal rapport in your workplace to go against it.

Rose saw that for her to take days off she was going against the status quo. Midwives may see that change is necessary but are not willing to be the ones to make the changes. Rose, like Janet, also talked about how many of her colleagues did not think that taking regular time off-call was the way a LMC midwife was supposed to work. Continuity of care was seen to support a partnership between midwives and women as a way to empower women to stand up against the control of the medical model of birth (Guilliland & Pairman, 1995). Smythe (1997) related how those who inspired midwifery change in the early 1990s did so to bring women from dependency to partnership relationships. However, 20 years later, we still see women in relationships of dependency with their caregiver. This time not the medical profession but dependent on their midwifery caregiver despite the partnership model of care.

Rose found it was a difficult initially to arrange a satisfactory way to have regular time off. It was not just the attitude of her colleagues but also the structure of her practice:

I started and about two weeks later someone left and I inherited a case-load. And so I hit the ground running. From the beginning when I started, it wasn't possible to actually make my own plans and decide: oh, I won't have any people this month. I already had a case-load when I started for eight months ahead, ten months ahead. So I guess that reminded me that we need to sort of think about the work-life balance.

Rose had no hesitation to have time off-call but how to achieve that was not so easy. She had acquired a case-load and was so focussed on providing care that she was slow to realise that

she was not having adequate time off:

Nobody in our group had regular time off until I came. I took a weekend off every month last year. And holidays, well everyone takes holidays, but I made a point of taking a weekend off. And it's only just this year that my colleagues are also thinking about it.

Then Rose started to take days off and set an example for her colleagues to follow. She was pleased that the midwives in her practice were changing their thinking about needing regular time off. The midwives had been working without any breaks for months on end. Rose had come along and had demonstrated to her colleagues that it was possible to take time off regularly and provide continuity of care. Rose got to enjoy her case-loading work with regular time off. She had shown that you could step back and 'let go' of the women in your care.

It took time before the other midwives changed their ideas about taking time off-call:

In January we had a chat together about planning some regular time off, and had some very interesting discussions on what's possible and what's not possible. But I can see a lot of difficulties still with taking regular time off.

Eventually Rose and her colleagues started having more formal talks about taking time off-call on a regular basis. It took a lot of energy and time to work out a way to suit everyone. The midwives had different life needs; they cared for women in different geographical locations; the women had different cultural needs and social circumstances; and they had differing expectations about the maternity service. A balance needed to be found between caring for an individual case-load and having time off work. Rose's insistence and example to her colleagues about the necessity to take regular time off-call changed the way her group viewed continuity of care.

Changing our assumptions was about changing our midwifery culture (see fig. 12). We realised we needed to look after ourselves and make changes in our practice. We struggled with the conflicting obligations between commitment to women, commitment to our profession and commitment to ourselves. We had been listening to the voice of 'they', the unauthentic voice (Heidegger, 1995). We did want to change, and with our change created a new midwifery culture surrounding continuity of care. It required reflexive thinking. We had to examine not just what was being said but also the interactions, transactions and events that occurred in our social space (Bourdieu, 1990). When we heard the 'authentic' voice we could change our assumptions and how we provided the care.

Figure 12 The old and the new assumptions

Old assumption (old culture)	New assumption (new culture)
It is our duty to provide care to our women on-call 24/7 with the least time off-call as possible.	Midwives need regular and frequent time off to maintain a better work-life balance.
Women need their LMC to be with them to be empowered and have a satisfying birth experience.	The woman needs empowering for the birth experience rather than being dependent on the LMC.
Creating a close 'protective' relationship.	Providing a professional relationship focused on the need of the woman.

Summary

The data in this chapter showed how much we were swayed by our midwifery culture that determined the attitude we had to be continuously on-call. Our assumptions about how we practiced continuity of care had to be changed so we could set clear boundaries between our work and private life. The way we had thought about our responsibilities to women led many of us to work on-call 24/7 for weeks on end. Once we examined our rationale for why we stayed on-call we were able to make changes to our practice culture: this facilitated change. Some were still exploring what possibilities there were for them, others were making changes in their current practice setting and others created new practices so they could work in a team for regular time off-call. We realised change was a gradual process that needed careful consideration.

Empowerment was seen as an important resource. When a woman was empowered for the birth experience she was no longer dependent on having her LMC midwife present at the birth. This freed the LMC midwife from feelings of guilt if she was not present at the birth. The midwifery approach stayed centred on the woman's needs but the midwife was no longer pulled by the relationship to be there for a specific event. A changed dynamic in the midwife-woman relationship allowed a better work-life balance. There was a weighing up between working in a group or team with a structured business arrangement with days off as opposed to having an individual practice providing 24/7 on-call care. However, some CI midwives did not have much choice of how they could practice and needed to make change within this

restriction. The geographical situation, the numbers of other case-loading midwives, either too many or too few, could financially disadvantage the CI midwife if she had regular time off. Often she was left with no choice but to work on her own; only calling on another member of the group if she urgently needed back-up. Whether we lived in a rural area or lived in a city, we sometimes could not find other midwives to provide back-up.

Solutions to make change could be difficult and at times seemed impossible. We understood the attraction of having an individual case-load with a close relationship with the women. This produced satisfaction of care for the women and the midwife. The midwife who had her individual practice had her own type of autonomy: a freedom to choose her individual philosophy of practice. Yet this did not protect her. Her practice could be unsafe because of the demanding on-call hours she worked. The on-call nature of our work often caused havoc in our personal lives. To make change required us to think and practice differently about how we provided continuity. In chapter nine we look at the new challenges we experienced when creating a different practice structure. To have regular and frequent time off-call we needed to work closely with other midwives. Team work for some introduced a new work dynamic.

CHAPTER NINE

Agents of change

An organisation's story is constantly being co-authored.
(Cooperrider & Whitney, 2005, p. 51)

This chapter looks at how we worked through the challenges that came with change. Midwives internationally have found implementing and sustaining continuity of care presents new challenges and difficulties (Brodie et al., 2008). In particular this chapter deals with the challenge of being change agents. There were prerequisites the CI midwives needed to make their change successful. Some, who were in an individual practice, worked at providing better off-call cover with their affiliated group or restructuring their day-to-day practice. Others had made change to how we arranged our back-up cover working closely in teams with regular and frequent days off. In our resolve to make things better we learnt that a system for regular time off-call required well-organised teamwork. This needed a close-knit team or group coordinating the way they provided care. Yet still teamwork could bring conflict that needed to be resolved. This chapter presents how essential communication was in sustaining change. We had to learn how to manage our time wisely and when things could not be changed we needed to find innovative ways to meet these challenges. The chapter is divided into two sections. The first discusses how we overcame new challenges, and the second how we sustained change.

Overcoming new challenges

We all experienced obstacles when creating change. At times we struggled to achieve our effective change for different reasons. Some struggled to make change because of a conflict of priorities. Bronwyn for instance could not make changes in her practice until she decided whether or not providing continuity of care would be compatible with being available for her grandchildren. Rachelle had a conflict of priority between being on-call for women and having regular time off-call to spend with her partner. Until a CI midwife knew what priority was most important to her she could not action change in her practice to meet her needs. Others could not control their month-to-month case-load numbers as there were a limited number of midwives in the area. Some months they had too many clients and some months, too few. Both Rose and Skye found that sometimes this made them very busy putting them under a lot of pressure. Ellie, on the other hand, was experiencing conflict in her team as

members had a conflicting approach to practice. This was preventing them from making effective decisions for change.

The data so far has shown that being on-call 24/7 could push the CI midwife beyond her limits of safety. Her work-life balance was at risk and she could be faced with 'burn out'. Some of us in our individual practices worked at arranging a better system with our affiliated group for having time off-call. Alternatively, some CI midwives decided to work in a team to have regular time off-call. The CI midwife who was in a team gained a good balance between work and life but this way of working also had its drawbacks. The CI midwife who came from her individual practice to a team found there were adjustments she needed to make. She could feel less freedom to practice just as she wanted to. She needed to learn how to work closely with her colleagues. There were others also working with an affiliated group to arrange better off-call cover. Three themes emerged in the data about encountering and overcoming challenges that come with change:

- Prerequisites for change
- Communication
- Conflict resolution

Prerequisites for change

As we made changes in our practices there were certain elements that were required. Some that stood out included: changing old habits, trust and respect, perseverance and commitment, and flexibility.

Changing old habits

The CI midwives came to recognise the habitual nature of their ways of practise.

Janet's expectations of her care provision were based on habits formed over many years, yet she knew she needed to make her day-to-day practice more efficient to free up time:

I reviewed how I was doing things and realised that it wasn't necessary to see the women as many times in early pregnancy as I used to. Most women in my care now, have often had a scan before they come to see me and again at 12 weeks for Down's syndrome screening. They no longer need the reassurance of hearing the heartbeat as much as they used to (because they have already seen it on the screen and often heard it at the time of the scan). By seeing women less I can put more effort into other visits that are needed and it frees up more of my time as well. I'm not ready to let go of the post-natal visits just yet.

Out of habit Janet was seeing women more times than she now realised was necessary. She found that reducing the number of routine antenatal visits met the women's needs and allowed her more time to do other things. It took time for Janet to adjust her own expectations before she could make any change. She needed to feel ready to make the change. She had felt the benefit of reducing her antenatal checks and had already started thinking about how she would cut down the amount of post-natal visits she was making. These were well above the required minimum of seven visits in the six weeks following birth (Ministry of Health, 2007). Janet had discussed with us how she found it difficult to end the relationship with women at six weeks because of the bond that she had formed with them. Her care was about relationships and she struggled to put this into numbers and frequency of visits. She had come to realise that to manage her personal well-being she needed to make that choice.

Trust and respect

Taking time off and sharing the care of clients with other team members was based on trust and respect. This could be an issue for the CI midwife who had previously been in an individual practice with little arranged time off-call. When a CI midwife had been providing 'continuity of carer' it was hard for her to 'share' her client load. She could feel she had a certain ownership of the women in her care.

Lorraine found it was hard to handover to others:

For me part of it is trusting that my colleagues will do just as good a job that I will do. It's not how I mean it, but it's trusting that the things that you think are important are going to be important to someone else. And also in trusting the midwife you don't have to be the one providing the care. It is a trust issue that my colleagues are going to take as good care of those women as if I was there myself.

Lorraine struggled to trust her colleagues now she was working in a team. It was not a lack of trust that they were not good midwives rather it was that perhaps they would not be as attentive to the same things that she thought were important. Each team member needed to know what each one considered important, building that into how they provided care as a team. It may not just have been an issue for Lorraine but perhaps for them all.

Margie also struggled with entrusting her clients to another midwife's care. This was especially apparent when women came back to her care for another pregnancy:

For me the problems I am having is letting go of the control because I've had my own clients for eight years now, and some of them were coming back, which is fantastic. But I want to know how her sugars are, and I want to know what her pressure has been like because she had a problem with that last time, and I want to know. I have to

sit back and say, hang on, these other people are fantastic midwives or I wouldn't work with them. I have to trust other people, and it's a big issue. I didn't realise how big an issue it was. So I'm really struggling with it. I find myself, even on my days off, coming to work to view charts, just in case.

It was not until Margie commenced working in a team that she realised how much she had been involved emotionally with the women's care. She wanted to know everything that was happening with her clients, even on her days off. Now she had to relinquish control. She had to let someone else care for women that she knew well; women that she felt 'belonged' to her. Rose also had to learn to accept that other midwives do things differently. She talked about how she needed to trust her colleagues. Just because she would not do the same as another midwife does not mean it was wrong. The CI midwives were realising that they could not have ownership of the women's care if they were going to have regular time off-call. They needed to trust the midwives that they were working with and learn to accept that each midwife may approach the care in a different manner and the women would still receive the care required.

Respect for each other was an important attribute. If there was no respect then there would be no trust. Margie had to 'let go' of the way she liked to do things knowing that her team members may do things differently. Her experience demonstrated how she needed to respect her colleagues to create good team dynamics:

It is also acceptance of the way that someone else's practise will be different to how you practise, but it is the same philosophy. It is that even if they are not going to see her on this day, they will see her on that day. It is different ways to skin a cat.

Margie knew she had to work in with her colleagues. She knew she could not make decisions and do things independently as she had done when she stayed on-call 24/7 for her own case-load. She faced the challenge of working in with colleagues:

You know, if I'm second on-call, so my work is doing paperwork this week, I like to go and try maybe three times a week, get all the paperwork done. Other people leave it until Friday. That irks me. But I've had to let go of that because it doesn't matter as long as it gets done. We develop our own ways of doing things, as adults, and then we have to sort of, it's like being married I suppose, you have your way of folding the laundry and suddenly you have to take help from someone else.

Margie had to respect that her colleagues approached care in a different way. By working in together and covering each other to have time off-call and to have days off Margie learnt to adapt and accept that others may do things differently.

Perseverance and commitment

Changes did not necessarily come quickly. They were born of perseverance and commitment. Mary had talked about how it took a year of planning before her group started working together to provide regular days off. They met over this time socially as well as having work meetings. When they did start up a system of regular time off with clear guidelines of who was first on-call, second on-call with the other on days off, they knew they had to be committed to make it work. They had to persevere to get the group running to a level where the women and the midwives felt everyone's needs were being met.

Rose also needed to persevere as it was taking time for a system of cover for days off to be developed:

So I guess, since we talked last time, there's been a bit less, less of a wholehearted commitment in our group really, to really properly take time off. And whether that is because, um, several people have had less numbers and have therefore rethought about how they will work. There is one person who doesn't actually ever see the need to take time off, although, she's going along with our arrangement at the moment, but if she does have someone due she tends not to take the weekend off. She won't be off for a birth. On the other hand I still recognise my need for time off, so I am still sort of looking at ways of preparing women more.

Rose knew her work-life balance depended on taking adequate time off-call. She was committed to carrying it through and had to be prepared for a gradual change of attitude from her colleagues to establish suitable time off cover. She was aware of the barriers that prevented midwives taking time off but knew for her the need to be safe was greater than the obstacles.

Flexibility

Being flexible to try out different ways to bring about change was as important as being committed and persevering with the new group set-up.

Margie soon discovered the importance of not just persevering but being flexible and trying to understand things from another's point of view:

So yeah, overall, I'm still here, I'm still doing it. There's been some stuff that hasn't worked. And I think it's all about being flexible, trying it out. It is not just yourself to consider but understanding where others are coming from. It is a big issue, being considerate of others.

It required each member in Margie's team to be flexible and being able to recognise if the changes that were not working. Each member needed to be willing to accommodate how they

might have done things with the general consensus of what the group wanted. They had to persevere to make the team or group set-up work and be committed to each other and to making change.

Some CI midwives had been working in their individual practices and were used to making their own practice decisions. When they started working in a team, decision making involved all the members. This was hard to adapt to. Others who still worked in their individual practices needed to work in with other midwives in their affiliated group to make off-call arrangements. The CI midwives found that working in with others could be difficult and needed to address this.

Communication

Making and sustaining change could not occur without communication with our clients and communication between midwives in the group or team. Managing our own expectations and that of our clients was important. For us to be able to take time off, the clients needed to be informed of how our back-up cover worked. Communication between team members was essential also, but how, when and what to communicate was challenging. Conflict, we discovered, could happen when midwives worked closely together.

Robyn's practice had to work to find a way to suit everyone's needs. It seemed that there needed to be give and take from all involved:

You could be really grown up about it really, try to be open. So I guess in a way, that is what I want to work on, I want to try and work on it so that I can continue to work together quite peacefully with my two colleagues. And we do generally. It's just once or twice I've had one or two times, when there has been a misunderstanding, not necessarily someone hasn't done what they said they were going to do, or whatever, but rather they wanted the other person to do it their way. It has been a miscommunication really.

Robyn was experiencing the misunderstanding that could occur when a group of people depended on each other. There was a need for her to work at keeping the communication open. She could be seen as a peacemaker: a 'go between' for the other two colleagues. She did not want the group to fall apart because of unaddressed issues. The group members needed to make compromises and accept that they were not all going to do things the same way.

For those working in a team there were times of friction. Communication was seen as necessary to overcome the conflict. Robyn felt some issues were worth addressing but some things were better left unsaid:

When things really get on top of me, I will speak up and say something if it's really important. But if it is a small thing I tend to think, oh well, it will go away, I won't worry about that. And sometimes, I think, why bother about it. Don't let the little things upset you too much.

Robyn learnt to be discerning about which issues needed to be worked out. Sometimes things that might upset her were not going to affect the running of the practice so it was better just to let them be and usually they would self-resolve. Robyn and her team knew the value of keeping their communication channels open so they knew what each one was thinking and doing.

Mariana knew the importance of communication for teamwork:

And it is hard, and it does happen a lot in practise, in group practices, and you don't talk. It is not that much about miscommunication, I think it is more about open communication; it is a two way communication when you can hear the other person. And you could, you know you need to grow socially and have background interaction as well as your professional interactions. And learn about the behaviour of that person.

Mariana talked of the need for open communication. She talked of the danger of not communicating and communication that was not honest. Each needed to listen to the other. It was important not just to communicate about work but to interact socially as well. Mariana felt it was important that they got to know each other so they could better understand each other.

Margie's group talked to each other frequently on the phone. She said: *"their phone bills were as big as their petrol bills"*. To achieve the practical day-to-day running of the group the midwives in Margie's group were always on the phone to one another. They needed to discuss the client's needs to provide the necessary care. They needed to know the workload they each had so they could help one another. It was good for them to be in touch with each other in this way. They all knew how important communication was but they also knew it was not easy to achieve. They knew how to communicate about the everyday work to be done. Margie, however, intimated: *"we were not so good at was communicating or listening to how others were feeling"*.

Mary's group would make sure they had social and work meetings and sometimes combined the two activities quite successfully:

Every so often we will have a breakfast, and we did one recently, and that was good. We talked about other issues too not just work. We chatted about other things because we were in a non-work environment.

Mary found that meeting outside of the work context reduced barriers of formality. It created a neutral place for discussion to take place.

Midwives needed to have an understanding of their strengths and weaknesses. Robyn felt that at times she was not assertive:

Well, I tend to be a person that's not that assertive really. And I tend to go along with things and maybe feel a bit grumpy underneath it all a bit, but go along with it anyway, so I'm going to try and be much more open about things, and when they're upsetting me then I'm going to perhaps tell people. And I know that my colleagues are quite, well, grown up, we can all say things to each other that we don't feel comfortable with.

To have open communication Robyn had to be honest not just with herself but with her colleagues. It was about knowing the right time to bring up an issue.

Being honest with yourself and others was important. Robyn had to choose when to bring up an issue and when to let it be. Either way she experienced some stress but did not want to make an issue of something that would resolve itself. She said: *"I wonder if we felt why rock the boat, which was wrong I think, because it's still smouldering. Which isn't being very honest?"* Robyn was working on improving the communication in her group during the action research project. She identified the need for her and her colleagues to be honest. Sometimes they allowed their opinions to be buried which she felt in the long run would eventually come out. It was better to deal with the issue when it was at hand. Leaving an issue unresolved could have repercussions at a later date.

Clear communication was seen as important so that women and the midwives had clear boundaries about the midwifery care and their availability. Rose learnt that if women knew about what to expect from the service this helped shape their expectations:

I guess you've got to have communication with a woman, and let her know. Just the surety of knowing what the system is, is empowering for her. In that yeah, this is how we do it here. When they know the system, it's almost like they relax, they know their boundaries, and they know what they can expect.

Rose spoke here of being 'up front' with how her service worked. Not just expecting the women to know. This in itself was empowering for women. To be able to inform women like

this Rose needed to have a good back-up system organised and in place. She spoke of how it gave women clear boundaries. It most likely gave Rose clear boundaries as well. She could not change her mind and say “Well perhaps I could stay on-call for so and so”. It meant she had specific parameters to take days off without feeling guilt for not being there. It would also have provided her back-up person with clear boundaries of when back-up was needed.

Margie knew the importance of informing the women of how she provided care. She also identified with Rose about managing the woman’s expectation of care as being important for the woman to be empowered and satisfied with her care. Kathryn was also aware that to manage her own and the woman’s expectations she would need to inform the woman about her availability and need, to take time off.

Janet clearly communicated with women that she took regular time off-call and they responded positively. Janet was able to say: *“It’s universally a reaction when booking, that women say ‘that it is really nice you get every third weekend off. I’m glad that you get time off, is that all you get?’”* Janet’s experience showed her that when she explained to women about her need to have time off they understood. Janet had women even wondering why she did not take more time off.

Unfortunately, as the pregnancy advanced, Rose found that when women saw only her all the way through the pregnancy they easily forgot that she may be off-call at the time of the birth:

But people seem to, I think it is something about pregnancy, like you actually need to withdraw into yourself and become more focussed on yourself and your baby. It is quite a natural thing. And as your own delivery comes up and your baby is going to be born, you kind of forget what was said at booking and want to have the same midwife regardless.

It concerned Rose that women may forget that there was a chance that she might not be at the birth. She was aware that sometimes a woman can become dependent on having the same midwife. They developed a relationship with the midwife and an expectation that the same midwife will always be available for them, just because they had seen them for most of their antenatal visits.

Conflict resolution

To provide each other with frequent and regular time off-call there needed to be a good structure in place to coordinate the care of women and maintain team continuity of care. Yet those of us that worked closely together in teams reported incidences of disagreement and difficulty to manage the conflict. Appelbaum et al. (1999) refers to conflict as “a process of

social interaction involving a struggle over claims to resources, power and status, beliefs, and other preferences and desires” (p. 163).

It upset Robyn when issues arose that interfered with relationships in her team. She felt that sometimes a dispute may only need some time and it would resolve itself:

Usually things are not as big as you think they are and it's no point in getting really worked up about it and making a big deal out of something that's not a big deal really. It might seem like a big deal at the time but it's going to all smooth out eventually. So it's easy to burn your bridges. I might be upset about something at the start, but, after a while you do realise that it's not really that big and you get over it. But if it is niggling away at you something needs to be said.

Robyn felt a good resolve to conflict was waiting to let change take its course. Often circumstances that did not feel satisfactory at the time had a way of resolving themselves. If a concern persisted then honesty with each other was needed to address it. Robyn probably felt that if she had intervened prematurely it may have offended someone unnecessarily.

Margie felt that some midwives lacked the ability to deal with confrontation in a satisfactory way:

I think, sometimes, we haven't the skill to work through issues. I don't like confrontation. So I am happy to back out and just nod and smile and do my own thing anyway which is not particularly healthy or constructive. And we haven't really got anyone we can go to and say: 'Hey, we've got this issue'.

Margie experienced conflict in her team. Her situation was with a new group that she was setting up. It was not until the group was working as a team that issues started to appear that needed to be addressed. Margie would just nod her head even though she may not have agreed. She felt at times an issue may not have been resolved to her satisfaction but pretended that it had. Margie felt inadequate in resolving conflict in a satisfactory way.

Lorraine decided to have professional supervision to see if this helped her to know how to resolve issues with her colleagues. Lorraine found that sometimes she just needed to talk through issues with someone to help her see if it really was an issue. May found that professional supervision had made a big impact on how she saw things:

I was gobsmacked, I was like all open eyes and my goodness, you know. So I can see that is such a need for us to 'download'. To talk things through with somebody who is a mentor. Often it is a processing of change. Change is a practical thing, but processing change as in the development of your own belief about midwifery and, you, how it is for you can be helped by sharing with a mentor.

It was not until May had time in a counselling session that she realised she had so much to download and process. For her it required an intermediary to help her reflect and analyse her

situation. She was amazed by the difference it made. It gave her a perspective she had not considered.

We recognised the need to resolve group conflict but were often left with no choice than to let it take its own course. We could only try so much. We floundered at times in our ability to resolve situations that we felt were threatening our group viability. We felt we needed someone that we could turn to for advice. Despite this need no one had sought professional group conflict resolution. When it came to conflict resolution it was like we were on our own to solve our issues. Robyn said “*We are all adults*”. She felt that we should be able to work through our own issues. We discovered that no matter how well we seemed to have organised our group, conflict could arise.

Sustaining change

This part of the chapter presents our experience on sustaining change. It is grouped into three sections: managing the unchangeable; reflection, evaluation and adjustment; and being change agents. Sustaining change was an important part of the change process. If this did not occur the midwife could easily slip back to how she used to operate.

Managing the unchangeable

Some things we could not change so we needed to find ways to work around them.

When Rose found that her bookings were low she tended to stay on-call:

Since I started working as a case-loading midwife, February last year, the number of midwives in our area has increased by about three, so there are eight in our area now. This is great. It meant that if we're divided into two groups, then one group can have every third weekend off, which is my group. The other group has every second weekend off. But...like in November I didn't have any bookings. I had one, but actually she didn't know if she was due in December or November. And I had a phone call two nights ago, and she delivered out of my area anyway. I haven't seen her for about a month. So she doesn't sort of count. I got two births when other midwives in November were on their weekends off. Sometimes people in the team will stay on-call if they're not doing anything special. They want to catch a birth, either for personal reasons or financial reasons. Because I've had low birth numbers in November, I've found myself doing this too.

Working within a larger group provided opportunity for cover except when case-loads were lower than intended. This caused an issue for Rose as she wished to have regular time off but also was dependent on a regular income. Rose found that she had to stay on-call when her case numbers were low in any given month. Rose considered other ways to relieve the

irregular income and time off issue. She accepted that for now she would have gaps in her income while each member in the group slowly adjusted to the realisation of the importance of regular time off-call. Rose investigated if being a locum in another area would have been an option for her financially but decided it would make the care for her current clients too disjointed.

Although Rose was trying to have regular weekend's off-call, there were times when it did not work out this way. Instead she needed to adjust her weekly schedule to leave more time in the weekends even if she was still on-call. Rose realised that her work was being spread out over seven days. She told us: *"Although it made my day-to-day workload lighter it meant I never had a break from routine work"*. Because Rose could not always have her planned days off she found other ways to provide down time so it did not feel like she was always working. On advice from a colleague Rose now only does urgent visits in the weekend. Rose had been feeling the need to visit women no matter which day of the week. It was important for her to normalise how she worked.

It frustrated Margie and her team members that women were often not home when they made their postnatal visits. They got around this by arranging a clinic for the women to come to:

Yeah, we are doing the post-natal clinics. Um, when the women get to about three or four weeks down the track, we invite them, it's not compulsory, it's an option, if they would like to come to our rooms and we weigh their babies there. And there are other mums there, they get their boobs out, they feed their babies, they have a natter, they see their babies, they socialise, they bond, it is great, love it. It also means that you don't have to make 42 visits around, all over Auckland to someone's house who is not there anyway even though you rang especially and said I'm coming. She just decided anyway to pop out somewhere. Trying to fit a time around school and kindy drop off, whatever, they just fit in one more visit; it works out great for both. So from that respect I love it, but we're probably going to get our hands smacked over it.

Often they visited a woman's home and the woman had gone out. Sometimes finding a time when a woman would be home at the time the midwife was in the area was difficult. To provide an alternative Margie's team offered a post-natal clinic for the women to come to. This gave women a choice. This not only provided a suitable solution to organising a visit time satisfactory for both parties but it allowed women to meet each other, and chat about their experiences, which they really enjoyed. It did concern Margie that it may not meet the Ministry of Health (2007) Section 88 requirement for post-natal care which specified 'home visits'. Margie's team, however, felt that they were left with no alternative. The women also made the choice to come to the clinic.

Lorraine and her colleagues also wondered if they were meeting the specifications for post-natal visits. They too had started providing post-natal visits at their rooms. The opportunity for women to come and visit them at their rooms resolved the issue of women not being home when they called.

Reflection, evaluation and adjustment

To sustain change we needed the reassurance that we were meeting the needs of women and our own needs. Reflection was an important aspect of how we evaluated our change. The midwife is required to be a reflective practitioner (NZCOM, 2008b). We all sought feedback from our clients.

Rose was reassured by the feedback she received about care when she had been off-call:

I've had some feedback from some of the women for whom I didn't end up birthing them, and I can tell sometimes on the NZCOM feedback forms who it is who's writing, especially if I didn't get to their birth and was looking at the timing. One in particular, one of those that you think, oh, this person is lovely, and then you're not there for the birth. 'I'm sorry that Rose wasn't at the birth... but it was fine'. I just thought a lot of her acceptance must be her personality. But a lot of it also has been, I think, some of the things I have talked to her about in preparing her for the possibility I may not be there at the birth, saying you've got the resources to get on with it and do it. So I've been encouraged that it's possible for people to have a positive experience regardless of which midwife is there.

Feedback from women had been crucial for Rose as she implemented a system of having time off-call. She felt that clear communication with women was key to them understanding and accepting her need to take days off. She was reassured with the feedback. It was not necessary for Rose to be there for women to have a positive birth experience. She was changing both her own and women's expectation of care through clear communication. Although she wished to fulfil her commitment to continuity of care and to be there for the women, she knew she needed regular time off-call. Women instead of having the expectation that she would be there were now prepared that it could be a back-up midwife if Rose was off-call.

Rose was still working through the guilt she experienced for not being there for the births:

In some ways I felt very guilty initially for not being there but I've talked about it with her in the post-natal period, and for someone with her background she is incredibly gracious and went out of her way to say: 'oh, but it wasn't your fault that you weren't there, and it worked out okay anyway, and I've got my baby'.

A strong bond had developed between Rose and this woman and so Rose felt an expectation that she should be there. Guilt would have been a trap if she had not taken steps to manage it. Rose had put a system in place where the women had met the other midwife. She had clearly explained that she took regular weekends off. The women knew the possibility that Rose was not going to be there so she had not centred the experience on the expectation that 'her' midwife would be there. Reflection allowed Rose to put the birth into perspective. She was able to see the total picture of the care she provided the woman. She evaluated the change in her approach to her practice. Practicing self-care was paying off. She was learning how to manage her expectations and that of the client to achieve time off without feeling guilty.

Cherry found that reflection enabled her to look at her practice to see the big picture of her work pattern:

Reflecting back I think it helped me become aware of what my safety limits are, and when to say, look, I have done 22, 23, 24 hours with a labouring woman, and yes, I know you are short of staff. It is about knowing when to say 'that is enough, I have nothing left, I need a break'. I had to start setting the limits and saying, 'okay there is no back-up now I'm handing over to the unit and I need six hours break.' And that became apparent, and helped me to identify that.

This retrospective view showed Cherry a clearer picture of her situation than when she was actually in it. It helped her see how she was pushing herself beyond the limits of safety. She realised that it was not alright to work the continuous hours she had been working. The time in discussion with the other CI midwives had reassured her that she was not alone in this struggle. Cherry needed to place parameters around how she managed her work hours.

Margie did miss the close continuity that she had when she cared for her individual case-load:

We have put in a couple of changes. Now the women are visited, women give birth and you visit that week. That provides more continuity. So now you birth them, you see them that week, and also the next week and the next week as well. So you're doing that first two weeks, which really makes sense.

Margie had enjoyed the satisfaction she received when she was on-call for just her own clients when she had her own individual practice. She felt the team approach did affect how the women felt about their care also. This was an aspect that was missing from the teamwork that agitated Margie. They adjusted their structure to make the continuity work better for the woman and the midwife.

Lorraine also saw the need to adjust their team approach to provide better continuity:

...but what I find is that because a lot of women are people that I have cared for before, I know a lot of their quirks. A lot of them are first timers. And some things get

missed. If you see the women on day two and day three, you might know she needs a visit on day four as well. Whereas another midwife coming in on day four, she might think, oh, she has been seen on day one, day two and day three I do not need to see her. If you have that continuity, you're not going to miss them. Nothing serious has been missed, but just little things. And if we can make a difference, then that is what we are going to do. And so I am looking at how I am getting a work-life balance, and that is happening, but I want to get more satisfaction out of my work as well. So we are trying to streamline the continuity more.

Lorraine realised that in having time off-call she also lost something of what she enjoyed about case-loading practice. She missed the continuity of seeing the same women especially women she had cared for before. Her aim was to look at how they could build more continuity from the same midwife into their group structure:

So I re-did our 'on-call schedule'. We are now working as a foursome. We will work eight days and then have six days off. And it gives two weekends off a month. Because I was getting only one weekend off a month, it was not enough. And so now I can have every other weekend off. And the women are actually going to get better continuity because it is either going to be me or my partner that will be dealing with them as we work in twos with the other two midwives as back-up.

Making change meant making adjustments to improve the arrangement. This required the midwives in Lorraine's group to be willing to make the adjustment. It also meant informing women of the new changes so their expectation of care was in line with what the midwives were providing.

Sustaining change was about ongoing change. There was not an ideal practice to be found. Our practices kept on evolving. Our circumstances were always changing. Just when we thought we had it worked out someone could leave the practice or someone could join our group, or, with no warning, conflict could arise and disturb our group dynamic. We had to learn to be able to manage what we could not change and to change what we could. We had to meet the challenges that come with finding a balance between work and life when providing continuity of care.

Margie and her team have been working at sustaining change:

We've been doing this since April (eight months). We have had a few teething issues, but I think you get that with any group. Got a little lost along the way, but um, yeah, been pretty good about it...loving it. We have restructured a lot now. I have two weeks where I'm on-call, two weeks off-call, two weekends off a month, all good.

Margie had to work through issues that being in a team brought but is now enjoying the benefits of having secure days off and knowing when she is going to be on-call or off-call. It

has brought some normality to her life. It took time, it was not an instant change but worth working it through.

Being change agents

This third theme is about being prepared to make change and being an example to others. The CI midwives felt it not only important to explore ways to make sustainable change but also to take the responsibility of being leaders of change. Being change agents meant we developed our own theories of practise, we were enriching our culture and we needed to be innovative as we lead a culture of change.

Developing our own theories of practice

We found that as we made changes we started to see our philosophy of care changing and we developed new theories about how we practised. Our focus was on introducing self-care to our work and balancing this with the continuity of care relationship that we sought to provide women.

The notion of partnership took on a broader meaning. Evelyn saw that her partnership with her colleagues had taken on a new form of importance in how she now provided her care.

With our practice what I'm seeing is that the partnership is not a one-on-one partnership. The partnership is between the women and midwifery care. So that it is not so much you in that isolated little bubble with that woman, which at times can be quite claustrophobic. You're actually in partnership with your colleagues, but you're also in partnership with that woman as you are providing that care. Like it doesn't matter whether I go to that birth, or somebody else goes to that post-natal, that woman is going to get the exact aligning philosophy.

Evelyn's focus on partnership had the emphasis on a partnership between the midwives providing continuity of 'care' rather than continuity of 'carer'. The midwives in the group were trying to achieve the same consistent approach to advice and care. The care flowed regardless of which midwife in the group saw the woman. The midwives developed care plans and carefully kept them up-to-date and accurate. It is a Section 88 requirement that LMCs develop care plans with women to meet their specific needs (Ministry of Health, 2007). Margie agreed with Evelyn that continuity of care occurred when the members of her team were providing the same consistent advice and care to women. To provide continuity of care from a team there needed to be a partnership between midwives.

Innovation

Thinking about new ways of practise initiated some innovative ideas. Margie was keen for women in their care to feel like they had a sense of belonging. It had concerned her that women could see up to four midwives, not just one or two. She promoted the Internet as a source of information and support, to create the feeling of being a part of a group to meet the women's social and educational needs.

I've also just set up a website for the ladies, so they can put in a code, and then they log in, they can just drop us a line and have a chat. They can link in with other mums due the same month as them. They have got a group thing going on already.

It has been important for Margie to develop ways for the women to feel that they have a sense of belonging. When Margie cared for women on a one-on-one basis this was an important aspect of the care. They felt they could chat with her in a friendly casual manner which made them feel comfortable. In the same way Margie felt that the women, by sharing together on the Internet, could also bring that same feeling of informality and friendship. It also fulfilled a need she had to have close contact with women. The website helped fulfil that need and this time she had control over when she was accessed rather than needing to be on-call to respond to the queries. It allowed her to keep some distance and not feel she needed to be available 24/7 but still created an intimacy as a friend might have.

Margie felt that not only could the case-loading midwives feel isolation when they worked with their own case-load but the women could also feel isolated from others. Margie found that the website was fulfilling a need for women to network with one another. They formed a cybernet support group. To work in a close-knit team there needed to be opportunities to explore new ways to meet the needs of both the women and the midwives.

Leading culture change

We were leading the way for other midwives to follow, establishing a new culture of practise.

Rose was aware that there needed to be a culture change which encompassed having regular time off-call as an essential part of the LMC work-life.

There are two, one in each group of four whom, tend to stay on-call no matter what. But there's various times, despite them saying, oh I could never work like that and be totally off-call, both of them are actually starting doing that. I don't know if deep down they are changing, but they actually are agreeing to take time off at different times. And so I wonder whether their actual terms are changing. They have to cover

for the rest of us, when we're taking time off. So in that respect, there is a, it is becoming more normal, it is becoming more of a culture.

Rose had midwives in her group who felt that taking time off-call was not an option for case-loading midwives. Rose saw that the midwives were changing their attitudes and it was becoming a normal way to practice. They seemed to be becoming more aware of the need for self-care and were accepting that it was 'okay' to take time off-call.

Culture change came about through others providing the lead:

What is really important as well is relating to the other midwives and talking about time off. I think it's been really important for me and the other midwife who wrote up the ideas initially, just over a year ago, about taking regular time off. It's been really important for us to sort of not to enthuse the others, to a certain extent they were keen anyway, most of them, but just to encourage other people and to be vocal about it. Take time off, I will support you, do that, and they'll do the same for me as well. Yeah, it's being vocal and talking through things that have been really important for me.

Rose said that it was important for her to encourage the colleagues she worked with to be aware of the importance of keeping themselves safe and taking time off-call. Rose set the example even though at times it was difficult. She had issues with taking days off. It was not easy to work in with others. She was trying to establish a regular case-load and wanted to be there for women. However, she also knew the importance of a work-life balance and for her this meant time off-call.

We were creating a culture that was prepared to explore change. By meeting together we could discover what others were doing. We considered these ideas and could build on them to introduce them to our own practice if it seemed a good way to go. Some started using a call centre for out of hour calls to help ease the constant phone calls. Others used an 0800 number for urgent calls that they could change from phone to phone when they needed time off-call. Margie had created a blog site and she could respond to at a time convenient for her. These options of communication also allowed the woman to make contact at a time that suited her knowing she would get a timely response. Some practices had a person to help with paperwork and to process the claiming to the Ministry of Health for payment. This freed up the midwives' time for other things and kept their administration side of their business up-to-date.

Summary

Change is both exciting and challenging. We felt some inadequacy in how we dealt with conflict in our practices and tried to manage this to the best of our ability. It seemed at times that we floundered and conflict became a weakness in our teamwork. There were many things that were not possible to change managing as best as we could. This required innovation and business skill. To be able to see the need for change and to make adjustment and further evaluation we practiced reflexivity. Without this reflexivity, we could not see the need for change or understand and evaluate how the change had affected us and the women we cared for.

To sustain change we needed to constantly reflect, evaluate and adjust how we practised. Sustaining change was ongoing and challenging. Communication was a key in making and sustaining change. If we did not have clear communication with our team members it allowed room for misunderstanding. If we did not communicate clearly with our clients then their expectations of care may not have been met. When women knew their LMC had regular time off-call then it protected them from disappointment if she was not there. The midwife would not feel the compulsion to be there for them when she had well-organised time off-call. Clear communication with the women was pivotal to freeing ourselves from a self-imposed obligation.

The focus group encounters provided inspiration and encouragement to put change into place. Meeting together provided the planting of seeds of new ideas. We could see what was working for others and it encouraged each of us to explore the possibility of applying it in our own practice location. We fed off one another's' ideas. Change, however, took time and we faced challenges that needed to be worked through. We encountered obstacles along the way that we had to overcome. We understood the nature of personality differences but at times the conflict between group members was difficult to resolve. We each came with our own background and understandings of how to do things and had to negotiate and compromise as we worked in with others. We negotiated our changes using the attributes of trust, respect, perseverance and commitment, with a flexible approach. We broke with old habits and decided on our priorities in life to be able to make change. We stepped forward. We shook off a need to conform to our past ideology. Through absolute need to gain a better life balance we crafted practices specific to our circumstances. We created practices to meet our need for personal well-being and to enrich our midwifery culture through the exploration and

implementation of new possibilities. We were leading the way for other midwives to follow. We were being agents for change, supporting, encouraging and affirming each other through the process.

CHAPTER TEN

The continuing journey

It is an evolutionary process, and our ways of working and ensuring long-term viability are continuously changing as we learn, adjust and integrate new understandings about how to act in order to achieve the best from our model over time. (Brodie et al., 2008, p. 151)

In this chapter I firstly extend the synopsis from chapter four of how Bourdieu's concepts can be applied to the experience of case-loading practice. Bourdieu's ideas are used to provide some insight into understanding the life of the CI midwife and her need to change. Secondly, I summarise the journey of each CI midwife. We developed our practices in different ways reflecting our own situations to better protect our well-being. There was no single right way for us as case-loading midwives to provide continuity of care. We had to make the most of the situation which we were in. We strove to find ways to provide women-centred care that met our midwifery standards of practice required by the Midwifery Council of New Zealand (NZCOM, 2008b). We were also required to fulfil our obligations for maternity care set by the Ministry of Health (Ministry of Health, 2007). We explored ways to fulfil our obligation to continuity of care. It needed to meet both the need of women and our need to practise in a sustainable way.

Bourdieu and case-loading midwifery

To understand the tensions we were experiencing, our experiences are placed in the context of Bourdieu's framework of habitus, social fields and capital. As mentioned in the methodology section we coexisted in a large field made up of other maternity practitioners, alongside the women and their families, in a common field of power. In this field we had a responsibility to fulfil our obligations within the Ministry of Health criteria. Next we sat in a field with other midwives mediated by the philosophy and standards of practice set by the Midwifery Council of New Zealand. We were also situated in our own field of practice and the social fields that made up our own private world. What went on in each field was interdependent with the habitus and capital of the field and other interrelated fields (Thomson, 2008).

Habitus

Each person forms their own habitus: that is the cultural structures that exist in their bodies and minds, unique to them (Maton, 2008). Maton (2008) describes the habitus as a focus on

“our ways of acting, feeling, thinking and being” (p. 52). The habitus is seen as “capturing how we carry within us our history, how we bring this history into our present circumstances, and how we then make choices to act in certain ways and not others” (Maton, 2008, p. 52). The effects of the habitus rather than habitus itself are seen, which reveals how the midwives have been practising and were able to change their practice (Maton, 2008). To understand the practice of the CI midwife there was a need to understand both the habitus of the midwife that she brought to her social fields and the evolving fields in which she was situated (Maton, 2008). It was about the relationship between her habitus and her current circumstances in the field.

As well as our own habitus each of us shared a collective habitus of the field of midwifery (Thomson, 2008). New Zealand midwifery has developed a philosophy of partnership and continuity of care for women throughout the childbirth continuum (Guilliland & Pairman, 1994). The habitus of our midwifery field has become an embodiment of the concepts of partnership and continuity of care. Guilliland and Pairman (2010b) describe partnership as “a relationship based on negotiation, equity and shared decision making” (p. 630). Since 1990, women have had the option of choosing a general practitioner, an obstetric specialist or a midwife to provide their maternity care. Over the years this choice has narrowed with only a few general practitioners still involved in primary maternity care. Initially, the women who sought midwifery care wanted the holistic approach to birth that midwifery care offered. It provided an alternative to a medical approach. Birth advocates reflected this attitude of women and promoted natural childbirth and encouraged resistance to intervention. It was seen to be enabled through a close relationship with a known midwife (Flint, 1986; Kitzinger, 1991). As time has moved on women have become comfortable and empowered by technological intervention and have changed this stance of resistance (McAra-Couper, 2007). The CI midwife needed to negotiate the type of partnership care the woman wished to receive. Some women displayed a desire to have full participation in their care and seek a non-interventionist approach to birth and some saw that safety in childbirth was achieved through medical and technological intervention.

Academics have discussed how the partnership philosophy is understood and practiced in different ways and as such may not be a realistic representation of the nature of our practice today (Benn, 1999; Daellenbach, 1999; J. Skinner, 2003). Some CI midwives felt that they played lip service to the term ‘partnership’. They felt that it was hard to achieve a partnership relationship. From Bourdieu’s perspective we could view this ‘acting out of partnership’ as a

taken-for-granted, doxic status (Crossley, 2005, p. 98). This sees the partnership model as a classificatory struggle with the outcome and influence having outlived any reflective memory of the issues that were involved when it was formulated. Regardless, however, of the ideas we may have about partnership and its implication for practice, it underpins our profession. Midwives are to pursue a partnership relationship with women (NZCOM, 2008b). Everyone is shaped by different social and cultural values and beliefs (McAra-Couper, 2007). It cannot be expected that all women have the same understanding of a partnership concept. To project our understanding of the partnership relationship onto the women we cared for could create a deficit in power. We needed to create relationships of partnership that met the woman's needs. We needed to reformulate our own assumptions of how the partnership model could be used. We needed to re-inform our habitus. For some of us it required a complete change in our thinking. As Guilliland and Pairman (2010b) have reminded us "the partnership relationship between the woman and the midwife works to enable both partners to recognise and act on their own autonomy" (p. 631).

In our work with women we recognised that continuity of care enhanced partnership (NZCOM, 2008b). Yet in our pursuit of continuity of care we identified that providing incessant on-call care posed a potential risk to our well-being. We saw how our belief in our commitment to be available to women could drive us to excessive limits of availability in our care provision. This was not something that was expected of us from our professional body or necessary for us in fulfilling our contract with the Ministry of Health. It was the deep seated assumptions that had developed over time that had shaped the habitus of our professional milieu and our individual habitus and dictated how we went about our day-to-day business (Maton, 2008). Our habitus was structured by our past and present circumstances and was important in structuring our future. It did not act alone but was affected by an unconscious relationship with our position in the midwifery field and how the game in that field was played (Thomson, 2008).

Social field

The concept of fields is used to describe the systems or subsystems of the social world (Crossley, 2005). Bourdieu saw social life as a game where it was played out by the conditions in the field and the position of the player (Thomson, 2008). The maternity arena, the field in which midwifery sits, is constantly readjusting to the contemporary world. Some of us had reached a crisis point. It was a mismatch of our subjective expectations and the

objective reality. It was a conflict between the ideology of the past and how it is today. We had been carrying outdated ideologies into the present. As Crossley (2005) presented it “...habits and assumptions which steer action under normal conditions are brought to consciousness, questioned and replaced with a more deliberate and critical mode of relating to the social world” (p. 50). We were now seeing the need to create practices relevant to today. Midwives gravitate toward a sub-field of practice within their midwifery field that best suits their disposition. For example they will choose whether they wish to do shift work or provide continuity of care. The midwife would usually avoid a field where there would be a clash between her habitus and the doxa, the unwritten rules, of that field. The case-loading midwife would flourish when she had a field-habitus match. There would be the assumption, that went without saying, that set the limits of the “doable and the thinkable” (Maton, 2008, p. 59).

Changes in the field, to keep up with the times, can occur at a faster rate than the habitus of the members. This can cause a misalignment between their habitus and that of the field. The habitus of each individual is so instilled by the original biases that it develops a momentum to keep generating the same practises despite change in the field (Maton, 2008). The “hysteresis effect” is the term given when this occurs. The habitus dictates how the midwives attend to the present and anticipate the future in terms of their previous experience (Swartz, 1997). Hysteresis is about the habitus of members being out of sync with the field (Maton, 2008). The habitus of the CI midwives still embodied some of the dispositions that were required for practice of almost 20 years ago. Midwives then, were working in a climate of economic competition brought about by a wave of health reform where policy makers were rethinking their assumptions and exploring new ways of organising healthcare (Boston, 1991). The change in the Nurses Amendment Act in 1990 suddenly placed midwives with the responsibility of being a main maternity care provider. Midwives had a lot at stake to prove that they could provide a quality maternity service. Their holistic approach provided an alternative to the medical approach to birth (Donley, 1998). Many worked to provide 100% one-on-one care for their clients. The term ‘independent midwife’ came about to differentiate them from a hospital midwife. Independent midwives often worked in a very insular way separated from other health practitioners (Roberts, 1989). They tended to work on their own or in small groups with loose arrangements of cover between them. This ideal of partnership and continuity of care appears to have taken a toll on the midwifery work-force by placing high expectations on the compassionate nature of the midwife.

Some of the CI midwives had referred to themselves as having previously provided a ‘sole care provider’ service. They had developed a relationship with a woman that was like interdependency. They had to ‘let go’ of this ‘ownership’ of a woman in their care before they could work in collaboration with colleagues to have regular time off. Mary, Lorraine, Evelyn and Margie, for example, had been at the point where they could no longer carry on working in their individual practices so they joined a team. During this project they described their relook at their understanding of continuity of care and partnership. They needed to adapt their care philosophy to be able to work within a team. Evelyn described how in her team her clients were also seen by other midwives. They approached partnership not as a one-on-one carer but a partnership with a ‘shared philosophy’. No matter which midwife in the group saw the woman, the care would be given in a consistent manner of advice and application. So Evelyn knew in her absence the women would receive the care that she herself would have provided. She overcame her need to be the ‘sole care provider’.

Capital

The accumulation of capital is a competitive game used so one can be more successful than others (Thomson, 2008). The cultural capital of midwifery was important to the CI midwives. For many their cultural capital was the close relationship they received from providing continuity of care while working in partnership with women. They aspired to provide a one-on-one relationship giving 100% on-call availability. Partnership was written into the standards of practice where a midwife worked in many ways to provide maternity services in a close relationship with women and their whanau (Guilliland & Pairman, 1994). Midwives are expected to work in partnership with women, providing or supporting continuity of midwifery care throughout the women’s experiences. They are also expected to work collaboratively with other health professionals, when necessary to meet any additional medical, health or social needs of mothers and their babies. New Zealand midwifery has become a world leader in women-centred midwifery care that provides collaboration with other health care services. In 2011, at the 29th Triennial Congress of the International Confederation of Midwives (ICM) in South Africa, the New Zealand-led midwifery system was hailed as “leading the world in setting the standards for midwifery practice and professionalism, citing midwifery education, regulation and training, and strong collaboration with other health professionals” (NZCOM, 2011).

By forming an objective description of the social field it is suggested it can show where there is this disparity between appearance and reality in practice and by revealing the 'illusio' (the belief in the game) to free the agents in the field (Dreyfus & Rabinow, 1993). This is the use of self-deception to keep the players in the game to maximise the symbolic capital in some social fields. We received satisfaction of care from the close relationships we formed with women that we acquired through the provision of continuity of care. The more availability we provided, the greater the satisfaction or distinction we seemed to achieve. Yielding a profit in distinction, a profit in legitimacy, set us apart. It made us feel justified in being who we were and being what it was right to be (Bourdieu, 1984). The amount of accumulated symbolic capital we each achieved enabled us to feel we had achieved our part in the game. Our cultural capital of midwifery fed off our habitus and informed it. It kept perpetuating itself. We desired this relationship with women, yet saw that it also created a tension in our lives. Bourdieu might say that this commitment to women was about our belief in the game, an illusio (Crossley, 2005). It was the magic that animated our social involvement upheld by our doxic belief. The illusio set the tone of how we practised.

The emphasis of the field has moved from an insular view of the care between the woman and the midwife to a more collaborative view of the woman's care. The CI midwives had been striving to keep the care focussed between two parties when in reality women have multiple service involvement in their care. The LMC midwife has become more of a 'coordinator' of services rather than a 'sole-care' provider. The case-loading midwife, as the Lead Maternity Carer, was still the person constant in the women's care, but also the one who coordinates the women's care with the many services that are available to them. However, this continuity of care should not demand a 100% sacrifice of the midwife's time. There is provision in the Maternity Services Notice for the midwife to arrange her care provision for adequate time off-call. The barrier we faced in taking time off was not with official rules or regulations but from an unwritten rule of the game, the doxa, set by our habitus. As mentioned above our habitus had become out of line with the field in a process called hysteresis, where the practises of the social agents could be "anachronistic, stubbornly resistant or ill-informed" (Maton, 2008, p. 59). We were in a conflict between the out-dated demand of our habitus and that of the reality of the field; a mismatch between the subjective, what we thought was right, and the objective facts. This produced confusion in our role and subsequently affected our well-being.

Many case-loading midwives develop a close relationship with the woman which builds up their midwifery capital. The midwives working with a team approach to continuity of care switched from this view of gaining capital from the woman-midwife relationship. They now drew their satisfaction from knowing women were able to receive safe care that met the unique choice of each individual client. This was to cultivate a culture of midwifery that remained women-centred and was safe for the women but also for the midwife. Some of the partnership relationships we had formed had created a picture of dependency, not one of a healthy woman-to-midwife professional relationship. The more some of us worked in a close group or team situation the more we appreciated this flexible relationship with clients. It freed us from the strong emotional bond that had created an almost unsustainable commitment of always needing to be there. At times this had driven us to excessive hours of work that we felt had compromised our safety and that of the woman.

Some of the CI midwives talked about how their relationships with women had given them a status of power. They accumulated cultural capital through these relationships which became a sign of distinction for them. They believed this would keep women in their care and that others would be drawn to their care provision because of the commitment they displayed to women. Rachelle was fearful that she would lose clients from her care if she was not always on-call for them. Thomson (2008) notes that there can be a struggle in the field between various actors, either a struggle for transformation or for preservation. Skye, Janet and Kathryn represented actors who struggled for preservation in what they believed was right for them. They wanted to continue to seek the close relationships through one-on-one continuity of care. This form of care provided them with the capital to provide the status of distinction they sought. They pursued ways to create a better work-life balance within their existing doxa. Robyn, Mary, Lorraine, Margie, Evelyn and Rose were willing to forego this exclusive one-on-one relationship with women to preserve their work-life balance by providing continuity of care through a team care approach. They sought to build capital through a more collaborative approach to care.

The cooperative inquiry midwives' stories of action change

The CI midwives had different stories to tell. Following is a summary of each one's journey.

Cherry

The action research for Cherry empowered her to overcome the guilt she experienced when she was not available for her clients. Discussion of partnership and continuity of care in our group allowed Cherry to see the assumed expectations of partnership and continuity of care that she had taken on. She realised that she needed regular scheduled time off. For Cherry it had become an unreasonable expectation to be available 24/7 on-call. Sharing her experience of how she worked in the case-loading team helped her to examine her situation. Through the discussions in the focus groups she gained permission, being released from the ideals of continuity of care and partnership that she held. She was able to see that it was acceptable and necessary to have time off. Group sharing endorsed this need for time off so she could be a safe practitioner and enjoy her own time without being on-call.

The woman and midwife have a responsibility to make partnership work yet often the 'making it work' falls on the midwife. It may appear to come as second nature for the midwife but not for the woman. Cherry found she often needed to foster the midwife-woman partnership. When the power was out of balance it rested on her to compensate or correct. Cherry discussed the guilt she experienced when she was not available for a birth. She struggled with knowing when she could take time out. She had no control over when a woman may need her and she seemed to have created in the woman an expectation that she would be there for her. The language of 'partnership' for her had become a source of symbolic domination. Schubert (2008) sees that symbolic domination is becoming more significant in our contemporary capitalist society. There is political struggle in efforts to legitimise systems of classification and categorisation (Schubert, 2008). For example the effect of the consumer culture has placed an emphasis on the interests of the women as the consumer. In a subtle way this had turned the partnership Cherry had with women into a form of symbolic violence. Sometimes the woman could display her displeasure if Cherry had not been available. This made Cherry feel she was not fulfilling her obligation despite making every effort to be available. This guilt drove Cherry to take less time off-call. Cherry realised that she had the choice of giving into guilt or making changes to her thinking, examining why she practised as she did, and then to make changes to how she practised. Then clear communication with the woman was needed so the woman knew and understood why Cherry

would not be there and that her back-up would be available. Her habitus had to change; her belief in how she provided care had to change to be able to take time off-call without feeling guilty.

Cherry had an 'aha' experience to make her realise that she was not in control of her life. Her case-loading care dictated what she did and did not do. It controlled where she went and where she did not go. The opportunities in her life narrowed as her on-call responsibilities swallowed up her personal life. Cherry worked in a case-load setting with team back-up and time off-call. She had opted not to use this back-up on a regular and frequent basis. Despite knowing she would be unsafe if she worked long hours or knowing she needed days off to recharge emotionally and physically she still struggled when she did have to handover care. Cherry talked of the guilt she had experienced when she 'was not there' for the woman. Not until she realised that her belief in the continuity of care ethic of working 24/7 on-call was so embedded in her tacit understanding of how things should be, was she able to make effective change. As Cherry and others discovered, there was more to it than just simply getting someone else to cover or restructure how they practised. There needed to be a rewriting of their fundamental belief about how they provided continuity of care.

May

May has been working on streamlining her practice to free up more time during the day. She also has been working on getting more consistent time off. May had wanted to find a practice partner that she could have a reciprocal care arrangement with. Everyone else seemed to have someone to work with. Her busyness in life made it hard to find a suitable arrangement so she continued working in the larger group she was affiliated with. She did feel she remained in a vulnerable situation with poor cover arrangements. May continued to work on ways she could make her practice fit around her personal needs.

May, like many case-loading midwives, had rooms or a clinic, where most of her clients came to visit her for their antenatal checks. She found for some working women it was difficult to come to these clinical rooms during work hours. To accommodate their needs and to free up her time working later in the day at the rooms, May commenced visiting these women at home. Often this was still later in the day, but on her way home. The idea was also to save money as she paid for the room rent by the hour. Providing the antenatal home visits became frustrating for May. There were days when she did not always make it home at the time that she had planned due to the on-call nature of her role. In the end she decided it was

easier to have the women come at a set time and for her to pay someone else to see them if she was not available. Another way to reduce her workload, May had decided, was to not take women having their first baby.

A big issue that continued to face May was the love/hate relationship that she had with her midwifery lifestyle. She struggled with the phone calls that could come at any time of day or night. She struggled with being available anytime. Young (2011) found that an accruing antipathy toward their phone could be an announcement of burnout. May knew she needed to do something about this if she were to sustain her practice long term. She managed to relieve this burden of always needing to be available to answer the phone, at seemingly all hours of the day and night, by using a 24/7 0800 call centre service. The clients' calls were triaged by registered midwives who gave advice. The call centre midwives only alerted the LMC if it was an urgent matter. This gave May opportunity to turn her mobile phone off at night and the call centre could contact her on her home phone for just the urgent calls.

So, by default, May chose to continue working by herself with just loose group support. She could not find anyone else to work with. She would just take time off when there was a specific occasion that required it rather than set days off each week or fortnight. Working 'on her own' meant she could fit in private commitments during the day. For example, if her husband had been away and needed to be picked up or dropped off at the airport, then she was free to do this and not locked into covering clinics for others. She felt in the end that the beauty of being 'her own boss' rather than working in a group for cover gave her the opportunity for spontaneity and flexibility in her day time activities.

Skye

Skye worked in a rural location and had other midwives to provide back-up when it was needed. She liked to provide the women with one-on-one care. She expressed how through providing 24/7 on-call care she gained status in the community. This was important for Skye. Continuity of care provided Skye with symbolic capital. Symbolic capital provided her with status attainment (Calhoun, 1993). Yet Skye talked of how she faced burnout. Her belief in the game, her *illusio*, was threatened (Crossley, 2005).

Skye considered working in a team but felt it would not fulfil the commitment she had to women. Instead Skye chose to continue to provide 24/7 care and to use locum cover for arranged blocks of leave during the year. Skye received assistance through the rural locum

relief support fund that is now available through the New Zealand College of Midwives and the Midwives and Maternity Providers Organisation (Guilliland & Pairman, 2010b). This relieved Skye of the expectation to be there during that time. In this way she could continue with her case-load and cope through the busy times knowing she would get arranged time off. Having a locum meant another midwife was available to provide support to her colleagues and to provide care to her case-load. Having locum cover was a relief for Skye. It sustained her to still meet her belief in the game providing 24/7 on-call care during the rest of the year.

Mary

Mary wanted to provide case-loading care. She, however, found that it was increasingly difficult to balance the on-call nature of her work with her non-work activities. Mary had a busy home-life with adult children living at home and visiting and assisting aging parents. She liked to take leave in the school holidays at the same time as her partner. Mary loved handcrafts but needed the same time off each week to attend her craft group. Making trips out of the city to visit family was also important. Having structured time off gave Mary the opportunity to meet her professional commitments and enjoy her family and leisure time activities. Although it was not possible to attend every weekly craft group session Mary could definitely make it every other week as her days off were always the Thursday, Friday, Saturday, Sunday and Monday every fortnight.

Having regular and predictable time off turned life around for Mary. It gave her guaranteed cover for her days off with guaranteed income and she knew that her clients would be well cared for in her absence. Mary still struggled with the nine days she still worked on-call. This was alleviated though with the back-up from a colleague so that sleep during the day after an all-night birth was guaranteed. Any of the arranged midwifery visits during the day would be done for her by a team member. She found that, although it was rewarding to work in a team, the relationships between team members was challenging. Mary found that relationships and addressing conflict needed to be constantly worked at. Over the time of her involvement in the project she had worked on how to consolidate the practice. Communication became an important feature. Not only communication with the women so they knew that she may not be the midwife at the birth but also with team members. She ensured that they had regular weekly meetings recording all they discussed. Whenever there was a dispute within the group about changes they undertook, they could look back and see what they had actually agreed on. Mary found that it was not enough to just have a verbal agreement. This needed to be

backed by a written record. It was easy to forget what was said and agreed on. Having set meeting times with written records reduced unnecessary conflict situations.

Joan

Joan, simultaneously with the beginning of the project, organised regular cover and stopped agreeing to take on extra clients once she had reached her decided client load for a particular month. This meant she could enjoy life again and do the things she really wanted to do outside of midwifery. Unfortunately, it meant she would not carry on with the research project as she felt that she had achieved the work-life balance she sought. Meeting at the first focus group helped reinforce her realisation that a lot of midwives like her wanted to change how they were practising to make life better. Joan was fortunate that she had midwives in her area that also wanted to work in a reciprocal manner for regular and more frequent time off. She had put this into place and was enjoying the time off-call to do non-work activities. It was a relief to do these things, without the thought that a woman could call her anytime, and to be able to go places that would be out of range of the mobile phone.

Mariana

Mariana worked in a structured team environment employed by a District Health Board. This provided Mariana with adequate time off-call. What was difficult for Mariana was how to balance her day-to-day workload, so that when she was working, her load was not too heavy. Involvement in the action research project encouraged Mariana to make a difference in her situation. She collated data from her case-load to compare the time involved with the different women in her care. She observed that she cared for a lot of high-risk clients. These clients required more frequent visits and longer sessions to meet their needs. She felt this did not leave her with enough time then to be spent with the lower risk women in her care. Mariana was able to present this data to management and arranged for a lower case-load for those in her team who carried a case-load with high risk women.

Rose

Rose identified a personal need to have more down time to spend with her family. Rose has seen many casualties in her work experience, not just midwifery, but of those who have not taken time out from their pressured work situations. She set an example and encouraged other midwives to see the benefits of taking time off. She identified that women needed to rely on their own abilities and their family support rather than be dependent on a particular midwife

and her personality. The midwife, although she endeavours to be available at all times for the women, may or may not necessarily be available at the time of their birth. Rose experienced that if she was not available in this way, it created disappointment for the women. She developed feelings of guilt for not having achieved the woman's expectation and her own commitment to be there.

Rose investigated ways she could make arranged time off work for both the client and herself. She first knew the importance of providing clear communication about her back-up arrangements for days off. Empowerment of women was a poignant focus of her care so that women were prepared and strong for labour. It was important to Rose that women were satisfied with their care. The women in her care were given the opportunity to provide feedback about the care which she used for reflection in modifying how she practiced. It was hard for Rose but she was able to break free of the 'hysteresis effect'. This was where she felt that her practice had not been aligned with the thinking of the women of today. She had started to shape a new habitus that allowed her a better fit between the fields she mediated in, both her work and her personal life.

We discussed in our focus group sessions that no matter how much we wanted to attain 100% on-call availability, it was at odds with the other spheres in our life. Bourdieu developed a concept of orthodoxy with a corollary heterodoxy (Deer, 2008) which provides an understanding of how this 'game of midwifery' is played. We discussed how we felt that the accepted view of practice was where the woman and the midwife shared in a partnership. The midwife provided continuity of care and was available for the woman by being on-call 24/7. Her ability to accumulate other capital from other fields in her life however competed with her ambition to amass her midwifery capital: the close relationship that she gained through continuity of care. This imbalance in her life caused her to struggle to sustain her orthodox approach in her day-to-day midwifery practises. Rose and other midwives were able to break free of this mould. They became 'doxa breakers'. The tension that was always present had forced Rose to recognise the competing beliefs from other social fields in her life. Her life needed to have a better fit at the intersection of the other social fields in her life. In Bourdieu's terms she moved from a position of orthodoxy to heterodoxy. Her participation in the action research project reinforced her changed thinking as other co-participants were also going through similar changes. We learnt from each other about different ways we could practise continuity of care to make our work-life balance better.

Robyn

Robyn had wanted to provide case-loading care but already knew she could only do it if she had regular time off-call. It took time to establish a team of three to be able to achieve this. What was good for Robyn was the certainty of having days off and being able to plan off-work activities well in advance. The team had achieved a good level of structure so that the care they provided flowed. They had weekly business meetings and often met socially, as they felt this was important in understanding each other, to help teamwork. Robyn's biggest challenge was finding the best way to keep the communication open between the members. Although they worked together well, different issues would arise. For example, if more than one client was not happy with a midwife's care they needed to know how to discuss and resolve this. It was not easy to challenge a team member without the person feeling singled out. Deciding on annual leave was another issue that arose. Some midwives wanted the same time off. They had to negotiate and work it through. During the project a fourth member joined the group. This provided greater relief for taking time off. They booked out six weeks twice a year, summer and winter, where they took half their usual case-load. They each had three weeks off in the two blocks of time while the opposite pair of midwives worked to service the lowered case-load.

Sometimes discussions would become heated but they had to trust that they were mature enough to work through the issues. Being in the project reassured Robyn that conflict did occur in other teams as well. It helped Robyn to see how others resolved issues so she could learn from them. An important aspect of communication that Robyn learnt was to address conflict early or it could escalate. Appelbaum et al. (1999) agrees that conflict should be exposed early as avoidance can lead to its escalation. Robyn learnt to 'pick her fights'. Some conflict would be only fleeting and was best left alone. Other times conflict could be used as a positive change for the practice. It provided opportunity to put new structure in place to avert it occurring again in the future. Appelbaum et al. (1999) said "the aim therefore should not be in reducing the conflict but ensuring that the conflict is beneficial" (p. 60). Robyn learnt that conflict would be a part of her practice and that it could not be suppressed. It was to their advantage to make it work for them, not against them.

Evelyn

Evelyn found that although working in a group brought the advantage of time off, it also brought its difficulties in finding others who wanted to work in similar ways. It took Evelyn

time to build up a practice and bring other midwives on board so that the regular time off-call became a reality. The midwives realised they had been doing all the 'doing' with women which had created a dependency on them. This resulted in extra demands on their time. By modifying how they provided continuity of care it benefited both the women and themselves. They looked at ways to empower women rather than allow them to be dependent on the midwife for everything. The more empowered the women were the more they were in control of their circumstances and shared responsibility of their care in partnership with the midwife. The midwife maintained a good level of continuity of care but also had a safe practice by being able to have regular time off. The balance of power was restored between both parties.

Evelyn had been working on-call 24/7 with her individual case-load. She had been trapped feeling that the women were controlling her availability which intruded adversely on her 'non-midwife' side of life. In order for Evelyn to regain control of her work and private life she had to change how she practiced. Evelyn and the group she worked with had created their own practice philosophy to empower women in a way that they are not dependent on the same midwife. They called it 'a partnership with a shared philosophy of care'. All the women in their care knew that they shared the same approach to advice and care.

Evelyn's group arranged their cover to complement the different time off needs that each midwife had. They also shaped their practice so the clients would have a known midwife at their birth. They had two clinic days a week that were attended by all the midwives so the women could get to know them all. If someone had a birth they would cover any antenatal or post-natal visits for that midwife. When Evelyn worked on her own she found that sometimes a post-natal visit would come second to a woman in labour as it was difficult to arrange a visit from a suitable back-up person. Working as a group meant that if she was at a birth someone else was easily available and accessible, to see the client in the community, who shared the same practice philosophy.

There were no regrets, no reports of feeling less than a midwife once she had made this change. There was no indication that women were not happy with the service. She changed her thinking and her approach to allow 'me' time. Evelyn realised it was up to her to set the scene, to provide the women with the limits of her availability and set the expectations for the women. Evelyn had been assuming that the women would know when it was appropriate to call her or not. When Evelyn voiced her expectations for her care provision it provided the

women with clear communication about the care she would provide. They then had a realistic expectation of when to call and what to call for.

Evelyn felt that she had carried the burden of the group's development and often forfeited time off when there was limited cover so that others in the group could benefit. In the efforts to establish a group practice to provide a better work-life balance it brought other issues that needed to be addressed. It was hard to keep the team united. There were two midwives in the group who did not want to share in the same philosophy and wanted to work in their own way so they chose to leave the practice. This was disappointing for the group as it reduced the number of midwives available to provide back-up but the break up was necessary to maintain consistent practise from the group members. Evelyn found out that the bigger the group the more difficult it could be to stay together. Each midwife had equal status so decisions were made by general consensus. This made it harder to be innovative and stay together as sometimes conflict arose that was hard to manage.

Margie

Margie saw there were great benefits in a team approach to care. The foremost was not always being on-call. There were four team members and they worked a rotation of three weeks. One week you would be on-call, the second week you would be on antenatal visits and clinics, and the third week you would do post-natal visits. The fourth midwife would be the floating midwife working where it was needed. Women reported that they enjoyed the team approach. Two women recently changed from their care but it was because they wanted private obstetrician care not because of their team structure. It was so refreshing for Margie to have women enjoying a service where they were not disappointed if their LMC was not there for the birth. She enjoyed being on a salary and not having to worry about Goods and Service Tax (GST) returns, Accident Compensation Corporation (ACC) payments and everything else that comes with self-employment. She loved how she now worked and was thankful that she will not go to her death bed wishing that she had been there for her son's birthday or wishing she had taken on more clients to pay her bills. Margie no longer felt guilt for not being there for women. 'Being there' was no longer an expectation for either the women or for her.

Rachelle

Rachelle used the time of the project to confirm her ideas that she needed to work in a closer collegial relationship with a team to provide continuity of care. During her time with the project she examined her practice and felt that the on-call availability, although important for her to achieve a unique relationship with women, needed too much of a compromise toward time with her partner and her family. Rachelle commenced working in a team with three other case-loading midwives. They had a system where they worked in pairs to keep one-on-one care as much as they could for each woman but still have two days off each week including a weekend off every two weeks. Rachelle found that her actual work days may have been longer now she was working with the team but enjoyed the opportunity to have set days off to spend time with family.

Ellie

The group discussion empowered Ellie to make an effort to initiate changes to improve her group's dynamics. She planned to introduce a social as well as a work dimension to their team. She planned to discuss the attrition rate of the group with their team manager to see if team numbers could be increased. She was also going to look at ways she personally could make a difference in her relationship with the third member. Unexpectedly a fourth member re-joined her group and immediately the dynamics changed. On contact with Ellie after the project ceased she had decided to go into self-employed case-loading practice. She was thankful for the experience she had had with the cooperative inquiry group and intended to work in a group situation that provided adequate time off-call.

Janet

Janet worked on streamlining her practice to free up more time during the day to do other things. She was relatively happy with one weekend off every three weeks but felt the way she worked did not allow for any more time off-call. Janet, in her quest to free up more time in her day-to-day activities, identified that she was making too frequent and too many antenatal visits. She had not considered that women may prefer her to come less frequently and that their needs could still be amply met with fewer visits. This would allow Janet to spend more time on other more pressing matters or on more time out for herself. Many women in her care were working women who sometimes found getting time off work difficult and so did not want extra visits. In the past large hospital clinics processed women for antenatal checks so

developed strict visit protocol. These were adhered to so women were not 'lost' in the system. Now women can have a chosen LMC or a back-up that is available to them 24 hours a day so this would not occur as each woman is individually known to the LMC (the case-loading midwife). The NZCOM Standards of Practice have six decision points to be built into the antenatal care schedule (NZCOM, 2008b). Visits are tailor-made to meet the woman's needs rather than meeting a regimented schedule.

After cutting down the number of antenatal visits and being pleasantly surprised that the women did not even know any difference Janet chose to cut down the number of post-natal visits. Not only did she do that but she commenced a 'drop in' afternoon to cater for the needs of the busy mothers who found it too difficult to wait at home all day for the midwife to visit. Janet started thinking about what women would like rather than the routines and guidelines that she had always adhered to. She had been bound by her habitus which was controlling what she thought she should be doing. Participating in this action research gave Janet the platform to challenge her old ideas and explore and develop new ways of doing things. What Janet achieved opened up the way for others in the group to experiment and challenge how they ran their day-to-day practice.

Kathryn

Kathryn and others demonstrated an understanding of continuity of care that was an example of how their thinking was shaped by the 'doxa', the unwritten rules of the game. There was a strong current of thought that for continuity of care to be in its purest form the expectation was that the midwife should always be on-call. It needed a major life crisis to prevent Kathryn from not being there for the woman. If she could not provide care in this manner then she felt she could not continue to work as a 'true' case-loading midwife. Kathryn believed that she could only work on a 24/7 basis to fulfil her philosophy of practice. If she could no longer work in this way she felt she would need to work as a midwife in a hospital setting with set shift work hours. To provide case-loading care while sharing clients with other midwives she considered would be breaking the rules of the game.

Lorraine

Lorraine was tired of providing on-call 24/7 care. She had practised this for many years. The project helped her to work through why she had practised the way she did with such dedicated commitment. It allowed her to examine how she could practise as part of a team.

The voices of the other CI midwives gave her new ideas to consider and helped her change her assumptions of partnership and continuity of care. She realised the importance of practising self-care. She looked at her life and realised that often the way she worked, often working hours on end without a break, was not safe for either her or the women in her care. To achieve a more balanced approach to continuity of care and enrich her personal life she decided team work was the way she would like to practise. This did not come easily. She needed to find others to work the same way as her. They needed to have the same case-load numbers and complementing personalities. She felt it important to share the income so that no one was disadvantaged financially. They worked out an excellent system and did achieve to work successfully as a close team. Lorraine shared that her biggest challenges to working in a team were dealing with the communication and conflict that occurred between members and losing the freedom to make her own practice decisions.

Bronwyn

Bronwyn continued to wrestle with taking regular time off-call against being true to her philosophy of practice to be there at all times for all the women in her care. Over the past year and a half she had taken a small case-load and had done some locum work. She felt stressed carrying the phone as she found this intruded on her personal life. She loved her running and being available for her grandchildren. She would often have down time but it had become problematic because she could not care for her grandchildren when she was on-call. Over the eighteen months of the action research project Bronwyn was keen to set up a team to get a work-life balance that suited her needs and operate as a LMC with regular time off. This never happened. Bronwyn could not find anyone to work with. Everyone else in her area was in their own group arrangement with no space to accommodate someone else. She felt she could not continue case-loading practice.

Summary

Many of us were in crisis. We needed to address how we worked to be able to sustain providing continuity of care. Some were on the point of burnout. The concepts of habitus, capital and field provided empirically important tools for analysing the situation. It showed how the habitus and field had slipped out of alignment with one another. Our assumptions about how we should practise did not meet our personal needs. The way many of us were thinking about our practise did not match the current state of play in many of our social arenas. This process of change was about bringing the habitus and fields into alignment. Ideas

were shared, considered and taken on board by each one to change or modify their practices over the 18 months of research.

Skye, Janet and Kathryn continued to provide 24/7 on-call care to their clients taking minimal time off-call. Mariana was working in a team situation that provided her with a good balance between her on-call and off-call work. Throughout the project she had endeavoured to improve the selection of her client base to reduce her workload stress. Rachelle, Janet, May and Bronwyn used the time of the project to consider the direction they were choosing to take for their midwifery practice at the same time as working through current practice issues that faced them. Cherry, Mary, Joan, Rose, Robyn, Evelyn, Margie, and Lorraine used the process of the study to transform their place in the field. They saw a need to remould their assumptions of continuity of care and change their practise to keep in pace with the changes in the larger field of power. They needed to keep in pace with the other intersecting social fields of their personal world. They were prepared to lead a culture of change.

The habitus of each individual played an important part in how we played the game in our field of midwifery practice. Some CI midwives recognised that their habitus had not changed with the changes in society so they sought to create new rules of how to play their game. Other CI midwives chose to preserve their belief in the game and sought ways to relieve the tension in their lives within their existing doxa. Power struggles existed in the CI midwife's life as she sought to balance her personal and work responsibilities. A power struggle also existed between midwives as they all strove to find their place in the field of midwifery. They each were in competition to accumulate their cultural capital. Some identified strongly with the relationships they sought with women and others, through the professional care they provided in partnership with colleagues. They all strove to meet their statutory requirements and to meet the standards of their profession while achieving a better balance with their private world.

CHAPTER ELEVEN

Concluding chapter

The infinite human resource we have for generating constructive organizational change is our collective imagination and discourse about the future.

(Cooperrider & Whitney, 2005, p. 52)

It is important that we stop and reflect on our own situation and reflect on where others have been and what they have done. We need to learn from our own experiences and from those of others so we can create a better future. During the course of the research I took the opportunity to have a couple of weeks in France. I biked with my husband from Paris to Marseilles. Something that stood out for me that made the whole experience quite successful was the fact that I had read a book that had been written by some other cyclists who had made a similar journey not long before. I had not planned to read the book as I was really busy with my study and work and getting ready to go. A friend insisted that she loan it to me. It turned out to be the best thing I could have done. We were able to learn from their experience and know exactly how to prepare ourselves for our adventure. The sharing of this research through presentations and informal conversations is already achieving this same thing for others. It is giving midwives who want to make changes to how they work valuable insight to assist them with that change.

The findings of the research

This has been a project of critical participatory action research. The success of this project is not about following the steps faithfully but about evidence of the change that has occurred (Kemmis & McTaggart, 2005). There was more though than just making our work-life balance better; it was about how we achieved this through dialogue. Through group work midwives gained 'permission' to make changes, often needing a paradigm shift. For those that had already started a change process it gave confirmation to their actions and strengthened their resolution to carry change through. Over several cycles we joined together in focus groups followed by action in our practice settings. The activity of communal sharing, using principals of appreciative inquiry, provided us with resources to enable this change process to be achieved. These resources for communal sharing and change included: reassurance, inspiration, encouragement, belonging, reflection, empathy, opportunity to dream, discovery, voice, and vision.

This cooperative inquiry provided an opportunity for 16 case-loading midwives to pursue their own initiatives in participation with others. This project has captivated the strength of midwives. Midwives pursue women-centred relationships. Midwives have passion. Midwives have commitment. Midwives are 'called'. The project revealed these strengths were reinforced through dialogue. The poetic principle of appreciative inquiry likens a human organisation to an open book being constantly co-authored (Cooperrider & Whitney, 2005). From my experience and that of the other CI midwives we had seldom gone beyond our small group practices to share our ideas which had produced for us a fragmented story line. This project has demonstrated that to meet with others beyond our own practice setting with a common goal in mind provides a collective strength. It gave us 'shop floor' case-loading midwives; a greater voice. New Zealand midwifery has built a strong emphasis on the midwife-women relationship but it was time to add another verse to the popular midwife ditty 'women need midwives need women' to simply read 'midwives need each other'.

The midwives recognised their commitment to women's care. Not only was continuity of care a required component but they embraced the continuity of care ethic and owned it. It was a positive force in their lives. They needed though to work out ways that they could provide continuity of care to allow for adequate down time day-to-day, and for days off-call to meet their personal needs. An important part of practice change required the midwives to be innovative. For some they adapted continuity of care from 'the same midwife to one woman' approach to a group orientated approach where the woman would meet several midwives in the team. The midwife is governed by rules set out by the Maternity Services Section 88 for purpose of payment by the Crown for the LMC service provision of maternity primary care. The CI midwives believed that within these requirements there was room to be innovative. They developed a 'feel for the game' rather than following assumptions of how they thought it should be done. The idea of a 'feel for the game' has been developed by Bourdieu (Crossley, 2005). This concept helped us to understand how midwives can have varied approaches in their practices.

New Zealand midwifery practice is continuously being recreated to meet the changing needs of society. Each one of us had our own interpretation of the requirements for practice. We were shaped by our individual habitus and that of our midwifery habitus. It was not a conscious act but how the habitus had shaped us. Our habitus gave us the competence and know-how in 'playing the game'. Realising this and by changing from our adherence to the traditions we were able to circumvent the way it may have been done before. We used a role

of improvising, strategy and innovation in our practices according to how we embodied our world. We were changing our practice needs as society changed. We had a circular relationship with the world where “society creates the social agent, who then recreates society” (Crossley, 2005, p. 112). Through an innovative approach to care the midwife participants were able to change their practice and still provide continuity of care to meet the required standards for the Ministry of Health and the New Zealand College of Midwives Standards of Practice.

Continuity of care is seen to provide quality of care (Guilliland & Pairman, 2010b). Prior to 1990 the New Zealand Maternity care system predominantly offered ‘fragmented’ care. Fragmented care was when a woman saw different health professionals before the birth, intrapartum and in the post-natal period. It was thought to reduce the quality of the woman’s experience (Flint, 1986). Flint’s concept of a single caregiver providing woman-centred care had a great impact on New Zealand midwifery in the late 1980s (Smythe, 2007). When midwives gained the right to autonomous practice in 1990 many types of ‘Know your own Midwifery’ schemes and independent midwifery practices (now known as LMC care) fast established to provide this type of continuity of care. Midwives welcomed the ‘one midwife to one woman’ philosophy of care and became committed to being on-call for women 24/7. It had become an ‘unwritten rule’ for an independent midwife to be on-call continuously.

In the data there is reference to the ‘sole care provider’. I first heard this concept of being a ‘sole care provider’ when I was doing my midwifery training in the early 1990s. My heart raced. I wholeheartedly believed that this was the ultimate in care. I would be there, not only as the professional, but as their advocate to protect the woman from the unnatural, to nurture her and to be her friend. I was sold on the idea that women deserved the best care that could be provided and this would surely do it. I would save women from the hands of the medical profession. I would empower them to be in control of their own birth journey. The data has shown that others had also been in the grasp of this deep seated commitment to always be the one to be there for the women in their care. Over the years this thinking has become part of our culture: a belief that the midwife should be on-call for a woman 24/7.

In 1996, Notice 51 Maternity Services Notice (Northern Regional Health Authority, 1996) introduced the concept of Lead Maternity Carer (LMC). LMC was the term given to one person who coordinated the midwifery care for a woman. General practitioners and specialists who were LMCs could employ the services of a midwife, either privately or from

publicly funded services for the birth or post-natal services. The LMC midwife continued to be guided by her midwifery philosophy of 'one-to-one' care or as many understood it in layman's terms as a 'sole care provider'. This implicated the LMC midwife to provide 'exclusively' all the on-call care for a woman. When the woman only saw the one midwife they built a close relationship. Our group found that over time this one-on-one relationship made it difficult for the LMC midwife to take time off-call. It had become acceptable and easy enough to arrange to have one weekend off in a month. Having two days off in a week was less common and careful planning was needed to achieve this. The data from our action research project has mirrored this picture. The midwives feared taking time off because of the guilt they would suffer for not being at a birth when they believed that was their duty. In this project they worked at achieving a better balance between work and their personal life to overcome this guilt.

Many of the CI midwives who were providing on-call 24/7 availability with minimal time off-call were feeling that they could no longer sustain this way of working. They felt they needed to make changes to how they practised. To break this 'rule of the game' was not easy for them. These CI midwives had to struggle to overcome the notion of being on-call continuously. They had to create a relationship with women that allowed the women to be empowered for the birth experience and not to be dependent on their midwife to be there. The midwife also had to change her thinking. She had been thinking that she was pivotal to the women's satisfaction of the experience. Clear communication in negotiation with the women was an important aspect to ensure expectations of care with the women were met (Guilliland & Pairman, 2010a). For the midwife's well-being though it was also important that she changed the assumptions that were guiding her. If she believed she should always be there with the women then she would suffer guilt if she took time off. If she believed she needed time off to be safe and protect her personal well-being then she could become free of the obligation to be there.

Relating findings to other research

The case-loading midwife's work-life balance was an important issue to explore as it affects midwives now and into the future. Some case-loading midwives may be faced with a personal cost of burnout (Young, 2011) if they do not find suitable ways to make their on-call work sustainable. The CI midwives were concerned about their work-life balance. The way they were working posed a threat to their well-being. Some had considered leaving case-

loading practice. Other studies have reported that midwives leave the profession when they are unable to resolve the effect that on-call work has on their life (Cox & Smythe, 2011; Wakelin & Skinner, 2007; Young, 2011). In a cycle of reflection and action the CI midwives made changes to the way that each one worked. Effective change was made at the individual level and the group practice level with an ultimate benefit to the wider midwifery community.

To achieve a better work-life balance some of the CI midwives chose to work with a team approach to continuity of care. They found that to work in a team ‘trusting relationships’ with their colleagues was essential. They also found that team work provided them with new found collegial support where previously working in their individual practice they had felt isolated. In a recent Australian phenomenological study of a midwifery group model of practice, Moore (2009) interviewed midwives who commenced providing case-loading care with a team approach. They provided case-loading care to enable women to be cared for by known midwives. Essential elements that emerged similar to our findings were the attention to the work-life balance, a shared group philosophy, the advantages of peer support, and the organisational support in a culture of trust.

New Zealand also has evidence of successful team approaches to care. The midwives at the Newtown Union Health Service provide a team-based shared case-load model that integrates care to meet the need of women (Steinmetz, Pullon, & Gray, 2011). Their service is supported by multidisciplinary collaboration with the general practitioners, practice nurses, receptionists, practice managers, and the mental health and community health workers on site at the health centre. The women get to meet the five midwives throughout their antenatal care so that there is a ‘known midwife’ present at the time of labour and birth. Their experience has shown that women in their care get quality of care well-comparable with national data and that the team-based care works well for the midwives. Steinmetz (2011) when writing about the team’s experience testifies that “where health needs of patients are more complex, collaboration amongst health care professionals needs to happen to a greater extent - not only of medical but also social care, health promotion and illness prevention” (p. 5).

The CI midwives through their discussions have revealed that there were limitations to their knowledge about conflict resolution. At times it was difficult to be able to deal early and efficiently to resolve or manage issues. Gerardi (2004) identified how there can be many barriers that prevent effective resolution in time of dispute. He notes that these barriers 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). This research identified with all these barriers. In 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 provide an understanding from the nurses’ and midwives’ perspective. The findings showed that unresolved conflict seriously hampers the relationships individuals have in a group with each other which can even lead to the point of burnout.

Data shows that some of the CI midwives came to a realisation that they could not sustain a 24/7 on-call provision the way that they had been working. Some realised this in a moment of epiphany and for some it was a gradual realisation. Guilliland and Pairman (2010b) in ‘Women’s Business’ extensively covered the story of the New Zealand College of Midwives from 1986 to 2010. Many stories within the book have talked of the work of the case-loading midwife. One story was about Sue Bree, a case-loading midwife. Her experience mirrored our same experiences. Bree notes the enthusiasm and commitment with which she entered case-loading care describing an ‘over-zealous approach’. It took a significant event in her life for her to realise the extent of her commitment before she drew back and found a more balanced approach to her care. Bree said “it took the death of a friend and my perceived inability to attend her funeral because someone was due to have a baby, for me to realise the need to achieve more balance in my life” (Guilliland & Pairman, 2010b, p. 355). Her habitus played out as it did in our lives. We all had to revisit the basis of our commitment to continuity of care and partnership and find a way to address the passion that seemed to consume our lives. Bree and many of us were fortunate to find someone else to work with. However, not all relationships with other midwives are successful. It can be difficult to hold a team together. Not all case-loading midwives are able to find others to work with. It would appear we need an improved system to sustain case-loading midwives in practice.

Recommendations for practice

The CI midwives came together to work through their desire for a better life balance in collaboration with colleagues. This gave them power to make changes in their lives. As a practitioner it was more difficult to make effective change as they were subject to individual powerlessness. Young (2011) asserted that case-loading midwives who experienced burnout

also experienced a loss of “self-rule and self-sufficiency” (p. 227). The habitus of the CI midwives was affected by the habitus of the midwifery community. They experienced guilt when they tried to take time off-call. They had become beholden to the culture that was dictating the terms of how they practised case-loading care. The CI midwife became a change agent when she joined in collaboration with others. She discovered she was not alone in her experiences. The examination of her culture and ability to make change was facilitated through group empowerment. By holding on to what was positive about their practice they were able to change other aspects to improve their work-life balance. The CI midwives valued the close relationships they had with women and so developed ways that they could maintain a good level of continuity but also take care of themselves.

This research demonstrated that the well-being of the case-loading midwife could be affected in various ways. The constant tension between her professional life and her private life constituted a major effect on how the midwife was able to sustain her practice long-term. Other important issues were identified. These included:

- the type of case-load a midwife was carrying e.g. low versus high risk clients
- the robustness of the group structure for back-up
- how ‘savvy’ the midwife was in the day-to-day running of her practice
- interpersonal conflict in the midwifery team

The CI midwives in this study found strategies to cope with these issues. Many issues though also need to be addressed at the organisational level. The following recommendations are about a future investment in sustainability for the midwifery profession.

Acknowledging burnout

Burnout needs to be unmasked to be seen as a visible phenomenon. The CI midwives recognised how they struggled with managing their work-life balance. Some talked about having experienced burnout yet recognised the symptoms in time to be able to continue in their case-loading practice. Some midwives are not so fortunate. In an interview by Scott (2011), Marie-ann Quin discussed her burnout experience. Her experience reflected that of the case-loading midwives in Young’s (2011) research on burnout. These midwives had reached a point where they had become powerless to get needed support. Their lives were put on hold and they were left incapacitated to work. It is time to address the casualties of burnout. The potential for burnout needs to be identified before it has consumed the

midwife's passion for midwifery and eroded her private life. The more we acknowledge the risk of burnout the more chance that a case-loading midwife's life can be turned around.

Identifying and monitoring well-being

How can the case-loading midwife identify and monitor her well-being? This research has shown that case-loading midwives need to dialogue. Action research could be their 'future forum' opportunity. It could provide an important contribution to the midwife's professional development portfolio. Such dialogue would be an invaluable tool for peer review activities. Midwives could be trained as facilitators of such processes to launch an inquiry group. Alternatively midwives could undertake their own inquiry using specific guidelines developed to direct the process. This research was launched with the particular concern to address the midwives' well-being.

One of the prompts for investigating the work-life balance of the case-loading midwife was the feeling I had of being 'out of control' through the perpetual on-call availability. There were no clear markers to define a 'safe' boundary between my work and my personal life. Of course the on-call nature of my work would interrupt my private arrangements but how could I judge the extent of this intrusion? The response to the advertising for participants in the project of investigating the work-life balance was immediate. Many of these respondents were experienced case-loading midwives. This reinforced my hunch that I was not alone in my thoughts. Over the course of the research I developed an innovative tool to monitor the well-being status of the case-loading midwife (see fig. 13). This commences a process of building a better support system for midwives struggling to cope with the demands of on-call work. The tool seeks to highlight burnout so it does not remain a hidden and unrecognised phenomenon. Burnout needs to be identified before it is too late.

The Midwifery Standards Review is an opportunity for a midwife to review her practice on a bi-annual occasion in the presence of a consumer and a midwife. A midwife is required to participate in the Midwifery Standards Review as part of the recertification programme to maintain her practicing certificate. This is required by the Health Practitioner Competence Assurance Act 2003 (Midwifery Council of New Zealand, 2012). Young (2011) suggests that the midwifery system of peer review is perhaps not robust enough at present to identify those in a process of burnout. The skills of the reviewers could be enhanced so they are able to be more astute in identifying those at risk. However, as it stands at present, the review can be

used as an important opportunity for reviewers to monitor and promote a culture of self-care to protect the midwife's well-being.

Keeping the woman and the midwife safe

The CI midwives experienced exhaustion from the long days and nights they sometimes worked. Even if a CI midwife may not have been with a woman all night in labour she may have had interrupted sleep from phone calls for reassurance as the woman's labour was establishing. The CI midwife enjoyed the autonomy of her practice and being able to choose her case-load numbers and when and how she provided care. However, when it came to the numbers of hours she worked it was not a matter of autonomy but rather one of professional accountability. When the CI midwife was too tired to be able to make the call of handing over care this is when she needed clear guidelines of how long is too long to care for a woman.

How much time should a midwife have off-call to recover after caring for a woman during a long labour? Should there be a limit of the hours worked in a week? The midwife can make some effort in keeping herself safe but sometimes her commitment can override making sensible decisions. The literature review shows how airline pilots have strict criteria for rest periods between flights and the number of hours they are allowed to fly. The same applies to land transport services. Professional discussion across the regions is needed to consider and negotiate the acceptable length of time that is reasonable to work at one time. The professional body needs to address the work and safety issue. Boundaries may need to be set.

There needs to be a recommendation suggesting how much time off-call is reasonable for a case-loading midwife to have. There should be an expectation that the case-loading midwife can have two days off per week just like the rest of the country's working population. There needs to be the expectation that care will be handed over when the midwife is no longer safe due to long hours of work. Having a clear process for handover of care and defined boundaries would produce a safer work environment. The LMC is required to have back-up but if that back-up midwife also has been working long hours then the midwife has no alternative person to then hand over care to. It may be timely for regional NZCOM bodies to mediate a strategy with the local District Health Boards for alternative arrangements.

Figure 13 Work-life balance score

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	<i>Not enough time for family No social life</i> <i>Or.....</i>	<i>Difficult to plan activities with family and friends</i> <i>Or.....</i>	<i>Enjoy planned time to spend with family and friends</i> <i>Or.....</i>	
Time off call	<i>Difficult to get cover</i> <i>Or.....</i>	<i>Some cover but not as often as I need it</i> <i>Or.....</i>	<i>Regular cover for days off</i> <i>Or.....</i>	
Group/team work	<i>Work on my own but struggle</i> <i>Or.....</i>	<i>Tension between members Some conflict difficult to resolve</i> <i>Or.....</i>	<i>Great team work and support Or Happy working on my own and have support if needed</i> <i>Or.....</i>	
Physical wellbeing	<i>Not enough sleep No recreation Poor eating habits</i> <i>Or.....</i>	<i>Struggle at times to catch up on sleep Irregular recreation Irregular eating pattern</i> <i>Or.....</i>	<i>Able to catch up on sleep Regular recreation Healthy eating</i> <i>Or.....</i>	
Life satisfaction	<i>Life is a constant struggle</i> <i>Or.....</i>	<i>Feel up and down Feel guilt if not available for women</i> <i>Or.....</i>	<i>Life feels great</i> <i>Or.....</i>	

0-3: Life needs urgent attention! Intervene now before possible burnout.
Red Zone

4 to 7: The work-life balance needs some attention. Life could be better. Continuing like this could make continuity of care difficult to sustain long term.
Yellow Zone

8 to 10: 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.
Green Zone

Total score

How to use the WLB score:

The WLB score is only a guide. It could be used just once or as a comparison over time. It would be good to do when life circumstances change.

There are five criteria. Work through the five suggested criteria and decide the statement that corresponds closest to your situation. Alternatively write your own description and allocate the point you think it deserves. Then total the points to get your score to find out which colour zone you are in.

Once you know your colour zone choose a work life area that you feel could be improved. Even if you are in the green zone you may still want to make something better.

What situation do you find yourself in?

- Relationship difficulties
- Socially isolated
- Poor eating habits and weight gain/loss
- Cannot afford to take time off
- Personal and client safety at risk because of lack of sleep
- Chronic fatigue and burnout



Suggested resources:

- **Marriage counselling:** Yellow Pages
- **Professional supervision:** Yellow Pages
- **Nutritionist:** Yellow Pages
- **Conflict resolution:** Yellow Pages or contact your regional NZCOM
- **NZCOM conflict resolution support:** Regional NZCOM
- **Disputes Tribunal:** www.justice.govt.nz/tribunal/disputes-tribunal/contact-us
- **Data base providers and administration support:** SAMCL <http://www.samcl.co.nz/> MMPO <http://www.mmpo.co.nz/>
- **Small business support:** Accountant, NZ Government Business support information and advice (www.business.govt.nz)
- **Rural midwifery relocation and locum support:** MMPO manager@mmpo.org.nz

Created by: heather.donald@xtra.co.nz

The WLB score

(The work-life balance score)

How effective are you at integrating your personal needs around your on-call work?



This tool is designed to make you stop and 'think'. It is then up to you to decide if you need to make things better.

Some of the midwives in the project found that the issue of funding was alleviated by sharing their income. They needed to work out a way to allow them to have an even workload with the same client load and on-call and off-call arrangements. It is a concern though that midwives need to pool their money to make a living. Do other self-employed professionals need to pursue such measures? It would be timely to introduce funding for a second midwife to provide care when a midwife needs to handover care or take time off-call. In this regard the funding structure needs to be revisited to create a better balance for midwives.

Other CI midwives worked in rural locations. Fortunately over the years locum cover for rural midwives has been developed with the government providing extra funding. Not only did the rural midwives face possible financial loss when taking time off-call, so did the CI midwives in urban locations. On annual leave their back-up would be placed under extra pressure. Even though the midwives did not book women due in their annual leave time, there were still antenatal and post-natal visits to be done. The back-up midwife still had to attend to her own workload as well as providing antenatal and post-natal support for their partner's case-load. Often there were urgent call-outs for pre-term labours or women who were post-dates at the time of the midwife's leave. The Government also funds a Midwifery First Year of Practice Programme (NZCOM). This is another example of how midwives can be reimbursed for a lost birth fee. If a mentoring midwife or the mentored midwife miss a birth while off-call to attend workshops they are financially reimbursed. Such a programme for rural case-loading and mentoring midwives could well be extended to all case-loading midwives.

Collaborative peer support

Collaborative participation was an essential aspect of this research. The research project opened up an avenue that otherwise would not have been available for the midwife participants. They worked through the issues together providing each other with support and encouragement. Most midwives do receive some collaborative input from either regular or spontaneous group meetings, informal cafe meetings and in workshops. However, many midwives who work as individual practitioners do not have regular or frequent group meetings. I recall the different groups that I have worked with as an individual practitioner and that regular group meetings were attempted but often not achieved. We were all on-call which made it difficult to meet together. It could be a lonely road and an isolating way to practice. Workshops address the professional skills and learning around midwifery tasks and

the coming together of midwives can provide some opportunity for informal networking. The same informal conversations can occur in passing at the work place. Midwives may discuss what challenges them and they may wish to make changes in their practice but none of these opportunities provide a mechanism for a midwife to actually address serious issues such as their well-being in depth. This research showed the value of a collegial ongoing support network for midwives to review their practice at depth and to put changes into action.

Access to professional supervision

Some of the CI midwives recognised a need for professional supervision. Some had already experienced the support that supervision can bring and others were considering it as a means to work through practice and personal issues for ongoing support and development. Lennox et al. (2008) discuss three key processes of supervision available for New Zealand midwives including mentorship, preceptorship and clinical supervision. They discussed that an increasing number of self-employed midwives are now accessing clinical supervision. Others suggest that perhaps time, money and the misunderstanding of the value of such a service could prevent midwives accessing professional supervision (Smythe & Young, 2008). This, unlike mentoring for the graduate midwife or preceptorship in the hospitals, is at the midwife's own expense. Smythe and Young (2008) discuss their experience of professional supervision seeing it as "a valuable strategy towards preventing burnout" (p. 13). It is about being listened to and providing space for the practitioner to reflect on her practice, considering her own well-being.

Professional supervision provides space for the midwife to feel nurtured and valued. It can also provide a potential strategy toward revealing impending burnout. Through personal supervision Young (2008) found "a heightened sense of personal accountability both to clients and to her own well-being immersed" (p. 27). Smythe and Young (2008) have made a call to the profession to be proactive to address the effect that continuity of care can have on the well-being of the case-loading midwife. Professional supervision and life coaching need to be promoted as vital resources for the case-loading midwife to use in protecting her well-being.

Conflict resolution

Our project on the work-life balance has revealed a gap in the interpersonal competence not so much in the midwife-woman relationship but more so in the ability of sustaining effective

teamwork. It is noted that in healthcare doctors and nurses lack the basic skills required for resolving conflict (Gerardi, 2003). Gerardi (2004), a registered nurse who works in the area of mediation, has authored numerous papers on managing conflict in the healthcare setting. She advocates that healthcare organisations need to find ways to manage conflict in the development of healthy work environments. Gerardi proposes that the skills mediators use in development and techniques for balancing interests and communication can with practice be transferable for use by practitioners in their clinical setting. To protect the case-loading midwife's well-being, decision making and conflict resolution is an important and urgent issue for the professional body to explore further.

The extent of conflict that continuity of care places on the midwife in case-loading practice may not be fully recognised. The LMC midwife practices autonomously which gives her the control of how she operates. NZCOM do provide guidelines and rules for codes of practice and philosophy of care but consider it is not their place to be involved in how practices are run (Guilliland, 2007). Appelbaum et al. (1999) provided an extensive review of the literature confirming that "conflict is inherent in the nature of teams (and in the whole organization) as a factor that can determine their success. More specifically, how conflict is managed within the group can bring out the best or the worst of team-oriented organizations" (Appelbaum et al., 1999, p. 60). Case-loading midwifery is team work and makes up over half of the New Zealand midwifery workforce.

Involvement of the professional body may be required to provide more support and guidance to members in case-loading practices who experience conflict. Each NZCOM region has a Resolutions Committee. This was originally set up to provide a place for resolving disputes that women had about their care. Increasingly the service is being called on to meet a need for conflict resolution between midwives. It is worthwhile to consider a new name for the service and to promote this as a well-being service to the midwifery community. It could be a place where midwives learn about team sustainability and team building. It could still be the appropriate place to provide counselling and conflict management but enhanced with an additional service of trained professionals.

Recommendations for education

Educative strategies need to be put in place to prevent more case-loading midwives from enduring the anguish that comes from the conflict of responsibilities of 24/7 on-call commitment with their personal life.

Creating a well-being culture

Education plays a vital role in shaping the midwives for the future. Just as the CI midwives discovered their habitus may not have been aligned with the field in which they practised so too this could apply to the teachers of our future generation of midwives. They need to be aware of how their personal beliefs about practice could be reinforcing a state of hysteresis rather than keeping practice in context with the modern world. Many of us when we started case-loading were sold on the idea that women came first and the ultimate was being on-call for them 24/7. Now we are saying we need to build into this a framework that protects our personal well-being. We need to keep a healthy work force mentally, physically and emotionally. We have to look after the case-loading midwife. We need to set an example and teach self-care. Halldorsdottir and Karlsdottir (2011) in their research on professional caring felt that emphasis should not only be placed on their cognitive and practical competences but also on the evaluation of attitudes, interpersonal competence and self-care of student midwives. In creating a culture of a healthy workforce we have to be self-preserving not self-sacrificing. Personal well-being is something that is ongoing and should start with student midwifery training.

Perhaps a way can be found in our professional development programme through the ongoing educational programmes to ensure that case-loading midwives can be better prepared for their role. Some midwives do not even recognise their situation of burnout until it is too late (Young, 2011). The CI midwives realised that they had been neglecting their personal lives. Recent research supports the notion of improving self-care (Cox & Smythe, 2011; Young, 2011). Learning about self-care may help midwives to be more aware of the risk of burnout and to develop prevention strategies. Supporting the well-being of teams and groups should perhaps be a regional responsibility, with the College of Midwives having skilled group facilitators available to help teams maintain effective working relationships. Perhaps a professional supervisor could be appointed for a group or team. This would be a way to provide proactive measures to prevent conflict. Midwives need to be protected from burnout and it is apparent that it is not a responsibility that should be left to the midwives to overcome alone.

Recommendations for research

This research has been another step in the journey as we create a better environment for the midwifery workforce. Our midwifery field is a site of struggle (Thomson, 2008). We need to

identify how best to manage the clash of habitus between fields. By questioning and investigating our current culture we open up thinking to create change.

Investigating ways to sustain case-loading practice

Do we know what a viable sustainable case-load is or do we practise according to how our habitus informs us according to the current thinking? To make decisions about how to resolve work-life balance issues, research needs to uncover the reality of our situation. Concerns like how much sleep midwives really need in order to practise safely need to be investigated. We need to know when a midwife actually becomes unsafe. Resolutions and solutions need to be found about the number of hours a midwife can work at one time. We need to know what works for women and how continuity can be provided to meet the need of the woman and the midwife.

The CI midwives discussed ways to reduce non-urgent interruptions outside of 'business hours'. Some used a 0800 number so they could take turns at being first on-call. Others used a call centre that took all calls and notified the midwife if it was urgent. During this project Margie developed Internet blogs for women in her practice so that both she and the women could access the site when convenient to them. Midwives up and down the country have developed measures to protect them from interruptions and to provide boundaries between work and home. A study into the effectiveness of these methods would provide valuable input for current and future case-loading midwives wanting to find sustainable ways to run their practices.

Young (2011) spoke of the value of professional supervision for the protection from burnout. The topic of professional supervision was raised in our discussions. Some had actually used this as a way to cope with the pressure of the work. The advantages of online life coaching to provide sustainability in practice would be a valuable tool. Research of such tools is necessary to measure the benefit and to provide evidence for funding for case-loading sustainability. Research is needed to know if supervision is a valid way to keep the midwife safe. Future policy making can then address needs and solutions if there is substantial research to back-up claims.

This inquiry benefited those who participated in it. Action research inquiries could become a way for the future. Using action research inquiry the midwifery community can look into concerns, find ways to address them, and keep the power for change in the hands of the

practitioners. These do not require heavy financial investment. Inquiry groups could have optional ways to facilitate their inquiries. Participatory action research with cycles of action and reflection could be carried out to enquire into a wealth of topics. Appreciative inquiry and action science could be used as approaches to enquire into organisational change. However an enquiry is carried out, what is important is the participatory aspect of the process. It is a social process of collaborative learning for people to change practices themselves (Kemmis & McTaggart, 2005). It is about changing our understandings and the situations in which we live and work.

Conflict in small groups seemed to be unavoidable. In the literature review it was also mentioned how midwives were confronted with intra-group conflict which affected their well-being. The midwives in this project talked about how they struggled to hold their group together. The teams had no formal contracts or plans as to how to resolve conflict. There was awareness and knowledge about conflict but not about how to manage it when it occurred. Research to investigate the scale of concern of conflict in impeding effective team cohesion in case-loading midwifery and investigation into how to bring resolve to the issue is required.

Limitations of the study

This study was not about providing a definitive way for midwives to achieve a work-life balance. Neither has it been a way to develop advice to be able to say ‘do this and this’ to fix a problem. What it did achieve was a process for midwives to make a culture change in their practice arena. Each CI midwife had a burning desire to address a common concern about their work-life balance. The changes made were brought about through collaborative action and reflection in order to achieve a better work-life balance. It was in the terms that fitted each case-loading midwife’s criteria, in her time and space. If I had elected to conduct a survey it would have provided a larger sample. This would have given a greater representation of the New Zealand midwifery population. It could have covered the breadth of the country and if large enough could have provided statistically significant results. If objectivity was a key then observer subjectivity could have been greatly eliminated with standardised questions. Alternatively, ethnography could have provided a more comprehensive perspective. It would have had more potential to capture everyday experiences and could involve observation methods. In-depth interviews may have revealed nuances and subtleties that the focus groups, a more public forum, could not achieve. However, if cooperative inquiry had not been selected it would not have achieved

democratisation of both research and knowledge production. This research was about the CI midwives making a difference in their lives. It was about changing their culture to produce a better situation. It provided relevant and applicable research as the midwives who lived the problems, worked on solving them. They did not need to leave their work to conduct research as they were reflecting and acting on the work they did every day.

This action research used cooperative inquiry supported by appreciative inquiry to guide the discussions in the focus groups. I also used the analytical tools of Bourdieu for the analysis of the data. My concern was that I would not be able to give justice to these three approaches in the endeavour to understanding our social world better. If I did this all over again using the insight I have gained I most likely would have done it differently. It has been a process of immense learning in undertaking such a project. To give justice to all or one of these approaches I feel the data generated would have me studying and writing for many more years to come. There is, however, a limit of time and an urgency to share the midwives' journeys. It is hoped that other case-loading midwives will be encouraged to examine their own practices and be challenged to make a culture change if their social fields are in conflict. I have made every effort not to have trivialised these approaches but to make the most of them to craft a story worthy of being shared.

This research has been focussed on the well-being of the midwife. Due to time constraints, the voices of women have only been heard through the secondary source of feedback generated by the CI midwives. The same goes for the inclusion of significant people in the lives of the case-loading midwives. To have heard their stories would have added greater strength to the stories that the CI midwives were telling about the tension in their lives as they lived out their belief in continuity of care provision. Young (2011) in addressing burnout in the lives of case-loading midwives captures the voice of family members which talked of the same struggles the CI midwives were experiencing in balancing their work and their private world.

We were full participants in the changes we each created in our own practices. We were insiders in the study of our change so as co-researchers; we were able to place our own interpretations onto our findings. However, reflexive thinking was still required to be able to objectively understand the relationships between ourselves and our clients and the factors that have shaped us. As the writer of the thesis it required reflexivity as I interpreted and wrote about the experience of each midwife. Although this study focussed on our work-life issue

we needed to understand and monitor any effect that this had on our clients so as not to disadvantage them. All actions, therefore, were carefully scrutinised by the midwife implementing change. We needed to realise our own biases in the change process so that we could uphold the woman's best interests in the care she received.

Some of us were at the point where our survival to stay working as a case-loading midwife was under threat. The close relationship we established with a woman was a positive aspect of our care. It brought satisfaction to how we practised. We worked at how to retain relationships in balance with enough down-time to protect our well-being. This forced us to think in new ways about our partnership relationship with women and how we provided continuity of care in order to change the way we practised. The reflexive approach we used allowed us to see the way we were applying continuity of care as a possible 'misrecognition'. It had been imposed on us through our habitus. The embodied nature of this cultural capital served to naturalise and disguise its reproduction so that it had the appearance of being natural. Bourdieu maintains this is an outcome of enculturation (Crossley, 2005). Our midwifery culture had become so dominant that it had threatened the possibility of innovation and transformation. When the midwife was driven to the point of deciding whether to stay in the profession as a case-loading midwife she was forced to make changes to how she practised. It was this breakdown of social conditions beyond her control that an improbable situation could be made possible (Shusterman, 1999). This forced her into changing the way she thought about partnership and continuity of care in order to be innovative to change her practise. Such change was supported by the collaborative process of this research.

Reflection on the past six years

I have heard that life needs an element of tension or else complacency or boredom can slip in and you lose an edge to what you do. My life has had its variety of tension and struggle since the beginning of this project until the final write up and completion of this thesis. There has certainly been no room for complacency or boredom. For me, a practitioner and doctoral student, my work as a CI midwife has carried on. To add to this, and to my dismay, my midwifery practice broke up. Our communication lines broke down and we were unable to restore trust with one another. This brought great disruption both emotionally and also practically. It took over a year to return to a reasonable level of practise with regular cover. This meant establishing a practice with a new group of midwives. Through this experience I have gained a deepened understanding of the social dynamics that occur in the work setting

and in our personal lives. I have been able to use the powerful tools of Bourdieu to examine not just my work arena but my personal life and relationships as well. It has given me greater understanding of others' situations, to shed light on their difficulties and to provide guidance in how to respond.

Closing thoughts

The CI midwives participated in a process of action and reflection that had a positive impact on their lives through changes made in their practice arena. The actual extent of the benefit to each one was up to each CI midwife as they fully participated as co-participants and co-researchers. This thesis brings their discussions and findings into the public arena to stimulate and motivate others to take up the challenge to make a difference in their lives. The findings also contribute to a growing awareness and pool of research surrounding the difficulties for case-loading midwives who work on-call. It highlights the impact of continuity of care provision on the practitioner and as such is important for the policy makers, managers of midwifery care and for the midwives at the 'coal face'. Participatory action research has demonstrated a way that midwives can make their own practice changes in a process that provides empowerment and emancipatory benefit.

The action research project, firstly, provided the co-researchers a chance to stop and think about their work-life balance. This process was empowering for the midwives. To have the opportunity to share their practise experience in the company of others who understood where they were coming from, empowered them to make change where needed. Secondly, through democratic discussion, the midwives as co-participants and co-researchers guided each other to the examination of their work-life balance. Thirdly, the focus groups provided the midwives with a safe place to challenge and be challenged and even change their way of thinking. This provided the opportunity to sift through what was meaningful and positive in their practice and change those things that could be modified to achieve a more workable work-life balance. The journey of the CI midwives will continue with ongoing change. Their life needs will keep changing as societal needs and expectations for maternity care will keep evolving. What will remain the same is the midwives' passion to be with women.

REFERENCES

- Abercrombie, N., Hill, S., & Turner, B. (Eds.). (1994). *The penguin dictionary of sociology*. London: Penguin Books.
- Aboulafia, M. (1999). A (neo) American in Paris: Bourdieu, Mead, and Pragmatism. In R. Shusterman (Ed.), *Bourdieu* (pp. 153-174). Oxford: Blackwell Publishers Ltd.
- Air Nelson. (2008). *Air Nelson Limited NZALPA Air Nelson Pilots' Collective Agreement 2008 -2009*.
- Alhola, P., & Polo-Kantola, P. (2007). Sleep deprivation: Impact on cognitive performance. *Neuropsychiatric Disease Treatment*(October 3), 553-567.
- Andrews, S., Brown, L., Bowman, L., Price, L., & Taylor, R. (2006). Caseload midwifery: A review. *Midwifery Matters*(108).
- Appelbaum, S., Abdallah, C., & Shapiro, B. (1999). The self-directed team: A conflict resolution analysis. *Team Performance Management*, 5(2), 60.
- Ardmore Flying School. (2002). *Human factors and crew resource management for airline transport pilots*. Auckland.
- Argyris, C., & Schon, D. A. (1991). *Theory in practice*. San Francisco: Jossey-Bass.
- Ashton, T. (2005). Recent developments in the funding and organisation of the New Zealand health system. *Australia and New Zealand Health Policy*, 2(9).
- Association of Ontario Midwives. (2007). *Benefits to women needing obstetrical care*. Retrieved 28/12/11, from http://www.aom.on.ca/Communications/Government_Relations/benefits_to_women_needing_obstetrical_Care.aspx
- Bearden, M. (2009). *Conflict resolution for nurses*. Master of Arts. Health Science Centre. Royal Roads University. Colwood.
- Becker, A., Burgess, S., Churton, J., Frances, C., Hogan, I., Hotchin, C., & Waugh, H. (2000, September). *Midwives collective: Are we a model for sustainability?* presented at the meeting of the NZCOM Sixth National Conference, Cambridge.
- Benn, C. (1999). Midwifery partnership: Individualism contractualism or feminist praxis? *New Zealand College of Midwives Journal*(21), 18-20.
- Berger, P., & Luckmann, T. (1966). *Construction of reality. A treatise in the sociology of knowledge*. New York: Random House.
- Borda, O. F. (2006). Participatory (action) research in social theory: Origins and challenges. In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research* (pp. 27-37). London: Sage Publications.
- Boston, J. (1991). The theoretical underpinnings of public sector restructuring in New Zealand. In J. Boston, J. Martin, J. Pallot, & P. Walsh (Eds.), *Reshaping the state: New Zealand's bureaucratic revolution* (pp. 2-25). Auckland: Oxford University Press.
- Bourdieu, P. (1984). *Distinction* (R. Nice, Trans.). Cambridge: Harvard University Press.
- Bourdieu, P. (1990). *The logic of practice* (R. Nice, Trans.). Stanford: Stanford University Press.
- Bourdieu, P. (1998). *Practical reason*. Cambridge: Polity Press.
- Brodie, P., Warwick, C., Hastie, C., Smythe, E., & Young, C. (2008). Sustaining midwifery continuity of care: Perspectives for managers. In C. Homer, P. Brodie, & N. leap (Eds.), *Midwifery continuity of care: A practical guide*. Sydney: Churchill Livingstone.
- Brotheridge, C., & Grandey, A. (2002). Emotional labour and burnout: Comparing two perspectives of 'people work'. *Vocational Behaviour*, 60, 17-39.

- Brown, L. (2008). Physicians and sleep deprivation. *Current Opinion in Pulmonary Medicine*, 14(6), 507-511.
- Brown, M., Masters, D., & Smith, B. (1994). *Nurses of Auckland: The history of the General Nursing Programme in the Auckland School of Nursing*. Auckland: Brown, Masters, Smith.
- Bryder, L. (1994). A new world? Two hundred years of public health in Australia and New Zealand. In D. Porter (Ed.), *The history of public health and the modern state* (pp. 313-334). Amsterdam: Editions Rodopi B.V.
- Bunkle, P. (1994). Women's constructions of health. In J. Spicer, A. Trlin, & J. A. Walton (Eds.), *Social dimensions of health and disease: New Zealand perspectives* (1st ed., pp. 219-239). Palmerston North: The Dunmore Press Ltd.
- Burke, R., & Cooper, C. (Eds.). (2008). *The long work hours culture: Cause, consequences and choices*. Bingley, UK: Emerald Group.
- Bushe, G. (2001). Five theories of change embedded in appreciative inquiry. In D. Cooperrider, D. Whitney, & T. Yaeger (Eds.), *Appreciative inquiry: An emerging direction for organization development* (pp. 117-127). Champaign: Stipes.
- Calhoun, C. (1993). Habitus, field, and capital: The question of historical specificity. In C. Calhoun, E. LiPuma, & M. Postone (Eds.), *Bourdieu*. Washington: The University of Chicago Press.
- Calhoun, C., LiPuma, E., & Postone, M. (Eds.). (1993). *Bourdieu*. Chicago: The University of Chicago press.
- Caproni, P. (1997). Work-life balance: You can't get there from here. *The Journal of Applied Behavioral Science*, 33, 46-56.
- Caza, B. B. (2007). *Experiences of adversity at work: Toward an identity-based theory of resilience*. The University of Michigan, Michigan.
- Chick, N., & Rodgers, J. (Eds.). (1997). *Looking back, moving forward: Essays in the history of New Zealand nursing and midwifery*. Palmerston North: Massey University Dept of Nursing and Midwifery.
- Clark, H. H. (1990, March). Introduction of the Nurses Amendment Bill in Parliament [Parliament speech]. *NZ College of Midwives Journal* 9-10.
- Clarke, V. (2007). Why are intervention rates soaring? *Tummy Talk*(3), 33.
- Cole, S. (2006, December). *Midwifery oration*. presented at the meeting of the New Zealand College of Midwives 9th Biennial National Conference, Christchurch.
- Cooper, M. (1997). The Midwives Case 1920 to 1930. In N. Chick & J. Rodgers (Eds.), *Looking back, moving forward: Essays in the history of New Zealand nursing and midwifery*. Palmerston North: Department of Nursing and Midwifery Massey University.
- Cooperrider, D., & Whitney, D. (2005). *Appreciative inquiry. A positive revolution in change*. San Francisco: Berrett-Koehler Publishers.
- Cox, P., & Smythe, E. (2011). Experiences of midwives leaving lead maternity care practice. *New Zealand College of Midwives*, 44(May), 17-21.
- Coyle, A. (1992, August). *Six years of independent midwifery in London*. presented at the meeting of the NZCOM 2nd National Conference, Wellington.
- Cragin, L. (2004). The theoretical basis for nurse-midwifery practice in the United States: A critical analysis of three theories. *Journal of Midwifery & Women's Health*, 49(5).
- Craven, C. (2010). *Pushing for midwives*. Philadelphia: Temple University Press.
- Crossley, N. (2005). *Key concepts in critical social theory*. Thousand Oaks: Sage Publications Ltd.
- Crotty, M. (1998). *The foundations of social research*. Sydney: Allen & Unwin.

- Daellenbach, R. (1999). Midwifery partnership - A consumer's perspective. *New Zealand College of Midwives*(21), 22-23.
- Davies, R. (1994, August 1994). *The know your midwife service*. presented at the meeting of the 3rd National Conference New Zealand College of Midwives Incorporated, Rotorua.
- Davis, D. (2005). Evidence based health care: Raising issues from a midwifery perspective. *New Zealand College of Midwives*(32), 14-18.
- Davis, D., & Walker, K. (2011). Case-loading midwifery in New Zealand: Bridging the normal/abnormal divide 'with woman'. *Midwifery*, 27(1), 46-52.
- Deer, C. (2008). Doxa. In M. Grenfell (Ed.), *Pierre Bourdieu Key concepts* (pp. 119-130). Durham: Acumen Publishing Limited.
- Department of Labour. (2004). *Achieving balanced lives and employment: What New Zealanders are saying about work-life balance*. Retrieved 30/9/11, from <http://www.dol.govt.nz/PDFs/wlb-consultation-summary.pdf>
- Department of Labour. (2011). *Health and Safety in Employment Act 1992*. Retrieved 1/7/11, from <http://www.legislation.govt.nz/act/public/1992/0096/latest/viewpdf.aspx>
- DeVore, C. (1997). Midwives as business women 1900 to 1938. In N. Chick & J. Rodgers (Eds.), *Looking back, moving forward: Essays in the history of New Zealand nursing and midwifery* (pp. p44-57). Palmerston North: Department of Nursing and Midwifery.
- Dixon, L. (2007). Working together in a sustainable way. *Midwifery News*(47), 16-17.
- Dixon, L. (2008). Can midwives lead changes in childbirth practices? *Midwifery News*(48), 33.
- Dixon, L. (2009). New Zealand midwifery research: Coming of age. *Midwifery News* (54), 34-35.
- Donley, J. (1986). *Save the midwife*. Auckland: New Women's Press.
- Donley, J. (1991). It's still women & midwives in partnership. *New Zealand College of Midwives*(May), 12.
- Donley, J. (1998). *Birthrites: Natural vs unnatural childbirth in New Zealand*. Auckland: The Full Court Press.
- Dorling, P., Munro, J., Freeman, J., & Oxley, T. (2006). Can one-to-one midwifery care increase the normal birth rate? *Maternal - Fetal and Neonatal Medicine Book of Abstracts*, 19(May), 142.
- Dowell, A., Coster, G., & Maffey, C. (2002). Morale in general practice: Crisis and solutions. *The New Zealand Medical Journal*, 115(1158).
- Dreyfus, H., & Rabinow, P. (1993). Can there be a science of existential structure and social meaning? In C. Calhoun, E. Lipuma, & M. Postone (Eds.), *Bourdieu* (pp. 35-44). Chicago: The University of Chicago Press.
- Earl, D., & Hunter, M. (2006). Keeping birth normal: Midwives experiences in a tertiary obstetric setting. *The New Zealand College of Midwives*, 34, 21-23.
- Engel, C. (2003). Towards a sustainable model of midwifery practice in a continuity of carer setting: The experience of New Zealand midwives. *New Zealand College of Midwives*, 28(April), 12 - 15.
- Enkin, M. (2006). Beyond Evidence: The complexity of maternity care. *Birth*, 33(4), 265-269.
- Fereday, J., & Oster, C. (2010). Managing a work-life balance: the experiences of midwives working in a group practice setting. *Midwifery*, 26(3), 311-318.
- Firkin, P. (2004). The cultural capital of midwifery: Unique foundations for self-employment. *New Zealand College of Midwives*, 30, 6 - 10.

- Fitzpatrick, J. (Ed.). (2008). *The maternity services consumer satisfaction survey 2007: High satisfaction or low expectation?* (Vol. 12): Women's Health Action Trust.
- Fleetwood, S. (2007). Re-thinking work-life balance: Editor's introduction. *International Journal of Human Resource Management* 18(3), 351-359.
- Fleming, A. (2006). Caseload midwifery: How teamwork makes family life possible. *British Journal of Midwifery*, 14(6), 360.
- Flint, C. (1986). *Sensitive midwifery*. London: Butterworth Heinemann Ltd.
- Freeman, G., & Hjortdahl, P. (1997). What future for continuity of care in general practice. *British Medical Journal*, 324(7098), 1870.
- Freeman, L., Adair, V., Timperley, H., & West, S. (2006). The influence of the birthplace and models of care on midwifery practice for the management of women in labour. *Women and Birth*, 19(4), 97-105.
- French, P. (2001). *A study of the regulation of nursing in New Zealand 1901-1997*. Graduate School of Nursing and Midwifery, monograph series. Victoria University of Wellington, Wellington.
- Gerardi, D. (2003). Conflict management training for health care professionals. *AACN*, 15(2), 215-221.
- Gerardi, D. (2004). Advanced practice in acute and critical care. *AACN*, 15(2), 182-195.
- Gerkovich, P. (2006). Work-life policy and practice in the USA: Gendered premise, radical potential? In F. Jones, R. Burke, & M. Westman (Eds.), *Work-life balance* (pp. 276-289). New York: Psychology Press.
- Green, J., Renfrew, M., & Curtis, P. (2000). Continuity of carer: What matters to women? A review of the evidence. *Midwifery*, 16(3), 186-196.
- Greenwood, D., & Levin, M. (2005). Reform of the social sciences and of universities through action research. In N. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (Third ed., pp. 43-64). Thousand Oaks: Sage Publications.
- Greenwood, D., & Levin, M. (2007). *Introduction to action research* (2nd ed.). Thousand Oaks: Sage Publications.
- Grenfell, M. (Ed.). (2008). *Pierre Bourdieu key concepts*. Durham: Acumen Publishing Ltd.
- Guba, E., & Lincoln, Y. Paradigmatic controversies, contradictions, and emerging confluences. In N. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (Third ed., pp. 191-216). Thousand Oaks: Sage Publications.
- Guilliland, K. (1997). Section 51: Contract for autonomy. *New Zealand College of Midwives*(16), 6-9.
- Guilliland, K. (1999a, February). *Midwifery in New Zealand*. presented at the meeting of the Future Birth: The place to be born conference, Australia.
- Guilliland, K. (1999b). Shared care in maternity services: With whom and how? *New Zealand College of Midwives National Newsletter*(14), 1 - 4.
- Guilliland, K. (1999c). Towards a new millennium in partnership. *New Zealand College of Midwives*(21), 4-5.
- Guilliland, K. (2007). Forum. *Midwifery News*(47), 6-7.
- Guilliland, K., & Pairman, S. (1994). The midwifery partnership: A model for practice. *New Zealand College of Midwives*(October), 5-9.
- Guilliland, K., & Pairman, S. (1995). *The midwifery partnership*. Wellington: Nursing and Midwifery Department, Victoria University of Wellington.
- Guilliland, K., & Pairman, S. (2010a). *The midwifery partnership: A model of practice*. Christchurch: New Zealand College of Midwives.
- Guilliland, K., & Pairman, S. (2010b). *Women's business: The story of the the New Zealand College of Midwives 1986-2010*. Christchurch: New Zealand College of Midwives.

- Gustavsen, B. (2006). Theory and practice: The mediating discourse. In P. Reason & H. Bradbury (Eds.), *Handbook of action research* (pp. 17-26). London: Sage.
- Haggerty, J., Reid, R., Freeman, G., Starfield, B., Adair, C., & McKendry, R. (2003). Continuity of care: A multidisciplinary review. *British Medical Journal*, 327, 1219-1221.
- Halldorsdottir, S., & Karlsdottir, S. I. (2011). The primacy of the good midwife in midwifery services: evolving theory of professionalism in midwifery. *Scandinavian Journal of Caring Sciences*, 25, 806-817.
- Hannah, M., Hannah, W., Hewson, S., Hadnett, E., Saigal, S., & Willan, A. (2000). Planned caesarean section verses planned vaginal birth for breech presentation at term: A randomised multicentre trial. *International Journal of Gynaecology and Obstetrics*(356), 1375-1383.
- Hatem, M., Sandall, J., Devane, D., Soltani, H., & Gates, S. (2008). Midwife-led versus other models of care for childbearing women. *Cochrane Database Syst Rev*(4).
- Head, M. (2006, July 8). Beating burnout. *Listener*, 22-24.
- Heidegger, M. (1995). *Being and time*. Oxford: Basil Blackwell.
- Heron, J. (1988). Validity in co-operative inquiry. In P. Reason (Ed.), *Human inquiry in action* (pp. 40-59). London: Sage Publications.
- Heron, J. (1996). *Co-operative inquiry. Research into the human condition*. London: SAGE Publications.
- Heron, J. (1999). *The complete facilitator's handbook*. London: Kogan Page Ltd.
- Heron, J., & Reason, P. (1997). A participatory inquiry paradigm. *Qualitative inquiry*, 3(3), 274-294.
- Heron, J., & Reason, P. (2007). The practice of co-operative inquiry: Research 'with' rather than 'on' people. In P. Reason & H. Bradbury (Eds.), *Handbook of action research* (2007 ed., pp. 144-154). London: SAGE Publications.
- Herr, K., & Anderson, G. L. (2005). *The action research dissertation*. Thousand Oaks: SAGE Publications.
- Hinton, B. (1999). Maternity care: A decade of change. *Women's Health Watch*.
- Howarth, A., Swain, N., & Treharne, G. (2011). Taking personal responsibility for well-being increases birth satisfaction of first time mothers. *Journal of Health Psychology*(16), 1221-1230.
- Hunter, D., Bailey, A., & Taylor, B. (1995). *The art of facilitation*. Auckland: Da Capo Press.
- Hunter, L. (2008). A hermeneutic phenomenological analysis of midwives' ways of knowing during childbirth. *Midwifery*(24), 405-415.
- Janesick, V. (1994). The dance of qualitative research design: Metaphor, methodolatry, and meaning. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed., pp. 209-219). Thousand Oaks: SAGE Publications.
- Jatrana, S., Crampton, P., & Richardson, K. (2011). Continuity of care with general practitioners in New Zealand: Results from SoFIE-Primary care. *The New Zealand Medical Journal*, 124(1329), 16-25.
- Jones, F., Burke, R., & Westman, M. (Eds.). (2006). *Work-life balance*. New York: Psychology Press.
- Jones, L. (1994). *The Social context of health and health work*. London: MacMillan Press Limited.
- Kalliath, T., & Brough, P. (2008). Work-life balance: A review of the meaning of balance construct. *Journal of Management and Organization*, 14, 323-327.
- Kamberelis, G., & Dimitriadis, G. (2005). Focus groups. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (3rd ed., pp. 887-907). Thousand Oaks: SAGE Publications.

- Kemmis, S., & McTaggart, R. (2005). Participatory action research: Communicative action and the public sphere. In N. Denzin & Y. Lincoln (Eds.), *The sage handbook of qualitative research* (Third ed., pp. 559-603). Thousand Oaks: SAGE Publications.
- King, M. (1964). *Heideggers's philosophy: A guide to his basic thought*. Oxford: Basil Blackwell.
- Kirkham, M. (Ed.). (2000). *The midwife-mother relationship*. London: Macmillan Press Ltd.
- Kitzinger, S. (1988). Why women need midwives. In S. Kitzinger (Ed.), *The midwife challenge*. London: Pandora Press.
- Kitzinger, S. (1991). *Homebirth and other alternatives to hospital*. London: Dorling Kindersley.
- Kitzinger, S. (1999). Sheila Kitzinger's letter from Europe: Midwives on trial. *New Zealand College of Midwives National Newsletter*(15), 4-5.
- Kitzinger, S. (2003). *Sheila Kitzinger's letter from Europe: The clock, the bed, the chair*. Retrieved 11 November, 2006, from www.sheilakitinger.com/ArticlesBySheila/BIRTH_March2003.htm
- Kowalewicz, R. (2000, September). A personal perspective: Five years of case-load midwifery practice in a hospital setting Symposium conducted at the meeting of the NZCOM Sixth National Conference, Cambridge.
- Krueger, R. A., & Casey, M. A. (2000). *Focus groups* (3rd Edition ed.). Thousand Oaks: SAGE Publications.
- Land Transport New Zealand. (2007). *Work-time and logbooks 2007*. Wellington: Land Transport New Zealand.
- Langlois, A., & Anderson, D. E. (2002). Resolving the quality of life/well-being puzzle: Toward a new model. *Canadian Journal of Regional Science*, 25.
- Lash, S. (1993). Pierre Bourdieu: Cultural economy and social change. In C. Calhoun, E. LiPuma, & M. Postone (Eds.), *Bourdieu critical perspectives* (pp. 193-211). Chicago: The University of Chicago Press.
- Lennox, S., Skinner, J., & Foureur, M. (2008). Mentorship, preceptorship and clinical supervision: Three key processes for supporting midwives. *New Zealand College of Midwives*, 39(October), 7-12.
- Lower, J. (2008). Brace yourself here comes generation Y. *Critical Care Nurse*, 28(5), 80-84.
- Ludema, J., Cooperrider, D., & Barrett, F. (2006). Appreciative inquiry: The power of the unconditional positive question. In P. Reason & H. Bradbury (Eds.), *Handbook of action inquiry*. London: SAGE Publications.
- Mahar, C., Harker, R., & Wilkes, C. (1990). *The basic theoretical position, an introduction to the work of Pierre Bourdieu*. London: MacMillan.
- Major, D., & Germano, L. (2006). The changing nature of work and its impact on the work-home interface. In F. Jones, R. Burke, & M. Westman (Eds.), *Work-life balance: A psychological perspective*. New York: Psychology Press.
- Mansfield, T. (2011). From the chief executive's desk. *Tall Poppies*, 8(11), 3-4.
- Marks, S., & MacDermid, S. (1996). Multiple roles and the self: A theory of role balance. *Journal of Marriage and the Family*, 58(2), 417-430.
- Martin, A. (2006). Large-group processes as action research. In P. Reason & H. Bradbury (Eds.), *Handbook of action research* (pp. 166-175). London: SAGE Publications.
- Maslach, C. (1982). *Burnout, the cost of caring*. New York: Prentice Hall.
- Maton, K. (2008). Habitus. In M. Grenfell (Ed.), *Pierre Bourdieu key concepts* (pp. 49-65). Durham: Acumen Publishing Limited.
- McAra-Couper, J. (2006, December). *Guardian of what?* presented at the meeting of the New Zealand College of Midwives 9th Biennial National Conference, Christchurch.

- McAra-Couper, J. (2007). *What is shaping the practice of health professionals and the understanding of the public in relation to increasing intervention in childbirth?* Unpublished doctoral thesis, Auckland University of Technology, Auckland, PhD.
- McLachlan, H., Forster, D., Davey, M., Lumley, J., Farrell, T., Oats, J., ... Biro, M. (2008). COSMOS: Comparing standard maternity care with one-to one midwifery support: A randomised controlled trial. *BMC Pregnancy Childbirth*, 8, 35. doi:10.1186/1471-2393-8-35
- McLardy, E. (2002). Boundaries: work and home. *New Zealand College of Midwives Journal*(October), 33-34.
- McNiff, J. (1988). *Action Research Principles and Practice*. London: Macmillan Education.
- McNiff, J., & Whitehead, J. (2006a). *Action research principles and practice* (2nd ed.). London: RoutledgeFalmer.
- McNiff, J., & Whitehead, J. (2006b). *All you need to know about action research*. London: SAGE Publications.
- McNiff, J., & Whitehead, J. (2009). *Doing and writing action research*. Los Angeles: SAGE Publications.
- Mein Smith, P. (1986). *Maternity in dispute New Zealand 1920-1939*. Wellington: Historical Publications Branch Department of Internal Affairs.
- MERAS. (2010). *DHB's/MERAS multi-employer collective agreement* [Employment agreement]. Retrieved 28/12/11, from <http://www.midwife.org.nz/index.cfm/3,139,302/meras-meca-2010.pdf>
- Midwifery Council of New Zealand. (2011). *Midwifery Workforce Report 2010*. Retrieved 28/12/11, from <http://www.midwiferycouncil.health.nz/images/stories/pdf/midwifery%20workforce%20report%20%20updated%202010%20final.pdf>
- Midwifery Council of New Zealand. (2012). *Recertification programme: Competence-based practising certificates*. Retrieved 8/1/12, from <http://www.midwiferycouncil.health.nz/recertification-programme-competence-based-practising-certificates/>
- Miller, M., & McGowen, R. (2010). Strategies to avoid burnout in professional practice: some practical suggestions. *Psychiatric Times*, 25-31.
- Miller, S. (2002). How safe is a tired midwife? *New Zealand College of Midwives Journal*(October), 5-8.
- Ministry of Health. (1993). *Notice issued pursuant to section 51 of the Health and Disability Services Act 1993 concerning the provision of maternity services*. Hamilton: Midland Health.
- Ministry of Health. (2006). *Maternity care is strongly linked within the wider health sector*. Retrieved 7/11/06, from <http://www.scoop.co.nz/stories/GE0604/S00029.htm>
- Ministry of Health. (2007). *Maternity Services Notice pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000*. Wellington: Department of Internal Affairs.
- Ministry of Health. (2008). *Maternity Services Consumer Satisfaction Survey Report 2007*. Retrieved 20/10/11, from <http://www.moh.govt.nz/moh.nsf/indexmh/maternity-services-consumer-satisfaction-survey-2007#download>
- Ministry of Health. (2010). *Midwifery workforce: Summary results from the 2009 health workforce annual survey*. Wellington.
- Ministry of Transport. (2010). *Fatigue Crash statistics for the year ended 31 December 2009*. Retrieved 9/10/11, from <http://www.nzta.govt.nz/resources/factsheets/24/index.html>
- Ministry of Health. (2003). *Report on Maternity 2002 & 2001*. Wellington: Ministry of Health.

- Moore, A. (2009). *Pioneering a new model of midwifery care: A phenomenological study of a midwifery group practice*. Australian Catholic University, Fitzroy.
- Morell, K. (2010). Find your work/life balance: Burnout is an occupational hazard for hustling freelancers. *Writer*, 124(5), 5.
- Morgan, D. (1997). *Focus groups as qualitative research*. Thousand Oaks: SAGE Publications.
- Morgan, M., Fenwick, N., McKenzie, C., & Wolfe, C. (1998). Quality of midwifery led care: Assessing the effects of different models of continuity for women's satisfaction. *Quality in Health Care*, 7, 77-82.
- Morris, N. (2010). How to carry out a literature search. *Education for Primary Care*, 21, 124-125.
- National Institute of Health (NIH). (2003). *Sleep, sleep disorders, and biological rhythms*. Retrieved 4/9/11, from <http://science.education.nih.gov/supplements/sleep/teacher/>
- New Zealand College of Midwives. (2011, 15 July). Midwifery system hailed as world leader. *New Zealand College of Midwives media release*.
- Nicholl, S., Vano, V., Griffiths, C., & Skinner, J. (2000, September 2000). *Midwifery in a primary health service: A model for practice*. presented at the meeting of the NZCOM Sixth National Conference, Cambridge.
- Northern Regional Health Authority. (1996). *Notice issued pursuant to Section 51 of the Health and Disability Services Act 1993 concerning the provision of maternity services*. Auckland: Ministry of Health.
- NZCOM. *Midwifery first year of practice*. Retrieved 26/2/12, from <http://www.midwife.org.nz/index.cfm/1,171,html>
- NZCOM. (2006a, 3 July). *Press release New Zealand College of Midwives* nzcom@nzcom.org.nz. Retrieved 12 December, 2006,
- NZCOM. (2006b). Revision to draft Section 88 notice. *Midwifery News*(43), 29.
- NZCOM. (2007). *Midwifery standards review*. Christchurch: New Zealand College of Midwives.
- NZCOM. (2008a, 12-14 September). Choices, challenges and diversity Symposium conducted at the meeting of the New Zealand College of Midwives 10th Biennial National Conference, Auckland.
- NZCOM. (2008b). *Midwives handbook for practice*. Christchurch: New Zealand College of Midwives.
- NZCOM. (2011). *Midwifery system hailed as world leader*. Retrieved 1/12/11, from <http://www.midwife.org.nz/index.cfm/3,223,485/nz-hailed-as-maternity-leader.pdf>
- O'Grady, G., Loveday, B., Simon Harper, Adams, B., Civil, I., & Peters, M. (2010). Working hours and roster structures of surgical trainees in Australia and New Zealand. *ANZ Journal of Surgery*, 80(12), 890-895.
- Otago Daily Times. (2011, 17 June). Driver fatigue blamed for death. *The New Zealand Herald*, p. 3.
- Page, L. (2003). One-to-one midwifery: Restoring the 'with woman' relationship in midwifery. *Midwifery Womens Health*, 48(2), 119 -125.
- Pairman, S. (1998a). *The midwifery partnership: An exploration of the midwife/woman relationship*. Victoria University, Wellington.
- Pairman, S. (1998b). Women-centred midwifery: Partnerships or professional friendships? *New Zealand College of Midwives*(19), 5-10.
- Pairman, S. (2006). From Autonomy and back again: Educating midwives across a century Part 2. *New Zealand College of Midwives*(34), 11-15.

- Pairman, S., & Guilliland, K. (2003). Developing a midwifery-led maternity service: The New Zealand experience. In M. Kirkham (Ed.), *Birth Centres. A social model for maternity care* (pp. 223-237): Elsevier.
- Pairman, S., Tracy, S., Thorogood, C., & Pincombe, J. (2006). *Midwifery: Preparation for practice*. Sydney: Elsevier.
- Papps, E., & Olssen, M. (1997). *Doctoring childbirth and regulating midwifery in New Zealand: a foucauldian perspective*. Palmerston North: The Dunmore Press Ltd.
- Parry, T. (2009). Restoring work-life balance. *Financial Planning*(Nov/Dec), 13.
- Paterson, R., & Adams, J. (2011). Professional burnout: A regulatory perspective. *The New Zealand Medical Journal*, 124(1333).
- Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3 ed.). Thousand Oaks: SAGE Publications.
- Pelvin, B. (1990). The nurses amendment bill: The implications for midwifery. *New Zealand College of Midwives*(March), 6-7.
- Pepperell, S. (2011, 3 April). *Doctors, nurses in health gun*. Retrieved 3/7/11, from <http://www.stuff.co.nz/sunday-star-times/news/3831544/Doctors-nurses-in-health-gun>
- Polo-Kantola, P. (2010). Gender and ageing in the 21st century. *Maturitas*, 68(3), 224-232.
- Porter, F., Macdonald, C., & MacDonald, T. (Eds.). (1996). *My hand will write what my heart dictates: The unsettled lives of women in nineteenth-century New Zealand as revealed to sisters, family and friends*. Auckland: Auckland University Press.
- Reason, P. (1988a). Introduction. In P. Reason (Ed.), *Human inquiry in action* (pp. 1-17). London: SAGE Publications.
- Reason, P. (1994). Three approaches to participative inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 324-339). Thousand Oaks: SAGE Publications.
- Reason, P. (Ed.). (1988b). *Human inquiry in action* SAGE Publications
- Reason, P., & Bradbury, H. (2006). Introduction: Inquiry and participation in search of a world worth of human aspiration. In P. Reason & H. Bradbury (Eds.), *Handbook of action research* (2006 ed.). London: SAGE Publications.
- Reiter, N. (2007). Work life balance: What do you mean? *The Journal of Applied Behavioral Science*, 43(2), 273-294.
- Richardson, L. (2000). Writing: A method of inquiry. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 923-948). Thousand Oaks: SAGE Publications.
- Roberts, R. (1989, 15 November). Midwife lobbies MP over changes to law. *Advocate*.
- Robertson, A. (1994). *Empowering women*. Camperdown: Birth International.
- Rolston, L. (1999). The issue of midwife self-preservation. *New Zealand College of Midwives*(20), 25-26.
- Rothbard, N., & Dumas, T. (2006). Research perspectives: Managing the work-home interface. In F. Jones, R. Burke, & M. Westman (Eds.), *Work-life balance* (pp. 71-89). New York: Psychology Press.
- Rothman, B. K. (1983). In labour: Women and power in the birthplace. *Journal of Midwifery & Women's Health*, 28(2), 48-49.
- Ryan, G., & Bernard, R. (2000). Data management and analysis methods. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 769-802). Thousand Oaks: SAGE Publications.
- Saultz, J. (2003). Defining and measuring interpersonal continuity of care. *Anal of Family Medicine*, 1, 134-143.
- Saultz, J., & Albedaiwi, W. (2005). Interpersonal continuity of care and patient satisfaction: A critical review. *Anal of Family Medicine*(2), 445-451.

- Saultz, J., & Lochner, J. (2005). Interpersonal continuity of care and care outcomes: A critical review. *Annals of Family Medicine*, 3, 155-166.
- Schubert, J. D. (2008). Suffering/symbolic violence. In M. Grenfell (Ed.), *Pierre Bourdieu. Key concepts* (pp. 183-198). Durham: Acumen.
- Scott, M. (2011). Why you should care for yourself as you care for others. *Midwifery News*, 63, 28-29.
- Shotter, J. (1993). *Conversational realities: Constructing life through language*. Thousand Oaks: SAGE Publications Ltd.
- Shusterman, R. (Ed.). (1999). *Bourdieu. A critical reader*. Oxford: Blackwell Publishers Ltd.
- Skinner, J. (1999). Midwifery partnership: Individualism contractualism or feminist praxis? *New Zealand College of Midwives*(October 1999), 14-17.
- Skinner, J. (2003). The midwife in the 'risk' society. *New Zealand College of Midwives*, 4-7.
- Skinner, J. (2011). Being with women with risk: The referral and consultation practices and attitudes of New Zealand midwives. *New Zealand College of Midwives*, 45, 17-20.
- Skinner, N., vanKijk, P., Elton, J., & Auer, J. (2011). An in-depth study of Australian nurses' and midwives' work-life interaction. *Asia Pacific Journal of Human Resources* 49, 123 - 232.
- Smith, K. (2010). Work-life balance perspectives of marketing professionals in generation Y. *Services Marketing Quarterly*, 31, 434-447.
- Smythe, E. (1997). Phenomenology: A research approach for midwifery. *New Zealand College of Midwives*(April), 16-19.
- Smythe, E. (2000). 'Being safe' in childbirth: What does it mean? *New Zealand College of Midwives*, 22, 18-21.
- Smythe, E. (2007). A hermeneutic analysis of the rise of midwifery scholarship in New Zealand. *The New Zealand College of Midwives*, 37(October), 20-25.
- Smythe, E., Payne, D., Wilson, S., & Wynyard, S. (2009). Warkworth birthing centre: Exemplifying the future. *New Zealand College of Midwives*(41), 7-11.
- Smythe, E., & Young, C. (2008). Professional supervision: Reflections of experience. *The New Zealand College of Midwives*, 39(October), 13-15.
- State Services Commission. (2005). *Work-life balance: A resource for the state services*. Retrieved 30/9/11, from <http://www.ssc.govt.nz/worklifebalance>
- Steinmetz, M., Pullon, S., & Gray, B. (2011, September). *Maternity care embedded in a primary care service*. Retrieved 30/12/11, from <http://gpnz.org.nz/wp-content/uploads/Maternity-Care-Embedded-in-a-Primary-Care-Service-Sue-Pullon-Monika-Steinmetz.pdf>
- Stojanovic, J. (2004). Leaving your dignity at the door: Maternity in Wellington 1950 - 1970. *New Zealand College of Midwives*(31), 13-17.
- Stojanovic, J. (2008). Midwifery in New Zealand 1904 -1971. *Contemporary Nurse*, 30, 156 -167.
- Strid, J. (1991). Editorial. *Save The Midwives Newsletter*, 25(Summer).
- Strid, J. (1994, 12-14 August). *Consumer viewpoint: Four years post independence*. presented at the meeting of the 3rd National Conference New Zealand College of Midwives Incorporated, Rotorua.
- Stringer, E. (2007). *Action research* (3rd ed.). Los Angeles: SAGE Publishing.
- Surgenor, L., Spearing, R., Horn, J., Beautrais, A., Mulder, R., & Chen, P. (2009). Burnout in hospital-based medical consultants in the New Zealand public health system. *The New Zealand Medical Journal*, 122(1300), 11-18.
- Surtees, R. (2010). *Midwifery as feminist praxis in Aotearoa/New Zealand: A critical discursive exploration*: Lambert Academic Publishing.
- Swartz, D. (1997). *Culture & power*. Chicago: The University of Chicago Press.

- Tetrick, L., & Buffardi, L. (2006). Measurement issues in research on the work-home interface. In F. Jones, R. Burke, & M. Westman (Eds.), *Work-life balance*. New York: Psychology Press.
- Thomson, P. (2008). Field. In M. Grenfell (Ed.), *Pierre Bourdieu key concepts* (pp. 67-81). Durham: Acumen.
- Tinkler, A., & Quinney, D. (1998). Team midwifery: The influence of the midwife-woman relationship on women's experiences and perceptions of maternity care. *Journal of Advanced Nursing*, 28(1), 30-35.
- Tolhurst, N. (2007). *The a to z of corporate social responsibility*. Retrieved 10/11/11, from http://ezproxy.aut.ac.nz/login?url=http%3A%2F%2Fwww.credoreference.com/entry/wileyazcsr/work_life_balance
- Tracey, S., Sullivan, E., Wang, Y., Black, D., & Tracey, M. (2007). Birth outcomes associated with intervention in labour among low risk women: a population-based study. *Midwifery News*(47), 31-36.
- Tully, E. (1993). Innovative organisation. *New Zealand College of Midwives*(April), 10-12.
- Tully, E., & Mortlock, B. (1999). Professionals and practice. In P. Davis & K. Dew (Eds.), *Health and society in Aotearoa New Zealand*. Melbourne: Oxford University Press.
- Uno, K., & Ruthman, J. R. (2006). Wellness as a self-care philosophy for nurses and their leaders. *Holistice Nursing Practice*, 3-4.
- Wakelin, K., & Skinner, J. (2007). Staying or leaving: A telephone survey of midwives, exploring the sustainability of practice as lead maternity carers in one urban region of New Zealand. *New Zealand College of Midwives*, 37(October), 10 -14.
- Waldenstrom, U. (2007). Normal childbirth and evidence base practice. *Women and Birth*, 20(4), 175-180.
- Waldenstrom, U., & Turnbull, D. (1998). A systematic review comparing continuity of midwifery care with standard maternity services. *British Journal of Obstetrics and Gynaecology*, 105(11), 1160-1170.
- Waller, N. (2004). Reflection of practice. *Midwifery News*(June), 10.
- Weinger, M., & Ancoli-Israel, S. (2002). Sleep deprivation and clinical performance. *The Journal of the American Medical Association*, 287(8), 955-957.
- White, K. (1994). Social construction of medicine and health. In J. Spicer, A. Trlin, & J. A. Walton (Eds.), *Social dimensions of health and disease: New Zealand perspectives* (1st ed., pp. 240-256). Palmerston North: The Dunmore Press Limited.
- Whitehead, J., & McNiff, J. (2006). *Action research living theory*. London: SAGE Publications.
- Whyte, D. (2009). *The three marriages: Reimagining work, self and relationship*. New York: Riverhead Books.
- Women's Health Watch. (1996). A quick guide to what's wrong with the new maternity scheme. *Women's Health Watch*(September).
- Wylie, C. (2005). Sleep, science, and policy change. *The New England Journal of medicine*, 352(2), 196-197.
- Young, C. (2006). Keynote address Symposium conducted at the meeting of the New Zealand College of Midwives 9th Biennial National Conference 2006, Christchurch, New Zealand.
- Young, C. (2011). *The experience of burnout in case loading midwives*. Auckland University of Technology, Auckland.

APPENDICES

Appendix A: Ethics approval



M E M O R A N D U M

Auckland University of Technology Ethics Committee (AUTEC)

To: Elizabeth Smythe
 From: **Madeline Banda** Executive Secretary, AUTEC
 Date: 2 April 2008
 Subject: Ethics Application Number 08/11 **Action research: identifying effective strategies toward work/life balance for case loading midwives.**

Dear Elizabeth

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 11 February 2008 and that I have approved your ethics application. This delegated approval includes approval for the alteration of the title and is made in accordance with section 5.3.2 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 14 April 2008.

Acting under delegated authority and subject to endorsement by AUTEC at its meeting of 14 April 2008, the Executive Secretary approved the satisfactory completion of AUTEC's conditions and alteration of the title from 'Action research: identifying effective strategies toward work/life balance for independent midwives' to 'Action research: identifying effective strategies toward work/life balance for case loading midwives'.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/about/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 2 April 2011;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/about/ethics>. This report is to be submitted either when the approval expires on 2 April 2011 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at charles.grinter@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

A handwritten signature in black ink, appearing to read 'M. Banda'.

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Heather Donald heather@maternitymatters.co.nz

Appendix B: Recruitment advertisement

Identifying ways to achieve a work-life balance for the case-loading midwife

Heather Donald would like to extend an invitation to all case-loading midwives in the Auckland area who would like to participate in a dynamic research project to identify effective strategies for a work-life balance. This action research would involve you as a co-researcher and co-participant. This means you will have a say in how the research evolves. Heather is conducting this research in order to write a thesis for a doctorate in Health Sciences. It is hoped findings will identify effective strategies for a work-life balance which will help preserve our workforce by protecting midwives from 'burnout'.

We all know the effects that on-call work has on our private lives and we know of midwives that have not been able to sustain the lifestyle. This is your opportunity to modify or change the way you practise and make your practice one that you can sustain long term while still meeting the needs of the women and practising within the NZCOM philosophy of care and Government requirements. The research will involve meeting together in focus groups and individual journaling or phone interviews over a 12 to 18 month period starting in April, 2008.

Contacts for application or for further information:

Heather Donald

Lead Researcher

Ph 0275 848 444

Liz Smythe

Associate Professor

Auckland University of Technology

Ph 021 351 005

Judith McAra-Couper

Auckland Chairperson

NZCOM

Ph 0272 790 292

Appendix C: Formal invitation to participate

Participant Information Sheet



Date Information Sheet Produced:

2 April 2008

Project Title

Action research: Identifying effective strategies toward a work-life balance for case-loading midwives.

An Invitation

I am an independent midwife and I am inviting you to participate in research on the work-life balance of the case-loading midwife. Your participation is voluntary and you may withdraw at any time without any adverse consequences. This research will contribute toward my studies for a Doctor of Health Science degree.

What is the purpose of this research?

This research aims to generate practical solutions to provide a sustainable continuity of care service for the midwife. New approaches to the way the midwife provides care will be identified that are sustainable for the midwife. It will support the 'continuity of care' ethic endorsed by the New Zealand College of Midwives and the Ministry of Health. New ideas about care provision will be produced and refined in cycles as it is applied to practise. The participants will collaboratively develop and produce the data and findings. The outcome will result in sustainable care provision with an ultimate benefit for midwives and women.

How was I chosen for this invitation?

You have been selected in response to your stated interest to be involved in the research. The invitation is open to any case-loading midwife, either employed or self-employed working in the Auckland region.

Six to twelve midwives will participate in the research. If there are more than twelve midwives wishing to participate then a purposeful selection will be made from those who have offered to participate.

What will happen in this research?

This 'action research' will involve several cycles of journal writing and/or telephone interviews and focus group meetings. You will become a co-researcher and co-participant as you reflect and put into action changes in your practice and journal about how this process has been for you. Focus groups will be an opportunity for joint reflection and celebration of the journey you are on. The research period will be for 12 months.

What are the discomforts and risks?

You may feel uncomfortable or stressed at times due to the sharing involved in the focus groups. Some may experience difficulty in coming to terms with issues that you have avoided or you may not have dealt with before.

How will these discomforts and risks be alleviated?

You will be in control of how much information you share. Everything discussed will be confidential to the group. No information would be reported in the research that could identify any person without the express permission of the person or persons concerned.

Counselling services from the AUT Health and Counselling Services will be made available should you require them as a result of the study.

What are the benefits?

This research will provide you with an in-depth opportunity to examine and reflect on how you provide care. It will help you put in place ways to protect and enhance your work/life balance while still meeting the needs of women. You will achieve this with the collegial support of the other midwives involved. Hopefully we will have a lot of fun.

How will my privacy be protected?

Confidentiality will be assured. Each participant in the focus groups will agree to keeping information confidential. There will be full consultation with participants at every phase of the study.

What are the costs of participating in this research?

Costs will be kept to a minimum. These costs will include transport costs to the focus group venue and the time involved in attending focus groups and journaling. Focus groups will be held where they are accessible by all. Reimbursement of travel costs will be available. A writing book will be provided for journaling.

You will be able to decide how much time you can contribute. You will have choices in how you can best participate in the manner you feel more comfortable. For example you may choose journal writing or phone interviews for recording in the action cycles. Journal writing or phone interviews may take approximately one hour each week for four weeks and be repeated up to four times. There will be approximately four focus group gatherings and they will last at least two hours. The study will occur over a 12 to 18 month period starting in May 2008.

What opportunity do I have to consider this invitation?

An introductory meeting of potential participants will be held in May 2008 and a commitment from those wishing to participate in the research will be required at this time.

How do I agree to participate in this research?

You will be required to sign a Consent Form that will be available at the introductory meeting or from the principal researcher.

Will I receive feedback on the results of this research?

Written feedback will be ongoing through the research process for consultation for all the participants. A final full report will be available to all participants.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Elizabeth Smythe, liz.smythe@aut.ac.nz, ph 021 351 005.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Whom do I contact for further information about this research?


Liz Smythe Ph 021 351 005

Heather Donald Ph 0275 848 444

Judith McAra-Couper Ph 0272790292

Approved by the Auckland University of Technology Ethics Committee on *2 April 2008*
AUTEK Reference number 08/11

Appendix D: Consent form

Consent Form	 <p>AUT UNIVERSITY TE WĀNANGA ARONUI O TAMAKI MAKAU RAU</p>
---------------------	---

Project title: Action Research: Identifying effective strategies toward work-life balance for case-loading midwives

Project Supervisor: Liz Smythe

Researcher: Heather Donald

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 2 April 2008.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- ☐ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that while it may not be possible to destroy all records of the focus group discussion of which I was part, the relevant information about myself including tapes and transcripts, or parts thereof, will not be used.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one):
 Yes ☐ No ☐

Participants signature.....

Participants Name.....

Participants contact details:

.....

Date: *Approved by the Auckland University of Technology Ethics Committee on 2 April 2008 AUTEK Reference number 08/11*

Appendix E: Confidentiality Agreement

Confidentiality Agreement



Project title: Action Research: Identifying effective strategies toward work-life balance for case-loading midwives

Project Supervisor: Liz Smythe

Researcher: Heather Donald

- ☐ I understand that all the material I will be asked to transcribe is confidential.
- ☐ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature.....

Transcriber's name.....

Transcriber's Contact Details:

.....

.....

.....

.....

Date.....

Project Supervisor's Contact Details:

Liz Smythe

Ph 021351005

***Approved by the Auckland University of Technology Ethics Committee on 2 April AUTEK
Reference number 08/11***

Note: The transcriber should retain a copy of this form.

GLOSSARY OF KEY TERMS

Midwife

A midwife is a man or woman who has completed a recognised diploma or degree in midwifery and is registered with the Midwifery Council and holds an annual practicing certificate. In this thesis the midwife is referred to in the feminine as 'she' as there is predominantly more female than male midwives.

Lead Maternity Carer (LMC)

The LMC can be self-employed or a hospital based midwife, a general practitioner or obstetrician who has an agreement with the Ministry of Health under Section 88. The LMC is responsible for providing and coordinating a woman's maternity care throughout pregnancy, labour and birth and after the birth until 6 weeks. The choice of LMC will depend to some extent on where a woman lives, as the full range of LMC options is not always available in every area.

Case-loading midwife

A case-loading midwife cares for the same women from conception to six weeks postpartum. They can be employed by a DHB or private company or be self-employed. They are a Lead Maternity Carer.

Self-employed midwife or Independent midwife

Refers to a LMC midwife who practices privately funded through the public health system subject to the conditions of the Section 88 Maternity Services Notice.

24/7

Refers to person who is on call 24 hours a day, seven days a week.

Woman-centred care

The woman is the focus of midwifery care, and it is she, in partnership with the midwife, who identifies her priorities for care.

General Practitioner (GP)

A health practitioner who is, or is deemed to be, registered with the Medical Council of New Zealand and holds an annual practicing certificate.

Section 88 Maternity Services Notice

The terms and conditions for the provision of maternity services in New Zealand are set by the Section 88 Maternity Services Notice, under the New Zealand Public Health and Disability Act. The Notice provides nationally consistent terms and conditions for primary maternity care and sets out the payments LMCs, such as midwives, GPs and specialists can receive for providing the different maternity care services required during a pregnancy.

Primary and secondary care

Primary maternity care is generally provided at a community level by midwives and GPs. Where a pregnancy is more complicated a woman may be referred to secondary or more medically based care, to be more closely monitored. This includes care by hospital based midwives and specialists, including obstetricians. The process of referring a woman from primary to secondary maternity care is set out under the referral guidelines, which are part of the Section 88 Maternity Services Notice.

District Health Board (DHB)

District Health Boards (DHBs) are responsible for providing, or funding the provision of, health and disability services in their district. There are twenty DHBs in New Zealand and they have existed since 1 January 2001 when the New Zealand Public Health and Disability Act 2000 came into force.

In New Zealand the health care provision is divided into districts. Each DHB is responsible for the allocation of the health services. Section 88 is not included in this government distribution of funding from a DHB. Instead those practicing under Section 88 claim directly from the Ministry of Health.

New Zealand College of Midwives (NZCOM)

The New Zealand College of Midwives (NZCOM) is the professional organisation for midwives and student midwives in New Zealand. The NZCOM represents over 3100 members and works in partnership with maternity consumer groups such as Plunket, Parents Centre New Zealand, the Home Birth Association, La Leche League and individual women to ensure high quality maternity services in New Zealand.