

THE EXPERIENCE OF BURNOUT IN CASE LOADING MIDWIVES

An interpretive phenomenological study.

Carolyn M. Young

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Auckland University of Technology
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Primary Supervisor: Liz Smythe

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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.

Signed.....

Dated.....

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Abstract

Midwifery autonomy is epitomized in the provision of lead maternity care, a promoted and sought after consumer choice pivotal to the credibility of autonomous midwifery. The loss of experienced New Zealand midwives to autonomous practice through professional burnout has a local impact on midwifery services as well as global implications for midwives seeking autonomy of practice in other countries.

This study, informed by Heidegger and Gadamer, seeks to uncover the meaning of the lived experience of midwives who self identified as having burned out in the giving of lead maternity care. Participants were purposefully selected. Data was collected through twelve interviews with New Zealand registered midwives and, with the midwives consent, through a further four interviews with their partners to generate understanding of their experience.

The research showed that the reality of the weight of professional obligation in the provision of such care is largely invisible. The phenomenon of burnout is little understood within midwifery yet it seems that the nature of on call practice has a high potential for burnout. Emerging from my interpretation of the participants' stories were findings of burnout's ability to mask itself through semblance and appearance which is then further covered over by everydayness. The data is presented as first showing how burnout is masked, then how it is fuelled, and finally how the pain revealed itself within the conversation of this study.

A high cost of burnout for women, midwives and midwifery was exposed. It is hoped that by revealing the extent of these midwives personal destruction and pain, and at times that of their families, a discussion around sustainable practice, realistic professional expectations and the development of more avenues of support will continue to evolve within midwifery. Within the unknowing, burnout's fires are fuelled. Only as midwives understand the phenomenon will they be more able to identify contributing factors and the need to prioritize their own well being within the midwifery working model of care.

Chapter One: Introduction to the Study

Introduction

This interpretive phenomenological study explores professional burnout in New Zealand self employed case loading midwifery practitioners. The midwives who practice in this area of midwifery offer an option of maternity care that is valued by both women and midwives. The weight of professional obligation in the provision of this care is largely invisible within society. Pregnancy by its nature is a time of self absorption to ensure the perpetuation and well being of the future generation. In this natural environment of self-focus the affect on the caregiver of meeting extraordinary demands of service are peripheral to the service user. Self employed case loading midwifery practice involves demanding and complex professional responsibilities that continue to accrue. Yet it is a preferred area of practice for many midwives and a preferred option of care for women because of the unique and fulfilling relationship that is developed between the woman and the midwife providing her care.

Burnout is increasingly occurring in the modern work place and yet it remains a phenomenon that is not well understood, even by those who have lived through it. For those who have not experienced burnout it is even more difficult. It may be assumed that midwives who experience burnout bring it upon themselves. Other's seemed to cope with the demands of case loading practice, so why didn't they? From such a starting point questions then have a natural propensity to move on to other assumptions. What did these midwives do wrong? Why didn't they walk away and find something else to do if they couldn't cope with the work? Why didn't they achieve better life balance around their midwifery commitments? Within the phrasing of such questions those who have experienced burnout are judged. The judgements which surround burnout are embodied by those who have suffered it without establishing the validity of such conjecture. Yet research into the causes of work-related burnout indicates that it is not a problem of a weak individual, but the result of the structure of the work environment (Hoops, 1999).

The phenomenologist investigates subjective phenomena in the belief that critical truths about reality are grounded in people's lived experiences (Polit, Beck, & Hungler, 2001). Hermeneutic phenomenology uses the lived experience of people as

a tool for better understanding the social, cultural, political and historical context in which those experiences occur, (Polit et al., 2001). I undertook this study using hermeneutic phenomenology as my methodology. This came from my belief that the phenomenon of burnout and the paths which led to it were best explored by visiting the lived experience of it. Data was generated through audio taped interviews with sixteen participants. After confirmation of accuracy by participants, extracts from their transcripts were then used in my study with their permission. The process of reflection I engaged in included extended background reading, personal experience, the presentation of work to enable consideration of comments generated by it and attendance of midwifery and philosophy workshops and conferences. Through an interpretation of the narratives of twelve case loading midwifery practitioners who self identified as having burned out because of professional obligation, and four of their partners, this study seeks to make their experience visible and reveal its truths. It is hoped that with the knowing of burnout its ability to pervade and impact so adversely on lives can be reduced.

My pre-understandings

Van Manen (1990) suggests that frequently it is not...

that we know too little about the phenomenon that we wish to investigate, but that we know too much. Or, more accurately, the problem is that our 'common sense' pre-understandings, our suppositions, assumptions, and the existing bodies of scientific knowledge, predispose us to interpret the nature of the phenomenon before we have even come to grips with the significance of the phenomenological question. (p. 46)

Study may be initiated because of the researcher's own interest in a particular field of inquiry. As Van Manen tells us, this leads to the researcher bringing the history of their own experience to their work. I recognized that my many years of on-call midwifery practice would have generated personal beliefs. I have felt the extremes of fatigue when it is a struggle to stay focused to give prolonged care. I understand the weight of the evening phone call that heralds in attendance at a labour at the end of what has already been a long day. But I have not personally experienced burnout,

the phenomenon which is central to this study. My work has, however, bought me alongside midwifery colleagues who have burnt out in a process that was usually concealed. There appeared to be a slow diminishing of their former professional joy. They seemed to increasingly struggle with fatigue and their levels of tolerance of high demand clients progressively reduced. Their ability to negotiate work place difficulties was blunted making them increasingly vulnerable to any withholding of concern or support. They quietly floundered in some sort of distress amongst us all, the severity of which was covered over. Their burnout was not recognized in the assumption that they were just stressed or overtired. There was inconclusiveness in that vague general awareness that these midwives previous joy in their work was diminished; that it was taking some sort of a toll on them. Then suddenly they were gone from case loading midwifery with guarded comment as to why.

My professional history acknowledges that midwifery has been my life's work and is an ongoing source of passion and joy; this has meant that establishing boundaries around my personal time has not been easy. I am familiar with the challenge midwives can face to achieve this necessity.

I also have a long history of working with midwifery students and mentoring new graduates. While I have exacting expectations of what midwives should provide to women in their care, I am aware that I also have a protective attitude towards midwives. I disclose the passion for my work and the sensitivity I have towards the well being of midwives so it can be considered as a possible influence on my study.

I have now practiced as a midwife for forty years having qualified through a post graduate nursing course at St. Helens Hospital in Auckland in 1970. For two of these years I worked as a hospital employed midwife in a primary care level unit where I eventually held the position of charge midwife in the birthing suite. Childbirth in that era was a lonely disempowering process for both women and their families. In 1975, therefore, I moved away from the nature of that practice to work in the community supporting women to have their babies at home where choice was possible.

Midwifery was yet to become an autonomous profession. The small number of midwives who left the rigidity of the hospital system to provide community midwifery care worked with general practitioners who were empathetic to the needs of women around childbirth. The Home Birth Association was formed in 1978 and through it consumers, midwives and general medical practitioners formally challenged the medical establishment to justify their practices (Donley, 1998). This local reaction reflected the international move away from the medicalisation of childbirth encapsulated in the contention of the French obstetrician Michel Odent (1984) that women should be encouraged to trust in their own bodies.

My choice to practice as a domiciliary midwife within the community reflected my desire to empower women to have autonomy over their births; to optimize their experience through filtering out unqualified negative tensions. As the daughter of a midwife who was comfortable with birth, then as a mother who chose to have her own children at home with trusted caregivers, I believed that the influences of the environment in which women give birth on the nature of that birth is significant. I felt that a positive birth experience eased the transition to motherhood and thereby the path of the incoming generation. The then unique one-on-one relationship midwives working in the community were able to develop with the women they cared for maximized the opportunity to create a positive environment that best suited each woman.

Prior to the passing of statutory law in 1990 enabling midwives to practice independently, I worked in the community for fifteen years attending home births along with a supportive group of dedicated general practitioners. With the establishment of midwives as practitioners in their own right, I went through a transitional phase of offering women shared care with general practitioners. Ultimately I was to offer total care as more women took up the new option of midwifery-only based care.

As women's voices began to be heard and responded to, maternity care became woman focused. The nature of birth within the hospital systems continued to be progressively more and more philosophically challenged until it evolved into

something with which I was comfortable. Accordingly I took up hospital access agreements and began to include hospital births in my practice. The midwife was now able to meet the needs of the individual woman during her birth and mothering experience whether she birthed at home or in the hospital through the concept of continuity of care. Since undertaking this study independent midwifery practice is now more commonly referred to as self employed practice where the midwife has an agreement to provide care to the individual women on a case loading basis as their Lead Maternity Caregiver and facilitates and provides their care.

In summary, my pre-understandings were, that:

- Self employed midwifery practice offers a unique and valued service to women.
- It is an option of care that is worthy of protection through devising ways to ensure it remains sustainable.
- Midwifery, as offered within New Zealand self employed midwifery practice and hospital employed case loading midwives, promotes a provision of continuity of care that attracts global attention and comment.
- It is an option of care that is promoted to New Zealand women in a manner that may prohibit the recognition of any need for consumer responsibility around the levels and the timing of their non urgent service demands.
- Consumers have high expectations of midwives, at times assuming that they will be immediately available for any concern at any time of the day or night.
- The individual midwife is expected to re-craft a promoted consumer expectation within her midwifery practice to something which is sustainable.
- Professional expectation of self employed midwifery practitioners is high and the role continues to accumulate increasing responsibility.
- Midwives are attracted to this mode of practice because it allows them to enact the philosophical principles of care they strongly identify with and seek to emulate.
- Midwives do not fully understand the nature of the demands of the work they elect to engage in or how to sustain it through modification of consumer expectation and their provision of service.

- Midwives do not fully understand the need to establish boundaries around their professional duties at onset of practice and therefore establish patterns of over accommodation that becomes entrenched.
- Burnout forces experienced midwives out of their preferred area of work and, at times, out of midwifery.
- Midwives who experience burnout have their lives adversely impacted on.

My professional philosophical beliefs

My philosophical position as a midwife is that case loading midwifery practice offers a unique and valuable option of maternity care to women and their families. Such care captures the historical tradition of women supporting women during pregnancy, childbirth and early mothering through a trusted, evolved, one-on-one relationship.

The model of a continuity of care which is provided by a single identified caregiver and pivots around the individual woman's needs is appropriate to the profoundly personal and life changing experience of childbirth. Such a concept of care allows a trusting relationship to develop between the midwife and the woman that enriches the significant experience that they share. Not only does this enhance the quality of that experience, it enables the particular safety that comes from the knowing of another. Small deviations from well being are recognized promptly simply because there has been an opportunity to become familiar with what is usual for that particular person.

This model of practice captures the ideals of the developed midwifery philosophy of partnership. The partnership model was described by Guilliland and Pairman (1995) as a relationship which redirects the professional vision from ease of care giving to one of meeting the woman's needs. The focus is on the woman who defines her needs based on her knowledge of herself and her family, her life experience, intuition and wisdom. Partnership seeks to ensure that the caregiver works with the woman to fulfill her needs within the giving of professional midwifery care. The extended contact between the woman and the case loading midwife allows a knowledge of each other which promotes effective partnership.

How did this study happen?

I began post graduate study as a means of lifting my pre-degree era of midwifery qualification into the twentieth century. I had no intention of doing more than a little academic tweaking of my rusty qualifications, but somewhere along the way I found myself being channelled into doing a Masters Thesis. Ethics approval was sort for this and given by the Auckland University of Technology Ethical Review Committee in May 2006.

As I steeped myself in academia I was fortunate enough to have guidance that allowed me to rediscover the joy of new learning. But it was the passion I had for my study and for midwifery itself that was the driving force. Having begun working with participants I came to the conclusion that their story demanded a more in depth telling than I was able to do within the restrictions of Masters Thesis. I made the decision to transfer to a Doctoral degree. I believed that the stories of these midwives experiences needed to be heard. I subsequently applied for and received approval from Auckland University of Technology to transfer to a Doctoral Thesis one year later in May 2007 to allow for a greater depth of exploration of their experience.

What is the nature of lead maternity care provision?

The case loading midwife, has an agreement with the individual woman to be her Lead Maternity Caregiver and provide, or arrange, her total care for the term of her pregnancy and birth. This is then followed by the further provision of care for between four to six weeks for the new mother and her infant. Midwifery has now moved from primary low risk birth to providing and implementing care for women who may have additional complex medical and obstetric needs.

The midwife assumes the responsibility for giving conscientious and sensitive professional care. This includes appropriate referrals to other services, in a manner which reflects the woman's choices. It upholds the code of rights governing the provision of health care within New Zealand. The midwife must be available to the

woman from the point of her acceptance of the contractual obligation to provide the woman's care throughout her pregnancy, labour and birth and to both her and her baby throughout the post natal period. The Maternity Services Notice (MOH, 2002b) states that "The LMC or a backup LMC will be available 24 hours a day, 7 days a week to provide phone advice..." (p. 1060). It was only in 2007 that the requirement for the Lead Maternity Carer (LMC) midwife, a primary caregiver, to physically attend all women who were hospitalised for urgent problems involving secondary care was revoked. Under the previous Act it was only under 'exceptional circumstances' that a midwife could be exempted from an obligation to personally provide her client's care.

The Ministry of Health Maternity Services Information Kit (Ministry of Health (MOH), 2002a) further advised women that "if you have any doubts about whether your query or problem is maternity related, check with your LMC first," (p.6), and:

As soon as you register with your LMC: If you need any urgent maternity care outside your scheduled visits, your LMC is available 24 hours, 7 days a week, from the time that you register until the final maternity check four to six weeks after the birth (p.12).

This promoted obligation of continuous availability is at the woman's discretion as to how she assesses the urgency and the appropriateness of her enquiry. The Lead Maternity Carer is expected to meet this onus of responsibility personally. If unable to, she is required to arrange for a back-up midwife to take over the obligation of availability and/or provision of care to the woman on her behalf (MOH, 2002b).

This mode of midwifery practice optimizes the opportunity for the woman and the midwife to work together in the spirit of partnership throughout the woman's childbearing experience. Their partnership is founded on trust in the midwife's commitment to the exemplary fulfillment of her professional obligations and in the woman's commitment to her own and her baby's wellbeing. This expectation is enhanced by the knowledge of each other that is accrued during the giving and receiving of care. The knowledge of the woman's care expectations is formalized through the evolvment of a care plan with each woman during their pregnancies. This should formally reflect the woman's self identified needs and individual

preferences. The midwife has a responsibility to give the woman identified information to assist her in her decision making in a process of informed consent. The spirit of partnership also extends to a midwifery inclusion of respect for the people whom the woman identifies as key figures in her social and family structure.

What is the difference between core, hospital employed and self employed case loading midwives?

Midwives may be employed by the hospitals to work within the facility providing care on a shift work basis; these midwives are known as core midwives. In some district health board areas case loading midwives were, or are, employed to contract to women as their Lead Maternity Caregiver as part of a structured hospital based team. These midwives, sometimes known as 'Know Your Midwife' (KYM), have a prescribed case load in terms of numbers or complexity of care and work out of the hospital setting. Days off and annual leave are built into their employment agreement with the individual hospital with which they are associated. They have resources such as rooms, vehicle, paging systems available to them. They are able to access reviews, educational courses and professional support without cost.

The self employed case loading midwife, is authorized by the Ministry of Health to provide care to women on a case loading basis under the maternity service guidelines. She must acquire a bi annually renewable access agreement with each district health board to enable her to practice in nominated hospitals. There is an expectation that she will abide by the protocols and guidelines of those hospitals. She must provide her own practice resources and evolve her own way of practicing. This includes developing midwifery collegial relationships and devising financial or reciprocal arrangements with them that enable structured time off. As a self employed practitioner she is responsible for funding her own professional costs of on going education and practice compliance requirements.

The terminology used to describe midwives providing continuity of care has evolved through change. Pre midwifery autonomy in 1990 such care was only available within the community, hence their being described as 'domiciliary midwives.' When autonomy allowed hospital based care to be provided by non-hospital employed

midwives holding access agreements they became known as 'independent midwives.' The former domiciliary midwives were then included in this description. This designation evolved to 'self employed midwives' to reflect that these midwives were not external to the midwifery profession. With the development of self employed and 'KYM' midwifery services within the provision of continuity of care the term 'case loading' or Lead Maternity Care (LMC) midwives began to be used interchangeably. As the LMC role can be held by a general practitioner or obstetrician as well as a midwife for the purposes of clarity within this study the term case loading midwives will be used to describe midwives who offer continuity of care on an on call basis other than when directly quoting from literature.

Historical background of case loading New Zealand midwifery

In 1990 the Amendment to the Nurses Act gave midwives the right to practice autonomously in New Zealand. The vision for maternity care within New Zealand was that "Each woman, her whanau and family, will have every opportunity to have a fulfilling outcome to her pregnancy and childbirth, through the provision of services that are safe and based on partnership, information and choice..." (MOH, 2002b).

The provision of such care quickly became a midwifery responsibility. The remunerated professional obligation that had to be met under the new act was untenable for most general practitioners who had previously been well represented in maternity care provision. They were now obliged to offer service on an equal footing with midwives, which included continuity of care from the identified Lead Maternity Care (LMC) provider. Where midwifery care was provided by hospital employed midwives, the general practitioner's fee for service was reduced to reflect the lesser input. The flexibility and duration of labour and birth attendance was not easily accommodated within a busy general practice. The responsibilities of a LMC were increased and specified as being applicable to all practitioners who undertook that role. Part of the obligation of care involved the time consuming process of information giving on specific topics as well as the documenting of choice in a formalized care plan expected to be evolved with every woman. Guilliland and Pairman (2010) detail how some medical practitioners felt forced out of maternity

care and were dismissive of midwifery as having a professional capability of meeting the needs of the New Zealand child bearing women. But in 2001 the World Health Organisation (WHO) had concluded that midwives are the most appropriate and cost-effective caregivers in normal pregnancy and birth (WHO, 2001). The New Zealand College of Midwives seeks feedback from consumers as part of its quality assurance and women consistently and constantly feed back how much they value the LMC service model (New Zealand College of Midwives (NZCOM), 2005).

The case loading midwifery service is a monetary capped resource within the maternity services. The fee for post natal service is the only module that allows a single additional fee where there has been an extra high service demand. Otherwise the midwife has an undefined obligation of service. This may involve numerous antenatal visits as part of vigilant clinically indicated care, or reassurance visits for well but anxious women who are insistent on being seen. In addition to the provision of basic maternity care, the midwife is also now expected to provide services through all levels of care that were never considered as midwifery's responsibility. The midwifery focus was on normal childbirth when the Section 88 Maternity Notice was developed initially in 1996 and reviewed in 1998 (NZCOM, 2005). Capped service fees enables the Maternity Services to promote a practitioner availability that has no clear consumer boundaries and allocate LMC givers increasing obligations with financial immunity for the extended service expectations. In the prevalent economic environment people are evaluated as human resources. They must then be cost effective. The burden of an excessive work load is easily shifted from the establishment to the individuals who serve that establishment for them to personally resolve. Hoops (1999) believes that a work place environment that promotes economic values over human values contributes to burnout amongst employees.

The case loading midwifery practice reality

The practice reality of meeting such a variable intensity of service as well as the self identified needs within differing cliental requires extreme commitment. Pairman and Massey (2001) suggested that "the challenge for the Ministry of Health is to ensure that there are enough independent midwives to meet the demand and that their work conditions support case loading practice" (p. 21).

Women, as stated, are coached to contact their case loading midwife at any hour and view them as a 24 hour 7 day week service provision. This reflects in part the Maternity Health Services perception of the case loading midwife as a captured and monetary capped maternity service resource. The expectation is that the midwife will be immediately available to her clients at all times to respond to any calls, or to have arranged for a colleague to do so on her behalf. A high level of service expectation has therefore been generated with financial immunity for compensating for the increased service ask within statutory law.

The intent of such a direction to women around midwifery availability presumably meant to create a constant midwifery resource for women to use as a point of reference to ascertain their own and their infants' wellbeing. The practice reality of this advice, however, is one of on going after hour calls to midwives about non urgent matters. Participants told of being disturbed mid evening to be asked about the safety of hair dye. Of being text'd through the weekends regarding mundane events by young single women looking for attention. Of being disturbed at 2 a.m. to be asked a routine question by a woman that had already been seen that day but forgot to ask it. Midwives tell of receiving after hour calls from women not booked with them seeking advice and from the family members of booked women wanting to discuss their personal concerns. I myself have been woken at half past six on a Sunday morning and phoned after ten o'clock at night by women seeking to register for midwifery care. The process of re-educating women to have a more realistic expectation of the boundaries around the appropriate content of after hour's service requests is left to the individual midwife in the face of the unconstrained expectation that has been promoted to women.

This re-education proved difficult in the case of high need women with complex or dysfunctional personal and family histories with limited resources for support. Participants found some women had little ability or willingness to assume any self responsibility expecting their midwife to meet all their needs. Lynch (2002) believes that the tasks of many midwives are over whelming as they work with abused

women, disadvantaged women, prison inmates, teenagers, women from inner-city ghettos with histories of poor mothering role modeling or suffering from poverty.

There are encompassing statutory professional obligations to be met in addition to the extreme of availability at the woman's discretion (MOH, 2002b). The average time frame for such constancy of availability by the case loading midwife is that of 34 weeks per client. She may undertake care for up to 60 clients a year and have up to 50 women and 7 or 8 new born babies in her care at any one time. Where the case loading midwife was unable to meet this demand personally a back up service must be provided by her. As there is a single fee payable for each module of care, back up services require a midwife to take on the responsibilities of her own case load as well as another midwife's in order to facilitate the second midwife having time off. Fee splitting of the single birth fee frequently meant both practitioners were poorly paid for fulfilling a particularly demanding incident of service provision.

Time away from the responsibilities of your occupation is seen as a basic fundamental right of all workers. Yet for the case loading midwife structured time off was seen as being in conflict with her LMC obligations as set in statute. Clause 3.2 states:

The Lead Maternity Carer is required to make every effort to attend as necessary during labour and to attend each birth. In the occasional circumstances where it is not possible to attend the birth due to, for example holidays, or the requirement to be with another woman in labour, the Lead Maternity Carer will make appropriate other arrangements. (MOH, 2002b)

“Occasional circumstances” implies an irregular and special event of which holidays are given as an example. Routine days off were not legally recognized; the need and right to structured time off from professional obligation for self employed midwives was not upheld in law. In the 2007 supplement to the New Zealand Gazette governing Maternity Services DA23 (e) this was modified to: "if a LMC is unable to attend the birth because of holiday leave, sick leave, bereavement leave, continuing professional education requirements or other exceptional circumstances, the LMC

must make appropriate other arrangements with a back-up LMC" (MOH, 2007a, p. 1067). Again there is no legal recognition of a need for structured time off.

There was a further statutory requirement for case loading midwives contracted to provide lead maternity care "to make every effort to attend a woman within, on average, twenty minutes of the woman's arrival at the Maternity Facility or Birthing Unit where she will give birth" (MOH, 2002b, Clause 3.6, p.1 2). The reality of this requirement was that the midwife had to be immediately available at any given time night or day to attend the woman abandoning whatever was happening in her personal and professional life. One participant had an incident report lodged against her because she took longer than the twenty minute time frame to attend her client. Translated literally, the case loading midwife, was not expected to venture more than twenty minutes traveling distance from any hospital in which her clients were booked in her private time other than on "occasional circumstances." In the 2007 supplement to the New Zealand Gazette governing Maternity Services DA23 (d) this was modified to "making every effort to attend a woman as soon as practicable" (MOH, 2007a, p. 1067).

In a difficult labour care may move beyond the scope of midwifery practice and a woman's care may be transferred to secondary services. There are referral guidelines as to when such consultation should take place. There was a statutory requirement, clause 3.9, that even under these circumstances "the LMC will continue to be available to support the woman (except where this is unreasonable because of a lengthy labour...)" (MOH, 2002b, p. 12). This meant that even when the midwife was no longer responsible for the woman's care she was expected to remain in attendance as a support person. Conversely in recent years midwives are now expected to leave the facility once the legal responsibility for midwifery care has been transferred to a staff midwife. The ability to effect such transference of midwifery care may be dependent on hospital staffing levels. The practice reality of the participant population is that case loading midwives continue to provide care for their clients after secondary services are involved.

Lengthy labour is not defined but is informally termed a period of constant attendance by the midwife that exceeds twelve to fifteen hours. This definition however does not take into account that the midwife may have been called in to provide care after already completing a full working day. She may then continue to work through the night providing continuous unbroken care without having obtained sleep or having any meal breaks. Relieving the case loading midwife of her obligations because of the circumstance of prolonged attendance through a “lengthy labour” still requires the availability and the willingness of hospital core midwives to take over her clients care when her back up partner is unavailable.

The New Zealand College of Midwives (2008) transfer guidelines now address the transfer of care from primary (midwifery) to secondary (obstetric) services and identify that "If a *transfer* has occurred it is because a deviation from the normal has been identified" (Appendix Two, p. 2). In detailing midwifery responsibilities they describe that where there is a handover of care to core maternity staff the LMC leaves the facility and the woman is now under the care of the core midwifery staff (Diagram three flow chart). Guidelines governing obstetric responsibilities on transfer to secondary services state that:

It is ultimately the LMCs decision on her ability and willingness to continue or not to continue to provide care once clinical responsibility has been transferred to obstetric services. It is acceptable for an LMC to withdraw from care provision if it is her judgement that she has reached the level of her expertise, is tired or has other community midwifery obligations which take priority e.g. returning to rural practice. (New Zealand College of Midwives, 2008, Appendix Two, p. 3)

These guidelines recognize caregiver fatigue without the proviso of the midwife having been seen to have attended an undefined lengthy labour, but they are guidelines and not statutory law. However in legally defining reasonable practice these guidelines may then guide the law.

The majority of District Health Boards have decreased their employed midwifery workforce and many have shifted care co-ordination and responsibility to the case

loading midwife regardless of the woman's co-morbidities (NZCOM, 2005). Indeed in some facilities it is not unusual for case loading midwives to receive phone texts from desperate charge midwives requesting assistance with their hospital understaffing dilemmas. They are asked to assist by providing labour care for women whose care was planned to be given by a hospital core staff midwife or by working a shift in the post natal wards. In situations where there are workforce issues there can be an inability to hand care over to hospital midwives which may see case loading midwives working in excess of twenty-four hours without respite.

Midwives providing this care are now required as part of their access agreement to have supportive collegial relationships with other case loading midwives. This is to allow them to be relieved by their colleagues under circumstances of prolonged care rather than by hospital employed midwives. It assumes a constancy of a back up network availability. To uplift collegial help involves one midwife working for no payment to support her tired colleague or their splitting the single birth fee. The definition of midwifery attendance of a woman in labour includes the midwife remaining in attendance for a further two hours after the woman has given birth to comply with statutory requirements. Miller (2002) comments on this that "the situation is somewhat unique to Midwifery; most other occupations that involve high levels of responsibility (and concomitantly, stress) do impose time restrictions on continuous performance" (p. 6).

The practice reality that was revealed within this study was one of where at times the midwife may not be able to find an available colleague to handover care to because their back ups are providing care to their own clients. In these situations midwives are obliged or coerced to work excessive hours that may then lead to unsafe practice. Women can also exacerbate this situation by insisting on their midwife's presence and an investment of her time and support from early onset of labour.

Lynch (2002) tells us that: "the notion of caring for the caregiver is relatively new. It is a preventative measure against the epidemic of work-related exhaustion and burn-out that is occurring around the world" (p. 178). Where midwives are not cared for the result is not only an abuse of the caregiver but the creation of an unsafe situation.

Women experiencing a complex labour requiring vigilant and exacting care may be being cared for by an exhausted midwife. Most case loading midwives now endeavor to evolve reciprocal arrangements with their colleagues. Structured time out from practice is also being put in place as the concept of sustainable practice begins to be advocated.

The midwifery code of ethics and philosophy was formulated by the NZCOM and requires the midwife to uphold the rights of the women in their care. The midwife is expected to "respect the decisions made by the woman, even when these decisions are contrary to her own belief" and also "the woman's right to decline treatments or procedures" (NZCOM, 2008, p. 16). The Ministry of Health Maternity Services Access Agreement (2007) demands an obligatory compliance of practitioners with the professional standards of care embodied within hospital protocols and guidelines. Guidelines are deemed flexible although they may guide legal opinion as to appropriate care, whereas protocols must be adhered to.

The practice reality is that repeated failure by a midwife to influence her clients to comply with guidelines and protocols may ultimately reflect on the midwife. Participants recounted incidents of conflict focusing on their practice not the woman's right of choice when interfacing with secondary services when women were non compliant. It was suggested to one participant that she needed to "try harder" as a midwife to achieve client compliance. Non compliance was seen midwifery failure not upholding client choice. The midwife is expected to negotiate between conflicting principles of care to achieve something that is safe and acceptable to all in her quest to respect women's "decisions contrary to her own belief" (NZCOM, 2008, p. 10).

Where the midwife cares for women who choose care outside the recommendations upheld within guidelines and protocols, despite the possibility that she herself may be in professional conflict with their decisions, the midwife may become associated with a non compliant mode of practice. The Ministry of Health Maternity Service Notice (MOH, 2007a) standard terms and conditions of access to a Maternity Facility or Birthing Unit states that practitioners access is conditional on the agreement that

"the practitioner undertakes and agrees that all statutory, regulatory, legal, and professional requirements that apply to primary maternity services provided by them are complied with" (clause 11, p. 1108). It is further stated that the general manager of the Maternity Facility has the right and complete discretion to immediately suspend access where there is "...substantial or repeated breach of this agreement" (MOH, 2007a, clause 10, p. 1108). Practice guided by women's choices that regularly takes a midwife outside compliance with standard health care provision, maybe deemed to reflect the practitioner's clinical input.

Such a decision is at the Manager's discretion and could lead to the termination of the midwife's hospital access agreement. It is a statutory requirement that the practitioner "must have an access agreement for the use of that maternity facility or birthing unit" which she utilizes (MOH, 2002a, p. 1052). The effect of withdrawing rights of access to hospital facilities from a midwife means that she can only work in the community attending planned home births. She must handover care should hospital admission become necessary. Should this occur, the midwife's scope of practice and her ability to generate an income are directly impacted. Because midwifery is a specialist area of health care the midwife who has had a direct entry training focusing entirely on midwifery is limited as to where she can work if her credibility is impacted on.

There is a tension therefore for case loading midwives when providing care for women whose choices fall outside the boundaries of recommended practice, even though decision making is ideologically woman led and the woman's right to do so is set in statute, (MOH, 2002b). This creates an environment where, contrary to the premise of women's choice and control of care, there is pressure to manipulate clients to conform so the midwife's practice does not come under adverse scrutiny.

The strategies of boundary setting now being advocated to survive this highly demanding professional role. Boundaries must be evolved by the individual midwife with each client despite an environment promoting constancy of care availability. Women may have no perception of the difficulties of the providing such care. In a study which evaluated the safety of a tired midwife women made comments such as

"I felt 100% sure and safe and loved and nurtured and quite frankly I didn't give a damn if [mw] was tired or not" (Miller, 2002, p. 5). In the face of such self focused expectation the midwife is expected to evolve a sustainable practice. Professional survival has led to group practices, structured time out and fragmentation of care that undermines the underpinning principle of continuity of care. Rural midwives are now able to uplift a 7 day block of funded locum service to enable them to achieve work respite (MMPO & NZCOM, 2009).

A significant number of midwifery practitioners have withdrawn from practice, and at times from midwifery itself, because of self identified burnout (Pairman & Massey, 2001). Through the sharing of stories external to those of my participants, I am aware that other case loading midwives are struggling to meet the professional demands of their role. Some of these midwives did not anticipate they would be able to maintain their practice long term and most view this possibility with deep regret.

The cost of burnout

New Zealand's autonomous midwifery practice draws the eyes of the world. It will ultimately influence the opportunities for midwives in other countries to practice autonomously. Midwifery within this country is a justly proud profession. There have been years of complex negotiation to achieve autonomy. Consumer support has been won through a philosophy of inclusion and consultation. Midwifery care continues to focus on women's needs as New Zealand midwives continued to ensure professional credibility through an accountability of practice.

But there is a population of midwives who have paid a high price for professional dedication and idealism. As Pines (1993) an early researcher of burnout observed, in order for someone to burnout first they have to be on fire. These midwives who bought the fire of passion and dedication to their work were driven from it by burnout. They have been silenced by the assumption that somehow the burnout they suffered was their fault despite having few professional mechanisms to protect them from the rigours of their work.

This assumption within midwifery suggests that it is the inadequacies of the individual midwife's practice management which generates burnout not the burden of professional obligation. It is suggested that "some midwives have been slow at adapting their professional outlook ... as a result a number have become burnt out" (McLardy, 2002, p. 33).

Engle (2003) conducted a study amongst New Zealand midwives on maintaining sustainability of practice in a continuity of care setting. She observed that "keeping the balance between job satisfaction and setting boundaries around one's practice were seen as integral to the sustainability of practice" and that midwives "had different strategies on setting boundaries" (p. 15). It was shown within her study that midwives sought individual, and subsequently inconsistent solutions, to a consistent midwifery practice problem. Engle concluded that while the midwife's own philosophy was influential on her practice, the issues of the demanding nature of the work, the lengthy hours on call, exacerbated by the structure of the single fee funding model, were common to all midwives working within this model of midwifery. Yet the consistent professional difficulty is left to the individual midwife to address within her practice.

McLardy (2002) comments that work balance is more likely to be achieved once "the person processes their stress points and understands their coping skills" (p. 33). By shifting the focus from the commonality of practice difficulties to the individual practitioner the apparent wide spread of such difficulty escapes critique. Guilliland (2007) asserts that it is no one else's responsibility to address such difficulty other than the individual midwives as "it is up to a case loading midwife to manage being on call" (p. 6). The midwife is thus isolated with the difficulty. Her assumed failure to achieve work life balance becomes the focus rather than the stress that being experienced. By making the individual practitioner responsible for meeting a prescribed practice demand, the statutory and professional bodies that uphold that demand are exonerated from addressing any of its difficulties.

Lynch (2002) argues that: "the onus of caring for the caregiver does not just rest with the caregiver herself; it is the mutual responsibility of everyone in the workplace" (p.

183). She suggests that it is not appropriate to make a caregiver self responsible for her professional wellbeing. Statutory and professional bodies carry an equal responsibility to evolve ways to keep midwives and the women for whom they care safe.

The assigning of and the proportioning of blame to the phenomenon of burnout further legitimises ignoring those who struggle with it. Stein (2001) talks of the alienation and exploitation of people as commodities which is especially prevalent amongst health-care workers around the world. Such alienation inhibits self disclosure by midwives in burnout and negates their right to ask for help. The abdication of any professional accountability condones ignoring what is happening to the colleagues whom we work alongside. This blame, and its associated guilt, leads to covering up a phenomenon which already owns a mastery of disguises.

Burnout is not a phenomenon confined to new case loading practitioners who have not developed practice survival strategies but also occurs amongst midwives with years of experience in providing this care. To lose highly experienced midwives through burnout induced attrition is a significant loss to the midwifery profession and to the women to whom they dedicated their care.

My research question

My research asks what is the experience of case loading midwives who burnout? By exploring this phenomenon through the words of midwives who have experienced it, I seek to reveal some of the essential structures of the phenomenon of burnout.

Benefits that may arise from this study

I believe the benefits of this study will include:

- Making the experience of the case loading midwives who burnout more visible. This will facilitate, through an understanding of the practitioner's experience of burnout, the revealing of insights about the reality of providing such midwifery care. Such knowledge may lead to developing improved supportive strategies

for these midwifery practitioners and reduce the rate at which this phenomenon is occurring.

- Raising the consciousness of society to the presence of the phenomenon of burnout within case loading midwives. For a professional service to survive, the level of expectation of the provision of care must be survivable by the professional. Client awareness of the professional realities in the provision of their midwifery care allows a realignment of expectation to achieve a non compromised but realistic level of professional service. Partnership implies a two way responsibility.
- Ensuring that case loading midwifery, as a focus of autonomous midwifery practice, remains an option to uphold the belief that midwives are well able to provide a viable and important autonomous service.
- Protecting the quality and diversity of service that autonomous midwifery offers the women of New Zealand.
- To promote and support autonomy midwifery practice as a viable form for the provision of maternity care by midwives practicing in other countries.

Summary

My question of what is happening to case loading midwives to induce professional burnout is appropriately studied through interpretive phenomenology which seeks understanding through the lived experience of other.

For a midwife to embrace the philosophical ideology of her profession encapsulated in case loading practice and to then find she cannot sustain work she has committed to was shown to be overwhelmingly damaging. To be forced to leave her chosen mode of practice because of burnout is to feel that she has failed in the work she aspired to and loved. Midwifery is less able to be compartmentalized by the case loading midwife because the unique on call nature of their work allows it to permeate their life. The feelings of failure associated with burnout not only erodes midwives professional image but leaves them feeling personally damaged, sometimes irreparably. Their experience of burnout was the focus of my proposed research project.

I believe that childbirth is re-entering a phase of being accorded pathological qualities that generate fear. Within the case loading midwifery practice the midwife and woman work together in partnership towards achieving a positive experience. The sustainability of a practice that promotes the normality of childbirth and offers the support of a known caregiver is becoming increasingly important.

As a midwife who has had such joy in providing continuity of care I have a commitment to ensuring that it remains a viable future option for women and midwives. The successful modeling of this care within New Zealand allows it to be upheld as an option of care for women and midwives in other countries. My study sets out to protect this unique model of midwifery care valued by both women and midwives. By uncovering how burnout erodes the ability of dedicated midwives to continue to offer such care, sustainable practice can evolve.

In the following chapters this study will be situated within the context of the background from which it evolves. It will also be situated within the knowledge current literature allows of burnout. The philosophical methodology and the application of it to my own work is stated. The findings of my study are detailed within the themes that emerged and are linked back into the guiding philosophy to enrich the knowing that is enabled by participant interviewing.

At the conclusion of my thesis the implications of this study are discussed and ways in which its findings could be implemented into midwifery practice considered. Throughout the thesis I have threaded poetry I have written in response to each interview which reflects what was shared with me. The insight of each participant allowed me to build a continually evolving understanding of what they had experienced. I captured in poetry what I learned from each person and carried forward into my knowing of burnout.

I thought burnout was invisible
and made of flames
but it is ice
made of
frozen feelings.
Blinding icicles
in which
the world cracks
into ice islands
fracturing families
fracturing self
freezing women
until warmth
breaks through
in a sad
melt down of
self.

Chapter Two: Context of the study

Introduction

Gadamer (1975/2004) tells us that "understanding is essentially a historically effected event" (p. 299). To better understand this study of burnout within case loading midwifery practice it must be situated within the evolving history of New Zealand midwifery. To understand modern care principles calls for a knowledge of the historical health reforms within the New Zealand health services. This enables the ways in which they have influenced the current giving of care within midwifery to be seen.

Heidegger (1927/1962) tells us "that in man we are presented with a more or less important 'atom' in the workings of world-history, and that he remains the plaything of circumstances and events" (p. 433). We do not always control what is shaped around us. History happens to us and lies all around us in our day-to-day living. What is evolving is not always seen during its shaping, nor do we always choose or understand that shaping. Reflection on the past allows a greater understanding of how historical influencing has both knowingly and unknowingly prejudiced our present and of how it may continue on to influence our future.

This chapter seeks to place the phenomenon of burnout within case loading midwifery in the context of today by exploring the relevant history that has led to the midwifery environment in which this phenomenon occurs. It examines the development of modern health care within New Zealand and how midwifery is situated within this spectrum. The strong links between the mode of childbirth and the mode of midwifery care are considered. The difficulties within the midwifery philosophy that are surrounded by silence are examined. The location of continuity of care within the evolved midwifery partnership with women and the collegial relationship midwives have with each other is also discussed.

Pre-European influenced childbirth

In Maoridom birth comes under the sway of Hine-te-iwaiwa, identified with Hina the moon-goddess. The moon is connected with productiveness; fruitfulness of crops

and women. Birth was customarily seen as a natural event that took place with the support of whanau, (extended family). There are descriptions of the use of herbs and vapour baths to assist in making childbirth easier (Kowhai Maori New Zealand, 2009).

Women giving birth were tapu (restricting spiritual power) and segregated to a temporary shelter known as whare kohunga or "nest house" outside the bounds of the village. Only when the tapu was removed could they return to the village and mix with others (Best, 1934). Donley (1986) concludes that such tapus served to protect the mother and her infant by isolating her from the larger community and the increased risk of infection.

Ani Mikaere (1994) discusses Maori Birth Rituals and advises that Maori women enjoyed the full control over their birth process. They, with the help of tohunga, (priestly scholar) midwives and whanau, controlled conception, abortion, birth and parenting. There was no interference at a labour. If problems arose the most appropriate tohunga who specialised in that particular situation was called upon to resolve the problem. Female attendants were designated to care for the mother during her time in the whare kohanga. During the birth itself, the mother was assisted by her attendants, her parents other female relatives and her husband. Ruth Hungerford (2010) also describes pre-European birth as a family orientated event with the woman attended by her mother, grandmother and tohunga. Best (1934) comments children were raised carefully and solicitously to ensure they were strong and healthy.

History reveals that traditionally birth attendants were local women with an ease of geographical availability and ready access to additional support. The unpredictable nature of labour and birth was accepted. This is shown by the availability of the tohunga if there were difficulties that could not be dealt with by the women accompanying the birthing mother through the natural progress of her labour (Mikaere, 1994). The women birth attendants had an established relationship with the labouring woman and her coming child as part of her whanau or of a trusted

relationship. Their traditional support of her was one of a committed nurturing care that was not tainted by blame if things did not go well.

The Treaty of Waitangi, signed between Maori, the indigenous people and the Crown in 1840, with its principles of equity, protection and participation has become an integral part of all legislation in modern New Zealand (Skinner 2005). The latest Midwifery Council of New Zealand (2010) workforce statistics show that the greatest shortfall in availability of same ethnicity of caregiver is for Maori. The percentage of birthing mothers who are of Maori ethnicity is 20.5 while the percentage of midwives who report Maori as their first ethnicity is 4.6 (Midwifery Council of New Zealand, 2010). Midwifery in this current era within Maoridom now moves across cultures. It brings strangers together. Unknown European midwives now predominantly attend Maori women in a clinical setting with prescribed mores of procedures. Maori women were once bound to their birth attendants by strong family ties of commitment to their and their babies wellbeing within which paradigm both joy and grief were mutually shared. Now there is usually only a clinical connection of professional duty with the woman's need for care. The evolved clinical distancing between mothers and midwives invites critical critique of that care in adverse outcomes even when it is blameless.

To bridge cultural difference Turanga Kaupapa was developed by Nga Maia o Aotearoa in 2006 as a tool for use by health professionals and whanau to consider aspects of Maoritanga, (Maori culture). The New Zealand College of Midwives and the Midwifery Council of New Zealand both formally adopted Turanga Kaupapa (guiding tool for Maori health care) as the cultural framework which guides midwives practice. It is used as a reference and source of support for midwives, wahine (women) and whanau (NZCOM, 2008).

Care however is still given within a professional relationship defined by Westernised constraints of protocols and guidelines. Where the Maori midwife worked solely from her heart and her traditional skill base, midwives now have to answer to an accountability of practice that goes beyond the investment of their time and care in the supportive relationship they have with the woman. Poor outcomes are critically

scrutinized in a society that mostly assumes that birth will go well or will be salvageable when it does not. The midwife in the modern world of accountability of practice faces different challenges from those of the traditional birth attendant.

Midwifery as it once was

Midwives and midwifery has always existed. The book of Genesis 35:17 describes "when she was in hard labour, that the midwife said unto her fear not; thou shalt have this son also" (Holy Bible, 1920, p. 30).

Childbirth for European women in early twentieth century New Zealand was family centred. The majority of births took place in the home, accepted as a difficult but natural part of a woman's role in life. In 1920 most New Zealand mothers had their babies at home, or in small unlicensed one-bed privately run maternity homes (Mein Smith, 1986). Midwives were mostly married women who worked autonomously and had usually borne children themselves. Often they were widows who needed to generate an income in order to survive (Stojanovic, 2008). Donley (1986) tells of how pregnant women would engage a trained or lay midwife who would arrive several days before the expected birth and take over the household work. She would attend the woman in labour and assist her with the birth, then remain with her for a few days to take care of the household. Donley (1986) comments that "the work was arduous and poorly paid" (p. 27).

Yet there was a satisfaction for both woman and midwife. Donley (1992) speaks of attending the funeral of home birth midwife Vera Ellis Crowther. A woman spoke of the friendship that had been formed between them both forty years before when Vera attended her at the birth of her baby during the Second World War and of the richness of the time that they had shared together. The woman told fellow mourners of how "she still could recall the joy of that birth experience" (Donley, 1992, p. 19).

The early shaping of midwives and women

New Zealand had a high maternal mortality rate of 6.48% maternal deaths per 1000 live births in 1920, in which puerperal sepsis played a large part (Mein Smith, 1989).

Before antibiotics, epidemics were associated with some hospitals and particular practitioner's practice which spread the contagious infection; concern now became official (Mein Smith, 1989). Doctors, whose variety of practice exposed them to sepsis more than midwives, were more likely to carry the infection into the situation. The new medical doctors took over birth in the 18th century believing that with the emerging science they now offered a rational knowledge where previously there had only been ignorance and tradition (Papps & Olssen, 1997). Two other things of significance in the late 1800's were the legitimisation of hospital births and the beginning of prenatal care; technology and intervention increasingly became synonymous with a safer and better outcome and a more positive experience of childbirth (McAra-Couper, 2007).

In New Zealand the Midwives Act of 1904 established state control of midwives although midwives working in the community were still able to offer care independently without the supervision of a medical practitioner (Daldy, 1998). The 1904 Act categorised midwives as having either trained in St. Helens, or at a recognized overseas institution or having had a minimum of three years practice experience (Mein Smith, 1989). It also initiated the setting up of a series of St. Helen's maternity hospitals for women to give birth in. The place of birth was shifted through the establishment of St. Helen's hospitals from the community with flexibility of midwifery care to an institution where midwifery care was overseen within a hierarchical model of authority. By 1924 the transition from midwife to doctor had taken place and by 1935 78% of babies were born in maternity hospitals (Mein Smith, 1989). The attraction of painless childbirth through medically administered analgesia and anaesthesia helped to ensure this.

Although midwives remained autonomous in the community, within the hospital environment they were made subordinate to the medical profession (Kate Sheppard Midwifery, 2010). In the years that followed the setting up of this act midwives were progressively diminished in their ability to work autonomously or participate in decision making around childbirth, both in practice and in the political arenas. The Nurses and Midwives Registration Act of 1925 introduced the maternity nurse who could not work alone in cases of normal labour but needed to work with a doctor

(Mein Smith, 1989). "Whereas in 1904 most women were classed as midwives, after 1925 the majority were categorised as maternity nurses" (Mein Smith, 1989, p. 37).

Midwives moved to medically guided care that controlled and did things to women rather than the traditional role of working supportively with women to help them birth their babies without intervening. They became compliant and distant in their giving of care. Dobbie (1990) relates a woman's account of her labour in the 1940's in which the woman recollects her isolation and the devastating affects of her indifferent care by midwives. She recalls her distress when her husband came to see her after the birth of their baby "I could only say, I'll never have another child, and I wept" (Dobbie, 1990, p. 7).

By the 1940's the midwife as an autonomous practitioner had all but disappeared while "the hospital midwife had become the obstetrician's handmaiden" (Donley, 1986, p. 49). Women, who had previously birthed their children in their own communities with their family's and a known midwife's support, were now isolated in their labour care in a foreign environment with unknown dominating caregivers. It was a situation which combined to make women both fearful and biddable. Their labour and births were increasingly controlled by the predominantly male perceptions of what was best for women and their babies (Walsh, 2005).

Medical control of childbirth

By 1951, 95% of births in New Zealand were attended by doctors in hospitals (Donley, 1998). Midwives remained the primary caregivers but now worked to deliver the medically prescribed modes of care, including analgesia, sedatives and narcotics (Jowitt, 2000). The medical profession continued to progressively dominate childbirth. It was able to assume the responsibility for and the control of all care given by midwives within New Zealand law by the passing of the 1971 Nurses Act. This new law forced all midwives to work under the supervision of a doctor regardless of their work location. They could no longer attend and care for women who chose to give birth in their homes unless there was a doctor in charge of them. Vera Ellis-Crowther, who introduced me to home birth, (personal communication, January, 1979) commented that doctors who were familiar with and

sympathetic to midwives would simply sign their names to the midwifery care that was given without ever seeing the woman or attending the birth. I also found this to be so within my own early domiciliary midwifery practice.

The ability of women to choose how to birth their babies and influence the decision making that was being made around them in labour was also eroded by the new perception of birth. It was now seen as being best managed as a medically controlled process. Dobbie (1990) recounts a woman wanting to birth her baby without analgesia being told by the obstetrician, "you must leave everything to me, my business is to bring your baby safely into the world - I've yet to see the woman who didn't welcome all the pain relief we can give her" (p. 1). The philosophical umbilical cord that unites women and midwives in their ability to view birth as a normal life event was evident in the link between the diminishing of midwives status and the simultaneous diminishing of women's choice and the increasing interventions in birth.

The role of medical practitioners had previously been to deal only with difficult births when called in by the midwife. It now extended to managing pregnancy and normal birth through a process of prevention and correction, often through intervention (Papps & Olssen, 1997). Birth became a 'thing' to be 'managed' and 'handled' and no longer a process to be waited on, or attended to and the role of intervention in childbirth was cemented in place (Wagner, 1994). This rational approach to childbirth as a medically controlled process undermined the body of knowledge of traditional midwifery practice (McAra-Couper, 2007).

Birth in the eighties

Rates of intervention for 196 women having first babies in St. Helens Hospital, Auckland from December 1981 to January 1982 told of a 22.56% caesarean section rate, 14.35% forceps delivery rate, and 26.15% Ventouse extraction rate (Gunn, Fisher, Lloyd & O'Donnell, 1983). These statistics showed that over that two month period 63.06% of women had assisted births. Further, that 10.76% of them required general anaesthesia, 46.15% epidural anaesthesia, while 53.84% received Pethidine analgesia. In this bitter soil of lonely and, at times, traumatic birthing practices the

seeds of the need for women and midwives to unite within a spirit of partnership were being sown. There were slow but strengthening reactions around the world to the rigid and isolated mode of birth that had emerged. Greer (1984) suggested that "if we succeed in crushing all pride and dignity out of child bearing the population explosion will take care of itself" (p. 30).

Dobbs (1990) spoke of how women instinctively knew that there had to be a better way than what they were now being told was the 'best way'. Young women planning to birth at home in this era to avoid running the gauntlet of the institution had their choice reacted to with horror by their mothers. It revealed the fear that had been generated around childbirth in their generation. Their grandmothers, who gave birth in a different era, nodded their heads sagely in full approval of their granddaughter's choice (Joan Donley, personal communication, April, 1980). Atwood (1972), in her second novel 'Surfacing', wrote movingly of the trauma of the powerlessness that surrounded giving birth when the establishment claims women's birthing power as their own and manipulates her body to comply with their assumptions and expectations. Atwood's character surmises that she never wanted to have another child after her first one; birth was too much to go through.

The counter reaction away from medical controlled birth

Grantly Dick Read, an English obstetrician who believed in women's ability to birth their babies spontaneously, began a reactive work to develop breathing techniques to enhance their ability to cope in labour (Read, 1958). Within New Zealand his work began to be promoted by The Natural Childbirth Association which formed in 1952, later renamed Parents Centre (Dobbie, 1990).

The study furnishing the St. Helen's statistics over a two month period by Gunn et al. (1983) previously referred to was directed at evaluating the benefits of antenatal education classes, 78% of the women in the study population having attended antenatal education classes. Their findings were that the group who went to antenatal education classes had a significantly longer second stage in labour and required more forceps assistance during delivery compared to non-attendees. There was no difference in the type of pain relief required amongst the two groups. It concluded

that "there was no evidence that attending antenatal education classes will ensure an easy and less complicated childbirth" (Gunn et al., 1983, p. 90).

It is possible to conjecture that the efforts of women to educate themselves in order to dilute the impact of medical authority on their care was not well received, hence the study having been undertaken by the medical establishment to gauge its usefulness through clinical outcomes. Deutsch, a Polish psychoanalyst, cited in Dobbie (1990), spoke of the new passivity of women in birth and of how "even in normal cases, the duration of delivery now depends upon the obstetric technique used" (p. 38). She draws our attention to the fact that the definition of what constitutes prolonged second stage in a prone non mobilising woman and the need for subsequent intervention was but an obstetric opinion in the absence of foetal distress. The lack of inclusion of any evaluation of the benefits of support, mobilisation and lesser alternatives to analgesia or anaesthesia speak poignantly of that era in childbirth. Women were now being advised that knowledge alone could not combat the very real possibility of having a difficult birth.

The Parent Centre movement in the 1940's and 1950's came as the first wave of feminism in New Zealand offering women the knowledge to regain confidence in birthing their babies. Dobbie (1990) quotes one woman as saying "the knowledge was so important, it shattered the mystique that surrounded the doctor" (p. 131). Women were beginning to move from passivity to the questioning of the authority of the medical profession. They began to equip themselves for birth with an independent knowledge and coping strategies. The institutionalisation of birth meant that what women had once learned naturally within their community through their exposure to birth now had to be taught formerly in a classroom setting. Yet within that altered structure of the seeking of an independent acquisition of birth knowledge the feminists had arrived.

Feminism

New Zealand midwifery was dominated by a patriarchal system that was sexist in its expectation of subordination of both midwives and their clients to the male dominated medical authority and policy makers. The New Zealand Nurses

Association (1988) Midwifery Policy Statement draft suggested that "the subordinate role, a decreasing number of midwives and feelings of powerlessness result in low self esteem" (p. 14). From this low point in midwifery, where it had been diminished to a profession which now had few rights or autonomous capabilities, midwifery, aided by the determination of the women they served, set about reclaiming its status. In the 1960's and 1970's, important social movements such as feminism demanded accountability with regard to childbirth, and women set out to reclaim their bodies back from intervention, technology and the medicalisation of childbirth (Papps & Olssen, 1997).

Midwives and women recognized the need to find their own voices. Their finding of that voice called for the raising of their levels of consciousness and an awareness of women's different ways of knowing (Belenky, Clinchy, Goldberger, & Tarule, 1986). With the diminishing of midwives' ability to provide reassuring and supportive care, women's childbearing experience had been reduced to one in which they felt fearful, powerless and unsupported. Women and midwives began to fight back.

Over the next twenty years women began to reclaim birth and set about educating themselves politically through the women's health movements as well as practically through childbirth education (Vague, 2003). During the 1970's a new feminist ideal emerged with women seeking to regain control of their own bodies. Greer (1984) suggested that "the woman who demands the right to make her own decisions will find herself conducting a running battle with health professionals. There are good grounds, for example, for giving birth at home" (p. 10).

As part of the burgeoning and widespread backlash to the increasing imposition of a medical model of birth, empathetic doctors, unconvinced of their profession's stance, continued to work cohesively with midwives in the community offering an option of home birth. Women in New Zealand began to increasingly choose to birth their babies at home in a familiar environment that enabled choice. Because of the opposition and condemnation midwives who attended these births received from their colleagues they banded together and eventually formed the Domiciliary Midwives Association in 1981 (Banks, 2006).

The perception of birth throughout the world within social groups ready for change began to alter. In New Zealand women had lost trust in the medical profession's management of birth with the use of sedation and increasing use of forceps and sought more natural ways of birthing (Donley, 1998). The social perception moved from one of birth always needing medical management if it was to stay safe to one of birth being an essentially normal event in a healthy woman in the absence of complication. Further, the new perception was one in which the woman giving birth was the focus, not the opinions and needs of those who attended her.

Ripple effects of women returning to home births

The feminist movement also coincided with a movement by the public and greater nursing workforce questioning the acceptability of many of the doctrinaire medical practices of the day (Kate Sheppard Midwifery, 2010).

Albeit grudgingly, the Maternity Services Committee of the Board of Health was forced to re-consider its policies in their document "Obstetrics and the winds of change" (Barker, 1979). They spoke of feeling threatened by the changing attitudes of their patients and how being questioned made medical and nursing professionals "feel most uncomfortable" (Barker, 1979, p. 1). In an endeavour to "protect the lives and IQ's of our future citizens" in the face of homebirths gathering momentum, the Maternity Services Committee spoke patronizingly of finding ways to make birth less institutionalised within the institutions to lure women back to them (Barker, 1979, p. 1).

But women, no longer willing to be lured back to hospitals continued to birth at home. Their choice was not based on curtaining fabrics and pastel paints but on having genuine choice. They reclaimed a confidence in their ability to birth their babies or receive timely help should it be needed. Donley (1992) tells us that despite the number of midwives who were working in the community remaining static at 17, from 1981 to 1982 there was a 32% increase in the number of women birthing at home (350 to 461); families supporting the home birth option through membership to the Home Birth Association which was founded in 1978 increased by 82% (414 to

753); while doctors supporting home birth increased by 34% (76 to 105) (Donley, 1992, p. 15).

Legislation strikes again

A further significant piece of legislation was enacted in 1983 with an amendment which was made to the Nurses Act. This prevented midwives who did not have a nursing background from providing continuity of care.

The midwife's professional body, until 1989 when New Zealand College of Midwives was founded, was the New Zealand Nurses Association. Midwives were simply regarded as a speciality area of nursing. Midwives, always in the minority within the organisation, were reminded that while they numbered only 600, the nursing membership numbered 20,000 (Banks, 2006). Banks cites Donley (1988) who speaks of their comment that "such a small group of midwives cannot expect to sway the opinions of the nursing profession" (p. 28). Effectively midwives who did not have a dual nursing qualification were restricted in what they could offer, while those who did have the dual qualification were restricted in what they could say. Neither group had a voice that could be heard.

Midwives had now lost their ability to practice autonomously and influence maternity care decision making through practice. They were also submerged within the New Zealand Nurses Association as a special interest section with little right and no recognition of their essential difference. Midwives who had trained exclusively as midwives were seen as lesser than their colleagues who had come from a nursing background. Socialist Evan Willis (1989) concluded that "the subordination of midwives was achieved by its incorporation into nursing, an occupation which was already structurally located in a position of subordination to medicine" (p. 93). He believed that by midwives being reduced to a special interest branch of nursing in nurses own attempt at professionalism, midwifery moved from an independent status to a subordinate one.

As we have seen there were other factors that also contributed to this steady demise of midwifery. The effects of colonization; the adaptation of a medical model of

childbirth that undermined women's innate confidence in their ability to birth their babies; the erosion of both women and midwives ability to influence the practices that had developed around childbirth. Legislative changes had worked towards the demise of midwifery as an autonomous profession. This created a powerless workforce to do the bidding of the medical profession. As midwives sank into near oblivion, so did women's rights of choice. Their confidence in their ability to birth their babies spontaneously ebbed away. Guilliland and Pairman (1995) suggest that "with the fragmentation of the midwife's role the understanding of birth as a normal life event became distorted while patterns of care within this environment taught women to fear birth and distrust their innate ability to give birth" (p. 35).

Women and midwives fight back

Dobbie (1990) cites a statement by Maureen Thompson, the Parent Centre's Auckland executive member that "the dying out of midwifery in New Zealand could change the face of obstetrics irrevocably" (p. 126). Thompson further concluded that "we need midwives. Our babies need midwives. The doctors need midwives. The whole health system needs midwives" (Dobbie, 1990, p. 126).

The year 1983 was a defining year for mothers and midwives. The Save the Midwives Society was formed. The initial newsletter in the spring of 1983 announced that it had been instigated by women who saw their rights as consumers being ended by the Amendment Bill (Williams, 2010). It was to continue publishing newsletters for eight years. Williams recounted how West Auckland women formed an Obstetric Watch group to monitor attempts to close smaller maternity units and channel women into secondary care hospitals. In 1985 Maternity Action was founded, a coalition of Auckland parenting and women's groups to further resist the closure of small primary care maternity units (Williams, 2010).

The result of the steady and relentless oppression of midwifery by the medical profession and statutory law was a powerful reactionary movement within midwifery, co-interested consumer groups and individual women; 'Save the Midwife' was the merging catch-cry. The New Zealand College of Midwives was established and the inaugural meeting was held on 2.04.89 (Guilliland & Pairman,

2010). Women and midwives worked in committed partnership. Strong and astute leaders amongst them worked to reverse what was happening within midwifery and the care of women with remarkable success. The tide had begun to turn, not only within maternity care but within all health care.

The changing face of health care

Case loading midwifery practice came into being at a time of sweeping change within the New Zealand health services. New Zealand's health reforms of the 1990's followed the world trend to try and find ways of dealing with the escalating costs that were linked to the advancement of medical care and technology (Carden, 2007). Within New Zealand this was further complicated by a stagnant economy. There was a philosophical shift from the concept of health care as a benevolent service to one of the provision of a health service modelled on commercial enterprise. This was essentially an experimental model of care that ultimately foundered leaving unresolved tension between managers and clinicians (Easton, 1997).

Society was simultaneously moving away from a paternalistic health system where the professional administered to the consumer as they saw best. The new vision was one with a consumer focus where the professional now worked with the client to meet their self perceived needs. It set out to uphold their choices through a process of informed consent. The need to respect ethnic and individual difference within the giving of care was recognized and built into care (Easton, 1997).

The Cartwright Report, released in 1988 after an inquiry by District Court Judge Silvia Cartwright into the un consented to trials of the management of cervical cancer, laid the foundations for the 1996 Code of Health and Disability Services Consumer's Rights. This was to set in law the right for all people to be treated with dignity and respect. They were to have full information of their care options and the right to consent to or decline procedures as well as a mechanism to lodge complaints (Health and Disability Commissioner Act, 1994).

Not only were there significant philosophical changes occurring within the health services, the system under which New Zealand Health care was delivered was itself

experiencing momentous change. There is little doubt that at the beginning of the 21st century informed choice is one of the cornerstones of practice and understanding in relation to childbirth (McAra-Couper, 2007).

Changes within the health system

Before 1990 public hospital services were run by thirty territorial boards, locally elected and financed directly from the Ministry of Health. In 1990 these local boards were grouped into fourteen Area Health Boards (AHB's). The new AHB's, which were the result of numerous earlier reports and many years consultation, were not given time to establish themselves. Half way through their transitional phase of three years they were summarily dismissed and replaced by four Regional Health Authorities (RHA's) organised on a geographical basis (Ward, 1998).

The RHA's directors were appointed solely by the Minister of Health on their proven business and administrative experience. A dominant feature of the new system was the split between funder and provider creating a quasi market between purchaser and provider (Mackie, 2010). Unlike the earlier Hospital Boards and AHB's, the RHA's were funders but not providers of health services. They received grants from the Government. These were allocated to purchase health services on a contractual basis from public hospitals, now termed Crown Health enterprise, as well as from providers such as private hospitals and practitioners. The RHAs each covered a region of the country and was responsible for purchasing health and disability services within its own region (Ward, 1998).

In 1996, a National led coalition government was produced under New Zealand's first Mixed Member Proportional (MMP) election. This led to reform of the health system yet again. The CHEs were renamed Hospital and Health Services (HHS), with their focus being moved from profit and towards public service (Ward, 1998). The four RHAs were also centralised to one organisation, the Health Funding Authority (HFA). The year 1999 produced a change in government to a Labour-led coalition, as well as another change to the health system. The year 2000 saw the removal of all quasi-market elements, by establishing twenty-one District Health Boards (DHBs). These are responsible for the purchasing, providing and planning of

services in consultation with their local community (Ward, 1998). The HFA was abolished, and the Ministry of Health asserted as lead policy advisor, planner and funder. However, these reforms were not planned and carried out well, resulting in disillusionment of many officials working within the sector, who were unconvinced of the effectiveness of the new system (Mackie, 2010). There are now twenty District Health Boards in New Zealand which are responsible for the providing, or the funding of, the health and disability services within their districts (MOH, 2010).

The result of these reforms was a tension between managers and clinicians over clinical values and commercial values (Ashton, 1999). Funding of services became a significant issue within the health services framework. Within this context of tensions, the then Minister of Health, Helen Clark, introduced and won a law change.

The 1990 Nurses Amendment Act

The culmination of cooperative effort by women and midwives to reinstate midwifery was the legislative changes encapsulated in the Nurses Amendment Act (MOH, 1990) which reinstated professional autonomy for midwives. Midwives in New Zealand could now claim the place as the main maternity care providers (Skinner, 2005). Through the passing of this law women were enabled to once again have a choice of care provider while midwives were enabled to provide such care. The Act also allowed midwives to access hospital facilities for their clients and to prescribe maternity related medications for them if necessary (Pairman, Pincombe, Thorogood, & Tracy, 2006).

Importantly, it also paved the way for an experimental education programme. This enabled midwives to train specifically for midwifery practice without being obligated to first obtain a nursing qualification. Direct entry midwifery allowed midwives to be recognized and educated as an autonomous professional discipline that was differentiated from nursing. This was developed with the amending of the Nurses Act 1977 in 1990 (Guilliland & Pairman, 2010). Again this achievement reflected a major contribution from women external to midwifery. The initial task force for this was set up in 1986 (Williams, 2010). The first midwives graduated from the New Zealand Midwifery Degree programme in 1994.

By 1997 all New Zealand schools of midwifery offered this programme. This now became the only way that students can gain entry to the midwifery register (Midwifery Council of New Zealand, 2010). As expected, the proportion of midwives in the workforce holding a Bachelor of Midwifery or Bachelor of Health Science (Midwifery) qualification is increasing as new midwives enter and older midwives retire. New Zealand direct entry midwives made up 30.5% of the workforce in 2009, an increase from 19.8% in 2005 (Midwifery Council of New Zealand, 2010).

To assist midwives new to practice, the New Zealand College of Midwives is now contracted by the Ministry of Health to run the midwives first year of practice programme. This is a supportive process that allows 32 - 56 funded mentored hours and 69 - 80 hours of funded education for midwives entering into practice and 24 hours of mentoring education for mentoring midwives (NZCOM, 2010a). Graduate midwives are reported as finding this of "huge benefit professionally" (NZCOM, 2011, p. 2). The need for professional support within the clinical environment was acknowledged. The naming and understanding of the breadth and depth of the function of mentoring, precepting and supervision is important (Lennox, Skinner, & Foureur, 2008). There is a need for clarifying the concepts attached to the roles of professional support. This has been done in New Zealand with the publication of the mentoring framework (Gray, 2006).

Funding issues

A significant factor in the way in which maternity services have evolved within New Zealand, limiting the number of domiciliary midwives pre 1990, had been the funding structure (Pairman et al., 2006). Midwives originally working in the community were poorly paid. The fee structure did not pay for the three mandatory antenatal visits as these were seen as 'social' visits to inspect the home and to advise the woman of what she needed to prepare for her birth and not the provision of professional care. Midwives were paid through the Department of Health as a set fee per service, while general practitioners were paid separately under the Maternity Benefit Schedule at a considerably higher uncapped rate (Pairman et al., 2006).

Prior to 1975 domiciliary midwives who attended on a visiting rather than live in basis were able to earn just over \$2,000 per annum. New rates introduced in January 1975 increased their earning capacity to \$3,648 per annum (Department of Health, 1975), a figure that still fell well below the national average income. To generate this income depended on the midwife having a full client base, not always achievable in an era of fearful childbirth, and working without days or time off. J. Donley, (personal communication, December 1973), commented that out of the \$11 fee for labour and birth care the midwife was expected to provide her own equipment, to supply and launder the linen used during the birth then pay for the linen and her instrument and bowl sets to be sterilised. This had also been my own early domiciliary midwifery practice experience.

The 1990 Nurses Amendment Act enabled midwives to claim the maternity benefit fee independently of a medical practitioner at the same rate of remuneration (Pairman et al., 2006). As it was payable at an hourly rating it also allowed them to claim for the whole time they attended and oversaw the entire labour and birth process. Their right to do so was challenged by the Medical Association, but the Maternity Benefit Tribunal in 1993 convened by the then Minister of Health, confirmed midwives entitlement to claim under the same scheme as general practitioners on the principle of equal pay for equal work (Pairman et al., 2006).

The open ended nature of this maternity expenditure put pressure on the already stretched overall health budget, especially at a time when the government was trying to constrain growth in public expenditure (Daldy, 1998). Within five years the average cost per live birth had escalated from \$980.00 to \$5,261.00 (Daldy, 1998). While the Medical Association claimed that midwives had caused a budget blow out, it was not until now that the true cost of maternity services were exposed (Guilliland, 1999). When general practitioners and obstetricians had provided antenatal care, the midwifery care in labour, birth and postpartum provided by hospital midwives was invisible and unaccounted for within the bulk funding of hospital services (Guilliland, 1999). The small number of Domiciliary Midwives attending births in

the community had previously received very minimal payment for their services under the Department of Health so their costing was insignificant (Banks, 2006).

There were concerns about the increasing amount of public funds being spent on maternity care. The large differences in what could be claimed by either the case loading midwives or GP's, prompted the Ministry of Health (in consultation with GP's, midwives and RHAs) to introduce new funding arrangements in July 1996 (Daldy, 1998). The new contractual arrangements were also designed to improve continuity of care, to avoid duplication of services and to contain the costs of maternity care (Daldy, 1998).

Under these new arrangements each woman chooses a Lead Maternity Carer (LMC). The LMC must be a named person, not a team or an institution as the woman must be able to build a relationship with her caregiver (MOH, 1996). Lead maternity care sets out to provide a woman and her baby with continuity of care throughout pregnancy, labour and birth and the postnatal period as described in Subpart DA with the Primary Maternity Services Notice 2007. All practitioners offering LMC services must sign a contract with the Crown. This contract was instigated in 1996 and was known as Section 51 of the Health and Disability Services Act (MOH, 1996). There were some minor modifications made in 2000 and it became known as Section 88 of the New Zealand Public Health and Disability Act (MOH, 2002b).

The LMC has control of a capped budget for each pregnancy which is broken down into modules of care during pregnancy, labour and postpartum care. Despite the implications within the Maternity Services Notice (MOH, 2002b) of continuity of care, modules of care, and in particular postnatal care, are subcontracted out in practice (Midwifery Council of New Zealand 2010). The LMC may be a midwife, general practitioner or obstetrician. Acute and secondary services were separately funded. Only private obstetricians who have a private practice are able to charge over and above the set payment for services (July 1996, Section 51 Notice). The LMC has the responsibility for assessing the women's needs, planning her care and the care of her baby or babies (MOH, 2002b). It was expected that the lead maternity carer model of care would ensure good co-ordination and continuity of

care and referral to support groups, community agencies and other health care services as appropriate (Daldy, 1998). If more than one practitioner was involved with care then they had to share the funding. This created difficulties around midwives achieving time off with the unpredictability of birth, the fee for which attendance represented the greater part of

Establishment of Midwifery Council

The passing of the 2003 Health Practitioners Competence Assurance Act saw midwifery become a fully self regulating profession with the establishment of the Midwifery Council (Guilliland & Pairman, 2010). This was a historic event recognizing midwifery as a profession in its own right as the Midwifery Council now took over all regulatory functions and responsibilities from the Nursing Council (Pairman et al., 2006). Midwifery now took on the task of setting up mechanisms to ensure that consumers were protected by ensuring that midwifery was of a high professional standard that encompassed safe and competent care. The council is comprised of six midwives and two lay members (Midwifery Council of New Zealand, 2008). It oversees undergraduate midwifery education, registration and the issuing of annual practice certificates, compulsory requirements for the maintenance of professional competency, processing of serious complaint and competency reviews.

The re-establishing of midwifery as an autonomous profession was achieved in an era of wide spread health reform, social change and economic uncertainty. There was now an ability to educate midwives as midwives and not just as post graduate nurses and for midwifery to govern its own profession. In twenty years New Zealand midwives were taken from the brink of extinction to being global leaders in showcasing the government funding of an autonomous midwifery service. Without the women on whom this service is focused sharing the steps involved in making this huge journey the destination may never have been visualised or reached.

What has midwifery history taught us?

The re conceptualisation of birth in the 17th century meant that the body was increasingly viewed as a machine. The physician was seen as the one to keep the machine running, and even to make it run more efficiently (McAra-Couper, 2007). Midwives became part of this perception as they increasingly did the physician's bidding. They now did things to women where they had previously supported them. Skinner (2005) comments on the return that was made within New Zealand midwifery to the more traditional role of the provision of watchful and caring support where "we 'be' with women, alongside them as they give birth. Essentially we are not there to 'do'" (p. 54). The immediate history had taught us that midwives are a united group of health professionals. They are able to form close and cohesive relationships with women and work with them for the common good. That midwifery has the capability of claiming its rightful place within the New Zealand health services has been made evident by the history which surrounds it.

The College of Midwives reflects its beginnings in the women's health movement in its commitment to partnership. It has instigated processes to ensure that women have a safe and enabling birth experience (Pairman et al. 2006). The assurance of this standard of care is achieved through consumer feedback, practitioner standards reviews, and a supportive mentoring process for graduate midwives first year of practice (Guilliland & Pairman, 2010). Mechanisms for addressing low level consumer concerns within midwifery were put in place through Resolutions Committees. The Midwifery Council has the further capability of undertaking competency reviews where there are serious breaches of care (Guilliland & Pairman, 2010).

All this was achieved in partnership with women within which philosophy the bicultural spirit of the Treaty of Waitangi of 1840 is upheld and appropriately guided by Maori (Pairman et al., 2006). The nature of the on going provision of care sought to honour the close and effective relationship between women and midwives that had been resurrected in their shared struggle to reinstate autonomous midwifery care.

The unfolding of case loading practice

Newly autonomous midwives set out to provide care to women on women's terms. Participants spoke of a generosity of availability and lack of any awareness of a need for professional boundaries. This did not solely arise out of a philosophy of women focused care or working co-operatively with the self determining women who had valued and fought for midwifery and midwives. It also arose out of the need for midwifery to woo women over from the traditional model of medical care with its practitioner protective restricted access to a new model of midwifery care. It was care that prided itself on a promise to be there for women twenty-four hours a day every day of the year.

With the advent of midwifery autonomy and its new attractive level of remuneration there was a sudden influx of midwives now seeking to join the midwives who were already practicing within the community. Not only were women now needing to be won over by midwives to midwifery care. They also needed to be won over by the individual midwives who were trying to establish a client base. Hospitals, also able to apply for the same funding for midwives giving Lead Maternity Care (Guilliland, 1999), had set up services such as the Know Your Midwife scheme and were also touting for clients. Capping of fees meant that women with complex histories had difficulty finding a midwife to care for them and tensions were evident between case loading and hospital employed midwives (Daldy, 1998).

The new motivators driving midwifery did not go unnoticed. Judi Strid, a strong consumer voice and activist throughout all the many midwifery processes that had transpired, commented four years after autonomy was achieved: "midwives have been caught up in a struggle for territory, identity and a host of other professional issues" (Strid, 1994, p. 93). Within this struggle the practical application of the staunch philosophical underpinnings of midwifery care began to evolve.

The unfolding of continuity of care

Care also set out to honour women by centring it on their individual needs. Within the concept of continuity of care, just as women had walked every step of the journey with midwives to achieve autonomy, autonomous midwives now determined to

accompany women every step of the way in their pregnancies, labours and births and early mothering.

Smythe (2007) comments on the impact Caroline Flint, author of 'Sensitive Midwifery' (Flint, 1986) had on New Zealand Midwifery when she addressed a midwifery conference in Auckland in 1988. She demonstrated the confusing number of people that may have input into a woman's pregnancy. Flint (1988) drew attention to the reality that in the Western world a woman could be seen by as many as fifty health professionals during her childbearing experience. She believed that the fragmentation of care undermined women's ability to labour with confidence. She suggested that analgesia could be necessitated simply by the change of shifts because of the disruption to her labour of an incoming caregiver bringing in differing philosophies of care. Flint suggests that "when midwives are strong, women are able to labour safely and without interference" and that "women and midwives are intertwined" (p. 14). The knowledge of an individual woman's needs and strengths and the integrity of the midwifery commitment to honouring her wishes within her care is best evolved within a continuity of care that allows a historical knowledge.

Prior to Flint's (1986) promotion of the concept of a single caregiver who developed a relationship of trust with the woman, domiciliary midwives who already provided such a service in the community were looked on unfavourably. They were seen as 'risk takers' by many of their colleagues because they supported the option of normal birth taking place outside the hospital environment. With Flint's advocating home birth with its possibility of continuity of care as the most supportive midwifery option of care, collegial attitudes began to change. Banks (2006) tells that "domiciliary midwives experienced insults and derogatory remarks, spreading of gossip or malicious rumours and acts of being shunned by their hospital colleagues" (p. 204). Donley, who also attended the conference (personal communication, October 1988) recollected arriving at the 1988 conference with the usual need to justify her attendance of women giving birth at home to hospital employed midwives. She left feeling validated in her work preference and philosophy of midwifery care for the first time.

Continuity of care thus became an integral part of the philosophy that now surrounds New Zealand midwifery care. This study argues that the mode of continuity of care that has evolved within autonomous practice exposes the midwifery practitioner to a high risk of potential for burnout. Part of this risk is the intrinsic factor of continuity of care. This is not only because of the nature of on call work but the way in which midwives provided such care. McAra-Couper (2007) suggests that within the reality of what is known there still remains the tension between the shaped, the shaping and the shapers. These combine to mean that an individual may still not act or choose in a way that is self-determining. Care can be modelled on an evolved expectation that dominates and controls its practical application by the individual within the guise of personal choice.

Strid (1994) believed that the mercenary element that was declaring itself within midwifery had "got in the way of collective co-operation and collaboration with each other" (p. 92). But within the original legislation governing practice the assumption was that the care would be provided in person by the professional who had contracted to the woman to provide her care. The difficulties of the provision of continuity of care for the practitioner once they were carrying the responsibilities of a full caseload and the obligation of continuous immediate availability were beginning to surface.

Yet despite identified difficulties, a postal/telephone survey of 11,511 women conducted by the National Health Committee on behalf of the New Zealand Ministry of Health in 1999 to evaluate consumer satisfaction with midwifery services was reassuring. The report concluded that the majority of women were happy with the care they received and that the preference expressed was for a midwife to assume the role of the Lead Maternity Carer.

The philosophical relationship of partnership

The supportive relationship developed between midwives and women in resurrecting midwifery care was embraced in a philosophical model of professional care (NZCOM, 2002). This set out to make women central to the planning and provision of all care. The midwife now met them on an equal footing devoid of any

manipulation through the inappropriate wielding of professional power (NZCOM, 2002). Informed consent was an integral part of this process. With the new Act of 1996 governing informed consent, such principles of care were now moved from a philosophical choice unique to midwifery care to a statutory requirement for the provision of all care for all professions (Health and Disability Commission, 1994). The Health Practitioners Competence Assurance Act of 2003, which was reviewed again in 2009, also provides a framework for the regulation of health practitioners in order to protect the public (MOH, 2003).

Midwifery had had a long history of working co-operatively with women before the nature of their care became dominated by medical practitioners and obstetricians. During that era many midwives transferred their allegiance to the doctors and obstetricians who now controlled birth away from the women to whom their care traditionally belonged (Donley, 1986). Childbirth was no longer seen within the context of the family; fathers and children all being denied involvement in the birth process (Dobbie, 1990). The battle to resurrect midwifery from its death bed had been one in which consumers had played major roles and the essentially ancient ties between women and midwives were re-established during their joint effort.

Banks (2006) speaks of the with-woman relationship between domiciliary midwives and home birth women laying the foundation stones for the partnership that would be built on by the New Zealand College of Midwives. The mutual respect that existed between the women and midwives who challenged the dictatorial mode of birth that had evolved within the hospital system by electing to give and attend birth at home was the beginnings of such a trusting relationship. The debt of gratitude that was then owed to New Zealand women who had partnered midwives to achieve autonomous practice was reflected within the philosophical approach to midwifery care which continues to be upheld within the midwifery practice standards (NZCOM, 2008). This entitlement to such a nature of care is further upheld in statutory law: MOH (2002b) states that "each woman, and her whanua, will have every opportunity to have a fulfilling outcome to her pregnancy and childbirth, through the provision of services that are safe and based on partnership, information and choice" (p. 11).

Yet Strid (1994) commented that "the enthusiasm with which midwives have individually seized any and all windows of opportunity, since the change in legislation which restored midwifery autonomy, has alienated them from the partnership that helped to make them strong" (p. 92). Her comments suggested that within four years of midwifery autonomy partnership was being modified within practice in the absence of robust open debate to something now being identified by women as not always working well for them.

Interviewed midwives consistently spoke of their initial passion for and commitment to this prescribed model of care which became eroded as the realities of its provision began to unfold. Guilliland and Pairman (1995) agreed within their discussion of the partnership model for practice that the concept of partnership was recent and the application of it in practice was still evolving: "Our theoretical explanation of this partnership therefore, will of necessity develop as the lived experiences of women and midwives in the context of childbirth are further explored and analysed" (p. 33).

Partnership was revisited in 1996/7 (Pairman, 1999). It was upheld as "part of our identity as midwives in New Zealand" (p. 6). It was suggested by Pairman (1999) that when midwives find themselves in circumstances where they feel partnership is unworkable that "perhaps the question really is what it is about that midwife or that situation that means that woman will not or cannot work in partnership with her?" (p. 9). The implication is that while partnership traditionally implies an equality of power base, the assumption is that the onus always rested with the midwife to make it work. That it reflected poorly on her professional ability when it did not. The opinion expressed within the article is again that partnership was still evolving (Pairman, 1999). Yet at that time, despite the acknowledgement that it was a philosophy in progress, adherence to the current model of partnership was upheld as being obligatory to good practice. Any difficulties it presented were dismissed as problems that should be laid exclusively at the individual midwife's door.

Within the midwifery partnership women hold the decision making capacity which the midwife must then respect and uphold (NZCOM, 2008). Skinner (1999) describes a situation where the woman she was providing care for was seldom at

home for arranged visits after having her baby. The woman who was indulging in alcohol and drugs, was contemptuous of Skinner's input as a midwife and verbally abusive of her. In her article Skinner questions whether partnership is achievable under such diverse circumstances and is it therefore still the most appropriate model for all care? When discussing women who are not at home for visits, or fail to attend appointments, Pairman (1999) reminds midwives that the woman is only exercising her personal power through resistance; that "critical reflection on practice can help us challenge our own practice so it is dynamic and evolving; able to respond to women's individual needs" (p. 10). Even under these circumstances the midwife is therefore still expected to broker an effective interpretation of partnership.

Benn (1999) asks however that "where women default on visits does it mean that the woman and the midwife are no longer in partnership (in it together)?" (p. 19). She discusses the relief a midwife may feel if the woman withdraws from her care while continuing to wonder how they can work with women who have a different perception of what constitutes good care from their own. Alternatively Benn suggests that "if they remain in the partnership they live in fear of the risks to their career, their livelihood and their personal lives" (p. 19). Midwives are faced with a significant paradox in attempting to work a 'birth is normal' paradigm within a 'birth is risky' context (Skinner, 2005).

Partnership has been established as the philosophical centre of the provision of midwifery care within New Zealand, but it has not evolved within its upheld ideology to reflect the lived experiences of midwives who enact it in practice within a constantly changing social environment, (Skinner, 1999). The blanket assumption that partnership is always possible and when it fails to be enacted it is deemed to be midwifery failure (Pairman, 1999), does not offer practical tools to the midwives who work with women in complex social situations. As Skinner (1999) recounts, there are social situations where there is an automatic suspicion of all external input or authority. Within that setting she was seen as a resource to be abused without regard, not as a partner in the provision of, and acquisition by the woman and baby of, safe midwifery care.

The partnership model of practice lies at the foundations of midwifery care as upheld by the New Zealand College of Midwives, but Pairman, quoted in Smythe (2007) stated "we hadn't defined it, and it was like, 'what is it?'" (p. 22). The "what is it" of partnership is differently interpreted by individual midwives and by the women for whom they care. Yet the monograph on Midwifery Partnership written by Gulliland and Pairman (1995) was a model that set high expectations, especially in relationship to continuity of care. In 2005 Skinner commented that partnership has not been critiqued in its concept of risk and management. At that time partnership, as a founding principle of midwifery care, appeared to be staunchly guarded. Its ideology was upheld at the possible detriment of evaluating the difficulties of its practical application.

Thompson (2004) draws attention to the absence of the voices of childbearing women and midwives in the context of the mother-midwife relationship. She comments that "there was a paucity of discussion on the ethics of everyday midwifery practice" (p. 170). Discussion around partnership is dismissive of the difficulties of the practical application of the model of care that was voiced by midwives while only the women's voices for which partnership has worked well are publicly heard within the midwifery environment. While open discussion by women and midwives remained inhibited the difficulties of partnership could not be addressed. This forced partnership to evolve haphazardly within practice in a manner that had the potential to undermine the essential philosophy it embraces.

Skinner (2005) asks:

when we place partnership as central to midwifery, and the woman rather than the foetus at the centre of care, are we trying to recreate a way of being a midwife that is now obsolete? If we are managing woman centred, partnered care what does it look like and where does risk fit? (p. 59)

She suggests that both the woman and her baby are the central focus of midwifery with a prioritizing of foetal wellbeing, not the woman as a single entity with a prioritizing of personalized choice over clinically indicated choice. Also that care

which has a philosophical focus that does not identify the practicalities of risk is difficult to visualise and put into practice.

Since this point in time evaluations of the model of partnership have begun to occur. Workshops offered in 2009 evidenced much discussion and critiquing of the difficulties experienced translating the philosophical concept of partnership into practice. Guilliland and Pairman (2010) encapsulated partnership as a relationship in which women and midwives recognize and act on their own autonomy. They now comment that there must be an essential reciprocity to their relationship for it to work effectively. They suggest that "partnership is a relationship based on negotiation, equity and shared decision making, which if done well protects both the woman and the midwife from miscommunication and failed expectations that could impact negatively on a woman's maternity experience" (p. 631). There is an expectation that partnership will always work, unless it is not 'done well' in that assumption. That even in fraught sociological situations of compromised well being negotiation, equity and joint decision making is always achievable. The responsibility for doing partnership well ultimately continues to rest with the midwife.

The present of case loading practice

The Notice Pursuant to Section 88 of The New Zealand Public Health and Disability Act 2000 allowed a greater flexibility around the obligations for the Lead Maternity Carer's provision of care with the use of a back up midwife. Statutory reasons for using a back up midwife to attend a birth on the lead maternity midwife's behalf were still described as "holiday leave, sick leave, bereavement leave, continuing professional education requirements or other exceptional circumstances" (MOH, 2007a, p. 1067). Regular days off is still not recognized in law for midwives.

Case loading midwives make up 39.4% of the workforce. Most of these are self employed LMC midwives claiming the Section 88 maternity fee (30.7% of the total workforce), (MCONZ, 2010). The remaining case loading midwives (8.7% of the total workforce) work as employed case loading midwives, paid either by a DHB or by another employer (MCONZ, 2010).

The 1996 Section 51 Notice recognized the need for the chosen caregiver, (LMC), be they general practitioner, midwife, or obstetrician, to be clearly identified as assuming the responsibility for all modules of that particular woman's care. Within this role there was now the opportunity to sub contract or delegate certain aspects of a woman's care to other practitioners registered with the Regional Health Authority to provide maternity services (Guilliland & Pairman, 2010). While the practitioner registered as the woman's lead maternity carer was personally liable for payment of any care delegated to other practitioners, it enabled midwives to now legally go 'off call' periodically from the constant obligation of continuity of care.

An article published in the New Zealand College of Midwives Journal evaluating rural midwifery services in New Zealand conceded that there was a midwifery workforce shortage, that there had been a 12.5% increase in New Zealand births over the past six years, but the midwifery workforce grew by only half this rate, 6.5% (Hendry, 2009). Rural midwives expressed huge on going difficulties because of the small numbers of midwives to spread their work load over.

Well...'pass the work on' I hear everyone say... 'who to exactly?' I ask...

Writing this makes me have a little knot of worry in my tum and I just keep telling myself 'just step by step and I'll get through'... I am not sure how I am going to get through the summer. (Muller, 2007. p. 24)

The extent of the impact of case loading care on midwives personal lives was exposed within New Zealand findings which revealed the stress midwives suffered in the provision of such care (Rolston, 1999). The New Zealand media have featured articles with themes of loss of midwives to midwifery because of their long hours, workloads, inadequate waging and burnout since midwifery autonomy (Andrew, 2005; Catherall, 2001; Humphreys, 1999a; Humphreys, 1999b; Paltridge, 2001).

A survey of LMC midwives concluded that "there need to be changes to the way LMC midwifery is practised and that there is some urgency in attending to this. Midwives clearly need more time off with better funding structures to support this" (Wakelin & Skinner, 2007, p. 10). The survey identified funding issues as a major cause of dissatisfaction as the modular single fee for service, the bulk of which is

paid for the labour and birth module. This meant midwives who called a back-up midwife in to relieve them at a long birth, or to attend a birth on their behalf while they were on days off, were then economically penalized.

Between 2005 and 2009, more midwives moved from case loading to core (176) than in the other direction (122) (MCONZ, 2010). The Midwifery Council expressed concern at the number of midwives who reported working very high hours. Johnston (2008) stated that the Midwifery Council was very aware of the fragility of its workforce with an overseas recruitment of midwives and plans to increase student intakes. Overseas recruitment drives were also featured in the NZCOM Midwifery News (2008). The Council registers approximately 200 new midwives each year. These are made up of about 115 New Zealand graduates and 85 overseas educated midwives (MCONZ, 2010). The number of overseas-educated midwives is significant. This is more so when considered in the context that most New Zealand graduates stay in the workforce longer than midwives coming from overseas. Midwives recruited from overseas were questioned as to whether their work expectation had been met, 53% said yes, 42% said no, with the balance undecided (MCONZ, 2010). The questionnaire asked open questions of participants to rate the challenges they found with midwifery practice in New Zealand. Amongst the six key themes identified that were unrelated to transitioning to a new mode of practice were meeting the midwifery recertification requirements, the interface between primary and secondary maternity services and the challenges of autonomous practice.

The midwifery population within New Zealand is aging: the average age of currently practising midwives is forty-seven (MCONZ, 2010). Statistics reveal that the midwifery profession in New Zealand is also characterised by the number of New Zealand educated midwives entering the workforce for the first time, at a late age. The proportion of younger midwives not renewing their practicing certificates is also greater than the proportion of younger midwives in the workforce (MCONZ, 2010). While the reason for this is not identified, it suggests there are issues within midwifery that are causing younger midwifery practitioners to turn away from it.

A study of why midwives leave Lead Maternity Carer practice revealed themes of feeling betrayed and outraged and relief to be leaving (Cox 2008). She concluded that:

the value that these LMCs have given to their profession and the women they work for and with cannot be underestimated. The lack of support and recognition they received from their profession and colleagues reflects sadly on the undervaluing of LMC practice in New Zealand. (p. 66)

The most common reasons given for leaving practice in 2009 were family circumstances, overseas travel, and stress/burnout (MCONZ, 2010).

Burnout was seen as the leading cause for midwives leaving practice. The highest numbers were amongst case loading midwives in an article that cited a shortage of midwives throughout New Zealand causing increased work loading and stress amongst midwives remaining in practice (Johnston, 2008). As committed and experienced midwives familiar with the New Zealand midwifery culture leave practice because of burnout the work demand is exacerbated. This increases the vulnerability of those who remain in practice. The on going loss of experienced midwives to the profession through burnout is both regrettable and unsustainable.

Summary

Midwifery has had a convoluted and difficult history which has been detailed. It has passed from an informal knowing of birth handed down through the generations of lay midwives who have cared for the women within their community to one of professionalism, research based knowledge and legislated practice. Midwifery has reclaimed its right to practice autonomously but this time it is within the modern world of accountability, informed consent and consumer rights. The metamorphosis of midwifery has been accomplished within the perimeters of major changes in the mode in which all health care is provided and given within New Zealand. This transition from professionally dominated care to consumer led care is part of a change reflected in other parts of the world.

There are clear links between midwives and the women for whom they care. Not only do midwives bring a passion to their commitment, but the women themselves are equally dedicated to optimising and safeguarding birth options. It is a commitment that has been shown to extend beyond the individual woman's own childbearing experience to an altruistic drive to continue to make things better for future generations. Many of the women activists who led this change were women who had completed their own childbearing. Historically it is evident that when midwives are strong and confident, women are strong and confident in their expectations and ability to ask for what they need. When midwives lost their option of supporting women through all their phases of pregnancy, birth and mothering women lost their vision of the predominant normality of birth.

The fragmentation and medical domination of care became something for which both women and midwives have paid a price. Women have clearly chosen midwifery care as their preferred option, organised themselves and fought for this right. Midwives have honoured those battles within their philosophy.

Autonomous practice, partnership and continuity of care within the current era of health care has been evolved in a mix of legislative, philosophical and individual interpretative processes. The philosophy of partnership is seen as central to the supportive relationship women and midwives share. Despite the original intentions of partnership being a work in progress when the concept of partnership was formalised, it has not always evolved to reflect what is workable between women and midwives in practice.

The continuity of care of case loading practice is a concept valued by both women and midwives. Practical strategies for achieving this and evaluating how well it is working need to be openly debated by both women and midwives. While it remains a valued option of care it would appear that ways need to be devised in its implementation which protects the giver of the care as well as the recipient. The difficulties of its provision within the study population are lost in the silence that surrounds burnout.

Midwifery has been shown to have a potential risk for burnout; a risk that effects both women and midwives. The premise that as an autonomous practitioner the responsibility for sustainable practice rests with the practitioner does not offer protection, as the participant population shows us. It narrows the scope of devising ways to resolve the difficulties; it fails to protect the fundamental principles of autonomous midwifery, partnership and continuity of care.

The following chapter considers the literature that defines and explores burnout. By building the knowledge of burnout revealed within existing literature on to the knowledge of the context in which burnout occurs within midwifery, a greater depth of knowing of the phenomenon is made possible.

I thought burnout was made of ice.

but it is made of silence.

Sound dying in a conspiracy
that renders families speechless,
colleagues deaf and blind.

A silent isolation

in which

the inner voice

is muffled.

Self quelled,

until in a startled sob

physical self

breaks

and breaks

and breaks.

Chapter Three: Exploring the Literature

Introduction

A literature review helps to site a study within the context of existing writing that is relevant to its focus. It was revealed that burnout is a phenomenon that is being constantly examined and analysed worldwide indicating that it is widespread. Burnout is described as a state of physical, mental and emotional exhaustion caused by long term involvement in demanding situations. Gryna (2004) suggests that it is a consequence of stress experienced over six months or more. It is accompanied by an array of symptoms and represents a breaking point at which the ability to cope with the environment is severely hampered (Gilliand & James, 2005).

There are no previous studies on the experience of burnout within New Zealand midwives or autonomous midwifery practitioners. International studies did not always separate out the nurse/midwife experience and focused on hospital employed midwives. Existing literature on burnout has predominantly used a quantitative methodology. Phenomenology has a specific philosophical approach to this process which differs from other methodologies.

The phenomenological approach to the exploration of literature

Hermeneutic research calls for an understanding of the influences that lead the researcher to interpret writings in a particular way. Crotty (1998) in discussing the foundations of social research talks of the absence of an objective truth. He advises that as truth, or meaning, originates from our engagement with the realities in our world it is subject to our own interpretations. He tells us "Meaning is not discovered, but constructed" (p. 5). Findings may be set out and validated within literature but the interpretation of the meaning of those findings invites variables of understanding by the readers of that literature.

Phenomenology asks us to "set aside all previous habits of thought, see through and break down the mental barriers which these habits have set along the horizons of our thinking... to learn to see what stands before our eyes" (Husserl, 1931, p. 43). The call to Hermeneutic researchers is to see things afresh with new eyes and new

thinking; in this way what was always there but unseen because of a prescribed way of viewing our world is freed to come into our focus. In order to approach literature with an openness to discover what is both apparent and less apparent the researcher first needs to approach themselves with an openness to discover what may obscure their ability to see what is there.

Gadamer (1975/2004) describes text as something that rather than being a source of absolutes of truth is simply a medium that captures the writers "conscious and unconscious interests at play" (p. 241). With time the assumptions held by a writer become less evident and prejudice is covered over; text then becomes assimilated as truth not just as the truth of a particular writer's experience of their world at that time. Hermeneutic inquiry seeks to look beyond what is presented. It searches for the meanings and assumptions that are hidden in the text which may not have been recognized by the writer in order to become better aligned with certainties within their interpretation. It draws on academia, poetry, fiction and spans time and different disciplines seeking to engage with the reader to provoke thinking. It is about being attuned to the meanings that emerge in various guises.

That assumptions lie within all interpretations is a reality all researchers must address, not only in what they read, but in what they write. (Heidegger 1927/1962) talks of the nature of understanding and of the fore-having that the researcher brings to their review of literature that forms their understanding of their research topic and the original formulation of what they seek to discover. I was drawn to my research by the proximity of experiences of burnout amongst midwifery colleagues and the silence and stigma that surrounded them. Neither they nor those around them understood the phenomenon of burnout; it was something unknown and not well linked with midwifery in the world in which we practiced. The lack of knowledge and understanding fuelled the fire of their experience. I therefore approached my research predisposed towards having empathy and compassion for those who have suffered from burnout from an assumption as to the depth of their pain.

In reviewing literature a phenomenological approach recognises the existence of fore-having, a pre-existing understanding, fore-sight, the anticipation of what may

prove helpful in the future, and fore-conception, a belief as to what will be encountered (Heidegger 1927/1962). All are elements that can influence the interpretation of findings, fore-conception having the potential to blind to what is there because of our pre-formed way of thinking.

I had assumed burnout would be most predominant amongst the busy executives of the world but found that it was most evident amongst the caring professions, such as health workers (Maslach, 1976). Lynch (2002) suggests that "burn-out happens most frequently to people who are passionate, idealistic, and who have chosen caring for others as their work" (p. 178). In reviewing literature I found a need to spread my net wider and wider because of the scarcity of information about burnout both within midwifery and within New Zealand. Yet Lynch (2002) surmises that: "Midwives are passionate, idealistic and caring is central to the work we do. This issue of exhaustion and burn-out applies directly to our lives" (p. 178). Engelbrecht (2005) describes midwifery as highly demanding and an intense engagement with the job is a pre-condition. She believes that this over dedication and high commitment is a characteristic of midwifery. These traits predispose towards burnout, yet midwives are mostly unaware of the occupational risk of their profession. The scarcity of information of the experience of midwives with burnout seemed to confirm the assumption that had pre-empted my research; that midwives and midwifery knew little about burnout and burnout was then better enabled to exact a painful price for that unknowing.

Phenomenology allowed me to move beyond this to the recognition that it was too easy to move from an assumption to a premise; in this instant to assume that midwives and midwifery should have known more about burnout. To do so would have introduced restrictions of engaging with issues of culpability that would have detracted from and limited a truer understanding of the phenomenon itself. Maslach (1982) warns that the blaming that has become attached to burnout allows the broader aspects that contribute to it to be trivialised creating incomplete information.

The limitations of language

The research language of the literature reviewed struggled to convey the depth of the experience with its encapsulating clinical words of 'depression,' 'low self esteem,' 'anxiety' just as the word 'burnout' only partially captures the complexities of the phenomenon it seeks to understand. Jevne and Williams (1998) use the analogy of the Russian doll where the layers that strengthen its fragility appear to be intact outwardly, but the central core that completes it is missing. Cornell's illustration of an article by Bomms (2009) depicts a humanised phoenix perishing in fire. Other literature draws on the analogy of a burned out building, the external facade appears intact but the internal integrity lies in charred ruins. The imagery of the extinguishing of a candle and the running down of a battery that provides central energy were also used.

Literature reviewed did not reflect that when the flame of passionate dedication was extinguished something of intrinsic value was lost to both the individual and the profession with which they were involved and to the clients who used their service. Often there was an acceptance that this is just something that happens within the world of working endeavour from time to time; if you were the sufferer heal yourself and move on, if you were the organization recruit replacements.

What does burnout mean?

I began my process with an attempt to grasp the elusive meaning of 'burnout' and its causes to discover that many others had gone before me and had failed to reach a consensus of opinion.

The concept of burnout is not a new one, or confined to European perceptions. Native American teachings refer to the healer giving part of their mind, body and spirit to the healing process - in so doing eventually the healers themselves will need healing (Mehl-Madrona, 1997).

In *The Passionate Pilgrim*, a collection of poems attributed to William Shakespeare published in 1599, he writes:

She burnt with love, as straw with fire flameth,

She burnt out love, as soon as straw out burneth. (p. 1066)

The image conveyed is of fierce passion that flares up and dies down with equal intensity and speed. There is an amused pathos; the flame of her love is fierce when ignited, but fickle in its ability to endure. Graham Greene's novel of the 1960's *A Burnt-out Case* tells the story of a man who is described on the back cover as "the victim of a terrible attack of indifference." Such a statement introduces a raft of speculations. How do you become a victim of an attack of indifference? Victim implies you are an injured party, but it can also insinuate that you have been duped; the butt of an external set of circumstances that you did not detect so may yourself have invited in. The central character Query arrives at a Congo leper colony where he is diagnosed as the mental equivalent of a 'burnt-out case', a leper who has gone through a stage of mutilation in which his leprosy has burned itself out.

Despite the research that began to be initiated in the 1970's revealing the seriousness of burnout that same early dismissive approach which disables understanding is still present in modern literature and attitude. Schaap, Schaufeli and Hoogduin (1995) relate a burnout case study of Mr Dijkstra the teacher who was 'very disappointed' and developed symptoms after he was passed over for promotion. The choice of language and the simplistic scenario blunts acknowledgement that the impact of burnout is significant whatever the cause and external judgement of it. Such obscure innuendo persists around burnout despite the research findings.

Cordes and Dougherty (1993) believe that a primary characteristic is the employee-client relationship not just the employee-organisation relationship of 'Mr Dijkstra's' experience. They held that the longer the client relationship lasts the higher the incident of burnout. Midwives engage with each client for approximately nine and a half months.

The World Health Organisation (2007) listing of classified diseases and health problems now includes burnout under 'Problems related to life management difficulty' where it is described as 'state of vital exhaustion' (ICD-10, Z730). The implication of their listing makes it unclear as to whether, by their definition, burnout

is attributed to work induced difficulty around life management or individual difficulty in managing the working aspect of their life. The same difficulties of clarity permeate the literature on burnout.

The coining of the phrase and beginnings of research

The term burnout was first used outside fictional literature by Herbert Freudenberger, a New York psychoanalyst, in the seventies in his book *Burnout, the High Cost of High Achievement* (1974). While working alongside idealistic volunteers in a free clinic for young drug addicts he observed that many experienced a gradual loss of motivation accompanied by mental and physical symptoms. He believed that burnout, rather than being associated with personal disgrace was the description of a phenomenon born of good intentions. Freudenberger epitomized the clinical approach that regards burnout as symptomatic of intrapersonal conflicts and wrong coping mechanisms (Schaufeli, 2003).

Over the four decades following his identification of burnout the explanation of why this phenomenon occurs has been strongly debated and different explanations put forward. Christina Maslach, a social psychology researcher, took a scientific approach which regarded burnout's root causes as interpersonal, social and organisational factors (Schaufeli, 2003).

Burnout by any other name?

The depression of burnout is believed to differ from endogenous or dysthymia depression, both of which have elements of biochemical and hereditary components; therefore burnout induced depression will not respond to the treatments for these forms of depression (Jevne & Williams, 1998). They further postulated that the depression of burnout is more closely allied to the transitional depression of grief but it may exacerbate a pre-existing endogenous or dysthymia depression. They advocate therefore that the depression associated with burnout is more appropriately treated with a psychosocial approach.

While individuals experiencing burnout may experience depression, depression is characterised by additional core symptoms as well as job dissatisfaction and emotional exhaustion. Burnout is context related, usually work related, where as depression is pervasive interfering with all aspects of a person's life (depression v burnout, [www.swissburnout.ch/Depression and Burnout](http://www.swissburnout.ch/Depression%20and%20Burnout), n.d.).

Edelwich and Brodsky (1980) believed that the driving force of burnout is the discrepancy between personal dreams and the real world: "The seeds of burnout are contained in the assumption that the real world will be in harmony with one's dreams," (p. 16). They suggest that we should pause to ask ourselves what we can do better to prepare people for the reality of the work they are trained to do.

Jevne and Williams (1998) interpret burnout as the breaking of a dream, the pain of which they capture in the words of one interviewed man: "it threatened to pull me down and down, until I lost my sense of balance and felt as though I would not survive" (p. 105). They parallel burnout to the breaking and controlling of our spirit and suggest that in burnout "we lose our own voices, speaking learned messages," (p. 39).

Stebnicki (2008) suggests that there are a variety of labels given to the professional fatigue syndromes such as compassion fatigue, burnout, secondary traumatic stress and vicarious traumatization which are dependent on the researcher and discipline, (p. 16). He believes that the critical common factor is empathy with the client and that there is a correlation between burnout and empathy fatigue. Stebnicki surmises that empathy is more than just sympathetic listening, that it calls for a compassion that moves us so deeply we want to help the person we are involved with. The nature of empathetic response to an exposure to multiple client needs can result in a natural accumulative empathy fatigue that leads to the loss of and detachment from self.

Compassionate fatigue gives rise to feelings of powerlessness and vulnerability and a feeling of loneliness and separation from support, (Huggard, 2003). While burnout develops gradually and progressively worsens if not recognized, compassionate

fatigue has a rapid onset, occurs without warning and has a quicker recovery time than burnout (Halpern, as cited in Huggard, 2003)

Literature reviewed explored the impact on caregivers of meeting roles where there are professional expectations of caring that ask for empathetic and compassionate interaction with clients. Midwifery involves more than the provision of safe clinical care. There is an expectation that midwives will embrace and meet the individual needs of the women who are central to that care. The code of ethics for midwives includes the responsibility for "Midwives to respond to the social, psychological, physical, emotional, spiritual and cultural needs of women seeking midwifery care, whatever their circumstances, and facilitate opportunities for their expression" (NZCOM, 2008, p. 5).

Maslach (1982) believes "that burnout is high when people lack a sense of control over the care they are providing" (p. 40). Midwifery care is subject to protocols and recommendations which only the woman has the right to decline, resulting in an obligation to offer care that the midwife may not be in philosophical agreement with, or to work without being able to give the level of care that she regards as basic good practice. The midwifery relationship with women is also philosophically prescribed. Maslach believes that "burnout can be affected by the sorts of rules that govern the contact between provider and recipient. These rules, which determine what is said and done and what is not, have the potential to increase the emotional stress of the helping relationship" (p. 28).

Jevne and Williams (1998) propose that caregivers can sacrifice themselves on the 'alter of caring'. They reach out to others with little sense of self and "do not notice the inner voices that tell us to rest or recreate.... we come to see ourselves as 'people who care for others'. Our care giving becomes our identity" (p. 76). They advocate a need for the recognition of appropriate boundaries so the caregiver is not so defined by their role that they lose sight of themselves and their own wellbeing.

The midwife does not bring an extensive in depth multi disciplinary educative background to her practice that equips her for the safe provision of such a

multiplicity of social, psychological, spiritual and emotional responsibility when dealing with complex women. (Egan, 1998) warns that there is a "shadow side" to empathy, something which midwives have a limited understanding of. He believes that understanding the issues of another in order to work supportively with them may involve processes that impact on the helper's own world view.

Maslach's research

Christina Maslach began conducting research in the early 1970's amongst professionals in the caring professions and published an article on her findings. (Maslach, 1976). Prior to her work little was known about burnout and following this publication she described receiving thousands of responses from the public, many of which expressed relief that "this taboo subject had been made public" (Maslach, 1982, p. 7). Her perception of burnout as a by product of work induced stress became a commonly held one endorsed by later researchers. Her work is recognized as ground breaking; for this reason I have paid it particular attention.

The Maslach Burnout Inventory (MBI) is regarded as the leading measure of burnout, (Maslach & Jackson, 1981). This was later adapted to the Maslach Inventory General Survey (MBI-GS) when it was recognized that burnout was not confined to the human services professions as was originally presumed (Schaufeli, Leiter, Maslach, & Jackson, 1996). The inventory encompasses the belief that burnout involves three stages. Its scores have been shown to remain stable over time, (Schaufeli & Enzmann, 1998). There is an initial response of emotional exhaustion which leads into depersonalization, which Maslach describes as "viewing other people through rust-coloured glasses" (Maslach, 1982, p. 5). She describes how in the stage of depersonalisation the response of the person suffering from burnout moves from detachment to active dislike and negativity towards those for whom they were originally highly motivated to provide care for. This produces distress and guilt in the caregiver as they find themselves becoming increasingly distanced from the professional idealism they strived to enact. These feelings then pave the way to the appearance of the third aspect of burnout, one of feelings of inadequacy and a self perception of being a failure. With the erosion of self esteem symptoms such as depression may occur.

Maslach's (1976) interpretation of burnout was that of a complex syndrome rooted in the meeting of a demanding relationship between caregiver and client and was upheld by researchers who followed after her (Schaufeli, Van Dierendonick, & Van Gorp 1996; Schaufeli & Enzmann 1998; Stebnicki 2008). Her pioneering and reputable work offered the world a reputable tool for measuring burnout and generated a quantitative approach to future burnout research. She was to suggest in 2001 that, while the previous 25 years had established the complexity of burnout, new conceptual models promised to yield new perspectives (Maslach, Schaufeli & Leiter, 2001). They believed that a social focus on burnout and the actual syndrome would make a distinct and valuable contribution. Nolan (2009) commented that within the predominantly quantitative research that has been conducted on burnout, qualitative research could now add a different dimension.

Who burns out?

As stated, contrary to my pre-conception that those who suffer from burnout would be dominated by the over extended executives of the business world it was shown to be most extensive amongst the caring professions such as the health services, counselling, fire and police services and teaching. Freudenberger and Richelson (1980) believed burnout was an affliction of "dynamic, goal-orientated men and woman or to determined idealists" (p. 82). According to their findings burnout occurs amongst idealistic carers who regard themselves as inexhaustible and disconnect from their more fallible self. Without this connection with the vulnerability of self, the positive fire of enthusiasm that warms becomes consuming.

Maslach (1982) believes that burnout "is a response to the chronic emotional strain of dealing extensively with other human beings, particularly when they are troubled or having problems" (p. 3). She asserts that what distinguishes it from other job stress is "that the stress arises from the social interaction between helper and recipient" (p. 3). Naisbitt (1984) recognized that professionals, whose care involves "high touch" such as nurses, are at risk of empathy or compassion fatigue. Empathy fatigue has been formerly linked to burnout by Stebnicki (2008). Midwifery is a profession that involves a constancy of a high degree of hands on care.

Schaufeli and Enzmann (1998) concluded that "employees in service professions run a particularly high risk of developing burnout because of the emotional demands they are facing in working daily with people (p. 12). They believe that inappropriate expectations and emotional demands play a major role in the development of burnout. While midwives were not specifically identified by them, they noted patterns of high levels of emotional exhaustion and reduced personal accomplishment amongst nurses. These were consistent across nations which they believe "underscores the validity of the multidimensional perspective on burnout" (Schaufeli & Enzmann, 1998, p. 65).

Claxton and Catalan's (1998) study looking at the factors related to burnout and psychological distress found significant associations between some demographic factors (age, gender, sexual orientation, level of education and occupation). Younger volunteers had higher anxiety and burnout levels than older; men had higher depersonalization scores than women, while heterosexual women scored lower on anxiety. Employed individuals with higher education scored higher on emotional exhaustion than unemployed with lower education levels. Englebrecht (2005) found that younger generation midwives were described as having a different occupational identity from older generation midwives in regard to the acceptance of high demands and low resources at work. Yet A. Easthope (personal communication, 4 June 2010) commented that within New Zealand new graduate case loading practitioners there is an adherence to the traditional midwifery identity, some of whom are experiencing feelings of burnout within their first year of practice.

Kurtz (2009) researched gender difference in burnout amongst police officers. He concluded that while family life can help males deal better with job stress, women do not have this because of the assumption that they meet a further caretaking role within the family at the conclusion of their professional one. The irregular work hours were seen as less acceptable for women - if a male officer missed a birthday party it was better tolerated by family. Schaufeli and Enzmann (1998) believed that while gender was not a cause of burnout it "may be linked to other factors such as

role expectations, role taking, or 'feeling type' that may act as causal agents" (p. 76). For midwives, a female dominated profession, this was a relevant factor.

Similarly age was not seen as a cause of burnout by Schaufeli and Enzmann (1998), but they felt it may be related to "age dependent factors, such as occupational socialisation" (p. 76). Other researches saw age as very relevant and believed that young people were at much greater risk than older people; that burnout is much more likely to occur in the early years of a career (Maslach, 1976). She felt this reflected not just the length of work experience but an ability to avoid the excesses of burnout. Maslach (1976) also identified an increased risk of burnout amongst people who were single while those who were in relationships but did not have children were more at risk than those who did. She believed this stemmed from learned skills of personal negotiation and social resources available to people with families.

Is there a burnout personality?

Psychodynamics were also used to interpret burnout linking it to the personality of the sufferer. Fischer (1983) analysed and treated three cases of burnout and believed it was a narcissistic personality disorder; that instead of giving up or lowering their ideals they continued to try and achieve an unrealistic objective. He disagreed with Edelwich and Brodsky (1980) who considered it was the loss of ideals that was the hallmark of burnout, believing instead that it was the inability to compromise. Later Glickauf-Hughes and Mehlman (1995) argued that in addition to the grandiose narcissist Fischer described, the depressive narcissist was also likely to burnout.

Garden (1991) applied Jung's psychodynamic theory to burnout of two distinct personality types, one of feeling and one of thinking. She concluded that there were three psychodynamic principles involved; a process reversal with a decrease in the two characteristic traits of either caring or ambition, a process of convergence where the two characteristic traits become less distinguishable and finally that burnout occurs when the job is suited to the person - emotional demands burnout the feeling person while mental demands burnout the thinking person.

Pines followed on with the theory that the person who seeks meaning and is highly motivated is pre-disposed towards burnout (Pines 1993; Pines & Aronson, 1988). She developed her approach on the assumption that "in order to burnout, one has first to be on fire" (Pines, 1993, p. 4).

Schaufeli and Enzmann (1998) however disputed the assumption that burnout is an affliction of a person with a particular personality or psychodynamic. They advocate that one of the three elements that are crucial to the domain of burnout is that "burnout is generally considered to be work-related and it occurs in 'normal' individuals who do not suffer from psychopathology and who have functioned at adequate levels before" (Schaufeli & Enzmann, 1998, p. 33).

Bakker, Van der Zee, Lewig, & Dollard, (2006) found that the literature on the relationship between personality and burnout was vague and inconclusive. They suggested that further research as to whether burnout was a social phenomenon or related to individual personality traits may protect individuals in the health professions against burnout.

Why do they burnout?

Meier (1993) followed with the criticism of both Freudenberger (1980) and Edelwich and Brodsky (1980) for their assumption that burnout was the result of a cause and effect interplay between the worker and their role. He surmised that it arose through wrong expectations that did not correlate to the work place reality. He believed three factors around worker expectation were involved. One was the expectation of personal reinforcement as to how the role was best enacted, the reality of which may conflict with the theoretical assumption; the second factor was when expectation was not realised and produced a powerlessness about the ability to alter the inevitable, and finally, worthiness expectations then diminished which linked to loss of the sense of self accomplishment through the belief that there is a lack of ability to influence or alter a situation.

Heifetz and Bersani (1983) saw burnout as a by product of a perception that standards of performance are not being achieved affecting both self worth and client

wellbeing. Burisch (1994) in a similar vein, sees burnout being set in motion by loss of autonomy in noisy confrontations between the individual and his environment. He believes that when the internal stresses induced by a situation there is a disintegration of a positive self image.

Schaufeli et al. (1996) advocated a dual-level of social interaction as a model of burnout. They believed that in addition to the professional and the client relationship there was a significant interplay between the professional and the professional organisation.

Schaufeli and Enzmann (1998) advanced the concept that lack of reciprocity between the level of the investment made and the satisfaction in the outcome achieved is critical to the development of burnout. They believed that "this mechanism works in similar ways at the interpersonal level of care-giver and recipients and at the organisational level of employee and organisation" (p. 122). They spoke of 'the contagion of burnout'. They observed that burnout seems to spread like an infectious disease and suggested that there is "a process of emotional contagion through which professionals take on burnout symptoms (particularly emotional exhaustion) that are observed among others who are in a similar position" (Schaufeli & Enzmann, 1998, p. 124). This concept introduces a third dimension to the dynamic of what may precipitate burnout; that of the professional and their client, the professional and their organisation and their interpersonal-relationships with colleagues.

Maslach (1982) identified that when people are overwhelmed by their work the common response is to work harder. "They do the same things they have been doing all along, only they do more of them" (p. 90). This tendency contributes to the stress of burnout rather than relieving it and change in work patterns are not put into place.

Individuals suffering from stress have the ability to devise strategies to make their lives more manageable, whereas those who are suffering burnout are unable to see any way of changing their difficult circumstances resulting in feelings of helplessness (Moodley, 2009). She suggests that the important difference is that

people suffering from stress are likely to be aware that they are suffering from it, while people suffering from burnout are not likely to be aware of it.

How does burnout happen?

Edelwich and Brodsky (1980) introduced the concept of a model for burnout that supported a gradual and progressive process rather than a sudden and rapid disintegration that had been encapsulated in the imagery of fire. They identified four phases; initial 'Enthusiasm' that gives way to 'Stagnation' as expectations are reduced leading to 'Frustration' because of increasing powerlessness culminating in 'Apathy' where there is a withdrawal from the job both physically and mentally.

Schaufeli and Enzmann (1998) concluded that the difference between work stress and burnout is that burnout takes place over a long period of time while stress is a temporary adaptation process. They identified over 130 possible burnout symptoms and theorized that this reveals the multidimensional nature of burnout as well as its work-relatedness. They believed that while "burnout shares indefinite distress symptoms with job stress, dysphoric symptomatology with depression and severe fatigue with chronic fatigue syndrome, it can be conceptually distinguished from these three alternative negative conditions" (Schaufeli & Enzmann, 1998, p. 41).

Burnout was further described as a pathological condition characterized by emotional and physical exhaustion caused by facing work stress for a long period of time (Maslach, Schaufeli, & Leifera, 2001). Maslach (1982) talks of the chronic tiredness of burnout, decline in both physical and psychological health, and lowering of the immune system. Wilson (2005) links burnout to Adrenal burnout, which he believes is triggered by trauma, excessive stress and work.

The cost of burnout

Burnout exacts a stern price from those who experience it. It is far from being a minor life event from which you can easily extract yourself and walk away unscathed. It has a ripple effect that extends out from the person who suffers burnout to those who are linked with them professionally and socially.

Burnout is the index of the dislocation between what people are and what they have to do. It represents an erosion in values, dignity, spirit, and will - an erosion of the human soul. It is a malady that spreads gradually and continuously over time, putting people into a downward spiral from which it's hard to recover ... What might happen if you begin to burnout? Actually three things happen: you become chronically exhausted; you become cynical and detached from your work; and you feel increasingly ineffective on the job. (Maslach & Leiter, 1997, p. 17)

It is not only the burnout sufferer who is singled. The recipients of their care pay a price as the caregiver withdraws and gives less than optimal service. The organisation loses skilled workers as there is a link between burnout and turnover. Research by Pairman and Massey (2001) published in the New Zealand College of Midwives (inc) Journal, following up direct entry graduates attrition rate from midwifery practice found that 12.1% answered "they needed a break," and a further 6.1% cited "burnout/overworked and underpaid," as their reason for leaving (p. 21). Grouped together the statistics reveal that 18.2% of midwives left practice because they had burned out or needed respite from their work within six years of completing a three year degree course.

Maslach (1982) discusses the impact on family life and comments on the reduced quality of life for families as the person who is in burnout progressively retreats from social contact. Her work revealed an increased incident of marriage breakdown.

How does burnout link to midwifery in New Zealand?

Borritz, Rugulies, Christensen, Villadsen and Kristensen (2006) concluded that midwives were in the top of the fifteen selected professions in which burnout was most marked. Midwives scored high in the personal, work related and patient related burnout scales. Literature showed burnout was very present within midwifery on a global spectrum but research was limited to the experience of hospital employed midwives who may also be involved in shift work.

Midwifery continuity of care calls for high commitment because of its unpredictable demands. New Zealand midwifery has a strong philosophical belief in care being

woman led and woman focused instead of one dictated by professionals denying women choice. Midwives enact that philosophy while continuing to carry a duty of care to mother and baby of ensuring optimal safety. Because of the nature of this midwifery with its call for high commitment, the emotive influences of the work and the shaping of a high service expectation there is a pre-existing potential within midwifery for the development of an excessive sense of duty.

Within New Zealand the Maternity Services Notice (MOH, 2002b) upholds that:

The objectives of primary maternity services are to-

- (a) give each woman, her partner, and her whanau or family every opportunity to have a fulfilling outcome to the woman's pregnancy and childbirth by facilitating the provision of primary maternity services that are safe, informed by evidence and that are based on partnership, information and choice. (p. 1033)

The legal expectation of the midwife service provider is therefore multi faceted and expected to exceed the dynamic of simply providing safe clinical care. The midwife is required to enter into a supportive relationship with each woman guided by the woman's terms and choices. This expectation is also upheld within New Zealand midwifery philosophy as well as within the law. Within the concept of holistic care recognizing each woman as having unique social and emotional needs that are interwoven with her pregnancy needs, there is an assumption of a professional ability to meet a complexity of service. It is a service that extends beyond the physicality of pregnancy, birth, infant and post natal care to one that is all encompassing.

Gustafsson, Norberg and Strandberg (2008) studied female healthcare personnel and concluded that the meanings of becoming and being burnout are to be torn between what one wants to be and what one manages. They believed that ideals become demands and regardless of circumstances you must be, and show yourself to be, capable and independent. When this is not able to be upheld in practice your self image is adversely impacted on. They concluded that it was important to be able to discuss your everyday reality.

Midwifery, unlike most other caring professions, does not have an automatic facility for individual debriefing after traumatic incidents. Where hospital employed midwives are exposed to such an event they may elect to access funded short term counselling services that do not have a specific knowledge of the professions they encounter. Case loading midwives, must self fund such services however the New Zealand College of Midwives now funds short term counselling where the College legal services have become involved with a particular incident. These scenarios depend on both the self recognition by the midwife that she is in need of such support and on her ability to then put it in place. When counselling and being stood down from duty is not automatically offered there is an expectation that ordinarily such an event could be processed alone. Neither does midwifery have a professional supervisory layer. Stebnicki (2008) in evaluating burnout amongst counsellors suggests that "counsellor educators and clinical supervisors are the first line of prevention in recognizing professional impairment conditions" (p. 136).

Maslach (1982) identifies that:

Helpers can also feel trapped when the job does not allow them to take temporary breaks from stressful contact with people. They are on the spot, with no one else to share the work or help them out. How can they leave the recipient without feeling some guilt in doing so? (p. 41)

Maslach captures the tension midwives described in uplifting time off or handing over care in an incident of prolonged labour. There is an assumption that the midwife will forge a close and supportive relationship with the women in her care under a care system that promotes continuity of care and high availability as its hallmark. Somehow she is then expected to extract herself from such an onus of promoted care and the carefully established relationship with the woman to meet her own needs without damaging her professional relationship with her client.

Malachi (1982) talks of how some job settings seem designed to promote conflict between co-workers rather than cooperation. Where there are individual case loads there are additional emotional pressures on each individual helper. The caregiver carries "full responsibility for the recipient, but has less access to peer support - partly because co-workers will be less familiar with the recipient's case, and partly

because a request for aid will be viewed as personal failure" (Maslach, 1982, p. 44). Again Maslach captures the tensions of the one woman one midwife ideal where the evolved relationship can not ever be handed over to a backup midwife in its entirety.

Guilliland (2007), CEO of NZCOM, states in Midwifery News Forum:

Self employed midwives are more personally responsible for the way in which they practice. The profession provides guidelines but the hours, caseload numbers, the leave and the time out decisions are the midwives' and no one else's. It is up to the caseload midwife to manage being on call. Hundreds of midwives manage the practice and financial components of their work without stress. Some however attribute disorganisation and poor management of their small business to midwifery. All small businesses can provide examples of successful and failing businesses and midwifery is no exception. The College provides practice management systems to their midwives via the MMPO and still some refuse to take advantage of this assistance. Taking control of one's own destiny is part of the autonomous profession. (pp. 6-7)

Cordes & Dougherty (1993) felt when "rewards and punishments are linked to performance" an environment is created which links to burnout (p.629). While the case loading midwife has autonomy over her practice, she lacks control over her hours of work, both in the timing and duration of them because of the unpredictable nature and duration of birth. The complex dynamics of her practice transcends that of a business enterprise. In an understaffed maternity unit if her back up colleagues are unavailable through their own work commitments, the reality is that a midwife may not have the option of support despite having carefully facilitated this. Her 'destiny' can be re-shaped by external factors that she cannot control. Schaufeli and Enzmann (1998) believe that burnout is a complex phenomenon that may have many causes and there is "a danger of falling into the so-called 'triviality trap'" (p. 190). They advocate that in order to prevent burnout "levels of burnout have to be assessed so that the individual's or the organisation's awareness of the problem is increased, measures must be taken to reduce negative arousal ... the person's job-fit should be improved" (Schaufeli & Enzmann, 1998, p. 183)

Maslach (1982) comments on the nature of being on call:

The provider's personal life is also disrupted 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)

Eustace (2003), quoted in *Midwifery News*, suggests "it was time midwives facing burnout asked questions of themselves like: Am I taking honest account of my limitations?" (p. 4). Further in the same article in 'Tips to Help you Handle Burnout,' cited in *Life of a Midwife*, a *Midwifery Today* book, it is suggested that "if you don't love the profession, get out of it, because you aren't doing it any good," and "burnout is not when you're too busy, too tired, or overworked. Burnout is when you lose passion for your work" (Eustace, 2003, p. 4). The implications of this advice is that the root cause of burnout is the individual's loss of passion, not the erosion of their love for their work by the damage of the professional demand. That when this happens you should just "get out of it." If you are no longer doing the profession good, even in some participant's situations of having given years of dedicated service, you are disposable.

Maslach (1982) talks of 'blaming the victim'; that the professional who sees people on an individual basis focuses on them as creating a unique difficulty for the caregiver. Similarly the caregiver can be blamed. "Thus, when employees complain to administrators about the emotional stress of their work, the typical people-orientated response is, "What's the matter, can't *you* take it?" Or "What seems to be *your* problem?" In one stroke the administrator takes the institution off the hook and hangs the complainer on it instead" (p. 12). Maslach believes that to do so fuels "a sense of alienation, failure, and self-hatred" (p. 12). She sees a need for organizational change as well as personal, that teaching people how to cope with a stressful job is not as effective as making the job less stressful and an organizational response to burnout shows their recognition of burnout as a legitimate problem. The concept of burnout in the giving of service is adverse to the promoted ideologies of

professions and their subsequent teaching may reflect that, leaving new graduates unaware of the realities they will face in practice.

Summary:

The literature review has been undertaken from a hermeneutic phenomenological perspective. Gadamer (1975/2004) suggests that the beginning of a review is the reviewer, therefore I have disclosed my assumptions because of their possible prejudices. Hermeneutics does not set out to be definitive and all encompassing, recognising that the nature of truth only partially reveals what is there (Gadamer, 1975/2004). Rather than pretending to hold the answers it seeks to draw the reader into emergent thinking.

Existing literature shows us that the phenomenon of burnout is associated with a centuries old dismissive attitude which I found to still persists despite the contrary findings of research. The environment in which burnout imbeds itself and the circumstances that enable it to flourish have been studied and debated since the 1970's. Maslach initially assumed it was confined to the caring professions. Her later research was to show that while these professions carried a higher risk of burnout, it occurred within a broad spectrum of occupations. Sheath (2006) talks of how burnout affects a "wide swathe of people worldwide including sportspersons, corporate executives, businessmen, students, journalists, writers and even those who feel the need to retire early because of exhaustion." That burnout is work induced is the one persistent generic element. This upheld a need for me to seek influences external to the specifics of midwifery practice.

Differing human behavioural disciplines have applied their principles to the question of why some people burnout and what happens when they do. Premises have evolved that suggest certain characteristics and personality traits predispose to burnout; idealism, passion and commitment to the nurturing of others. These are the same characteristics and traits that draw people into the caring professions which are heavily but not exclusively represented in burnout statistics. It led me to consider the links between the motivating intent to become a midwife and the predisposing personality traits for burnout.

Within the array of international literature the presence midwives experiences of burnout is minimal. The voice of the midwife who suffered burnout is mostly missing from the international debate because of its quantitative focus. When the midwife's voice is heard it does not include the experience of autonomous practice. Within New Zealand literature information surrounding the midwifery experience is sparse, some of which is directed to minimizing the phenomenon of burnout. Therefore after reviewing existing literature it seemed appropriate that this study listens to the voice of case loading midwives who have had the lived experience of burnout to further the understanding of it. Within New Zealand such a study has not been previously undertaken.

Burnout is mainly studied with quantitative methods (Gustafsson, Norberg & Strandberg, 2008). Amongst the qualitative research emerging many researchers use a mixed methodology of phenomenological and empirical approach. The differing perspective of qualitative methodology is now bringing a new lens to burnout. It is anticipated that this will generate a new knowledge of burnout (Maslach, Schaufeli & Leiter, 2001). My resulting awareness of a need for a diversity in the methodologies reaffirmed my original decision to use hermeneutic phenomenology as my research methodology.

The literature presented allowed for several conclusions to be drawn. Lack of acknowledgement, emotional overload, client overload, and problems experienced with the organisations could impact on midwives and precipitate burnout. It is possible that certain personality traits and demographic variables may also cause the individual to be more vulnerable to burnout. Burnout has been the focus of numerous studies amongst a diverse occupational population. This study focuses on the experience of the case loading midwife. What has become increasingly certain over the last two decades of autonomous practice within New Zealand is that burnout is real and its destruction can be readily demonstrated in the lives of those midwives whom it has affected. In the following chapter I set out the methodology used to undertake this study.

I thought burnout was made of silence
but it is made of fear
well fed
growing plumper
while self
grows smaller.
And dies
and dies
and dies
each day.
Until hollowed out
to almost nothing,
only heartbeats away
from disappearing,
pain, careful and deliberate
draws you back.
Reminds you
to breath.

Chapter Four: Methodology

Introduction:

In this chapter I have set out to explore the pathways that I followed in coming to my decision to use hermeneutic phenomenology to guide my study. In order to do so I have revisited the attributes of my chosen methodology and declared my understanding of them. I have then examined why I believe this to be an appropriate philosophy to bring to my enquiry.

I have identified Martin Heidegger and Hans-Georg Gadamer as the two philosophers who have principally informed this research and my reasons for this choice. I have set out my understanding of their hermeneutic premises and sought to show how I have translated these into my own work and used them to enrich my understanding. Finally I have set out my process of reaching the philosophical understanding that has allowed me to work with the findings that emerged within the context of hermeneutic phenomenology.

The choice of methodology

Before undertaking this research I evaluated differing methodologies and their philosophical underpinnings in search of the one which would best inform my study. Interpretive phenomenology already resonated within my own assimilation of lived experience and my natural mode of enquiry. Phenomenology had a philosophical richness that sought to capture the intricacies of human interpretation of the lived world and a method that sought to address the variables of that perception. Phenomenology recognised that findings can never be an absolute truth because human interpretation is a continuous and evolving process. I felt this was important, believing that truth is not static; historically mankind's attempts to uphold their current versions of truth as singular and absolute leads to oppression. To acknowledge this reality was not the stating of a philosophical flaw but the creation of a possibility for discovering the multiplicity of truths that are lost within the concept of one infallible truth. Harman (2007) advises us that "...phenomenology means a way of staying true to what must be thought" (p. 154).

I had observed that there was a painful silence amongst midwifery colleagues who had suffered from burnout within their experience of on call practice. Harman (2007) further tells us that "human life is not something visible from the outside, but must be seen in the very act, performance, or execution of its own reality, which always exceeds any of the properties that we can list about it" (p. 25). The lived experience of midwifery burnout was invisible to those who were outside it, even when they lived alongside the midwife practitioner. Rowan, a participant, says of his wife's experience, "*I clearly didn't realize... it was much worse than I had thought*"

Nor did the midwives themselves recognize that they were experiencing burnout as the phenomenon concealed itself from those central to it as well as from those external to it. Liz, a midwifery participant, tells us "*when I think about it now I don't know how I did it, or why I did it.*" While midwives knew 'something was wrong' they had no understanding of what there were experiencing. The unknowing firmed up the concealment that surrounded and permeated burnout.

My research pre understanding assumption was that staunch walls are only erected when something is sought to be guarded and concealed. I felt that the silence that surrounded burnout might indicate that a profound and multi layered experience was at its centre. I sought to discover the why of that invisibility; why was burnout concealed, what was the cause of that silence that contained a sense of stigma? I believed that the midwives who were afflicted by burnout held the answers within their lived experience. I projected that assessing those answers meant revisiting difficulty; that pain could be buried within the silence and may need careful uncovering. I looked for a methodology that would best do this. I further sought for a methodology that would allow participants to reveal what they believed it was important for me to know, rather than one that was researcher led or driven in which the participants insights could be lost. I anticipated that my participants' words would best tell their stories and that the knowing of their experience lay in the interpreting of those words. I believe phenomenology enables such disclosure.

When a lived experience is recounted particular aspects are often revealed to have been shared by many. The words that are used to disclose those themes speak

directly to those who listen and seek to gain insight into their experience. Yet Gadamer (1975/2004) warns that: "a person who seeks to understand must question what lies behind what is said. If we go back behind what is said then we inevitably ask questions beyond what is said" (p. 333). Gadamer's words were bourn out; as I learned to listen hermeneutically I heard more and subsequently began to ask questions previously un-thought of.

When midwives spoke of the urgency of their need to distance themselves not only from their work demands but from all claims of all people I began to hear the extent of their desperation to find a place of peace. The degree of the desperation which underlay their words disclosed the extremes of their distress. When they told of their struggle to be both a good family member and a good midwife I heard the silence that surrounded their sense of self and did not include their own wellbeing. The concept of re-evaluating work demands was not considered because they believed that they alone struggled; it disclosed a deep sense of personal fault that made changing their work patterns irrelevant. The silence spoke of the loss of self that was unspeakable, and of how isolated midwives were with the feelings of burnout.

Hermeneutic phenomenology offered a way to interpret what lay within the language used to uncover what was being expressed beneath the spoken words. As I began to work with my participants' transcripts I came to understand that interpreting enabled me to assess what was really being revealed through the words that were spoken. Heidegger (1927/1962) tells us that "in interpretation understanding does not become something different. It becomes itself" (p. 188). I vigorously questioned and revisited the meanings I believed underlay what was said and found those meanings consistently reaffirmed by participants. I was concerned at first that interpretation offered the interpreter the opportunity to alter or contaminate the truth that was being expressed, but came to recognize that it was a process that allowed a more accurate sourcing of that truth. Interpretation enables what has always been there, but hidden, to be revealed. What lay in the dark of the not knowing of the phenomena of burnout could not be understood unless it was brought to the light.

I believe the philosophy and methodology I have chosen to guide my study offers an opportunity for those who are outside an experience to come closer to knowing what it was like for those who lived through it. I perceive the strong cohesion between phenomenological methodology and its underlying philosophy as strength. The variability and complexities of humanness requires a methodological approach which both recognizes and seeks to address such complexity. There is vigour of authenticity when the guiding philosophy recognizes the variability and fallibilities of humanness and reflects this within its methodology. When fallibilities are acknowledged and worked with there is an honesty that resonates within the findings.

Philosophical underpinnings

Heidegger

My study has been principally guided by Heidegger. The complexities of his thought and language initially led to my searching for less demanding learning, but I found myself always returning to his teachings because of their unquestionable depth. His philosophical contemplation of how humans engage with their world and find meaning was original and challenging.

Heidegger's influence on phenomenology

Heidegger's philosophy uniquely pursued the fundamental question of 'what is the meaning of being' back to the first philosophical contemplations of the ancient Greeks. Gadamer (1995) comments that "no one before Heidegger thought back so far" (p. 53). Aristotle's view was an objectivist one that centred on the real world dismissing human variables of perception. He believed that the study of being was the study of the primary beings and species; that how they presented was the reality of what they were and the meaning of 'being' evolved from that reality. This objectification meant that a phenomenon that was hidden within familiarity and covered over was only revealed when it was randomly disturbed. Harman (2007) suggests that Heidegger saw this as a common flaw within philosophy; Heidegger believed instead that the constant shadowy interplay between what was concealed and what was revealed should be the central focus of philosophy.

Heidegger shifted the investigation away from the classical metaphysics of 'what is the meaning of being' to the hermeneutic phenomenological one of 'what is the meaningfulness of what is meaningful'. In moving to the contemplation of human interests and purposes as the focal point of our understanding of how mankind interacts with the lived world from the objective structures of that world, Heidegger introduced the consideration of mankind itself. He believed there were many influences of perception on both conscious and unconscious levels which define our experience of the world. Further that it is only by uncovering them through interpretation that we can approach a fundamental understanding of what it is to be human; what it is to 'be'. My study sought to uncover what it meant to 'be' a midwife who had the lived experience of burnout.

Husserl and Heidegger

Husserl's work initially guided Heidegger. Husserl (1931) viewed phenomenology as a means of sourcing the essence of pure consciousness; that phenomenology was concerned with what is inbuilt in consciousness. He believed that through a process of phenomenological reduction pragmatic subjectivity could be suspended by the bracketing of empirical data. According to Husserl such bracketing neutralised subjective beliefs. Heidegger ultimately contested that we do not have the ability to distance ourselves from our lived experience of the world for we are such an integral part of that world we do not even recognize the fallibilities of our engagement with it. Husserl believed that when our world is encountered there is a priori correlation between what is meaningful and what constitutes that meaningfulness, while Heidegger came to argue that the lived context of the world in which things are encountered is the fundamental source of their meaning. It was not what came first, but what is first. In my study I sought to understand how the prioritising of midwives had led to the dimming down of self awareness which culminated in burnout.

Sheehan (2005) suggests that ultimately what separated Heidegger's phenomenology from Husserl's was Heidegger's hermeneutical shift to "identifying the world as the source of all meaning" (p. 197). Heidegger proposed that what made things meaningful was the circumstances of the human involvement with it and that

meaningfulness and function are altered by the context of the world in which things are encountered. Sheehan suggests that Heidegger moved beyond the contemplation of what it is to be human to one of what structures make it possible to be human; it was not 'being' itself that was important but it was what it meant to 'be'.

Lafont (2005) describes Heidegger's contribution as a "radical paradigm shift within philosophy itself" (p. 265). She believed that Heidegger introduced a new understanding of what it is to be human as the human is not primarily rational and consciously aware of being a self-interpreting entity. She holds that "it is precisely because human beings are nothing but interpretation... that the activity of *interpreting a meaningful text* offers the most appropriate model for understanding any human experience whatsoever" (p. 265).

Why Heidegger?

Heidegger believed that there is a facticity of life which prevents it from being described in theoretical terms. There is such complexity in our life encounters, the nature of which is influenced by a multiplicity of social shaping, that it cannot be captured within a formula. Instead he calls us to look at how people take up their existence in the world, using the word "Dasein" to capture the concept of human existence (Wrathall, 2005). The use of the neutrality of the created term of Dasein captured the notion of a universal humanness that transcends gender, race and belief systems, thereby excluding the prejudices and assumptions we may already have if it were termed differently.

How we engage with the entities of the world

The entities of our worlds make subtle shifts according to our level of engagement with them. In this way what is 'present-to-hand' can simply become 'ready-to-hand' when we disengage with it. The world that is experienced therefore constantly changes from one person to another, and alters yet again within the context of the lived experience of each person. Things within the world only become 'present' through their interpretation by Dasein but our interpretation may lack knowledge.

We conjecture, fill in with supposition and fail to recognize the blind spots that lie within our understanding.

Steiner (1978) comments that when we ask the meaning of being we "enter the famous hermeneutic circle, Da-Sein must walk this circle and penetrate, through its spiralling inwardness, to the 'clearing' where truth becomes 'unconcealment'" (p. 82). While acknowledging limitations, Heidegger calls this clarity of interpretation the 'clearing' of human existence, the open area of stability within the obscurity of the forest of our lived experience. Through a process of intense interpretation and continued re-interpretation of the layers of what presents we arrive at a place of understanding that could not have been reached otherwise. Dreyfus and Wrathall (2005) say of this however that "in the attempt to impose our light, we cover the sources of the clearing in darkness. We close ourselves off to them" (p. 448). They suggest that even in the clearing of understanding we arrive at within the obscurity of the forest of our lived experience there is still the reality of our being blinded by our own dawning knowledge when we identify the way forward at the exclusion of the other ways. This was evidenced in my study. Midwives recognition of their surfacing levels of distress within the clearing of emerging burnout led to their fixation on a particular cause and the consequent choosing of a path that they hoped would lead away from it which blinkered them to other awareness and direction.

How we interpret the world

Heidegger tells us Dasein interprets lived experience through interaction with the world. Such interpretation is a constant passage between the shades of what is contemplated and understood, or thought to be understood. Heidegger asserts that while there are fundamentals of authentic individual choice there are also complex elements of societal shaping in the 'worldhood' of our worlds. Such social determining may be so embodied that it is covered over and choice thus influenced becomes inauthentic without this even being recognized by us.

Heidegger further surmises that Dasein has no internal sense of self; that individuals sense of whom they are and how they live is instead shaped by external influences. Within my study midwives voiced their feelings of failure because of not meeting

what they believed to be the professional expectation of empathetic availability whatever the hour because the limitations of their humanness got in the way. They measured themselves against their perceived external expectation and not the expectation against their internal lives. Heidegger (1927/1962) asserts that the 'they' of our worlds both form us and mould our sense of self: "If Dasein is familiar with itself as they-self, this means at the same time that the 'they' itself prescribes that way of interpreting the world..." (p. 167). Because of the rigour of midwives beliefs surrounding what they believed "they" expected them to offer to their clients midwives rejected the validity of their own feelings which informed them the expectation was unrealistic. Instead they interpreted their feelings as indicators that they were 'bad midwives' and pushed themselves harder to meet the externally imposed expectation preventing their self recognition of burnout.

Heidegger (1927/1962) further reminds us that phenomena can show itself "as something which in itself it is not" (p. 51). The phenomena of burnout presented as semblance; it looked like something which it was not. Midwives therefore frequently sought cures for what they perceived to be random illness, not realising their symptoms were semblances of burnout which underpinned their physical and emotional manifestations of disturbed wellbeing. The focus on their health obscured their recognition of what was really occurring because it shifted their awareness away from the cause to the symptoms themselves.

Phenomena may announce itself through an appearance of something which may be assumed to be the phenomenon showing itself. Midwives in the menopausal age group believed they were experiencing the phenomenon of menopause, not burnout. Heidegger (1927/1962) warns of "the announcing-itself by [von] something which does not show itself, but which announces itself through something which does show itself" (p. 52). In this study the symptoms which presented and were then presumed to be menopausal was the announcing of burnout and not menopause as non menopausal participants experienced identical symptoms. The assumption that they were being shown manifestations of menopause prevented the recognition of their underlying burnout amongst those participants. Hermeneutic phenomenology allows an evolving clarity as semblance and appearances are identified so that the

phenomenon is progressively revealed. Uncovering what lies in the shadows enables a knowing of what may otherwise remain obscured and lost to our understanding.

What it means to 'be'

The endless passage between Dasein and the interpreted world of Dasein's being with its interplay of veiling and unveiling is described by Heidegger as 'time.' Time lies behind us, around us and even as it is present it flows by us to become the past while future can only be speculative. Time can therefore only ever be temporal. He believes it is this interaction between 'being' and 'time' that holds the key as to what it is to 'be'. Steiner (1978) suggests that Heidegger proposes that "We do not live 'in time', as if the latter were some independent abstract flow external to our being. We 'live time'; the two terms are inseparable" (p. 82). There is an 'everydayness' to our lives in which perception is blunted by familiarity, but it is in how Dasein "lives unto the day" (p. 422) that meaning is found. He suggests that 'being' is the encounter of Dasein with the life world around it, about which there will always be obscurity. Crowe (2006) suggests in this context that "life it seems, speaks louder than theory" (p. 220). Lived experience cannot be categorized, it must be interpreted and aspects of how we encounter life will always elude us.

Thrownness

The everydayness of our world holds a capacity for the 'thrownness' of situations which are already present in that world but are unexpected and not anticipated by Dasein. It is this unexpected event that exposes the fundamentals of being by breaking through the everydayness of Dasein to reveal what is hidden within it. Heidegger (1927/1962) tells us of thrownness, that "... this discovery of the 'world' and this disclosure of Dasein are always accomplished as a clearing-away of concealments and obscurities, as a breaking up of the disguises with which Dasein bars its own way" (p. 167).

In applying this principle to my study I recognized that the case loading midwife and her family are in a unique situation where they must learn to live with thrownness because it is the nature of her chosen work. There is an expectation within the

professional response to the difficulties of such availability that, as the midwife 'knowingly' chooses to be unpredictably on call, she should meet the demands without complaint as she has chosen this mode of practice. Yet midwives consistently spoke of their embodied high stress response that was triggered whenever the phone rang that went beyond an intellectual acceptance of on call availability and impacted on them physically and emotionally. As I learned to listen and interpret hermeneutically the ostensible thrownness of being almost permanently on call revealed the greater thrownness of the invasiveness of the sleep deprivation which midwives work with.

Midwives partners also discussed the thrownness of their family life. There was an acceptance of the capacity for disruption as when Max, a participant expresses "*that is just the nature of the job.*" But as with the midwives, for partners the thrownness was not just about the partner being on call and the constant potential for them to be pulled out of their family life by their working life. It was the immediacy of the necessity of response that exacerbated the disruption, the unpredictable lengths of absence, and the extended disruption when the family needed to further shut down to accommodate the midwives sometimes extreme need for sleep and withdrawal from demand when she did eventually return home. Within on call work, despite the element of choice surrounding it that can then be used to condone its burden, just as within life itself there are potentials for thrownness to reveal what was always there but hidden by external assumption.

Truth

Harman (2007) comments "for Heidegger truth is never a question of being correct or incorrect. Instead truth is an endless process of unveiling or unconcealing" (p. 177). Truth, Heidegger believes, can never be an absolute as it will always have components of shadow and light that both reveal and conceal and will always be evolving - to know what is true you must also know what is untrue.

Within my study I encountered altered perceptions of what was thought to be 'truth' according to the knowledge that was held and how that knowledge had been accessed and interpreted. There was a conjectured truth of what it was believed that 'they'

expected, of the prescribed knowledge held and what individual and collective experience and understanding had contributed to it. I recognized within my participants' words that there was a theoretical truth, a practice truth, an idealistic truth, a reality truth, a public truth and a private truth as well as truths that continue to remain obscure to me. It was very apparent that the truth perceived by those external to an experience could differ from the truth of those who lived it.

Within such differing perceptions of a truth there may be divisive interpretations of what that truth really is. Yet Heidegger's interpretation of truth is that it is found in the unhiddenness of disclosure. As Dasein's interaction with the world discloses, there is no truth without man who makes the propositions as to what constitutes truth. Within Heidegger's proposal that there are many shades of truth rather than one finite version lay the realisation that differences of perception of what is truth need not fracture unity. Difference creates the possibility of recognizing the pieces of the complex jigsaw that makes up lived experience allowing insight which otherwise may not be seen. Phenomenology enables the uncovering of the varied interpretations of truth so that we can draw closer to knowing what lies within it.

The political question surrounding Heidegger

In exploring Heidegger's work I found within my chosen methodology a depth of philosophical contemplation that I concluded would serve my study well. Yet there was the long shadow cast by Heidegger's political history which lay over his work. As a German teaching philosophy in Germany through the period when Hitler rose to power Heidegger was exposed to extreme political elements. The choices he made over that time are concerning and questionable. Heidegger's involvement with the National Socialist (Nazi) party demands consideration by any user of his philosophy. From initially feeling this was a politically inspired mandatory reflection, my reading, (Harman, 2007; Kisiel, 2002; Young, 1997; Steiner, 1978), led me to recognize that such a consideration was far from this. It was both relevant and essential for any user of Heidegger's philosophy to explore this aspect of Heidegger because of the horror associated with Nazism. It demanded an analysis of the thinking that led Heidegger to his particular political stance as it called the validity of his philosophical thought into question. Conflict therefore must always surround

Heidegger's involvement with Nazism and continue to demand careful consideration by those who are guided by him. Before I could use his work in good conscience I needed to decide for myself whether the taint of his politics ruined the worthiness of his philosophy, as must every student of Heidegger.

The debate around the implications of Heidegger's Nazi involvement on the integrity of his philosophy is widely spread. Gadamer (1989) observes that Heidegger's "political errors have nothing to do with his philosophy," and that "wholly unnoticed was how damaging such a 'defence' of so important a thinker really is" (p. 428). Rorty (1998), who had previously expressed contempt for Heidegger's work, concluded that "Heidegger's books will be read for centuries to come, but the smell of smoke from the crematories - the 'grave in the air' - will linger on their pages" (p. 2). Heideggerians often approach this controversy as Gadamer does, distancing Heidegger's philosophy from his political thought and insulating his achievements from his political errors, while the extreme of his critics have attempted to use his political errors to dismiss his philosophy. Personal integrity demands his followers to individually arrive at their own ethical conclusion regarding his work rather than readily identifying with the Heideggerian appraisal of his philosophy divorced from his politics or a rejection of his philosophy because of his political affiliations.

In April 1933 Heidegger had no affiliation to any party or role in politics and was persuaded to take on the rector ship of Freiberg University. To do so was to become a functionary under the new regime and he joined the National Socialist party early in May. His wife was also a member of the party and from accounts her involvement was both committed and staunch. My reading (Harman, 2007; Kisiel, 2002; Young, 1997; Steiner, 1978) has led me to believe that the seduction of power drew Heidegger in, something he was beginning to become familiar and comfortable with as his work gained widespread respect. The timing of his rising academic acclaim and the inroads of Hitler on the German psyche advancing a grandiose self image of superiority coincided. Heidegger supposed that he was able to lead Germany to a superior academic excellence within his limited conceptualization of what the Nazi movement was to become. In 1932 there were seven million unemployed in Germany and in a depressed economy Germany struggled to exist. Steiner (1978)

refers to comments by Heidegger, published post humorously in June 1976, in which Heidegger acknowledges that he saw no alternative to Nazism in 1933 if Germany were to survive the period in question. He suggests, however, that it is Heidegger's "complete silence on Hitlerism and the holocaust after 1945 which is very nearly intolerable" (Steiner, 1978, p. 124).

Heidegger intervened in the distribution of anti-Semitic tracts within the university and forbade a planned book-burning and purging of "undesirable" works from the library. While it is alleged that he authorized the banning of the use of the library by his Jewish predecessor, Edmund Husserl, there is doubt surrounding this, but there was also a lack of intervention on Heidegger's part (Steiner, 1978). Steiner continues with his account that with Heidegger's refusal to ratify the dismissal of two anti-Nazi deans of the university he resigned rector ship in February 1934, later leaving the National Socialist party although there is some controversy as to whether he officially tendered his resignation. These actions speak of a man who, on discovering the savage ethical burrs within the politics he had become caught up with, sought to address them, albeit faintly, within his own morality. But he did so at a time when the possible consequences for speaking or acting against the Nazi regime cannot be imagined within the majority of our own political worlds.

To further place this in context, Hitler did not assume complete domination until the 19th of August, 1934. At the beginning of Heidegger's political involvement with the National Socialist Party Hitler's true agenda was masked; Heidegger's resignation from the rector ship occurred as Hitler began to rise to power and that mask grew more transparent. The removal of Heidegger's dedication to Husserl in the new edition of *Sein and Zeit* in 1942 is attributed by some to be at the editor's insistence, not Heidegger's. It is recorded that Heidegger suffered a nervous breakdown in early 1946 with the stress of the de-nazification hearings. What is hidden in his illness is whether it was the denigration of self by other, or the denigration of self by self as the realisations of the Nazi regime's atrocities were uncovered.

Steiner (1978) suggests that:

Like millions of other German men and women, and a good many eminent minds outside Germany, Heidegger was caught up in the electric trance of the National Socialist promise. He saw in it the only hope for a country in the grip of economic and social disaster. The Nazism to which Heidegger adhered, moreover was as yet masking its essential barbarism. (p. 121)

Steiner continues to suggest that Heidegger made an error of vanity in believing he could influence Nazi ideology.

Heidegger's silence on Hitlerism and the holocaust after 1945 has become a major criticism and is referred to in terms of an indictment of his complicity. Kisiel (2002) comments:

Why did Heidegger remain silent until the end of his life about the bearing of his political complicity upon the Holocaust, which was the most gruesome issue of the regime he helped to install in power in its critical first year? Did he ever really face the full magnitude of his contribution to this later issue, albeit unintended? (p. 7)

It is possible that his silence was the protective response of a discovered fragility exposed through the erosion of his mental health previously induced by the stress of the revisiting his National Socialist connections? Perhaps it was also a choice of an aging man to stay focused on his work.

Kisiel (2002) continues to suggest that perhaps the closest Heidegger came to an admission of guilt was in a letter to Jaspers on March 7, 1950, "in which he explained that he had not crossed the threshold of the Jaspers household since 1933 not because of his Jewish wife, but because he "simply felt ashamed" (p. 20).

Out of the stories an all too human portrait emerges of Heidegger, a man who was made vain by fame, who was difficult to know and who could treat friendships lightly. A man who succumbed to the heady seduction of personal academic power and had the conceit to believe he could control the extreme circumstances of that

time. Yet he had the ability to inspire generations as a teacher, to gift a generosity of academic time to others and to offer his total dedication to his life work.

Ultimately I decided that it is his work that will reach out through time and its value should not be condemned by the limitations of the man himself, limitations which all of mankind share in lesser and greater forms. Perhaps one of Heidegger's lessons is the reminder that we must be vigilant in scrutinizing our own encounters with the world for none are immune to errors of judgement; to what Heidegger himself came to call "my most stupid mistake". This is not to exonerate him from the enormity of that mistake with our advantage of now knowing what atrocities unfolded under the Nationalist Social Party. Those who lay a single cobble on the pathway to such inhumanness must accept a responsibility for doing so, whether they did so knowingly or not. My resolve is to choose to accept what was honourable and enlightened within Heidegger's academic life despite the frailty of his personal life.

Gadamar

Hans-Georg Gadamar was a pupil of Heidegger's at Freiberg University. Heidegger's hermeneutic approach that meaning was lived experience, the truths of which could not be reached by a scientific route, became the basis for Gadamar's own philosophy. He built on Heidegger's premise that Being is discovered in lived experience advocating that such human experience is situated in language. Gadamar's work centred on the nature of understanding and the interpreting of language which he believed lay at the root of social communication. Where Heidegger's focus was the hermeneutics of existence, Gadamar's was the hermeneutics of text interpretation. Grondin (2002) suggests that: "This linguisticity of understanding was not crucial to Heidegger's practical understanding" (p. 41). Heidegger appears to have seen language as a vehicle for understanding, but not a source of understanding in itself.

Why Gadamer?

Dostal (2002) suggests that Gadamer asserts that "what one understands makes a difference in what one does. The practical application of knowledge is inherent in the very understanding of something" (p. 3). Without our understanding of

something through the medium of language we cannot take the knowledge imbedded in it with us into our practical living. I sought a knowing of a phenomenon through the medium of language. Further I would access that knowing through the conversation of interviewing and the interpretation of the text that resulted from the interviewing. Gadamer's prime focus was language and its importance in the human experience. Where Heidegger (1927/1962) dwelt with the horizons of "future, present, and having been" (p. 412) Gadamer (1975/2004) visualised horizons of inquiry that moved from what could be seen from one particular perspective to "not being limited to what is nearby but being able to see beyond it. A person who has an horizon knows the relative significance of everything within this horizon, whether it is near or far, great or small" (p. 302). It required me to locate myself professionally, declare my influences and make my methodology and its application to my study clear. Gadamer's philosophy led on from Heidegger and dwelt in an area of primary importance to my study.

Language

For Gadamer (1975/2004) language was the centre of philosophical hermeneutics maintaining 'nothing exists except through language'. He believed that language evolves with us and is imbedded in us, as we are in it; that language is the source of meaning rather than the vehicle for meaning. Wachterhauser (2002) comments: "Gadamer is not saying that all reality of 'being' is literally 'just words'. What he is saying is better comprehended by saying that all intelligible reality is 'enhanced' or 'increased' by words we find to comprehend it" (p. 66). Through language we discover the world we live in and share that discovery with others who in turn enrich our own discoveries. Without the ability language bequeaths to us our world view would be insular and closed.

Wachterhauser (2002) continues that "words do not create the intelligibility of the world, but they do more than simply mirror it in a representation. Words make the world more intelligible and accessible than it would be without words" and that "the 'languages' we speak provide a window onto the world that otherwise would remain shut" (p. 67). What emerges through language is a deeper understanding of the world. Words allow us to move beyond a neutral replication of what surrounds us to

a multi layered process of engagement that generates a multi dimensional perception of our world.

Through the use of language we achieve an understanding of our reality which can then be debated and shared. Gadamer's philosophy enabled me to see language in a hermeneutic light. For the first time I noticed language as language, giving validity to Gadamer's (1975/2004) comment that "we are confronted with the problem that our own use of language is unconscious" (p. 268). There was a realisation that conversation was so deeply hidden within its everydayness that its intricacy was both unseen and unnoticed; that the nature of dialogue wasn't consciously thought about in its everydayness. Only the thrownness of a situation caused words to be more carefully weighed and considered, or alternatively to become emotive and unmeasured, or even stilled. Environment could thus control language and, through the manifestation of such elements of environmental control within it, language then revealed the environment in which it occurred. I began to realise that language had its own voice in keeping with Gadamer's (1975/2004) assertion that "...conversation has a spirit of its own" (p. 383).

Language at work

Because language is a universal tool, Gadamer (1975/2004) further maintained that language allowed a global and historical understanding of truth and culture which was only revealed through dialogue. Warnke (2002) comments on Gadamer's assertion of historical content within dialogue: "Questions change and become part of different questions" and that "we inherit an understanding of the meaning of our history and traditions from them and we re-project that understanding back onto them" (p. 81). I found within the context of my study this proved a valid comment. As I learned to listen hermeneutically original questions gave way to new ones as my evolving understanding resonated within new dialogue.

Scheibler (2000) proposes that there are two dimensions to how language connects. One, which was advanced by Habermas, whose opposition to Gadamer was both famous and public, advocated that language directs us to the concrete world of Other. Heidegger, however, saw language as part of the revelation to Dasein of Being to

which end Other may well be a source of obstruction. Scheibler comments that "Gadamer is exemplary in maintaining our hold firmly in both directions" (p. 169). She holds that Gadamer took the middle ground, believing that language enabled the revelation of both self and other through the medium of dialogue with other and dialogue with the text of other. Language allowed a process of reflection and investigation which could not have existed otherwise.

What is dialogue?

Dialogue is explained by Grondin (2002):

to understand, in Gadamer's sense, is to articulate (a meaning, a thing, an event) into words, words that are always mine, but at the same time those of what I strive to understand. The application that is at the core of every understanding process thus grounds in language. (p. 41)

While we have an ownership over the words we use, that which we speak of also generates the words that we speak. There is a blending of the topic that is discussed with the words of the discussion that further promotes the possibility of understanding.

Gadamer (1975/2004) believed that for dialogue to be authentic and meaningful it must be unimpeded; that it is not trying "to discover the weakness of what is said, but in bringing out its real strength. It is not the art of arguing (which can make a strong case out of a weak one) but the art of thinking" (p. 367) and "conversation is a process of coming to an understanding" (p. 385). His proposal is so simplistic that it resonates with Heidegger's own philosophical observations, that we do not see what is in front of us because it is in front of us. Gadamer draws us back to the simple premise that understanding calls for a willingness to understand. There must be an openness to hear what is said by firstly allowing it to be said and then listening in a spirit that allows what has been said to be heard. Further, that for dialogue to hold meaning it must be meaningful. Words that are meaningful speak for themselves as meaningful without further manipulation of the listener by the speaker to imbue an artifice of importance to what has been said. When something profound is spoken and heard it is often followed by a silence in which thinking occurs. Gadamer's

philosophical perception moves the focus on from the dialogue itself to the quality of that dialogue.

Authentic dialogue

Figal (2002) further discusses the notion of authentic dialogue described by Gadamer as requiring conditions of listening. He comments that:

one is prepared for a conversation only when one is prepared to listen, that is, when one is prepared to let the other say something... Listening to one another and addressing one another are essential aspects of a conversation. These provide an openness that simultaneously renders a conversation both unpredictable and fruitful (p. 107).

These comments on conversation provoked my recognition that the mode of conversing Gadamer promotes is part of 'mannerly' socialising; the non interruption of another that accompanies polite conversing. Yet within this outward adherence to a socialised convention of dialogue, the quality of the interaction which Gadamer maintains is essential to its meaningfulness may be missing. What can seem an active listening may simply be a passive waiting. We do not always hear each other as we watch for an opportunity to insert our own thoughts into the conversation. Our focus can be on what we want to say to the detriment of hearing what is being said.

Gadamer draws us back to reconnect us with the quality of listening that seeks understanding. He reminds us of the spontaneity that allows the conversation itself to lead us, even if it is away from what we are fixated on or have a vested interest in saying. If we succumb to the temptation to rein a conversation back in to allow self to be inserted, we stifle what the conversation is revealing to us. Gadamer's philosophy around language holds essential wisdoms for anyone whose study involves interviewing and working with the texts to interpret meaning.

Gadamer's philosophy of interpretation

The central theme of Gadamer's (1975/2004) literary work, *Truth and Method*, is the phenomena of understanding and of the interpretation of what has been understood.

Dostal (2002) describes an interview on the occasion of Gadamer's 100th birthday which appeared in the *Frankfurter Rundschau*. In it Gadamer says that "what he meant by the famous proposition of Truth and Method, that 'Being that can be understood is language,' is that 'Being that can be understood begins to speak to us'" (p. 29). Being is encapsulated in language and revealed to us through language. As we begin to understand being we begin hear what it is telling us.

Dorstal (2002) also gives an account of Gadamer's response to the suggestion that psychoanalysis could be a model for interpretation in preference to the interpretation of text; that under the psychoanalytic model the therapist knows better than the disturbed patient whereas hermeneutics called for a dialogue between the text and the interpreter. Respect of other and the rights of other was one of Gadamer's principles of listening and of interpretation. The hermeneutic position is that the lived experience of other was most appropriately revealed in the context of how that experience unfolded and impacted on that person through the media of language. There was not a presumption that by means of professional knowledge or self experience anyone external to that experience was better able to reveal it. This resonated with my original supposition that the words of the midwives who had experienced burnout would best tell their stories.

My methodological process in reaching for the knowing that lay within their stories was to listen to those stories and then transcribe the spoken word into text. Once the transcription was verified as accurate, I then lived with that text in an interpretative process until the knowing that lay within the words began to speak to me.

The dynamic of Other

Gadamer's philosophy which advances language as part of the hermeneutic experience became my guide in hermeneutic listening and interpretation. Scheibler (2000) suggests that Gadamer has moved beyond traditional hermeneutics and the strength of his work is only just beginning to be evident. She articulates Gadamer's threefold analysis of the I-Thou relationship as a "very un conservative insistence on safeguarding the rights of the Other at a most fundamental level: it seeks to demonstrate that the Other *might* be right..." (p. 61).

I approached my study without an assumption of the right or wrong of burnout, but in order to know the phenomena itself. Interviewed midwives rightly knew more of what the lived experience of burnout was than I who had not had their experience. Scheibler (2002) comments further that "by remaining open, we can train the self to a level of sensitivity where we are told something that we could not know ourselves" (p. 61). To discover Other calls for a reverence of Other that protects and enables meaningful dialogue. Gadamer (1975/2004) advises that "this kind of sensitivity involves neither 'neutrality' with respect to content nor the extinction of one's self, but the foregrounding and appropriation of one's own fore-meanings and prejudices" (p. 269). I had an assumption that angst had been part of burnout and therefore of a need to revisit that experience responsibly as an interviewer. Hermeneutic listening transcends empathetic listening as it seeks to hear and understand without closing off pre-empting or leading disclosure through an influencing emotive response.

Figal (2002) tells us that "one should not take what the other says as an expression of his feelings and opinions, his intentions and hidden motives, but rather as a contribution to the matter at hand" (p. 107). To move dialogue beyond a contribution to 'the matter at hand' may mean altering the central focus of that dialogue as new questions formulate in response to what has been expressed and further interpreting the true depths of what has been said within that response. I reached an understanding that there are ways of listening to dialogue and text which better enable the hearing of what is said and the hearing of what is not said. As skill is gained in hermeneutic listening we learn what we could not otherwise know. We seek greater learning through a greater depth of conversation that acknowledges the knowing of Other.

Understanding and...

Dorstal (2002) comments that Gadamer

insisted that understanding is to be understood as a discovery of meaning and not an insertion. Finally he (Gadamer) suggested that the task of the interpreter is to disappear in the face of the text; that 'the interpreter, who gives his reasons, disappears and the text speaks. (p. 28)

Interpreting for me supposed the responsibility for staying true to what lay within the language of the participant. Should the interpreter be visible in the interview? To what extent should they be evident in the interpretive text? But Grondin (2002) comments that Gadamer takes "issue with the notion that to understand is to reconstruct, in a disinterested fashion, the meaning of the text... the interpreter is also very much concerned with the matter at hand" (p. 40).

I recognised that it was my concern that originally drew me to this study and I could not change that into unconcern. To do so would have negated the passion that maintained my focus throughout the study's undertaking. Nor was it appropriate to pretend an indifference that would not be brought to my interpretation. I concluded that my level of concern allowed rather than obstructed hermeneutic interpretation because the words of Other called forth my respect and committed attention. Ultimately out of my concern their words held such importance that they guided and shaped my questions, listening and interpretation. It was not possible to distance myself from the dialogue around burnout if that dialogue was to be meaningful, but it was possible not to orchestrate where that conversation led and to listen carefully to what was said. Which left me to then consider the process of interpretation itself.

... interpretation

Weinsheimer (2004) suggests "An interpretation that is not the same as what it interprets is not an interpretation but a new creation; an interpretation that is not different from what it interprets is not an interpretation but a copy" (p. 165). He believes that what distinguishes Gadamer's hermeneutics in this regard is that for him interpretation involves this interminable interplay between sameness and difference.

If the researcher's knowing only mirrored the participant's knowing then the uncovering of the unknowing that lies concealed within the participant's language is negated. Yet the interpretation of the meaning which lies behind another person's words can not presume to uncover an unknowing that will mirror that person's evolving sense of what may have been concealed from them. Ultimately I concluded that my interpretation was just that, my interpretation.

The onus of what I uncovered through my interpretation moved therefore from the participant back to me. My interpretation could not be referred back to them for confirmation because there had been a shift from the original conversation between us to a new dialogue between me and the text. My dialogue with the text could never replicate what the participant's own dialogue may become, nor did it set out to. My truth was simply 'my truth' and did not seek to contest any other truth or to claim a rightness that eclipsed other degrees of being right. The concept of the hermeneutic circle of understanding is one of drawing from the past and projecting into the future. It is an endless process of understanding that acknowledges that knowledge perpetually evolves. This study towards the understanding of burnout does not pretend to have answers or finality, but seeks to add further meaning to the phenomena of burnout.

By declaring the process of my interpretation that dialogue between me and the text was laid open and the influencing persuasions that guided it were made accessible to others. This transparency removed my voice so that the contents of the text itself could either validate or contest the interpretations I had made and accommodate different interpretation. Gadamer (1975/2004) states: "The important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings" (p. 269).

Summary

Both Heidegger and Gadamer have principally informed my study. I chose the methodology of hermeneutic phenomenology as best suited to answer the question of my research proposal because I believe it allowed the voices of the midwives who have been through the lived experience of burnout to be heard most clearly.

Heidegger's hermeneutics centred on how life experience shapes us. He further upheld that such lived experience was richly layered with depths that can elude us. We are saturated with influences many of which we do not detect because they are so integrated into our everyday lives that they have become invisible within the extraordinary ordinariness of that day. Crowe (2006) comments:

Jobs, chores, and other tasks have a weight that pulls us toward them... we see ourselves "in light of" what we care about, of what concerns us. The primitive values and concepts with which we make our lives meaningful, such as "success" or "failure," emerge out of our absorption in daily activities. (p. 81)

The phenomenon I wished to study was the impact of professional life on personal life. There were considerable layers of expectation, passion and everydayness that covered over the knowing of burnout. I believed Heidegger's philosophy enabled that uncovering.

Gadamer's hermeneutic philosophy of language further informed me of how I could assess the knowing as it was uncovered. Warnke (2002) suggests in relation to Gadamer that

the texts we most fundamentally need to understand, in one way or another, are the narratives in which we find ourselves. The interpretations we project onto these texts are not our own autonomous creations, however, but are rather bequeathed to us as part of the narratives themselves. (p. 80)

I suspect that few researchers initiate studies that they have no life association with or interest in; we pursue few conversations so ardently through the rigors of research if we have no interest in reaching the place to which they will ultimately lead. I had a pre understanding of the need to allow the words of another midwife to come to me as her words and as the words of Other, who had experienced what I had not. Gadamer (1975/2004) further guided that understanding with his warning that "it is the tyranny of hidden prejudices that makes us deaf to what speaks to us in tradition" (p. 270). He defines prejudice as that which is induced by the hijacking of openness by an authoritative voice or an assumption of knowing that negates careful examination of contrary information. With his philosophical influence I was enabled to develop a dialogue with the text that became such an intense process that the participants simply became their words. I lived with their words until those words eclipsed any conscious presence of the participant themselves. My interpretation

then grew up out of their words alone rather than alongside them and was enmeshed with the participants' words.

I found the need to disengage from my own experience of case loading midwifery so I could consider whether what was revealed would be understood by the non on call midwifery professional and those external to midwifery. It was only on reflection that I saw when a midwife spoke of the "feeling of dread" when the phone rang in the evening that she assumed an understanding from me as a fellow case loading midwife of 'why' that feeling surfaced. Would others who had not experienced the demands of on call work have that same understanding? Gadamer (1975/2004) suggests

all that is asked is that we remain open to the meaning of the other person or text. But this openness always includes our situating the other meaning in relation to the whole of our own meanings or ourselves in relation to it. (p. 168)

I realised I needed to move outside the limitations of my own everydayness of midwifery. I began to understand that my familiarity with that world that connected me differently to my participants than someone outside that world. Not only did I need to explain that world and to penetrate the invisibility it had taken on for me because aspects of it had become lost to me within its everydayness, I needed to view my participants as women and mothers as well as midwives to hear the depth of the impact of burnout on their total being. To this was added the voices of spouses coping with the realities of a partner who was an on call midwife. To move beyond the immediate world of midwifery was to further reveal what my participants had gifted to me. In my next chapter I have set out to demonstrate how I applied the methodology of hermeneutic phenomenology to my study.

I thought burnout was made of fear
but it was made of
uninvited, unexpected
tightly held tears
that suddenly seep
in an over flow
of sorrow.

That even years later
still cannot wash away
those barbwire memories
of the pain
that comes from
the death of dreams

Chapter Five: The Method

Introduction

This chapter first provides a bridge of how the philosophical understandings drawn from Heidegger have shaped my approach to method. I discuss how I arrived at an understanding of the philosophical methodology used and how I then applied it to my understanding of the world around me. I explore how an ethical robustness is upheld within phenomenological research and the ethical issues I encountered around my work are disclosed and commented on. In the light of my conclusion that the ethics of my study was underpinned by the trust that is achieved through openness, I recount the way in which I was drawn into this particular study and my professional and academic pathways. Participant recruitment and the make up of the study population are stated and my choices around this disclosed. The process followed in interviewing, transcribing and interpreting is similarly detailed to demonstrate research integrity.

My expectation of this chapter is that it will demonstrate that this study was carried out with ethical and scholarly integrity and with due care.

Bridging from methodology to method

In the methodology chapter I discussed my arrival at the decision to use hermeneutic phenomenology philosophy to inform my study. Crowe (2006) suggests that "phenomenology must take its point of departure from life itself, not from some limited 'extract' of life" (p. 30) and that "...hermeneutics is about life-experience and belongs to it. Hermeneutics is the lived experience of lived experience" (p. 26).

My study set out to better know the phenomenon of burnout through the lived experience of case loading midwives. My assumption was no one could better inform me than the midwives themselves. As Crowe (2006) advises, a phenomenon cannot be compartmentalised - it permeates life itself, the extent of which cannot be predicted or measured by those external to the process. I found that the impact of burnout on the participant midwives had affected many aspects of their lives and had

then continued to filter down to affect the lives of their families and friends. Burnout was mirrored in those effects.

Gadamer (1975/2004) tells us that "every experience is taken out of the continuity of life and at the same time related to the whole of one's life" (p. 69). Only by allowing the participants to reveal the complexities of their experience within their own life can the phenomenon of burnout's impact on their lives begin to be known. Yet burnout still hid within that impact.

Heidegger (1927/1962) tells us that "The pure 'that it is' shows itself, but the 'whence' and the 'wither' remains in darkness" (p. 173). The less accessible layers of burnout slowly revealed themselves in the midwives accounts through hermeneutic listening and interpretation.

The process to understanding

I began my process by seeking an understanding of hermeneutic phenomenology that I could work with. I joined a Heideggerian reading group where I first sat somewhat dazed. I read philosophy papers, research papers and books, the stack of which was to measure a metre, with a dictionary at my elbow. My learning was amplified by attending a conference which explored and contemplated this philosophy in depth. As my understanding grew my decision to use this methodology was re-affirmed.

Hermeneutic phenomenology has altered the central core of my perception of my world and my understanding of what it means to live in that world and how we engage with it. It has been to discover a new way of thinking and processing information. Where I once saw the flat flow of the river I came to develop a greater knowing of the myriad of concealed currents that cause it to flow. This heightened understanding informed my interpretive analysis.

The greater part of my understanding has come from conversation and discussion rather than isolated reading, although that too has had its "Ah ha!" moments as things I read resonated within my own life experience and compelled me to see things differently. Yet Gadamer (1975/2004) wisely draws our attention to how "fore-

meanings that determine my own understanding can go entirely unnoticed. If they give rise to misunderstandings, how can our misunderstandings of a text be perceived at all if there is nothing to contradict them?" (p. 267). Discussion enables such important challenge, the value of which I quickly recognized .

I believe the advantage of such discussion as a learning method arises from the particular complexity of Heidegger's work. It engages the reader in an intense process of re-looking at what humanness means and how we assimilate lived experience. In so doing we evaluate the assumptions we hold, sometimes without any conscious awareness, and are then able to develop differing perceptions of how the human world works. In a two way conversation or group situation interpretations of Heidegger's work were able to be shared, debated and then developed through discussion to become part of my own understanding.

But Harman (2007) also tells us that:

The fact that we are talking does not mean we are thinking. In our era, everyone talks more and more and seeks increasing amounts of information, yet everyone becomes more and more thoughtless. Humans today flee from thinking even though it seems we have become more educated than ever. ... Thinking now jumps from one opportunity to the next and never becomes reflective; it has lost its nourishing soil, and all great works must be rooted in soil. (p. 149)

As I developed a phenomenological awareness I recognized the trap of the peripheral bouncing from one thought to another that occurs in conversation and thought. I learned to still my own process and just dwell with thought in depth so that it was exploratory and contemplative, allowing new insight. I found that sometimes the smallest aspects of the information participants shared with me held unseen depth as I came to understand that truth hides from conscious view. As each new visiting of a participant's story continued to reveal new insights I also came to understand the assertion that truth continually evolves. But how could I be sure that what I was discovering was 'truth'?

As I began evolving a different world view it became impossible to hold emphatic opinions in my new awareness of the validity of variable view points. I steadily became increasingly sceptical about absolutes of static truths or answers. Historically it is evident that with time almost all answers become obsolete, yet we seldom project this demonstrable reality into future understanding in the immediacy of our urgent quest to be right. There is a driving force within society to accomplish being 'right' as rightness increasingly becomes the hallmark of success. But being 'right' is open to a subjectivity that may hijack truth or blind us to it.

To develop this understanding was to take the black and white franticness out of life, to see with Heidegger that time and being is 'now' and 'our being' with that 'now'. To know what happens at this junction between a human and their lived environment to formulate being is outside moral judgement. Capturing lived experience is not to be right or wrong, but to know what 'is'. With this understanding I grew comfortable to be still and dwell with the words of my participants. I had learned to trust that to do so would reveal the truth of that moment of lived experience. Truth was not a moral truth that needed to be 'right.' Within that understanding lay the philosophical rigour.

The rigour of phenomenology

Palmer (1969) tells us that

Hermeneutics achieves its most authentic dimensions when it moves away from being a conglomeration of devices and techniques for text explication and attempts to see the hermeneutical problem within the horizon of a general account of interpretation itself. (p. 8)

Phenomenology opens itself to the premise that there is no absolute truth and by doing so it allows endless possibilities of enquiry and consideration to be used as the building blocks towards knowing. Different builders use different materials and evolve different designs but when they are genuine and sustainable one cannot be more 'true' than another. As Palmer (1969) has suggested, the preoccupation with intellectual artifice to somehow ensure the extraction of a specific kernel of truth from the considered text inhibits the discovering of greater meaning by blocking spontaneous insight and understanding.

Within our society it is habitual to establish being right to validate the truth of what is maintained, sometimes at the expense of truth itself. Within my own work I would find myself reverting to being blinkered by an exclusive and specific focus on an aspect of midwifery practice that I believed to be a key issue. My determination to reach the 'truth' of that issue ultimately narrowed my vision. After my zeal had run its course and I returned to a 360 degree overview of my findings, or from the fresh perspective of a new interview, I would see other truths that had run parallel to the aspect I had focussed on but unseen because my vision had been so blindly locked on to that theme.

Phenomenology is appropriately a different process from that of scientific interpretation. It seeks different information from that which can be captured by a formula or upheld in a demonstration of verification. It calls for an alternative approach to access phenomenological information and different criteria to demonstrate its validity. Phenomenology does not set out to answer the why and how of human existence but the nature of the meaning of that existence. Crowe (2006) tells us "Heidegger suggests, human life is more like a richly layered novel or poem than a technical manual that 'wears its meaning on its sleeve'" (p. 96). A technical approach which enables a scientific accuracy by rigid constraints could not hope to capture the meaning of humanness; the robustness of such a study can only resonate within humanness itself.

Within my work such meaning declared itself. It was spontaneously endorsed by other participants, or evidenced itself in the profoundness of its resonance in the impact of its discovery. There was a lack of guile in what participants said as there was usually little or no understanding by them of what they had experienced or of burnout itself. Because of this the phenomenon spoke through them rather than the participants words being shaped by their prior knowledge of the phenomenon.

Burnout proved to be a master of semblance. Again participants did not recognise they were dealing with semblances of burnout. They took these manifestations at face value, citing incidents such as depression, menopause, migraines, insomnia,

gastric ailments, and sought specific cures for these. But, as these manifestations were increasingly revealed to have affected so many participants in identical ways, the semblances were uncovered and burnout's mask slowly began to melt. As it did so and the true face of burnout was revealed, one by one by participants recognized it of their own accord. This recognition was often accompanied by deep distress as midwives realised their experience had been prolonged and exacerbated by their unknowing of burnout. The profoundness of their response further confirmed the extent of the havoc that the phenomenon of burnout had caused within their lives and how severely that havoc had impacted on them.

Rigour within phenomenology asks for a demonstration of conscientious thoroughness along with a transparency of methodology. Koch (1996) talks of a robustness that is derived from trustworthiness. She suggests this is achieved by enabling the reader of the study access to the influences and persuasions of the researcher as well as the text that was worked. I believe that credibility has to be earned through openness, the quality of which must be sufficient to reduce all ambiguity. Unless a study includes an integrity that enables its findings to be trusted it is valueless. However, no researcher can guarantee integrity, for their own fervour or familiarity may blind them to the possibilities of prejudice. Such is the complex nature of trustworthiness. One can only say out of a genuine sincerity, "I tried".

Trustworthiness

I approached this study with an ethical commitment to produce work that was dependable and honest throughout every process. This is the principle that I believe underpins trustworthiness, an integrity essential to all study if it is to be worthy. In the beginning I was not sure how the trustworthiness of my interpretations would declare themselves to me, but I believed that without this vital ingredient the contribution of my participants would be dishonoured and the findings of the study devalued. The need to arrive at an understanding of how trustworthiness could be best achieved within my work introduced me to the writings that explored this.

The notion of rigour in qualitative research has been widely discussed but no consensus has been reached regarding the most suitable way to assess the

trustworthiness of studies (Rolfe, 2006). The criteria used to affirm credibility within quantitative studies is generally regarded as inappropriate as tools with which to evaluate the trustworthiness of qualitative studies. Halpern (1983) describes an "audit trail" as a means of creating trustworthiness within qualitative research. She asserts that it is important to have a clear description of the research path that includes research design, data collection decisions, the analytic steps taken and the rationale underpinning these decisions that the reader can follow. Koch and Harrington (1998) believe that rigour in an interpretative study is best upheld within the concept of openness and that disclosure should include the back grounding of the researcher and how they themselves are situated within the study process. Their belief was readily identified with by me.

Aspects of trustworthiness will be discussed using the notions of reflexivity, credibility, transferability and dependability, which were first proposed by Guba and Lincoln (1989) and then further described and applied by Koch (2006; Koch & Harrington, 1998).

Reflexivity

Qualitative research calls for a researcher to reflect on the nature of their involvement in the research process and the way in which this shapes the research question and its outcomes. Within a hermeneutic study we unknowingly bring aspects of ourselves to our interpretation of our participant's words. To disclose what has shaped our world view, and therefore may influence our interpretations, enables such shaping to become visible. I have detailed my background as a midwife, my philosophical understandings and the path that led me to my research question having identified the need for such disclosure to bring openness to my study. By declaring my pre-conceptions and personal philosophy not only are the influences which I brought to the study disclosed, but the background shaping of the research question itself is able to be considered. There was a further need to state my understanding of the philosophy underpinning the methodology I had used and the influencing of other writers on what was revealed within my study.

As Van Manen (1990) tells us, knowing involves a process of moving from the whole to its components then returning to the whole with the new knowledge gained to reconsider it again in a hermeneutic circle of evolving understanding. Reflexivity required me to constantly revisit where I was situated within that emerging knowledge. It involved discussion with peers, some of which conversation is included in my study. I was guided by conversations with my supervisors, Heideggerian scholars and students, extensive reading, and a lengthy process of writing and re-writing. After each interview I dwelt with the participant's words to discover what was the particular knowing of burnout they had gifted to me. I captured what they had taught me within a poetic journaling of my evolving knowing which is scattered throughout my thesis in my belief that readers can only self evaluate an interpretative study's credibility when they have full disclosure of all its components, including such journaling.

Gadamer (1975/2004) says of interpretation that in understanding meaning and significance of what is in the text the interpreter "must not try to disregard himself and his particular hermeneutical situation. He must relate the text to this situation if he wants to understand at all" (p. 324). I recognized that I could not take the midwife out of me, nor would it be an advantage to my understanding if I were able to do so. But I needed to acknowledge and fully disclose my midwifery background and practice mode and to revisit this in a process of reflexivity as a possible source of influence on my interpretation and findings. Only by such openness could my academic work be further examined for any possibility of bias or prejudice linked to my professional history which was not self evident to me.

Koch and Harrington (1998) further advocate for a distinction between the voices within the study and that of the researcher so that the participants and those who have influenced my interpretations and thinking are identifiable within my work. Again this need resonated with me. Gadamer (1975/2004) reminds us that hermeneutic phenomenology calls for interpretation and that, while interpretation only builds on what lies within the words that have been shared, the interpreter owns what they see. Different eyes see different things, so the varying influences within a study must be distinguishable and identifiable from the researcher.

Credibility

Credibility demands that a study stays faithful to the participants' experience. The reader should be able to see how the interpretations were arrived at from the participant's words and recognise the described experience if re-presented (Koch & Harrington, 1998). The method of data collection and interpretation has been detailed and I have striven to anchor my interpretations to the words of my participants while distinguishing between their words and mine.

By presenting the words of my participants to be heard before my interpretations they are able to be considered and appraised in the light of the original comment. I accept that my findings will not resonate with all readers as new eyes bring the opportunity for new understanding. I believed I owed participants the investment of whatever was needed for me to best interpret the information they entrusted to me, while simultaneously acknowledging it could only ever be my interpretation.

To achieve this I lived with the transcripts of participants for long periods of time, continuously writing and rewriting and reflecting on what was being revealed. The participants became their words during this intense process and the de-personalising of their words was a further development that neutralised bias. The image of the particular midwife receded from my consciousness and they became the anonymous 'Amelia' or 'Myrtle' or whomever and preconceived opinions were left behind.

Disclosure sets out to allow an examination and critique of my interpretations as well as establishing that an authentic and trustworthy process was adhered to in the gathering of the participant information that was worked with.

Transferability

Transferability involves demonstrating the applicability of the results of the study in one context to other contexts. The findings of this study represent an interpretation of the lived experience of case loading midwives who self identified as having burnt out in the giving of their professional care. Koch and Harrington (1998) believe that

if there is openness and clarity within the study then a reader can make a judgement as to whether its findings can be applied to other situations.

Davis (1995) suggests that transferability can be enhanced by providing what is often referred to as *thick description* (i.e., giving enough detail so the readers can decide for themselves if the results are transferable to their own contexts). Within my study I have sought to create a clear picture of the key phenomena through the words of my participants to allow the reader to easily identify where there is an opportunity for transferability. Marshall and Rossman (1989) note that transferability is the responsibility of the person seeking to apply the results of the study to a new context, that is, it is the responsibility of the reader. Davis (1992) believes that "the responsibility of the original investigator ends in providing sufficient descriptive data to make such similarity judgments possible" (p. 606). Part of the research responsibility within the framework of trustworthiness therefore is providing full enough information and data to enable a reader to recognise the appropriateness in which transferability may occur.

Dependability

Dependability requires open and thorough reporting of the research process. It extends beyond the detailing of the collection of data into the manner of the philosophical and interpretive decision making of the researcher.

Gadamer (1975/2004) focuses on the integrity of the researcher when he states that:

The man of the world, the man who knows all the tricks and dodges and is experienced in everything there is, does not really have sympathetic understanding for the person acting: he has it only if he satisfies one requirement, namely that he too is seeking what is right - i.e. that he is united with the other person in this commonality. (p. 323)

Part of the ethical robustness of this study arose from a basic premise of respect, the sense of which Gadamer captures in his words. I had explored the various methodologies available to me before deciding that hermeneutic phenomenology was a good fit with my research question and came to the personal conclusion that it best

enabled my participants to tell their stories. I had observed the pain of burnout amongst colleagues and been moved by the extent to which it had eroded their lives. I wanted to minimise any undue distress that could be triggered by revisiting their experience. This was enacted by creating conditions that protected participants and allowed them to feel safe. Initially this was through pre-information as to the nature of my thesis. This was followed by a process of consent that allowed adequate time to consider what was involved and then an extended period for the right to withdraw consent. Conditions of confidentiality were strictly adhered to and each participant retained control over what information would ultimately become part of my study.

Feedback was resourced from my participants and built into future interviews, as well as from my supervisors and peers. I presented preliminary findings at both national and international conferences and found that they resonated within the experiences of other midwives within New Zealand as well as other countries. They expressed relief in having their own feelings surrounding case loading practice validated adding authenticity to the emerging findings and confirming the appropriateness of the methodology to the research question. This chapter seeks to enable the reader to gauge the integrity of the processes followed within this study through an openness that demonstrates trustworthiness.

Gaining ethical approval

I began post graduate study to update my pre-degree era of midwifery qualification. After completing the certificate and diploma studies I made the decision to move on to a Masters thesis focussing on the experience of burnout amongst case loading midwives. I sought ethical approval to interview an estimated eight to twelve midwives who practiced in this area of midwifery and who self identified as having experienced burnout in the course of meeting their professional responsibilities. Ethics approval was given for this by the Auckland University of Technology Ethical Review Committee in May 2006.

As my work progressed I made the further decision that the scope of what was being revealed would be better met within a doctoral degree. When resubmitting my application to transfer my study to a doctoral degree from the Ethics committee, I

also applied for approval to extend my selection of midwifery participants to be interviewed. I had begun to consider whether burnout in self employed case loading midwives was paralleled in hospital employed case loading midwives? This approval for these changes was received in June 2007.

My thinking had been further provoked by a comment shared with me by one of my participants. She told me that her husband had remarked "if she wants to know what burnout is like I hope she is going to interview me!" It led me to realise that more lives had been affected through burnout than the midwife's alone. I realised that through interviewing partners I would obtain another perspective of how burnout had impacted on both the midwife and her family. The further approval to interview partners with the participating midwife's consent was granted in November 2007.

I briefly considered further extending my enquiry to the children of midwives, but decided against this. In part this was because of the ethical difficulties of interviewing minors, but predominantly because a midwife had commented to me in her interview "we can't even go there; thinking of how it may have affected our children." I considered her words carefully and concluded that I needed to respect them to keep participants safe from what may be damaging knowledge. A midwife external to my study however allowed me to quote her daughter's words: "Mummy if I was really, really sick and in hospital and someone was having her baby would you leave me to look after her?" (T. Ferguson, personal communication, April 2008).

How were participants recruited?

Midwife participants self identified as having burned out or as being at risk of burnout. They were made aware of the study through general discussion by me amongst midwives, conversation with each other and through academics that were aware of my undertaking. Partners of midwives were chosen on the basis of the participant midwife first consenting to their partner to be approached, a willingness of the partner to then be interviewed and the variation of the family experience in terms of independent and dependent children. The partner's of midwives were always interviewed with the formal consent of both the midwife and her partner. Partner's interviews took place at separate times and locations away from their

spouses at the conclusion of my interviewing of all midwives. Polit et al. (2001) advise that “the phenomenologist believes that lived experience gives meaning to each person’s perception of a particular phenomenon” (p. 215).

I looked for the diversity that was present within the randomly selected study group to see if they might represented a cross section of the midwifery population. I found that within in it participants included:

1. Midwives who came from a nursing background and had trained for midwifery as a post graduate module and midwives who had been part of the direct entry programme
2. who had initially worked as a hospital midwife and those who had begun case loading practice straight after graduating
3. with varying lengths of practice and a variety of practice experience
4. who were single or married, who had no children, had dependent children and had adult children
5. who worked with informal or structured collegial support systems
6. who worked in a stand alone practice with back up or were part of a group practice
7. who were of a variety of ages (between 32 - 60)
8. who had practiced within differing district health boards
9. who were continuing to practice as case loading midwives, who had moved to another area of midwifery or who were considering leaving midwifery

In total twelve midwives were interviewed. These were made up of:

- A. Two case loading midwives who felt that burnout was likely to force them to leave practice
- B. One midwife returning to case loading practice after burnout hoping new measures she had put in place would enable sustainable practice
- C. Five midwives who had case loading practice and now worked as hospital midwives doing shift work; of these one had also worked on a case loading hospital team

- D. Three midwives who had left case loading practice and now worked as community midwives with no on call work and regulated daytime hours of work; of these two had also worked on a hospital employed case loading team
- E. One midwife who was working as a hospital employed case loading team midwife but was considering leaving midwifery because of burnout

Four partners of midwives were also interviewed, three of whom now had adult families and one of whom was still parenting young children.

The number of necessary participants declared itself to my primary supervisor before it did to me. Kvale (1996) says that the answer to the common question of how many participants need to be interviewed is simply "interview as many subjects as necessary to find out what you need to know" (p. 101). I finally self recognized that I was now hearing similar stories from each interview and no new knowledge was emerging. I had gathered a huge amount of data deserving of in depth focus. It was time to move on to work with interpreting.

The process of the interviews

Interviews were at a location nominated by the participant, usually in a private setting, and at a time selected by them. Prior to the interview taking place each potential participant was sent an information sheet to consider before consenting to be interviewed (See Appendix B). This detailed the purpose of my study, the nature of the interview and approximate duration. It gave reassurance of confidentiality and contact people should they have concerns regarding my work and the manner in which it was conducted. Further it included contact people should they need support as a consequence of unsettling feelings that may surface during the interview. A week after participants received this information sheet verbal consent to be interviewed was then obtained and a time arranged for this. The verbal consent was then followed up by a written consent to be interviewed which was signed before the interview commenced.

All interviews were conducted confidentially and the use of a non de plume offered. Spouse's interviews were subject to the same confidential conditions, conducted

away from their partners in a place of their choosing and focused on the personal experience of the participant themselves. There was no referencing back to their partner's interview during the actual interview or within the thesis. In these four 'couple' interviews a second non de plume was allocated to their partners if they were referred to by name to further mask their identification or a linking back to the midwives own interview. I believed that each participant's own words should directly inform my study.

Each participant understood that they could withdraw from the study and retract their information should they wish to after receiving the written transcript of their interview to consider, however all participants continued to wish to be included. While confirming that the written transcript was an accurate record, at times participants uplifted their option to change some of what they had expressed. Where this happened the transcript was revised and edited accordingly and the altered transcript then re-sent to them for re-approval. Only accepted and further consented to used sections of participants' transcripts were used within the study.

After transcript content was confirmed and accepted, I began a process of working with the content of the interview separating out the material I wished to be able to access in my thesis. As had been discussed with participants' at the onset of each interview, modification of any identifying references, such as people's names or place names, were made when the transcript was made of the interview. At this time 'ums' and 'ahs' were also deleted from the interview within the transcript but pauses denoting hesitancy or distress, tonal changes and incidents of laughter or tears were retained as significant to the process of interpretation. The edited interview was unidentifiable and utilised non de plumes where these had been requested. They had been grammatically corrected where needed and were now comprised only of the material with which I wished to work. Caelli (2001) describes this process of arriving at the decision of the content of the interview that was to be worked with and interpreted as "deriving narratives from transcripts" (p. 277). The questions that were asked by me were deleted from the transcript to allow me to focus on the participants words alone. Through a process of reading and rereading the different threads of what was said were drawn from the body of the interview and woven

together to form the collection of stories that had been told within the interview. These stories were then grouped into chronological order to allow further clarity. This version of the transcript was then sent back to the participants to enable them to confirm that the process of extraction and editing had not altered the meaning of what they had expressed during the original interview. Any modifications or corrections were then made and the altered transcript re-submitted for approval by the participant. Consent was then sought from them for me to incorporate extracts from this information into my thesis. Once this was received I began the process of interpretation while staying within the boundaries of the information from the interviews that I had requested and obtained permission to use.

The nature of the interviews

Gadamer (1975/2004) tells us:

It is not simply that an experience remains vital only as long as it has been fully integrated into the context of one's life consciousness, but the very way it is "preserved and dissolved" (*aufgehoben*) by being worked into the whole of life consciousness goes far beyond any 'significance' it might be thought to have. Because it is itself within the whole of life, the whole of life is present in it too. (p. 69)

As Gadamer suggests, the phenomenon of burnout presented in multi layers within the midwife's professional and personal life and the impact of this was reflected within their experience of burnout. There were effects which the midwife was acutely aware of while others were covered over by such mechanisms as natural coping strategies, semblance, internalisation and normalisation.

Interviews were participant led. At times I simply listened to an out pouring of feelings and at other times there was an on going exchange between us both. At first I was reticent in engaging in discussion as I did not want to guide what was said but realised this was overcome if I stayed with the aspect that had been raised. Participants were hungry to understand what had happened to them and their conversation searched for answers that I did not have. There was a rawness of pain, wounds thought to be healed were re-opened and then found to have never healed. I

learned to set my audio tapes away from the table when we sat at one after spending hours deciphering interviews through the sounds of the agitatedly clattered teaspoon, hands hitting the table in frustration and in anguish. There were tears: there was the laughter of the relief that came from the knowing that they were not the only one.

Crowe (2006) asserts that "Heidegger contests that an understanding of the 'I' is gained not through theoretical reflection, but rather through 'enacting the "am"' (p. 31). The 'enacting' of the 'am' was both powerful and profound. The severity of the impact of burnout on midwives lives was evidenced throughout their interviews. The extent of their stress and the erosion of their family well being also spilled over to be revealed within their partner's accounts. I was made humble by the extent of participants willingness to revisit what had clearly been a significant and deeply painful experience and share it with me, the researcher.

Transcribing

Participants were told again verbally at the commencement of their interviews that I would alter anything that could identify them, such as the names of places, hospitals or persons along with their rights of confidentiality and withdrawal from my study. This section of the interview and their verbal response was included in the transcript.

I ultimately elected to transcribe all interviews from the audio tapes myself to maintain an ethical confidentiality that I could personally uphold. Where I was unsure of a word I did not improvise as to do so would make it my word and not the participant's. Instead I relied on the participant to reiterate what they had said by phoning and asking them. As I transcribed all interviews promptly this did not seem to create any difficulty in their recollection. I also phoned each participant a few days after their interview to thank them and tell them that the transcript was now being mailed out to them. This also gave them an opportunity to express how they felt about their interviews and to identify any need for counselling arising from the impact of the interview on them.

Interpretation

Gadamer (1975/2004) says of interpretation that it is a process "in which the interpreter has to make his hermeneutical way back along the creative path, carrying on this process of *rethinking* within himself" (pp. 511-512).

I began the process of interpreting what was said with an enormous sense of responsibility for staying true to my participants' words. I felt the need to only see what was there and not trick myself into seeing what wasn't there because of my concern that the intensity of my scrutiny could be creating mountains out of mole hills, or mole hills out of mountains. This heavy onus was off set as I came to understand that my interpretation belonged to me and reflected on me alone. Therefore all responsibility for misinterpretation ultimately rested with me and could not be levelled against my participants who retained the right to see things differently.

As with the other processes followed, I also came to trust the interpretative one. I found that what was there would reveal itself authentically as the phenomena slowly gave up some of its secrets. There was a sense that as burnout began to declare itself within my thesis; the thesis began to write itself. Yet I always remained aware that my interpretation could only ever be just one possibility of the knowing of burnout.

As I worked with the data I realized that it gave what Merleau-Ponty (1945/1962) described as an "atmosphere." There were greater depths to the words that had been spoken creating differences in what was said and what was meant. I recognized that some of the exchange was based on the participant recognition that I was familiar with the culture of on call midwifery practice. That I understood therefore that the angst of receiving an evening phone call was not the disturbance of the phone call itself, but the possibility of the overnight sleep deprivation it may be announcing. Recognition and inclusion of these ambiances was part of the process of interpretation.

But I discovered that when I strayed away from the path of the knowing of burnout, erroneously believing I was on a major route, it always declared itself. The trail

petered out naturally and I would be pulled back to the starting point to begin my search again. I would find that something was or was not upheld by other participant's words and in this way I came to identify key issues.

Alternatively I would sense that there was something more underpinning what had been said that I needed to understand. I learned to live with that unknowing in order to know. I retraced my steps back to the original words over and over again in order to rediscover what I didn't know or hadn't seen. Each journey was part of my learning. Similarly when I thought I finally knew the destination the information was beginning to reveal to me, I would find myself arriving in a different place altogether with new things to consider and know. This is part of the hermeneutic phenomenological process (Smythe, Ironside, Sims, Swenson, & Spence, 2008).

The process

Before I began interviewing I had firmed up my understanding of the definitions that were to lend structure to my study through my literature research, which is detailed in the chapter dedicated to this. The essential question I began with was what was the lived experience of case loading midwives who burned out? How to show its meaning? I had not experienced it myself, but had evidenced the impact on other midwives. But in the initial phase of my study that impact was largely hidden by the midwives who suffered from it because of the association of burnout with the shame of professional failure. I was also yet to learn of the severity of the ability which burnout has to affect people's lives.

In the general community it was apparent that burnout meant different things to different people. Some saw it as low level; 'a bit over the job,' 'should get out,' 'needs a holiday,' 'buck yourself up' sort of situation, while others saw it as 'devastating,' 'debilitating' and 'life threatening.' I came to understand that the critical difference in the two view points was whether the person commenting on the level of adversity burnout inflicts had experienced or lived alongside someone who had experienced it or was contemplating it from a safe distance. I approached my interviewing with an open mind as to what might be revealed, but with the sense that I expressed in my pre-understanding interview of, "I think burnout will prove to be significant and may

even be worse than I imagine it to be." This proved to be the final scenario that did eventuate. The seriousness of burnout far exceeded my pre-assumptions.

Once I had selected the essential information from participant interviews and re-confirmed its validity with them in its extracted form I began to work with it, having again verified their consent to do so. It was the beginnings of a lengthy process of reading and re-reading, and reading again and again. By so doing I was able to identify common themes within the interviews and having done so I reassembled information taken from the individual interviews under these emerging headings. Not only did this enable me to isolate out the themes and focus on them exclusively, but it allowed me to accurately evaluate how frequently these themes were referred to by the interviewed midwives. The importance which they attached to it was also made apparent through a consistent intensity in their choice of words. Van Manen (1990) suggests that a phenomenologist sees the complexities of 'talk' "not as a problem to be solved, but as a question of meaning to be inquired into" (p. 24).

I began with the broad themes that arose from the interviews, such as the original call to midwifery, the passion of that call, the shaping of the midwife, the loneliness of the workplace, horizontal violence. From there I moved to the specifics of the information received. This focused on areas such as semblances, the hostile relationship all midwives in burnout eventually developed with their cell phone. I realised their animosity monitored the extent of their struggle to be on call, the affects of sleep deprivation on their ability to function proficiently, the over flow of professional exhaustion into their family and social life. I wound up with volumes of writing and pages raining from the printer.

The next phase was one of pruning back that overgrown garden of words to discover what was most important or concealed within that vast expanse. I found I had an attachment to participant's words and my early discoveries which made those first few months of pruning one of mainly tentative clipping in the air. There was also a tendency to cut back a sprig only to discover that it had concealed something vital that then needed to be considered. But as the months and then years went by and I continually worked with the information it became easier to see what was repetitive

and static, where a theme was revealed most clearly, what had mattered and what hadn't and where my interpretation had strayed away from what my participants had revealed. I grew less sentimental and metaphorically shifted from a small pruning tool to a chain saw.

Ultimately I packed my findings into the trunks of far too many chapters and still had to sit on their lids to close them. Then began the lengthy unpacking and repacking over and over again to discover what really had to stay and what didn't. After many months of this I was able to begin the final repacking phase to achieve the most functional presentation of what my study had found.

Ethical issues

Working with a participant population who were often unpredictably busy and unavailable made interviewing complex. Some needed to sit with their transcripts for some time because it evoked feelings and memories that were etched with difficulty. Others searched for the time to consider them. I needed to allow that time and to find the patience to do so.

At one interview I was given information that was compromising because of its personal nature. At others actual people were named and had judgemental comments made about them. I did not work with any of this information as I felt it was not appropriate to do so and nor did it contribute to my consideration of burnout.

One of my participants was very fragile at the time that led up to her interview. I was left feeling concerned for her well being and safety. This led to a dilemma of not knowing whether to breach the confidentiality of my interview which disclosed her extreme vulnerability and seek intervention, or to risk the consequences of non intervention. Ultimately, with my supervisor's guidance and with the participant's permission, counselling was sought for her through Auckland University of Technology services. While I was clear that her interview had not precipitated her distress I felt a moral need to ensure she received the support she needed.

Summary

In this chapter I have set out to demonstrate that I have followed an ethical and conscientious process within my study. The manner in which it has been conducted has sought to both protect and respect my participants. In working with their information I have been guided by the participants' words and stayed with the primary truths that they have expressed.

I have endeavoured to achieve an openness surrounding my work that allows any unwitting bias or prejudice to be exposed and critiqued or considered in the light of such disclosure. This has included offering my professional background for scrutiny as well as the detailing my philosophical understandings.

The process I have followed to arrive at my findings is laid out and detailed to achieve a transparency that invites critique to demonstrate robustness arrived at through the trustworthiness of my study. While only I can ever own my interpretations I have set out to demonstrate that they have been arrived at with honesty, integrity and due diligence.

I believe that the findings of this study are important and more than justify the need for particular and exemplary care in both realising and presenting them. This chapter has sought to demonstrate that this work has been undertaken with integrity. In the following three chapters I have set out how I worked with and interpreted the participant's interviews to arrive at my findings.

I thought burnout was made of tears,
but it was made of awfulness.

Such awfulness
that it had to be shut away
from self.

With seals so strong
that if they were ever broken
and the steel doors prized open
you would blind yourself
so you could not see
what was there...?

Only your heart
would betray you
in quiet moments,
continually remind you...
it was the worst.

Chapter Six: The unmasking of burnout

Introduction

Burnout flourishes in the darkness of 'not knowing' within midwifery and midwifery practice. This work seeks to bring some of the unknowing of midwifery that surrounds burnout to the light.

The work of midwives is demanding and calls for extraordinary commitment. There is limited support in processing work induced stress or awareness of the extraordinary levels of fatigue that may accrue. The extent of midwives work demand is covered over and lost in its everydayness. The call of care is a complex phenomenon that is difficult to define and set boundaries around; at times it was part of a pre-disposition to burnout.

The ways in which burnout manifests makes its early detection difficult even when there is a pre-empting professional awareness, something which midwifery has previously lacked. Midwives told of their struggle to understand what was occurring and of the debilitating impact of burnout further reducing their ability to see what was there. They resisted capitulating to the manifestations of burnout which slowly forced them away from the work they loved, unwittingly preventing their recognition of the need to address the destructive elements of their practice by their toughing it out. Afflicted midwives unconsciously engaged in minimalism of the signs of burnout blocking their identification of its presence in their lives. Burnout was never addressed in a timely manner and seldom recognized even in its severity.

Burnout was shown to be further masked by the assumption that it occurs because of the midwife's own inadequacies. Midwives tell of how they strove to keep up with their expectation of practice berating themselves for their perceived inadequacies which they self consciously covered over. This focus distracted from the need to establish boundaries and modify practice; a process that becomes increasingly difficult as burnout progresses, prior to which such need was not recognized.

This chapter explores why burnout was difficult to recognize, its processes and impact on the lives of midwives who self identified as burning out, through listening to their stories. The knowing of burnout allows its patterns to be recognized and addressed before it becomes disabling. Participants have shared their stories of what has been a catalytic and debilitating experience in their lives in the hope of protecting future midwives.

The invisibility of burnout

Max, the husband of a midwife, tells us:

I didn't see burnout coming – everything seemed fine, I felt sorry for her that she was working all those hours. At first I felt she was getting tired and fractious but then it became the worst experience and we have been together twenty-five years. Only the death of her mother was as bad, which is how bad it became. It has been alright for us as a family, but it hasn't been that happy. We are getting by just doing the day to day sort of things. She is still struggling. Initially it was just not wanting to drive Then not wanting to see anyone – not wanting to go out. She still can't drive to her place of work without feeling sick; she really was pretty bad. She has had to fight over getting leave. She talked about not being able to keep going; I don't think it would be very good for her confidence if she finished this way, but if she doesn't go back to midwifery, she doesn't go back. I wouldn't be happy about her going back to on call work to be honest. I think the price is too great. The money is good but it is too high a price to pay. I would rather have less money. (Max)

Max's story is that of a husband who watches his wife burnout. It tells us of the difficulty of recognizing what is happening in burnout. Despite living alongside a burnout sufferer Max believed that "everything seemed fine..." Part of this difficulty lies within normalization. Jane's fractious behaviour had become usual and attributed to tiredness; 'usual' then began to be seen as 'normal' concealing the deterioration in Jane's well being. Her work necessitated driving - feeling unable to drive kept her safe from her work and if she did drive to her place of work she felt physically sick putting another barrier between her and it. Her body knew what she hadn't yet recognized and acted to protect her. There were emotional wounds for her family. It had been unhappy time; they "are getting by" mechanically processing one day at a time. Jane had begun isolating herself, increasingly withdrawing from all

demands of 'other' from her former position of a constant response to 'other.' Withdrawal from social contact was evident in other midwives who burned out. Max identifies that in the long years of their relationship the emotional impact of burnout on Jane is only paralleled by the death of her mother. It is severe. But within the professional world of midwifery her extreme stress is unrecognized by colleagues or by her manager, forcing Jane to fight to obtain sick leave. A collegial unawareness of developing burnout was part of every participating midwife's experience.

The midwife's own unseeing

Derryn tells us:

I had no idea at all of what was going on. Part of the danger is that it is not talked about. I believe I often worked when I was unsafe because of fatigue. You don't know you are unsafe. You don't know you are burning out. (Derryn)

Midwives do not self identify that they are in burnout despite having a professional awareness of physical and emotional well being. Derryn believes a silence surrounds burnout, yet midwives are skilled communicators. Self recognition is impaired by the blunting of chronic fatigue while lack of knowledge disallowed colleagues to identify what was happening to a midwife they are working alongside.

The call of care

Heidegger (1927/1962) tells us of the conscience of the call of care:

That which calls the call, simply holds itself aloof from any way of becoming well-known and this belongs to its phenomenal character... the caller is solely interested in summoning us to something, that it is *heard only as such*, and further more it will not let itself be coaxed. (p. 319)

Interviewed midwives spoke of their call to midwifery as something that summoned them and resonated within their desire to be of service. As Heidegger suggests, it is not possible to quantify the nature of such a call. Within it we each hear what we then respond to; we cannot analyse what that is, or conjure up the caller's voice if we

do not hear it; the call just *is*. Such calls have the capacity to inspire and override self interest, while we cannot define or control what it is we hear it becomes our driving force. Amelia says of her call "*the passion keeps you hanging in despite the cost to yourself*". The call to midwifery has the capacity to become the Achilles heel of burnout; it is the commitment that overrides its manifestations. In burnout the call grows deafening and self loses its voice.

The fatigue of care

Liz comments: "*In my practice I was really, really tired. My practice was okay, I think... I think... I think...*". One of burnout's many masks is tiredness. The midwife continues to respond to the call of care despite her fatigue. Her focus is always on client need, not self need, while each woman is further invited to regard her every need as paramount. Midwives accept that this is just what midwives do and selfless practice is modelled all around them because the frustrations and modifications of practice realities are mostly hidden. Chronic fatigue becomes normal. The quality of the care giving of burnout must also be considered; Liz thinks her practice was "okay", but when she looks back she isn't sure.

What does midwives tiredness reveal?

King (1964) discusses Heidegger's concept that mood is not accidental but reveals the world of the person. She suggests that "'Fear itself,' the fearing (being afraid), discloses the fearsome by opening itself to its fearfulness," and that fear "is not discovered as an objective 'fact' and then feared, but fear itself discovers something in its fearsomeness" (p. 79).

Considered in this way the commonality of the participant midwives experience of extreme tiredness discloses the exhausting nature of their work demand through its capacity to fatigue. Exhaustion is not discovered objectively but through exhaustive demand. "*I just got to where it felt as though I was permanently tired – I don't know when I didn't feel tired actually*" (Jemima), while Anne relates "*that constant comment of you look tired, I am not tired, I have just been working. You just accept being tired*". Through the tiredness of midwives the tiring nature of midwifery is

disclosed. Midwives grow so familiar with tiredness it becomes invisible. The acceptance of fatigue as part of midwifery masks tiredness as a burnout indicator. Even when Liz describes being "*really, really tired*" she continues to work.

Jemima shares her story:

I just think of some of those really desperate times when I felt like crying, but I knew that crying wasn't going to make me feel any better. I just felt... just devastated. I was absolutely in limbo. I was pretending I was okay, I was pretending to be an all-encompassing midwife. I didn't feel like I was providing good care because where I was at was interfering with the care I was providing. I was probably getting quite depressed... I think I am going to cry (starts crying five years after burnout)... it is so stupid... (Jemima)

Jemima tells us of her pain, the desperation of being 'in limbo' knowing something was wrong but unable to determine what? She knows "crying wasn't going to make me feel any better" because the listening of midwifery would not hear her cry for help. She pretends she is alright, within which need for pretence the knowing that she is not alright is revealed. To be 'alright' for Jemima meant being an "all-encompassing midwife" not a woman who works as a midwife. This gauging of personal well being by the ability to still perform adequately in their professional life despite their increasingly severe manifestations of burnout was evident in other participants. Jemima's pretence also reveals a need to conceal her professional vulnerability. When she reconnects with her pain, acute enough to cause her to weep five years after the event, she berates herself for doing so, "*it is so stupid...*" Even now she denies herself the right to express the extent of her anguish; such deep hidden pain was evident amongst other participants. Within the depth of that pain lay the lived experience of burnout.

Unidentified, the chronic tiredness of burnout becomes progressively more invasive and the midwife has to struggle harder to cope. Derryn describes her feelings of:

I couldn't sleep. I would get really anxious at bed time. The phone would ring and I would curse at the phone. I would cry. I started taking sleeping tablets because I discovered that I could work on half a one. That was the most important thing – going to sleep. I couldn't switch off, I couldn't, I just couldn't, go to sleep. I just couldn't get enough sleep. (Derryn)

Interviewed midwives described escalating anxiety around work related sleep deprivation. The anxiety then also disturbs sleep patterns when uninterrupted sleep is possible, further impacting their chronic fatigue. Yet they continued to practice. Derryn tells us of resorting to low level medicating with sedatives so she could still wake up and go to work if she had to. She unknowingly 'treats' her burnout symptoms so she can keep working despite them, further compounding its impact on her, while not recognizing the need to evaluate the working environment that is inducing her burnout.

The tiredness of the caregiver must inevitably impact on the quality of the care that is given. Amelia comments over an incident of care that she would never *"have stayed out of the room for so long knowing I had just turned the syntocinon up if I hadn't been so exhausted! I realise now that I should have handed over care."* She recounted being extremely tired after giving extended care over many hours and leaving the room despite knowing it wasn't appropriate where she was providing labour care after increasing the rate of syntocinon to stimulate uterine contractions. She found when she returned to the room that the woman had experienced a tonic contraction with a foetal deceleration. Celine also recalls thinking *"did I put the antibiotics down that epidural and the epidural top up down the intravenous line because they are both similar sized syringes?"* when providing care when she felt she was perhaps 'beginning' to feel unsafe because of fatigue but was not able to get support. Amelia similarly tells us of *"I took my epidural top up and went to attach it to the woman's IV leur, pulled back and thought whoops! It was only then that I realized that I was too tired"* (Amelia). Both participants were experienced and conscientious practitioners whose discretionary judgment as to their ability to practice safely was impaired by fatigue.

Why didn't the midwifery profession know?

Burnout is a phenomenon that the professional body of midwifery did not have an initial awareness of or openly discuss as an awareness evolved. Autonomous practice in a modern accountable health provision was new to midwifery; the waters sailed were unfamiliar, its depths uncharted and the fervour of midwifery believed to

be unsinkable. The energy of midwifery administration was channelled into structuring a means of insuring a credible, well-disciplined delivery of autonomous care to fulfil the expectations of the maternity service promoted to women. The need for built in supervisory support, debriefing and practice boundaries was not recognized in the launching of autonomous practice. The midwife was seen as a competent self governing professional; a self sufficient practitioner who did not need looking after beyond the practice review processes in place. There was an assumption that should a midwife need support then as an autonomous practitioner she should self recognize and implement this personally. There was no anticipation that midwives would burnout fulfilling their professional duties. The impact of its manifestations on those who did experience it were seldom voiced in an environment of censure, further aiding the creation of the unknowing of burnout.

Yet Heidegger (1927/1962) considers that when only loud talk is heard and anything else is said not to have occurred that: “the ‘they’ merely covers up its own failure to hear the call and the fact that its ‘hearing’ does not reach very far” (p. 343). His insight suggests that perhaps it was not that the midwives in burnout didn’t speak up loudly enough and it was the listening of those external to their experience that was impaired.

Angela describes: *"I started feel useless and incompetent and very tired. I felt very alone with it"*. In the face of the midwifery expectation, midwives did not anticipate or recognize burnout, nor did the colleagues who surrounded them. Angela tells us of feeling alone with feelings of personal failure. Participants spoke of knowing that "something was wrong," but not knowing what it was or how to address it.

Liz comments:

What makes me really sad is knowing that there are other midwives who have also suffered this. I thought it was only me. That there are other women who have those same sorts of feelings makes me feel terrible, it horrifies me that there are others. (Liz)

Like Liz and Angela, interviewed midwives assumed they were alone in their struggle with burnout. To know others had shared the depth of her experience

distresses rather than comforts Liz showing us how ‘terrible and horrific’ burnout was for her. She would rather feel alone with it than to have had others suffer what she had. Isolated with an experience that there was no public awareness of, beset with feelings of failure, affected midwives were shamed into silence. The silence that still surrounded burnout allowed it to flourish within midwifery.

Why didn't the midwives know?

Dilthey (1985) suggests of lived experience that it is intertwined with history and only in thought does it become objective. Interviewed midwives told of their subjective focus on their clients covering over their own feelings of burnout. The passion of their call to midwifery blinded them from seeing the accumulating rents in the fabric of their own wellbeing. It clouded their objectivity while the immediacy of what had become an inundating work demand prevented an impartial overview. Liz continues:

Burnout for me became (Pauses)... tiredness, tiredness... when I think about it now I don't know how I did it, or why I did it. Hindsight is very smart in retrospect but it is like... why did I carry on doing it? All I can think of is that extreme tiredness. I remember it so clearly that I won't go back. Nothing could induce me to go back. I'm not going back. No! I could never do case loading practice again! (Liz)

As Liz states, hindsight now offers an intelligibility burnout obscured. Now she can access that clarity she recalls her exhaustion and can't understand why she continued to work; but in burnout she didn't consider stopping. Her recollection of burnout is still so disturbing she will never return to the mode of practice that triggered it.

Harman (2007) discusses the complexities of self recognizing what is happening in our lives. He refers to Heidegger's words “conscious awareness always skates along a thin icy crust, one that hides countless deeper layers that are also given to us, but not clearly and openly” (pp. 40-41). Burnout is a multi layered phenomenon which normalising frequently covers over while semblance and appearance further conceal disclosure. There are four components to the thin icy crust of midwifery burnout: unawareness of burnout; covering over of its presence and severity; professional focus on other to the detriment of self and a passionate ongoing commitment to the

work that generates the phenomenon. It is a combination of circumstances that enables burnout to become severe amongst midwives.

Heidegger (1927/1962) discusses the ways in which phenomena can be covered up:

In the first place, a phenomenon can be covered up in the sense that it is still quite *undiscovered*. It is neither known nor unknown. Moreover a phenomenon can be *buried over*. This means that it has at some time been discovered but has deteriorated [verfiel] to the point of getting covered up again. This covering-up can be complete; or rather - and as a rule- what has been discovered earlier may still be visible, though only as a semblance. (p. 60)

Heidegger informs us that phenomena such as burnout can be covered over by the unawareness of it. It can also be buried over when what becomes known is lost from awareness. When this happens the remnants of that vanished knowing give rise to semblance in which the manifestations of burnout resemble something else. Both the covering over of burnout by unawareness and semblance were evident amongst interviewed midwives who described “having no idea what was happening to them”.

Semblance

Heidegger (1927/1962) believed that the presence of semblance, where something "looks like but 'in actuality' is not, what it gives itself out to be," discloses the concealed presence of a phenomenon" (p. 51). Where semblance occurs there is an underlying phenomenon triggering it. Heidegger explains semblance as:

That which has been uncovered and disclosed stands in a mode in which it has been disguised and closed off by idle talk, curiosity, and ambiguity... Entities have not been completely hidden: they are precisely the sort of thing that has been uncovered, but at the same time they have been disguised. (p. 264)

In semblance the phenomenon is mistaken for something else which then becomes the focus while the phenomenon's presence continues to go undetected. The conjectures that arise from the unknowing contribute to the veiling of what is really

occurring. In this study of burnout semblance was contributed to by an assumption of a professional fallibility amongst afflicted midwives: this assumption became part of the covering over.

Amelia shares her story:

It was a combination of things that began to make me feel I needed some time out. One was... maybe four years ago? One was, oh increase in headaches, decrease in sleeping. A touch of menopause which wasn't particularly severe back then but was sneaking in there, so just days with the blues... I had never considered that some of those menopausal symptoms may have been burnout (she begins to cry). (Amelia)

Amelia tells of her earlier belief that her manifestations of burnout were indicative of the onset of menopause. Her realisation that burnout can present in a semblance of menopausal symptoms reduces her to tears. Just as the tiredness of midwives discloses the extent of the burden of their work, Amelia's tears disclose the true extent of the "touch of menopause which wasn't particularly severe back then." Rather than menopause 'sneaking in' perhaps burnout was sneaking in under the semblance of menopause. Other midwives share Amelia belief. Linda spoke of how she "*still wanted to keep practicing as an case loading midwife. I spent thousands of dollars on alternative health care trying to find an answer. I am approaching menopause, I think that compounded it*". Midwives interviewed reported searching for 'cures' for the semblances and appearances of burnout with no understanding that they were in burnout and burnout itself needed to be addressed. Amelia further typifies participants in her comment of "... *maybe four years ago?*" Burnout is a gradual process in which midwives grow accustomed to feeling compromised; it becomes the normality of their lived experience and loses its visibility because of its everydayness.

Heidegger (1927/1962) says of semblance: "This covering-up as a 'disguising' is both the most frequent and the most dangerous for here the possibilities of deceiving and misleading are especially stubborn" (p. 60). Semblance blocks recognition of what is happening preventing the underlying phenomenon from being addressed. The presumption of menopause was common amongst midwives in Amelia's age group.

The presence of semblance was evidenced by younger, non menopausal women experiencing exactly the same symptoms. Appearance can also cover things over.

Appearance

Heidegger (1927/1962) has told us: "... appearance, as the appearance 'of something', does *not* mean showing-itself; it means rather the announcing-itself by [von] something which does not show itself, but which announces itself through something which does show itself. Appearing is *not-showing-itself*" (p. 52). Heidegger parallels the appearance of something with the symptoms of a disease. The symptoms are not the disease itself but the indicators of its presence: the disease which is causing the symptoms is yet to show itself. Just as in ill health, when symptoms are assumed to be the actual illness and treated in isolation from the underlying cause, the appearance of manifestations of burnout can be similarly misinterpreted. Burnout announces itself through the appearance of indicators that something is not right, but the underlying presence of burnout continues to remain concealed. Derryn tells us:

I kept getting sick, but I didn't recognize that I needed to take time off because of burnout. I saw it as needing time out because I was sick. Gastric, headaches, feeling unwell, all those related symptoms. (Derryn)

Derryn's story is one of the covering over of burnout by the appearance of variable illnesses which she addresses as unrelated incidents of minor ill health. She does not recognize burnout is inducing her episodic illness. Jemima tells us: "*I had weekly visits with the homeopath and I took all sorts of herbal pills and potions*". Other midwives experienced random incidents of sub optimal health for which they sought cures believing their health was impacting on their practice, not realizing it was their practice that was impacting on their health. Their focus remained with their ability to provide good midwifery care despite the progressive erosion of self. The need to modify their mode of practice to allow good self care was not considered in the search for 'cures' to enable them to continue working as they were. There was no recognition by participants that their work environment needed to be modified.

Without such recognition burnout became more invasive but its increasing manifestations were covered over by their everydayness.

The covering over of everydayness

Heidegger (1927/1962) says of everydayness that it is:

The 'how' in accordance with which Dasein 'lives unto the day' ["in den Tag hineinlebt"], whether in all its ways of behaving or only in certain ones which have been prescribed by Being-with-one-another. To this 'how' there belongs further the uncomfotableness of the accustomed, even if it forces one to do something burdensome... (p. 422)

Within our daily living what is extraordinary is made ordinary through familiarity, even when it is arduous and stressful. The semblances and appearances of burnout are first accommodated and then made invisible because of that accommodation. What is always there becomes unseen when it is part of the daily landscape. Celine shares a story of processing difficult practice events:

We thought the baby was going to die. He is three now and is running around like you would not believe, yet he was fitting; he was one of the worst. He didn't have a heart rate for a time. That was really scary, even though I had the consultant midwife in there as the head crowned and she was the midwife who was always on top of her documenting. We listened to the foetal heart and it was alright and then the baby didn't have a heart rate for seven minutes. You are thinking how can that be, it didn't make sense. He was a sick little fellow for sometime but he is completely normal. We had a difficult shoulder dystocia too. I also had a still birth where the woman didn't cope very well. She had missed lots of her appointments; the back ground was very different. It still did affect me after a while because it was not just the one incident. I wonder if that took a toll on me, having all those significant events in one year? (Celine)

The covering over by the everydayness of midwifery practice means that it is only on reflection that Celine considers that the major incidents her practice has exposed her to may have taken a toll on her? There is a self depreciatory element in her comment "it *still* did affect me after a while because it was not just the one incident," revealing her assumption that she should have coped if there hadn't been a multiplicity of traumatic incidents. Celine draws our attention to the litigious anxiety that pervades

health care and surrounds poor outcomes with her comment that the senior midwife was a good documenter. The everydayness of the midwife, as Celine shows us, involves complex decision making, anxiety and exposure to incidents of great stress.

The signs of burnout

Heidegger (1927/1962) tells us:

In a symptom or a warning signal, 'what is coming' 'indicates itself,' but not in the sense of something merely occurring, which comes as an addition to what is already present-at-hand; 'what is coming' is the sort of thing we are ready for, or which 'we weren't ready for' if we have been attending to something else. (pp. 110-111)

Heidegger differentiates between occurrences that are visible and the signs that warn of new developments. Such signs may, or may not, be recognized and the pending happening may, or may not, be anticipated. Where it is not Heidegger tells us that when what has been coming has happened and run its course, hindsight allows the information that was being signalled to be accessed. He contends that signs "always indicate primarily 'wherein' one is 'at' at any time" (Heidegger, 1927/1962, p. 110). Midwives were 'not ready' for the signs that burnout was coming but the signs of burnout indicated where they were 'at'.

Anne tells us:

I pulled into the driveway at 11.30pm and my phone went. I cried. I think my tears were around the frustration of not being valued and having to achieve the gold standard. When you can't achieve it I would feel bad about myself. It goes back to feeling responsible for birth outcomes. It gets reinforced all the time. I didn't just fall out of the sky I lost altitude. Probably over five months I kept feeling suffocated. I just couldn't come up for air, I would try and come up and get a break or another perspective or clearer boundaries and another curved ball was thrown at you. Reliving it all I can't believe that it still brings up those feelings in me. I think it comes from being devalued and abused on many levels. The demand was all consuming. I didn't know where Anne was in any of it or who she was anymore. My life felt eaten up in terms of who I was. (Anne)

Emerging from Ann's words is what was to be identified as a familiar theme; a self critical struggle to maintain a high practice standard during the unrecognized debilitating process of burnout. Anne believes she must take on a personal responsibility for birth outcomes despite her having little control over how birth unfolds and she feels overwhelmed by this. She self denigrates; she sees herself as a bad midwife when birth does not go well for whatever reason. She does not identify that her tears are symptomatic of extreme tiredness, something she could address, but interprets them as indicative of a lack of appreciation of how hard she works, something she can't address. She engages with the vagaries of the expectations of 'they' rather than the realities of her exhaustive practice.

Heidegger (1927/1962) says this of Dasein:

Losing itself in the publicness and the idle talk of the "they", *it fails to hear [überhört]* its own Self in listening to the they-self. If Dasein is to be able to get bought back from this lostness of failing to hear itself, and if this is to be done through itself, then it must first be able to find itself - to find itself as something which has failed to hear itself, and which fails to hear in that it *listens away* to the 'they'. (pp. 315-316)

The assumption of knowing that is arrived at through speculative hearsay dulls down self awareness. When self listens to the criteria and opinions of 'they' at the exclusion its own mode of being it becomes lost. Self must be reconnected with if its voice is to be heard. When Anne focuses on her struggle to meet what she believes 'they' expect of her and the anger generated by that expectation, she is diverted from connecting with the knowing of her burnout. Yet an awareness of the destructive path she is on lies just below the surface; she shows us this when she describes herself as feeling suffocated, devalued and abused by her work. Her recognition of the obscuring of her knowing also lies in her comments of not being able to get clarity to put protective strategies in place. She identifies feeling consumed by her work and the loss of self that Heidegger speaks of. While her account is indicative of significant burnout, she believes she "*didn't just fall out of the sky, I lost altitude.*" Her story uncovers the insidious nature of burnout; a phenomenon which still evades recognition even as Anne feels "*eaten up in terms of who I was.*" When a mature,

experienced professional woman weeps when her phone rings she is falling out of the sky not just losing altitude.

Heidegger (1927/1962) tells us that: “That which is un-ready-to-hand is discovered circumspectively when we *miss* it [*im Vermissen*]. The ‘affirmation’ that something is not present-at-hand is founded upon our missing it...” (p. 406), suggests that we do not identify the absence of something until it is brought to our attention by the recognition of its lack of presence. Amelia continues:

I consider I was on the brink of burnout. One of the things that made me realize I had to change was a friend encouraged me to go away. We went out tramping and halfway around the National Park track I felt happy. I thought I can't remember when I last felt happy, what a wonderful feeling this is... remembering what happy felt like. By God I had forgotten! That is scary isn't it! It was about rediscovering a joy in life I didn't even know I had lost. (Amelia)

Amelia tells us of only recognizing her chronic unhappiness when she rediscovers the feelings of happiness away from her work and is made aware of the absence of joy in her life. Her story discloses the diminishing of self awareness in midwives who burnout; without that moment of recognition Amelia would have had no self awareness of the diminished quality of her life. Despite identifying that her life was rendered joyless, and previously disclosing high anxiety levels and significant depression, Amelia gauges herself as having been ‘on the brink of burnout.’

Anxiety

Grace comments on her signs of burnout:

It was the emotional demand, the mental stress. Was someone living in the back blocks going to birth their baby on the way in? If the network coverage is poor you don't know where they are - you can't sleep because you are wondering.... It is all that stuff, you can't switch off. I feel emotionally affected rather than depressed; that feeling of not always being able to cope. (Grace)

Grace describes how her anxiety around her rural practice escalates and impacts on her ability to sleep, she "can't switch off," and at times feels unable to cope. Anxiety

was another sign of burnout experienced by interviewed midwives. While Grace is aware of increasing work related anxiety she does not recognize it lacks rationale and is triggered by purely speculative situations she has no control over or responsibility for. Here she describes worrying whether someone might leave the journey to the hospital too late and give birth on the way? Are they contactable or not? Where are they? She does not consider logically that there is little she can do if a woman gives birth in her car even if they are contactable and she knows where they are. Later in her interview she comments "*and then after lying awake worrying, you find they have slept all night!*" Her excessive concern further compounds sleep deprivation. When signs of burnout are not recognized midwives continue to practice without modification allowing unwarranted anxiety to become entrenched and destructive.

Amelia tells us:

There were nights where I would lie in bed with my head just going round and round and not stopping all night with anxiety. Not about being called... oh yeah about being called and being too tired to go, but more anxiety about having left something not done and causing somebody's death (gives short laugh) by omission because I knew that I was too tired to be functioning clearly. The anxiety of knowing that I was over tired and yet I was still responsible. (Amelia)

Unlike Grace, Amelia's anxiety lacks a clear trigger; it just *is* as a constant frame of mind centring on her chronic fatigue. Will she be too tired to respond to a call? Has she forgotten something because she is too tired? Will someone die because of what she may have forgotten? She knows her function is impaired by her levels of fatigue which her anxiety exacerbates further disrupting sleep. Despite her knowing that she is excessively tired Amelia remains locked into the tradition of care giving.

Gadamer (1975/2004) believes that:

That which has been sanctioned by tradition and custom has an authority that is nameless... The real force of morals, for example, is based on tradition. They are freely taken over but by no means created by a free insight or grounded on reasons. (p. 280)

Gadamer explains that ethics and morals arising from custom and tradition are handed down and assimilated rather than embraced after a process of personal

evaluation by each individual. His words assist an understanding of why Amelia does not question still meeting her professional obligation even when she fears that her care could be compromised by her tiredness. Her work ethic of caring for other involved an educative process in the traditions of caring professions which firms up the original desire to be of service that participants identified with. As Gadamer informs us, tradition is a powerful moral force within which there is an absence of any questioning of the positioning of self. Interviewed midwives were consistently blinkered to the wellbeing of self by the traditions of duty and their staunchness in honouring client commitment. Any awareness of burnout's impact on the quality of their care was submerged beneath the weight of the onus of that care. Only one midwife considered a period of respite from her work.

Amelia's focus is only on getting through her work; her anxiety relates to "*having left something not done and causing somebody's death by omission.*" Burnout does not allow her to stop and consider if this is a safe way for her to be practicing as the critical factor becomes one of achieving safe practice despite her exhaustion. Modifying her practice to alleviate her exhaustion is not considered. This too was typical of participants; they pushed through the warnings of burnout with a stoicism born out of a sense of commitment that seemed to allow them no alternatives.

Depression

Depression was a further sign of burnout revealed to be experienced by participant midwives in burnout. Amelia tells us: "*I definitely felt depressed. I would say it was just about serious life threatening depression, but in short bursts*". Amelia describes her depression as 'just about serious life threatening' then ratifies the significance of her disclosure with 'but in short bursts.' Yet she has a professional knowledge of depression because of the midwifery awareness of how post natal women can be affected by it; that knowledge reinforces that life threatening levels of depression only require a moment to be acted on to become life taking. This minimalism of the depression of burnout was evident in other participants.

Candy describes:

I don't think I ever got depressed. I did have one weekend when I thought I just don't want to get out of bed, and that is the closest I ever got to it. I remember feeling like, sort of... oh God! (Falls silent...) But that was the only time. I just stayed in bed. But it was two days worth. I mean I love my bed, and I love being in my pyjamas but that time was different, that was different... (Candy)

Candy felt that she did not experience depression, yet tells a story of depressive behaviour. Her comment “I remember feeling like, sort of, oh God!” suggests that re-connecting with her feelings is so painful she pulls back from them abruptly. It is too close; she does not want to re-experience what is being shown about what was different when she took to her bed for two days.

Heidegger (1927/1962) tells us that a sign points at what is indicated but there are a multiplicity of possible signs:

Amongst signs there are symptoms [Anzeichen], warning signals, signs of things that have happened already [Rückzeichen], signs to mark something, signs by which things are recognized: these have different ways of indicating, regardless of what may be serving as a sign. (p. 108)

Signs are only indicators of what is, not the entity itself; they present in a variety of ways drawing attention to what is coming, or what has been. But, as Heidegger (1927/1962) continues, the sign is not always authentically grasped so that what is ready-to-hand “becomes accessible in such a way that our concerned dealings take on an orientation and hold it secure” (p. 110). The signs of burnout were the beginnings of the showing of burnout, as it moved beyond semblance and appearance to become ready-to-hand. As these midwives stories show, the presence of burnout in their lives remained inaccessible because of their pre-occupation with a moral and learned duty of care; the signs were assimilated into their lived experience and became invisible.

The catalyst

In other front line professions, such as law enforcement, fire and social services, exposure to significant events generates professional support in the mode of

immediate debriefing, routine counselling, a period of being stood down from duty followed by a planned return to work. C. Boyce (personal communication, March, 2011) advised that New Zealand social workers receive four hours of supervision a month, two of which are from an external source. They may be advocated to receive additional supervision and that there is also an ability to apply for stress leave, or to take unpaid leave. The profession that has exposed them to trauma assumes a responsibility to act to minimize its impact and support them. Similarly New Zealand police have a period of stand down from duty and follow up counselling after being exposed to a significant incident (L. Van Doormaal, personal communication, April, 2011).

Midwifery, as a professional organisation, lacked this facility until recently when counselling was offered to midwives involved in an incident where the New Zealand College of Midwives lawyer is involved (NZCOM, 2010). For these midwives the ability to take time out from a case load booked months in advance is dependent on the good will and availability of her colleagues to take up her work in addition to their own. While there is an option of passing women's care on to the hospital services negating the woman's original choice of continuity of care, participants clearly struggled with this and all but one worked out their commitments to women booked with them after they reached the decision that they needed to give up practice. Van Manen (1990) tells us that “nothing is so silent as that which is taken for granted or self-evident” (p. 112). That nothing is done simply amplifies the need for something to be done; where a problem refuses to be seen it confirms that such a problem does indeed exist. The consequences of limited support was far reaching for participant midwives, often precipitating the finality of burnout. Linda shares her story:

I think... the actual turning point was a foetal death. I just couldn't do it anymore. It was like ... that was it. I just can't do it anymore. It was like it is too ... I came home and I cried and cried, yet I didn't know the woman that well. I was just absolutely burned out; I had ongoing problems with sleeping, I was exhausted. It was the turning point really. It was just too much. (Linda)

The story Linda shares is not one of an inability to process death professionally but of personal depletion through burnout making the incident "too much". She puzzles over the extent of her grief given her professional relationship with the woman, not realising the catalyst event has also disclosed the anguish of burnout. Heidegger (1962/2006) tells us that thrownness can catapult us into an awareness that is lost within everydayness. He says of mood that "a mood assails us. It comes neither from 'outside' nor from 'inside' but arises from Being-in-the-world, as a way of such Being" (p. 176). The grief Linda experiences is part of the mood that arises neither from the baby's death, nor from Linda's reaction to it, but from being in her world. The intensity of Linda's grief reveals how distressing it has become for her to be in the world of midwifery. Liz shares her story of caring for a woman who has a stillborn baby:

The biggest thing that impacted on me was when I had a still birth and I never... I had real problems dealing with that and I blamed myself for... my partner would take me for long drives and I would just be crying... it was terrible... I was terrible. I used to look around incredulously at other midwives, wanting to hear their stories, wondering how they dealt with it, how they could still carry on because I didn't think I would ever be able to carry on again. Yet death and birth are so connected. Those first few days afterwards, months afterwards really, I was practicing with this incredible fear- it was just ... I had a lot of reassurance from other people that it wasn't my fault. I got more support from the obstetricians than I ever did from the charge midwives. I remember an obstetrician coming up to me, giving me a hug and saying 'its all right, this is not your fault.' It really helped. My midwifery partner came in. I stayed there, but I didn't actually deliver the baby. I couldn't... I couldn't, I just knew I couldn't do it. I should have done it, but I was there. I had no support from the charge midwives. That little voice of 'maybe if you had done this or that?' stayed with me for a long, long time and it just haunted the rest of my practice right until I finished at the end of that year. I had support from my colleagues but don't think I was ever able to talk to them in depth about where my head was at. I never really spoke in depth to anyone, only my midwifery partner and one other midwife. In corridors you would snatch time with people but there was nothing... towards the end of the year I decided I needed to see a counsellor but I was actually beyond it; I couldn't keep the appointment. I think that it contributed hugely to my anxiety but there was accumulated tiredness, it was just too much. I worried about how it would affect the mother. She went to her G.P. because she was depressed and the G.P. then put in a claim to A.C.C. so they wanted all the notes; my documentation has always been more than adequate so that was no problem, or with my practice when it came down to it. But I could never comfort myself with all that stuff... (Liz)

Liz describes her experience of caring for a woman who had a still born baby as “*I had a stillbirth.*” Her use of first person reveals the degree to which midwives embody a traumatic practice experiences; it becomes ‘her’ experience. Celine similarly comments “*I had two stillbirths and we had a shoulder dystocia,*” taking the stillbirth outcomes into herself and embodying them, but including others in the lesser crises. Liz’s story reveals the trauma of her experience; like Linda she describes it as “*too much*”. Her rationale of life death balance is unable to be translated into her emotional well being. She encapsulates her sense of loneliness and isolation with processing the event in her description of her partner driving her while she weeps, the paucity of midwifery support measures unfavourably against the very basic support she received from obstetricians. She wonders how other midwives have survived such an event, revealing the lack of communication within midwifery that surrounds such trauma. While exonerated from blame, she is haunted by that possibility shown in her frequent revisiting of it “not being her fault” and the “little voice” that continues to demand that she keeps critiquing her practice actions around that birth. Adverse outcomes affected other interviewed midwives similarly.

Gadamer (1995) talks of the *dialectical* experience: “Thus the negativity of experience has a curiously productive meaning. It is not simply that we see through a deception and hence make a correction, but we acquire a comprehensive knowledge” (p. 353). He suggests that such experience “must be of a nature that we gain better knowledge through it, not only of itself, but of what we thought we knew before-i.e., of a universal” (p. 353). Such reflective learning through exposure to the experience of loss was difficult for these midwives, yet midwifery prides itself on reflective practice. There is defensive fear in their frequent references to their having been exonerated of professional fault and their stories are permeated with an ongoing troubled self critique that tells of isolation and a lack of resolution. Derryn comments that: “*There is nowhere a midwife can go with those sorts of experiences. There was just nothing*”. Midwives can request a special review of their practice after a significant incident but, as these midwives experiences show, they felt alone in processing the trauma associated with these events and unable to achieve an objective perspective.

The recent publication "unexpected outcome?" by the New Zealand College of Midwives (2010) now guides midwives through such an experience and goes part way towards addressing this situation. Previously the lack of any formal recognition of the need for support by midwives involved in such incidents left them feeling they should be able to cope alone, as Celine expresses. Now there is an availability of three funded counselling sessions for midwives who are College members and who are either self employed, or employed by a small facility without such resources. However it is only available where the NZCOM legal adviser has been involved for practice related or indemnity purposes. This latter step does not always happen, in which event self employed case loading midwives are unable to access professional counselling unless they self fund it.

As Liz's story shows us, the ability to self recognise such need is not always present during a crisis; the midwifery focus remains with the woman, not on the midwife's own needs. By the time Liz recognizes her need she is emotionally unable to follow through. The 'unexpected outcomes?' handbook coaches midwives to seek support informally from colleagues, family and friends while warning that "natural responses can be fear, shame, grief, anger and / or guilt. You may not want to tell anyone what has happened for fear that you will be blamed for the outcome" (NZCOM, 2010b, p. 4). The wording primes the expectation of blame; midwives, like Liz, experiences unresolved grief without such priming which 'haunted' her practice. Her story of finding more empathy from an obstetrician than colleagues is shared by Grace:

After the neo natal death I was involved in, we had the police in – statements and God knows what – your whole practice is questioned. It is an awful thing. There was no mechanism for debriefing – just waiting for post mortems which took about 3 weeks was such an awful, awful, awful thing. One of the obstetricians got me through, he said 'that in this profession not everyone is going to make it and none of us are God. Yeah, there are going to be times that you wonder if I had done this would it have made a difference, but 'statistically with the numbers you look after not all occasions will end well and that has to be accepted as part of the job.' That always stuck in my mind; if it is something I can't change and my practice was exemplary and it is not because of anything I haven't done, then I have to accept that for whatever reason it happened. That has been the best advice I have ever had in terms of working as a midwife out in this area where we have got no back up at all... I haven't

got my name on the case loading midwifery list anymore and I won't be taking any bookings, I am looking at alternatives. (Grace)

Grace's story is also one of loneliness and angst. Other participants referred to hostile scrutiny and distressing waits to have their practices exonerated of fault after significant incidents, the awfulness of which Grace places heavy emphasis on. The natural grief of the midwife is fractured by the need to defend her practice, yet there are few resources available to support midwives at these times. Again it is an obstetrician rather than a fellow midwife who proves most supportive. This may be because obstetricians, who are exposed to the abnormal with its associated trauma and loss, have evolved strategies for coping with such events. Conversely the midwife who specialises in normal childbirth has little exposure to such distressing outcomes and is particularly vulnerable to their trauma. But in a personal conversation with an obstetrician after a traumatic incident involving a midwife the comment was made, "obstetrician's gather around their colleague and encircle them to protect them facing outward to watch for and deflect unfair comment, but midwives circle the midwife facing inwards to look for fault" (N. Matthews, personal communication November 22, 2009). While Grace feels the advice "got her through" she is giving up her practice. Amelia continues her story:

It is not all to do with work and over commitment. I think a lot of my suicide stuff - well it has to be post traumatic stress disorder really. I think it was triggered by one particular birth when I was covering for another midwife; it was a caesarean where the woman bled afterwards. It wasn't my fault though she and her mother thought it was. She nearly died. I spent two hours with the husband, we didn't know if she was going to live or die and it was horrible. That... intensified how I felt. Yeah, yeah, there wasn't anybody to... (Stops). There is no one to debrief too. We talk to each other, and theoretically we probably shouldn't because we might breach confidentiality. (Amelia)

Amelia recalls a highly stressful situation where she felt that family believed she was responsible for the woman's haemorrhage becoming life threatening, despite the woman being under secondary care. This may link into the anxiety she feels at night worrying that she may "have caused someone's death by omission." She believes her unresolved feelings over this led to her suicidal feelings. In hindsight Amelia now believes she suffered from post traumatic stress disorder as a consequence of this

episode of care. Review processes critique the care given and may informally exonerate those involved of any perceived mismanagement. NZCOM Resolution processes and Health and Disability processes are available where women have grievances with their care. In achieving resolution for the woman the midwife can also indirectly reach a place of peace. But there is no debriefing process that focuses on the emotional wellbeing of the caregivers themselves without proviso, or which automatically puts in place the support they may need. Amelia's story shows us the potential seriousness of this omission. Opportunities to address ongoing stress are lost and the destructive course which it may be taking is unidentified and taken in hand. Serious subsequent depression can place caregivers in danger that they are too traumatized to self recognize. Myrtle shares her experience:

I have just gone through awful stuff with a very ill woman. That made me depressed. Yeah that made me ... (begins to cry)... I had already made my decision to leave but it was like... that's it. It was the final nail. I finally sought help through counselling; my hospital gives some funding for it. What bought me to that place was this woman was getting better, then I rang her partner and he said, 'no she is still spiking temperatures.' I felt sick and the whole feeling that she wasn't going to live came back to me... descended on me really badly. I woke up in the morning and I couldn't function. I was just hopeless, I was useless I couldn't do anything, I was in a really bad place, I was really weepy again. So I organized counselling that day. It was in the evening after work; it was easy to organize. It was funded for two sessions of I think about an hour. I was met by this old lady wearing Kumfs. I don't mean to be rude – if I was a bit younger and a bit shallower I would have gone 'oh God, you are never going to be able to help me.' She sat me down and said I would just like to fill in these statistics. How old are you, are you self employed, are you a manager? I just went 'I don't give a shit about your statistics; I am not here to fill in your fucking forms, there is stuff I need to talk about! I don't want to fill out your forms straight away, why don't we talk and then I will fill them out.' It felt like the wrong thing to start with.

I got up to leave, and then I sat myself down and said to myself 'look you have got to give this thing a try because what is going to happen if you leave, you are a mess.' So I sat there and I talked to this woman. She had that classic kind of training where they have no emotion, 'pause, yes, yes, and well carry on.' I found it really hard to just dump it, but it was busting out. So I told her the whole story. I just don't want to talk to her again; she is not the sort of person I would choose to talk to. She was fine on the day, and I don't mean to be rude, but she didn't come across as someone I wanted to talk to and the way that she responded to me didn't make me feel that it was genuine. But by the time I had told her

everything I felt that she connected with me. I know someone else who went there and walked out. She said that she had to leave, that it was just hopeless. These counsellors offer wholesale counselling for all health professions but I needed someone who understood the terminology that I was using. In retrospect some of it must have gone over her head. She certainly had no concept of my job. She didn't understand what a case loading midwife referred to. I wasn't in the mood to educate her! (Laughs). But things got really bad that day so I am glad that I went because that day I was open to any help I could get. So it did the job but it is not something I would pursue again with her. I believe that the stuff that has happened around that woman has affected me permanently. I will never recover from what happened. I think I will carry a piece of her with me forever and that is not uncomfortable for me, I am not afraid of that. (Myrtle)

Myrtle's experience of caring for a woman who developed a life threatening illness affected her deeply and reinforced her decision to leave hospital employed case loading practice. She too gauges the impact of the crises precipitated in terms of her own ability to still perform her professional duties. She describes herself as "hopeless, useless, couldn't do anything" rather than perceiving herself as too debilitated by severe stress to function and in urgent need of support. Yet despite this self recognition Myrtle still presents for her days work and her extreme distress is not recognized by her colleagues or manager. She is self responsible for organizing her counselling from an internal service which has no working knowledge of midwifery, which Myrtle believes to be a disadvantage. Her concluding comments suggest that her distress is unresolved, and that she has no expectation of recovery from the traumatic experience her work exposed her to.

These midwives stories reveal working lives that contain a myriad of complexity and stress with which even very experienced midwives struggle. Apart from Grace, who is supported by an obstetrician colleague who helped her gain perspective, each story has a similar vein to it, one of unresolved pain and trauma. A supportive process at such a time affords the midwife greater protection from a debilitating aftermath triggered by a traumatic event she is exposed to in the course of her professional duty. The catalyst event, as for Myrtle, may simply be 'the final nail' for the midwife rather than the single critical event that allows the insight that removes them from practice.

Gadamer (1975/2004) says of the insight that occurs in the presence of tragedy that it is an absolute moment of self forgetfulness and mediation within oneself: “what rends him from himself at the same time gives back the whole of his being” (p.128). The catalyst event pulled midwives out of their customary circumstances and traditions and handed them back their lives free of subterfuge, exposing the burnout that resided in them. While they finally became able to see what was there, the grief and trauma that precipitated it remained unaddressed. The catalytic event was not so much the loss of a baby, but the turning of midwives’ eyes inwards reconnecting them with themselves. They see what their lives has become, and then puzzle over the extent of their grief, not knowing that they also weep for themselves.

The experience of burnout

Van Manen (1990) advises that:

Phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience. A universal or essence can only be grasped through a study of the particulars or instances as they are encountered in lived experience. (p. 9)

Phenomenology seeks to understand not how an experience happens but what the experience is like for those who have lived through it by uncovering its depths. While the catalyst event precipitated the recognition of burnout, living through burnout was a separate life experience. Jemima tells us how it was for her:

I put it off making the decision to stop practicing over that couple of years because I felt that I was letting myself down. That I couldn't cope, that I was useless, a no good midwife, you know... can't cope with this job. A failure! I think I knew it was time to stop long before I did but I angst about giving up. In the end I thought, well bugger it. I've had enough. I am just not going to do this any more. I am not going to cover up, I am not going to put my life on the line and I am not going to pretend. I would put burnout very close to the top of my life experiences. I have had other huge things in my life that would surmount burnout but it is high, it is up there. Probably because case loading practice was a passion, it was a passion for the profession, and it is damaged... (Cries) (Jemima)

For Jemima burnout culminated in the recognition of her need to leave practice for her self preservation. In its extreme burnout becomes a survival mechanism: the sufferer is afflicted to such an extent that they are made physically and emotionally incapable of continuing to do the work that is destroying them. Jemima's feeling of pretence is voiced by other participants: "*I felt like I was wearing a mask. Yes, burnout for me was pretending to be something that I once was and that I am not any more*" (Anne). Heidegger (1962/2006) speaks of when "one's knowing-oneself gets lost in such ways as aloofness, hiding oneself away, or putting on a disguise..." (p. 161). The pretence midwives engage in prevents the recognition of their real feelings. Stopping pretending may be less of a conscious choice than a situation of reaching a point where pretence is no longer possible. That participants felt a need to pretend they are coping with their practice reveals their non expectation of empathy or support and the lack of a professional understanding of burnout that allows such disclosure. The pain of that time is still raw five years later. (Jemima left case loading practice and now works part time; her passion for midwifery has never recovered.)

My son lost the plot, I lost the plot and I had a total nervous breakdown. I went on medication. It took three years before I realized how bad it was and that something was wrong with me. I totally attribute it to burnout, totally! Absolutely that is where it came from. My son didn't help at all but the value of what he did was let me see that I couldn't cope. I felt like a total failure, I had failed at my job, I had failed in my home, but it was a relief to know that I wasn't crazy and I could start being normal. I felt crazy ... I just couldn't cope with ordinary things in life. I had thoughts about suicide... what frightened me was I woke up one morning working out what I could do to kill myself: it was that simple. If a midwife told me she was going into case loading practice I would tell her "My God you are crazy" (laughs)! The severity of burnout as a life event for me is that, oh God! It is one of the worst! (Derryn)

Derryn believes her son's illness, rather than precipitate her own crises, reveals what is already there in her own life. She expresses her feelings of extreme failure, the slow recognition of how severely she is affected, her reduced ability to cope with the "ordinary things in life" culminating in her contemplation of suicide as a way out from a situation she can not quantify or understand therefore sees no end in sight. She expresses her relief at recognising that she was in burnout and realising there is a

way out from feeling as she does; she can “start being normal” after living through the “worst” experience of her life. (Derryn has left case loading practice and now works part time as a core midwife in a low level midwifery unit.)

I had panic attacks. I would feel like my heart was jumping out. It affected me mentally; I panicked and didn't make good decisions. I couldn't get stuff out of my head. I had nightmares, I had reoccurring kind of flashes, I used to get... it was really a grief process. I would have solar plexus burning, physical burning. It was the sort of thing I had after my Dad died and when I lost other people I was close to. They were normal grief symptoms but I had the same feelings in burnout. I had terrible flash backs all the time, all the time. I became very depressed. I can't remember if I took anti depressants or not... I don't know if I did. I actually can't remember, but if I didn't I should have. There are big blanks, there is a lot of stuff I don't want to disclose but there are huge blanks in my memory. I was reluctant to give up practice because there were things I loved about the work and I kept feeling it was just me and not the work. For a long-time and probably still now, I feel like a failure. Fighting A.C.C. after our accident and not being paid any money for four months was pretty bad. Having to support a husband who came home and couldn't walk and having my own physical injuries to overcome plus psychological from having a head injury. (Pauses)... I actually felt burnout was worse than that. The accident was life changing, but for me burnout was worse. (Liz)

Because burnout is not understood within the midwifery profession Liz still has unresolved feelings of failure that she carries with her. She describes burnout as being akin to grieving after significant loss; more devastating than recovering from a serious accident. When she speaks of burnout she describes experiencing physical symptoms of burning. The blanks in her account are both chosen and involuntary. That some significant memories are missing, including basic recollection of whether or not she took medication, suggests depths of pain that she is unable to consciously revisit. (Liz has stopped practicing midwifery.)

I think burnout is different for everybody. I nearly lost my marbles once and it wasn't until looking back on it that I realised I might have flipped my lid completely. I can remember lying on the settee with the kids. I was lying in a foetal position and my mind was going round and round and round and I couldn't stop it. I was thinking I want the world to stop, I want all this to go away – I want – I want... where is me in all of this. I thought so this is how people feel when they flip their lid? It is the nearest I have come to it. I was crying... I was lying on the settee crying

thinking why am I thinking these thoughts? The kids were... 'what is the matter Mum?' (Brenda)

Brenda's experience of burnout culminates in a physical and emotional exhaustion where she feels her mental health is becoming seriously compromised. Even in severe burnout she is still asking herself 'why am I thinking these thoughts?' revealing the lack of awareness she still has of either the process she is caught up in or how to address it. She wants it "to go away" because she doesn't know how to make it go away. (Brenda has left case loading practice and now works as a core midwife).

Burnout felt like being dead; just sort of zombie like. If my children were all wanting things at the same time I looked at them as they talked but I couldn't hear them. It was like watching my life, not being actively in it. My first serious sign was zoning out. The sensation was like when you meditate and you completely relax all your body. The person is still there – your brain is still there and you still have control of it – and you can bring yourself back at any time. But then I found I couldn't. That was frightening. My first feeling was oh God I am having a stroke. I couldn't talk. I couldn't... I could not get my brain... the first time coincided with my husband having a go at me about something. He was in the bedroom. I was on the toilet... it took me twenty minutes to get off. It actually took me... I thrust my arm – whacked it on the tap and thrust it under the cold water. That is what it took me to get my senses back. Your mind is okay... but you can't move. That happened to me three times. My mind started to change from sadness to anger. Burnout, for me felt like being removed. I found I couldn't handle any tension. I would go into a sort of panic rage. I would leave the house and just drive off. I became irrational and that was when I took myself off to the doctor and went on medication. As a life experience burnout for me was big. Big, big! Big, big, big!" (Angela)

Through the period Angela describes, she continues to work unaware that her work is the precipitating cause of her illness and unable to self evaluate how ill she has become. Her reaction to stress suggests a survival mechanism built into extremes of burnout that immobilize and mute her, just as Myrtle's emotional and physical inability to drive prevents her from working. Angela perceives herself as being dead to the world, a zombie, removed from all demands of the world she knows. When her children have simultaneous needs she reacts to the stress by becoming 'deaf' and can't physically hear what they are saying. In survival mode she is physically and

emotionally pulled back from the extreme brink that burnout takes people to; it is reasonable to speculate that in some instances it is not enough to save people.

Heidegger (1962/2006) suggests:

That the pallid, evenly balanced lack of mood [Ungestimmtheit], which is often persistent and which is not to be mistaken for a bad mood, is far from nothing at all. Rather, it is in this that Dasein becomes satiated with itself. Being has become manifest as a burden. (p. 173)

Heidegger's words resonate within Angela's mood and the behaviour it engenders. She retreats from all stress because she no longer has any ability to process it: her physical and emotional responses protect her from the need to take action. She is bland and withdraws from any controversy; she leaves the situation physically or becomes emotionally removed from it. Being is a burden she can no longer assume. When Angela relates how her behaviour became irrational, she tells us of how her mood shifted from sadness to anger. Heidegger (1962/2006) tells us that "In a state-of-mind Dasein is always bought before itself, and has always found itself, not in the sense of coming across itself by perceiving itself, but in the sense of finding itself in the mood it has" (p. 174). The anger of Angela's mood uncovers the anger that is already there and allows her to connect with it. This same mood of anger is shared by other interviewed midwives as they begin to recognize the price they have paid. (Angela returned to case loading practice after a long absence, but has left again to work elsewhere.) Celine shares her story:

The level of impact would be right up there. It was the beginnings of burnout, but I wouldn't want to go any further than what I did – in terms of its severity out of ten I would put it at an eight. It was serious. After stopping practice if I heard a cell phone with a ring like mine I felt that horrible sick feeling. (Celine)

Celine, like Amelia, does not self recognize the extent to which burnout has affected her. She believes she was in 'the beginnings of burnout,' yet classifies the impact of what she experiences as serious and describes a sick feeling spontaneously triggered as a reflex reaction to cell phones ringing which have the same ring tone hers. (Celine, after an absence, returned to case loading midwifery but began to re-experience burnout and now works in another area of midwifery).

I don't sit there for three days thinking I am going to kill myself, but I did get spells where I would think that the easiest way out was to die. (Gives short laugh). I know it was serious but it was just in little bits. I realized after the first few time that it was intermittent and it would pass, so I would just tell myself 'oh don't be stupid Amelia, its hormones' ... it might or might not be hormones, but it passes... yes... yes. I still feel I am at the cross roads, but in a better place. I haven't had any suicidal thoughts for months now. (Amelia)

Amelia is one of the participants who experiences feelings of suicidal depression in burnout and whom also struggles to differentiate between menopausal symptoms and burnout. She self recognizes that her burnout is serious but uses minimalism to negate it. Even now Amelia evaluates her improved wellbeing against the criteria of not having 'any suicidal thoughts for months now,' revealing a distorted perception of what wellbeing is. (Amelia has given up her case loading midwifery practice).

Heidegger (1962/2006) believes that in adverse mood:

Dasein becomes blind to itself, the environment with which it is concerned veils itself, the circumspection of concern gets led astray. States-of-mind are so far from being reflected upon, that precisely what they do is assail Dasein in its unreflecting devotion to the 'world' with which it is concerned and on which it expends itself. (pp. 175-176)

As Heidegger shows us, the lived world of the midwife can blind her to what is happening. Her professional concern is directed to other at the expense of self, the lack of balance of which becomes excessive in burnout. Her wellbeing is called back into focus by an assault of mood which assumes whatever extreme it must to finally break through and seize her attention. By this means mood is eventually able to interrupt the consumption of self by the world of concern in which an excessive energy is being invested. It forces recognition of the erosion of self and demands a reintegration of its fragments of self. This is the phenomenon of burnout; a phenomenon with many faces and complexities that is not acknowledged or understood within midwifery by either self or by other. By bringing the phenomenon to the light of knowing the destructive capacity for burnout to flourish in such

deceptive shadows and become life threatening amongst case loading midwives is reduced.

Summary

This chapter set out to explore the onset and progress of burnout as seen through the eyes of the midwives who have experienced it. It seeks to know of that experience through the listening to and hearing of their words.

Heidegger (1927/1962) reminds us that:

Just hearing something "all around" is a privation of the hearing which understands. Both talking and hearing are based upon understanding. And understanding arises neither through talking at length nor through busily hearing something "all around." Only he who already understands can listen. (p. 207)

As Heidegger observes, understanding is not realised by generalised random listening or by lengthy conversation. There must be an understanding of a situation before a person is able to truly listen to what is being said. Despite the phenomenon of burnout being an intensively destructive one, the lack of knowing that enables an understanding of it obstructs the listening that can hear what is said.

Burnout has been trivialized; perhaps through fearing it reflected a potential for fallibility within a professional option for maternity care that prides itself on excellence. It has been interpreted as individual failure, not as a phenomenon that has been revealed to occur within self employed and case loading midwifery practice. Burnout is not the natural shedding of workers who decide that their work does not fit well or asks too much of them so they simply elect to walk away from it unscathed. Within midwifery it was not about leaving midwifery, or changing roles within midwifery by choice. It is about experienced and dedicated midwives who burned out in the giving of midwifery service and were forced into their decision to leave their chosen field of work in order to survive.

Burnout is a recognized phenomenon that has the ability to induce an invasive and damaging process into the lives of midwives and take them to places of personal

disintegration and danger. It establishes itself in the selfless care of the exceptionally committed midwife and then turns on her and drives her out. In its extreme burnout becomes a survival mechanism, removing midwives from the destructive nature of their work by incapacitating them to such an extent that they can no longer work, the engagement with which has become life threatening for them.

Van Manen (1990) speaks of *epistemological silence*. “This is the kind of silence we are confronted with when we face the unspeakable” (p. 113). Within midwifery burnout has been shrouded in such a silence leaving both midwives and midwifery unprotected. Hölderlin (1996) reminds us that "where danger is, grows the saving power also" (p. 462). Within the recognition and understanding of burnout lies the ability for the midwifery profession to address it. In my next chapter I seek to explore the ways in which case loading midwives are made vulnerable by their work.

I thought burnout was
an awfulness
but it was the
abandonment
of joy. The
shedding of self knowledge
learning to pretend
first to others,
then to self
unknowingly,
that it was
the woman
the day,
the difficulty
the demand
steadily shutting doors
on insights.
Becoming whom
you did not recognise
until even when
that woman
that day
that difficulty
that demand
has been abandoned
you still did not know
that joy had
abandoned you
or why it did.

Chapter Seven: Fuelling the fire

Introduction

In the previous chapter the unknowing of burnout was explored and its progress traced through the lived experience of midwives to its more serious outcomes. Their stories show us that the impact of burnout is huge, raising the question of how did they allow it to become so bad? Why didn't they, their families, their colleagues or the profession itself see what was happening and intervene sooner? Instead the situations were left to become so severe that some participants talked of feeling suicidal. This chapter seeks to understand how this happened by exploring the areas of vulnerability within the midwifery environment participants identified.

Looking back with understanding

Gadamer (1975/2004) says of understanding that it is "not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were" (p. 379). Understanding comes from the embracing of different knowledge to allow a new viewpoint, not the capitulation of one opinion to another. Interviewed midwives participated in this study in the hope of such understanding. To revisit hard won autonomous practice when it appears to be working is difficult for midwifery and for midwives. The challenge of burnout is complex and for the participants it was as if the profession abdicated any responsibility and handed it to the individual midwife to address. They felt they were made responsible for re-educating women to a sustainable service expectation in the face of an unconditional service offer that is legally upheld and professionally endorsed. Participants believed that when the midwife cannot contain that expectation and burns out in meeting it, her burnout is seen as signalling individual poor practice management while the external shaping that induces a high potential for burnout continues to avoid scrutiny.

Gadamer's (1989) hermeneutic rule is that: "The movement of understanding is constantly from the whole to the part and back to the whole. Our task is to expand the unity of the understood meaning centrifugally" (p. 291). As Gadamer informs us, understanding is not acquired by static focus on the area of central enquiry. It

requires a consistent visiting of all the influences that circulate around it. The impact of those external factors must be gauged if there is to be an integrated understanding of what has been shaped within the core. Understanding can only be achieved by exploring the nature of midwifery, the nature of the midwife and the dynamics of case loading care. The beginning point of understanding burnout is to first understand that the participants of this study began with a deep passion for being a midwife.

The professional influence

Bob observes of midwifery autonomy, "*they took over the service as well as providing the actual care*" (Bob). In addition to their traditional nurturing role, midwives took over a new complexity of concerns. The NZCOM (2008) Midwives Handbook for practice instructs midwives that she "facilitates the decision-making process without coercion" (p. 7) intending the new power to be held by the women themselves, while partnership called for the ideology of shared investment and shared responsibility. But participant midwives commented of some women "*their attitude is here is my pregnancy, you take it and you deal with it*" (Jemima). Whatever version of care the midwife brokers with the women, she remains ultimately culpable for the professional care and outcomes. Partnership called for a major change in the midwifery role which women and midwives needed to become familiar with.

Bob comments further as someone external to the profession:

It seems the Midwifery Council or College of Midwives has needed to prove a point but it has to change because you are destroying people's lives. As the midwives drop out at a rapid rate at one end, midwifery is bringing in younger and younger midwives just through school and throwing them into the fire. There has got to be a mechanism for change because if they really supported the midwives they would recognize all this stuff. (Bob)

Bob believes that the original need for midwifery to prove itself has to be tempered with the emerging knowledge that midwives can pay an unacceptable price for their profession. He likens the unknowing of case loading practice with the strong

analogy of a fire into which innocents are flung by their profession to burn. He believes that there is a lack of recognition and failure to address burnout at the governing levels of midwifery practice which discloses indifference.

I feel that the College has set up this romantic picture of case loading practice and what a midwife was without the real understanding of what the midwife did at the grass roots level. The reality is quite different from how it is portrayed by the college. (Jemima)

Jemima, along with other participants, believes there is a gap in the understanding of the actual experience of the practicing midwife and their professional body's perception of it. For these participants there is a hierarchical unknowing of their practice reality by the professional body on whom they rely to negotiate and influence key decisions governing practice. As burnout becomes known and nothing changes, midwives become alienated from their professional bodies. They voice feeling that they are "abused" and "devalued," while Jemima weeps as she tells how her passion for midwifery was damaged.

The midwifery passion

Participants spoke of their midwifery passion and the nature of their call to midwifery. Gadamer (1975/2004) says: "driven by the dialectic of passion, whatever his passion tells him is right seems so" (p. 322). What calls a midwife to midwifery can be fraught with vulnerability because for some it comes from the heart with a capacity for selfless giving. Max made this comment of his wife: "*She has a huge commitment to her woman; she does that extra mile to make sure it is a positive experience for them. That is one of her problems, she cares too much*". Max describes a passionate commitment that focuses on 'other' to such an extent it becomes problematic for 'self.'

Yet the message given to midwives is that, burnout is not the result of fatigue and overwork but the loss of passion; that it occurs when you lose passion for your work (Hartley, 2003). Within this opinion midwives who burnout are erroneously condemned for not caring enough, but Lynch (2002) believes that "by understanding the causes of stress, exhaustion and burn-out, we can begin to effect change in the

political arena, our profession, our workplaces and our approaches to daily life" (p. 179). Through the knowing of the experience of burnout understanding enables necessary change to be made to protect women, midwives and midwifery.

Passion meets practice

For interviewed midwives there was a sense of vocation in their call that became eroded in burnout. Some spoke of their desire to change the experience of another because of an adverse childbirth experience they had. Angela had "*wanted to change things for the teenagers because of my own experience as a teenage mother*". She tells of her feelings when she came to choose where to practice:

Basically teenagers are such a dangerous area to work in. There can be a lack of seriousness about some young girls and they play you off because they understand the system. That had been my first choice of where I wanted to be but when the opportunity presented I felt so vulnerable, I didn't have the compassion I went in with. (Angela)

Angela tells us that her learning and practice experience sabotaged her original desire to work with teenage mothers. Her pulling back discloses fear as her compassion is hijacked by her altered perception that young women are 'dangerous' to work with. What does this show us of Angela's experience of midwifery practice as it becomes coloured by fear? Midwives and women become adversaries; midwives feel they are made unsafe when women make unsafe choices and they begin to believe that women can abuse midwives when they understand how the system of care works. Angela's original perception of young teenage mothers as deserving of special support and her desire to help them is eroded by her experience of practicing as a midwife and her exposure to burnout.

In the rural area, which is where I ultimately chose to practice, women wanted something different prior to midwifery autonomy [G.P. care] as they weren't happy with what they were getting. We hoped to improve the levels of pregnancy care and have better outcomes once midwifery independence became a reality. (Grace)

Grace's choice of case loading practice is also altruistic in her aspiration to provide rural woman with better care in an environment that is taxing to service because of

the long distances involved. She shares the collective vision of midwives that midwifery could offer women a better service than the general practitioner. Yet in burnout she now concludes of those same women:

Women can be very fickle. Don't we know it! Very much so, and play one against another so very easily. The perception around birth is different. It has to fit it in with their job; we have to fit in with their needs including appointment times. We constantly have – well I need you to do this, you are the professional so you are on a different level and you fit in with me! It is because we are women too, because we are female. They wouldn't expect that of a G.P., or an obstetrician. Anyone that is male – even if it is a female GP it isn't expected of them, but they expect it of midwives.
(Grace)

The women Grace specifically set out to help in burnout appear to be adversaries. Like Angela she sees women as manipulative; in this instant playing one caregiver off against the other. Grace believes they have abused the midwifery service offer and the client demand she experiences is selfish. She struggles to identify why, linking it to shared gender then to a perception by women of the midwifery status as one that is subservient without any rights of consideration. Grace's practice experience shows the difficulties within her provision of care which impacts on her desire to improve the lot of rural women. Amelia shares her story:

I was drawn to midwifery after I attended a birth. I was blown away by the whole thing and thought I want more of this, I need more of this! I think midwifery is totally about passion. It is a way of life! I actually didn't put me ahead of midwifery. I was absolutely prepared to run after women. I used to say phone me day or night if you have any problems, and I would leap in the car and hare off.

Passion inspires but, as Amelia shows us, also introduces the potential for abuse by skewing a professional objectivity of need assessment. Without clarity as to what is reasonable, the midwife is compromised by the excessive client demand she allows. Amelia's engagement is totally involving; there are no boundaries between her and her midwifery. She *needs* the fulfilment that attending a birth offers her, her passion changes her professional obligation to one of personal need to be of service. It is only in burnout when her changing level of work satisfaction forces her to redefine her professional role Amelia introduces boundaries into her practice. She now says in burnout:

If that means a delay of an hour or so while they get a baby sitter or the husband has to come home with the car, so be it. The doctor is not going to make a home visit, why should I! I used to be shocked when I heard other midwives saying nasty things about their women behind their backs but now I am guilty of it. My tolerance of the women is not what it used to be. It is reduced totally. I am not ... yeah (sighs deeply). I am shorter tempered, more impatient. A bit of my lack of tolerance and a bit of the women's expectations... (Pauses)... yeah, but some woman are just... silly! (Laughs). I don't care to pander to it any more. I am overdosed, totally overdosed. I wasn't like that in the beginning; I used to tell the women I'm here to serve you, not the other way around. In trying to survive I have to confess that, while my passion has lessened, I have been able to step back and say "back off, too much!" My time is my time. (Amelia)

Within midwifery there can be a covert hostility in the barriers put between midwives and their clients as Amelia's comments about midwives conversations show. She reveals her struggle to feel comfortable with boundaries. While Amelia now recognizes unreal expectation and doesn't accommodate it, she self blames for her intolerance of it. She sees herself as capable of saying nasty things about the women in her care, being short tempered, impatient, intolerant; she "confesses" to the lessening of her passion and speaks in a monotone with an air of self protective caution. She does not recognize that her manner is a way of creating barriers between her and the excessive expectation she perceives her clients now have of her without having to formally verbalize that to them. It reveals the difficulty of establishing professional boundaries. Her story shows us how a midwife can begin practice with no understanding of boundaries and that women can see midwives as resources to be used without discretion. Linda tells us:

I thought I need to give up. I started to get like some of the other midwives, moaning about the women and I couldn't have cared less if I was there or not. If another woman had never rung me I couldn't have cared less. (Linda)

Linda identifies feeling disconnected from and indifferent to women. The significance of this is clear when paralleled with her original feelings of "*Just the special ness and privilege of being there when the baby is born, the relationship between the woman and the practitioner.*" Linda's practice reality again shows the burden of care that is felt by midwives which is verbally expressed within the safety

of the fold. Midwives professionalism and their partnership model of practice sets out to absorb inequality in the power base between midwife and client by directing the midwifery focus to client need, but the culture of covert client complaint within midwifery that is referred to reveals disharmony. Participants practice experience show that the midwifery model of care within the phenomenon of burnout may invite in a dependency and excessive demand that does not benefit women or midwives.

As these stories show us, in burnout the midwife begins to emotionally distance herself from her work and become increasingly detached and clinical. She withdraws from the area of focus that formerly locked her into midwifery in which she gave and received the most. The midwife who loved birth no longer cares if she is present; the midwife who was totally available withdraws availability; the midwife who was drawn to a particular need disengages from that need; the midwife who wanted to make women's care happier becomes hostile to them. Practice exposure inverts the source of joy making it the source of angst. In detaching herself the midwife detaches herself from what called her to midwifery. As the focus of discontent shifts to the women themselves the midwife begins an internal struggle with the ideology of her call. The reality of practice caused interviewed midwives to critique their sources of understanding.

The power of "they"

Heidegger (1962/2006) writes of the impact of 'Other' on self. He contends that exposure to other can dissolve our sense of self; that our own opinions "as being distinguishable and explicit, vanish more and more" (p. 164). He describes how we embody opinion and comments further:

We take pleasure and enjoy ourselves as *they* [*man*] take pleasure; we read, see, and judge about literature and art as *they* see and judge; likewise we shrink back from the 'great mass' as *they* shrink back; we find 'shocking' what *they* find shocking. (p. 164)

Where "they" speaks from a position of authority within an environment that expects unity, their voice is strong. Guilliland (2007) offers the opinion that "midwives who

voice their discontent by resisting the requirements of professionalisation could ultimately feel more empowered if they worked with the profession not against it" (p. 7).

There was the further assumption by Guilliland (2007) that difficulties of practice reflect poor practice management by the individual midwife with a subsequent accumulation of stress leading to the failure to sustain practice as a business enterprise. As detailed in the literature review chapter, in the New Zealand College of Midwives publications, *Midwifery News*, midwives who struggled with the demands of practice were told their difficulties with practice arose from their lack of passion (Hartley, 2003); to get out of the profession because they weren't doing it any good (Angela), and were asked if they were taking an honest account of their limitations (Eustace). In a further publication, *Midwifery Today*, Eustace (2002) suggests that midwives ask themselves "Am I just 'all out' for myself or am I thinking and acting in a way that will benefit midwifery as a whole?" and to consider taking a weekend off a month to restore life balance.

Yet the common perception of the burnout indicators emerging from their practice amongst participants was: "*I can't remember there being an incident when the light went on, I don't know that I ever recognized that I was burning out...*" (Jemima). Their signs of burnout are covered over by semblance and appearance, "*I used to get really bad headaches, and it was only stress, nothing else. I thought it was because I had put my neck out and I would go to my osteopath*" (Anne).

This lack of understanding of burnout causes an uninformed critiquing of those midwives who suffer it reinforcing the reluctance to disclose their symptoms of burnout amongst midwives because of the professional stigma surrounding it. The subsequent non disclosure of burnout by midwifery practitioners because of its association with 'failure' reinforces the professional perception that it is a low key and easily managed event only evident amongst a few less able midwives. Guilliland (2007) states that "hundreds of midwives manage the practice and financial components of their work without stress" (p. 6), effectively isolating midwives who do experience stress. Brenda's comment of "*I couldn't believe that this good*

midwife that I was, I shouldn't be feeling like this..." reveals her belief that *good* midwives should not feel as she does. She is locked into the perception that burnout doesn't happen to good midwives. To be in burnout conflicts with Brenda's self awareness of her professional integrity and she is therefore unable to identify what she is experiencing. Conversely Jemima accepts the condemnation and subsequently refers to herself as a "*no good midwife.*" Angela believed her deteriorating documentation was indicative of her "*slackness*" not the accruing stress of burnout, while Derryn tells us "*I just thought I was tired – I thought maybe I was a bit crazy, a failure...*" Participant midwives in burnout consistently commented on feeling trivialized and abandoned by their profession; of being alone with their difficulties of practice and their feelings of failure.

The midwife interfaces with her own professional world, other professional worlds and the individually prescribed consumer worlds and must listen to them all. Each of these worlds assumes an authority of "they" which prescribes everyday being. Heidegger (1962/2007) suggests that "they" can be made liable for everything negating personal evaluation:

The "they" (that) is there alongside everywhere, [ist überall dabei] but in such a manner that it has always stolen away whenever Dasein presses for a decision. Yet because the "they" presents every judgment and decision as its own, it deprives the particular Dasein of its answerability.
(p. 165)

We are influenced by the concept of a "they" that fades whenever clarity is sought while the power of that "they" negates individual responsibility by midwives for the framework in which they must function. The voice of "they" begins to suggest practice induced stresses are symptomatic of the midwife who practices without basic business acumen and practice management skills; that she is culpable for her situation, not her profession (Guilliland, 2007). Emerging knowledge of burnout was re-covered over in a culture of blame in which the profession distanced itself from the difficulties of case loading practice and participants in turn blamed their profession for a seeming indifference. Ultimately participants began to project

blame onto the women for whom they cared for the extent of the care demand, the provision of which was impacting on their personal wellbeing.

Love/hate tensions

Heidegger (1962/2006) speaks of resoluteness as a way of "authentic being." He suggests:

When Dasein is resolute, it can become the 'conscious' of Others. Only by authentically Being-their-Selves in resoluteness can people authentically be with one another-not by ambiguous and jealous stipulations and talkative fraternizing in the 'they' and in what 'they' want to undertake. (pp. 344-345)

Heidegger believes that only when we are strong enough to talk of things frankly without subterfuge can there be authentic understanding. Such strength allows awareness that would be otherwise lost.

I would come out of delivery rooms hating women. Just wanting them to push the baby out, wanting them to have a caesarean so I could go home to bed. Being angry how pathetic their pushing was. You know, does she not realize I have been up for hours and I am desperate for sleep?
(Angela)

Angela talks candidly of her feelings in burnout showing how her own exhaustion erodes her empathy, while Anne speaks of telling a midwifery colleague: "*I hate my women. She said 'which one?'* and I said *all of them*". Midwives in burnout do not re-evaluate how they practice. That they do not discloses an assumption that their practice lacks negotiability or that the complexity of modification of their practice is too overwhelming to be undertaken in burnout. Seeing no other option to keep themselves safe within case loading practice, the women, seen as the source of their angst, become the enemy. Midwives interviewed said of women: they demand too much, they call too often, they call too late, they call too early, they ask silly things, they do silly things, they lack commitment, they don't try hard enough or long enough. Once women had birthed their babies there is a greater acceptance of their need. Perhaps birth works its old magic and draws midwives back in? Perhaps the

midwifery anxiety around sleep deprivation dissipates when the possible marathon of birth attendance has been met?

Even as these midwives recognize that they are struggling with the demands of providing around-the-clock care in often stressful situations, they find it hard to let go. Linda speaks of how this tension plays out in her life: *"It is akin to being a battered wife who is still in love with her abusive partner; you struggle to recognize that you need to leave"*. She shows us how the midwife hides her growing sense of burnout because the thought of giving up her practice is too painful despite feeling so abused that she links it to violence. Yet, like the situation Linda refers to, she finds herself returning to her love, midwifery, again and again. A cycle is set up of abuse (exhaustion, stress, lack of control of personal time) to be counterbalanced by the original midwifery joy. Liz moves beyond Linda's lingering sense of still wanting to practice to say very assertively:

*I would say after I gave up, remember the Jews? Never again! (Laughs)
I would never ever do it again. I ended up never wanting to do something
I once loved. I still remember it so clearly that I won't go back. It asks
too much, it extracts... it takes too much! (Liz)*

For Liz burnout destroys her deep passion for her work; the intensity of which is still too present for her to ever consider returning to it. Liz shows how love becomes hate where there is no recognition of burnout and opportunity for appropriate intervention. Without this, midwifery risks losing experienced practitioners who become so seriously affected they are lost to the profession (Pairman & Massey, 2001). Liz echoes the sentiments of other interviewed midwives about their reality of case loading practice, *"it takes too much!"* Ann speaks of her sense of being consumed by midwifery until she was left with little sense of self, Jemima relates to this view commenting *"the work demand erodes your whole personae"*. Myrtle shares a story of her feelings of being invaded by her work:

*That feeling that I can't do this forever comes from my heart as well. I
am too tired, I am too flipping tired. I am exhausted. Emotionally I am
drained. Exhaustion! People being late for clinic, not turning up and
suddenly you have got three people in the waiting room. A woman
paging you urgently because they have got back pain or something
without even trying simple basic measures and want you to check it out. I*

am out of energy for that. I can't even laugh about it anymore I feel like going just piss off and leave me alone! Then I feel guilty because I feel like that, but that is the reality. (Myrtle)

Myrtle previously spoke of her feelings of privilege to be a midwife. Her words show us the depletion of burnout. She feels physically and emotionally exhausted; too tired to care anymore. She is harassed by the usual rigors of a busy clinic day, irritated by women leaning on her to solve every concern and angered and invaded by their demand. She wishes the women she once set out to make a difference for would now '*just piss off and leave me alone.*' Heidegger (1962/2006) says that "a mood makes manifest 'how one is, and how one is faring'" (p. 173). Myrtle's mood therefore is not just that of a grumpy disillusioned midwife who should leave midwifery, it is a disclosure of the faring of midwives within midwifery through the mood that is created within them by their work demand. Not understanding this Myrtle feels personal guilt because of her altered attitude. Heidegger (1962/2006) believes that guilt controls the extent of input; "This 'Being-guilty' as 'having debts' is a way of Being with Others in the field of concern, as in providing something or bringing it along" (p. 327). He draws our attention to how we can still be manipulated by guilty feelings of not giving what is owed to someone; of not providing what is expected to be provided even when the expectation is excessive and burdensome and destructive of self.

As these stories show women become the victims of midwives burnout. An adversarial stance occurs when the midwife's selfless drive to serve shifts to one of needing to protect herself from the excessive servitude that then surrounds her. Not recognizing she is engaging in survival strategies the midwife's altering attitude causes internal conflict. The ethics she brought to her caring is at variance with the reality of that care as the need for boundaries declares itself in the face of the extent of the consumer ask that has been generated.

Practice boundaries

Heidegger (1962/2006) speaks of how we are influenced by the way in which something first presents itself to us and then, once it is taken on, we carry that understanding into the future. Interviewed midwives consistently brought an ideology

to their midwifery practice that exclusively focused on the rights of women. Walling themselves off from the women was in conflict with their passionate commitment, their graduate level of understanding of partnership and the midwifery philosophy of care. They believed professional distance emulated the medical model of care. Establishing boundaries is complex when women are coached to have high expectations of care entitlement. In burnout midwives often backed off women's demands by low level hostility. Now midwives were offered a tool to deal with it, boundaries. How to establish such boundaries was left to their discretion while the promise of highly available twenty four hour care continued to be promoted to women.

The midwife is the least important person. The world thinks that this case loading midwifery and the services that we give to the women are wonderful, so why aren't they looking after us so we can keep doing it? It is a great service second to none. (Brenda).

Brenda asks "why aren't *they* looking after us?" while "they" ask her back why should you be looked after, you are autonomous practitioners? Change how you practice through boundaries; practice expectations will not change, therefore you must. Yet Derryn tells us:

We did not attend elective caesareans or consultations, we would initiate inductions but then handover care until the women were in established labour. This way of practicing evolved over time. Lots of midwives would go "oh you shouldn't do that!" (Derryn)

Practice input level is very visible and subject to scrutiny. Here Derryn tells us of having adverse comments made when she and her midwifery partner begin to modify their practice to try and create something more sustainable. It is shown that colleagues do not recognize when a midwife is in burnout, therefore they do not recognize when practice is being revised to curtail burnout, only that the midwife is altering the status quo of the established expectation and they are critiqued for doing so.

Heidegger (1962/2006) speaks of maintaining the status quo:

In this averageness with which it prescribes what can and may be ventured, it keeps watch over everything exceptional that thrusts itself to

the fore. Every kind of priority gets noiselessly suppressed. Overnight, everything that is primordial gets glossed over as something that has long been well known. Everything gained by a struggle becomes just something to be manipulated. Every secret loses its force. This care of averageness reveals in turn an essential tendency of Dasein which we call the “leveling down” of all possibilities of being. (p. 165)

Heidegger explores the way in which common experience becomes validated. Simply by being the common experience it becomes part of the averageness of the world in which it occurs. It is maintained by the monitoring and suppression of anything that may disrupt it by the denying of its significance and the defusing its discovery; “every secret loses its force.” Disruptive knowledge is manipulated so that it does not disturb what has become established and truths remain hidden. He identifies the human characteristic of maintaining the status quo, even when change is constructive. Burnout within midwifery is no exception to Heidegger’s philosophical observation. Linda talks of how the established expectation impacts on her as a midwife:

Women would phone up at 9 o’clock at night and ask you if it was okay to dye their hair... really dumb things that you would never phone your doctor at home for. I am happy for people to phone me up during the day. But they always rang in the evening. You would get into bed and someone would phone to tell me that the baby hadn’t moved all day. It encroaches on your personal time. Even when we say only call at night if it is urgent they get to define ‘urgent.’ Women are self centred when they are pregnant. They don’t think about us. You have to try and protect yourself as much as you can. (Linda)

As participants show us, in their original passionate idealism, despite their educative process, they begin practice believing good care means unconditional care; a premise in which their patterns of care giving are established. Linda feels compromised by women's external coaching in service expectation. She moves from her spontaneous joy of caring for them to protecting herself from their demands through boundaries she has to somehow evolve in private.

I feel you have to have clear boundaries and you make them clear. I had a single girl living in a supportive hostel situation who would text me all the time at weekends because the other girls went away and she got

bored. I would say it is my weekend off, but she would keep on sending texts or come back with the "I haven't felt my baby move." There was the filter of a housemother they could go to, who would assess urgency and then call you but this girl got access to my phone number and she would text me all the time. (Ann)

Despite establishing boundaries, including a system for assessing urgency of need, Ann's story is one of being subjected to excessive demand because of the woman's youth and social circumstances. Most participant midwives who evolve to strong practice boundaries still recount stories akin to Myrtle's of *"being contacted at 2 am. to see if she could take anything more than panadol for toothache,"* or Derryn similarly woken to be asked *"what hours are 24hour pharmacies open?"* Midwives in burnout did seek practice solutions. Angela tells us: *"I went to a salary paid position in an organized practice because I believed I would get more support and have structured time off, but at the end of the day you are on your own"*. As her account reveals, established burnout is not always able to be addressed simply by adopting a different mode of practice. Candy comments: *"I tried to implement a different system with the midwife I was working with and it was a disaster on so many levels it went back to how it was"* while Liz describes *"not being able to look at things logically and put things in place –I just kept going until I was basically beyond it"*. The many variations of midwifery practice tells us that there is no infallible model for sustainable practice while the midwife in burnout loses her ability to implement effective change and look at things logically. Needy women do not always have the ability to respect boundaries in the immediacy of that need while some participant midwives believed that the dynamics of partnership fostered such neediness.

Partnership difficulties

Partnership within the midwifery philosophical model of care is one of woman focused care and women led decision making. Thompson (2004) concluded that "the present analysis shows that an ethically adequate mother-midwife relationship is partnership wherein the midwife's power is exercised 'with' the woman" (p. 152). Participants felt that this model of care was difficult to translate into practice. They believe the focus on women's rights leave the midwife to broker a workable

professional position from a position of inequality which leads them to an excessive servicing of women's need, particularly when women's decision making was concerning.

My understanding of partnership came from my training, the College of Midwives and other practicing midwives. The philosophical ideas are part of the intrinsic way of practice and I suppose my interpretation of them was very literal. In retrospect I feel very cynical about it. In pursuit of partnership I went too far, I gave two hundred percent and I was far too available. The dependency partnership can create is a disservice. (Liz)

Liz finds that her literal interpretation of partnership is unsustainable. It is only in burnout that she finally recognizes the need to moderate her understanding of the ideology of partnership to something workable. Most participants share her experience; Ann tells us “*We were all given the whole mantra around partnership right from day one. I took that to the extreme*”. Jemima shares a similar experience:

I was well indoctrinated in my training that the partnership model was the gold standard; that my job as an 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! (Laughs loudly). It was just an idea. I would like to think it wasn't expected to be the panacea that it has become. (Jemima)

Jemima also discovers that her interpretation of partnership founders in practice and hopes that the version of partnership established within midwifery has been evolved accidentally rather than deliberately. Her comment reveals that the degree of difficulty she finds within the partnership model of care is so great that she prefers to think it wasn't intentionally arrived at. Other participants believe that the difficulty is not in translating partnership but in the original ideology, as when Angela comments that: *The ideology of partnership left me exposed*”. She expresses a belief that partnership fails to protect midwives. Derryn held strong views:

I think midwifery has unclear perceptions; it lives in an illusion and the philosophy has flaws. Partnership is skewed from the start. Yes there are some women doing their best, they read everything, they want to be the boss. Others don't give a rat's arse and want to be told. We are taught that women need to make all their decisions and we go with the flow, but it doesn't allow for safety. It makes for incredibly uneven

relationships. This college partnership it gives me the... it is crap! It is a one way ticket. It is dangerous for midwives to take it literally, because it is absolutely a bottomless pit. (Derryn)

Derryn maintains that partnership is an ideology that begins to break down as soon as it leaves the theoretical world because of practice world difficulties. She regards it as being unsafe for women and dangerous for midwives who enact it without modification and setting up staunch boundaries around it. The professional expectation is that midwives achieve partnership with all women bringing together the consumer and professional dynamics in a woman focused and controlled model of care (NZCOM, 2002). The trust in a partnership of shared responsibility and accountability for decision making with woman is not evident within the dynamics of midwifery practice in burnout.

Heidegger (1962/2006) tells us “Being true (“truth”) means Being-uncovering” and “of taking entities out of their hiddenness and letting them be seen in their unhiddenness, (their uncoveredness)” (p. 262). Heidegger suggests that truth can only be pursued by bringing things into the open and seeing them for what they are. Partnership, as a linchpin of midwifery philosophy, originally repelled critique despite sociological change, such as caring for drug addicted women whose addiction alters their decision making ability. While addiction does not make partnership implausible, it makes it more difficult. It is possible that the model for midwifery partnership is not able to meet such complexity of care despite the assumption that it, or modified versions of it, can be applied to every situation.

Gadamer (1975/2004) tells us that "Horizons change for a person who is moving" and that "the closed horizon that is supposed to enclose a culture is an abstraction" (p. 304). He believes that life is about movement and nothing can be "bound to any one standpoint" (p. 304) that we continually evolve. But disclosure of difficulties in upholding the ideology of partnership within practice is not always well tolerated. Skinner (1999) voiced her concerns in an article in which she concluded that she "did not accept that partnership at a practice level is either possible or desirable as a useful model to take us through to the next stage of our development" (p. 17). Her opinions

evoked a hostile response that closed off any further discussion of partnerships difficulties in an open forum for some time.

Since that point there have been a number of studies, articles, conference presentation and regional workshops on partnership. Freeman (2004) undertook a study that evaluated the feasibility of achieving partnership in a multi cultural society within a relationship that had elements of inequality. Participants involved in the study concluded that this was achievable. Thompson (2004) comments on partnership that:

...despite much discussion in the literature and amongst practitioners about theory-practice gap in midwifery education, what is lacking in the discourse on ethics and midwifery are the voices of childbearing women and midwives, in the context of the mother-midwife relationship. (p. 1)

Heidegger (1962/2006) reminds us in the context of the authority of 'they' of the "averageness with which it prescribes what can and may be ventured, it keeps watch over everything exceptional that thrusts itself to the fore" (p. 165). Heidegger asserts that authority is maintained by dulling down anything that disputes the validity of its opinions by creating an environment in which compliance is rewarded and challenge denigrated. Where such an environment surrounds their practice some case loading midwives learn to covertly manipulate the philosophical premise to something they can work with while paying lip service to sustain the original ideology. Despite the revisiting of partnership, participant's accounts of the hostile conversations of midwives, who were external to the study group and therefore did not self identify as being in burnout, about their clients show us all is not well in some practice settings.

Midwives are advised to create firm client boundaries around their 'partners' to keep their demand in check and so that their practice is able to be sustainable within this ideological model of care. The professional focus seeks to uphold midwifery care by ensuring it is a credible and competent service that is respectful of those to whom care is given. The consumer focus dwells with the quality of that care; its authenticity, availability and the inclusion of a comprehensive recognition of consumer rights. For the consumers of the service, despite the partnership model of

transparency of care, ostensibly nothing has changed. Women are unaware that midwives struggle with the service demands and have burnt out providing their care.

Consumer expectation versus midwifery sustainability

It is our fault for giving too much, but I also think it is the fault of the media and the College of Midwives. Every where you look it says that your midwife will be there at any hour seven days a week, phone at any time with any query. (Linda)

Linda acknowledges her responsibility to contain consumer demand but draws our attention, as do other participants, to how this must then be achieved in the face of the care expectation promoted to women. Heidegger (1962/2006) discusses how expectation becomes established:

Publicness proximally controls every way in which the world and Dasein get interpreted, and it is always right – not because there is some distinctive and primary relationship-of-Being in which it is related to ‘Things’, or because it avails itself of some transparency on the part of Dasein which it has explicitly appropriated, but because it is insensitive to every difference of level and of genuineness and thus never gets to the ‘heart of the matter.’ By publicness everything gets obscured, and what has thus been covered up gets passed off as something familiar and accessible to everyone. (p. 165)

Heidegger suggests that when something is publicly announced it is made valid even if flawed simply because it has been put before everyone. While this may be deemed to be less achievable in the modern world where challenge is better accommodated, Heidegger contests that when something becomes public knowledge it controls public knowledge. It achieves this not because of its depth of understanding but because of an indifference to and disregard of anything that conflicts with it; it closes its eyes to genuine knowledge. In this way the world of some consumers contribute to burnout through their adherence to their rights within the proclamation of a level of service expectation which disregards the service provider. The right of around the clock availability for consultation, even when there is doubt whether it is maternity related, and a prompt expectation of care is legally upheld within the Ministry of

Health (2007) Maternity Services Act. The NZCOM (2008) Midwives Handbook for practice reminds midwives that "midwifery care is delivered in a manner that is flexible, creative, empowering and supportive" (p. 3). Women, having gained a service that must be on their individual terms and generous in its immediacy, availability and sensitivity understandably have no incentive to examine what is offered nor do they have any awareness of the need to. As some participants stories have consistently shown consumer demand within their practice was high and at times inappropriate; the service expectation was seldom tempered with consideration of the service provider thus driving the environment of burnout.

We all know that pregnant women are the most self centred group on earth. I don't have a problem with that, they have to be. But there has to be an educative process that says these are the possibilities; you can be as self centred as you like but this is the safe way of doing it. The rules and regulations almost set midwives up to fail because they took over a medical model of care with no understanding of how it would be for them. It is appalling. In claiming autonomy the midwives have been forced into proving themselves to be invincible to show that they are more than up to the job to placate the law makers. (Bob)

Bob believes midwifery care has safety issues for both women and midwives. He believes midwifery uplifted a service with strong medical traditions which restricted availability and had robust practitioner support systems in place. It then set out to eclipse that care by removing all those restrictions and offering unlimited support. In his opinion the lack of protection of midwives providing care on such terms invited failure. He uses the word 'appalling' and argues that it would require an 'invincible' person to meet such expectations. Derryn shares this belief: *"We are supposed to be these amazing people; it is our core teaching that has done it to us... our own ignorance. We set midwives up to fail before they start"*. The consumers' expectation remains unmodified and is maintained in the averageness of the consumer world, as discussed by Heidegger (1962/2006). Within this environment midwives must set up boundaries without provoking client condemnation for giving a lesser service than naive at risk colleagues new to practice may offer.

In my practice I am quite fierce about telling women that it is about them and they own it – it has become an issue the other way now. It is a bit of a hard talk, but I make it very clear because some of the stuff that is

available to them that talks about partnership. I have actually decided to protect myself from it now. (Liz)

Liz describes brokering a defensive, model of partnership that now primarily sets out to protect her as a practitioner from its pitfalls. She regards the information available to women as misleading and something she needs to firmly clarify with countering information to balance the promoted expectation of care. Her boundaries are staunch and put the onus of responsibility on the woman, "they own it" not the midwife. Derryn tells us:

Until you have burned out you don't believe how tight boundaries have to be because pregnant women and their partners are just sucky motors. We are teaching women that they can go over those boundaries and they can't! (Derryn)

Derryn also discloses a mode of practice that is defensive warding off excessive demands from the women she cares for. She believes the line drawn between the midwife and the women has to be both restrictive and non negotiable if the midwife is to survive practice. Her workable interpretation of midwifery partnership as a result of burnout has evolved to something which is adversarial. Interviewed midwives also told of conflict in their interfacing roles.

Collegial conflict

Gadamer (1975/2004) expresses his concern that we only focus on what divides us to detect difference and address it while what unites us remains without a voice. It has given rise to the normalizing of confrontation and bellicose attitude instead of the wisdoms of our solidarity.

I never had any real issues interfacing with secondary services. Obstetricians? I have never had anyone yell at me. I've had a few run ins with the anaesthetists, being sworn at by a couple of them especially at night time but I have stood my ground and said I will not be spoken to like that. (Anne)

Anne describes herself as not having issues with secondary services but then clarifies this as never having had an obstetrician yell at her. During her interview she describes a situation where she is treated patronisingly by an obstetrician "Anne you

should try harder," when she is not at fault. When anaesthetists verbally abuse her she objects, but does not follow through with a formal complaint in a workplace that declares a zero tolerance of workplace bullying. She identifies that it occurs more at night, revealing that anaesthetists also suffer from sleep deprivation but at times don't contain the mood generated and vent it on their colleagues. The absence of any "real issues" hinges on Anne's ability to stand up to bullying that otherwise goes unaddressed. At a medical forum on burnout organised by the University of Otago it was reported that "New Zealand hospitals are rife with bullying which was an important factor in burnout" from which it was estimated as many as 75% of doctors suffered (The Press, 2001, P. A9). It was suggested that a supportive culture within hospitals was needed to reduce burnout and that the high degree of stigma attached to asking for help compounded the problem; comment was made that district health boards needed to do more to reduce practitioner burnout.

Myrtle comments:

I don't have a problem dealing with the obstetricians. I have worked there long enough to know how they all work. I know who I hate having to ring at three o'clock in the morning. I know who needs to be grovelled to and treated like a Queen to give me what I need. I know how most of them work and we have a healthy respect for each other. The same with our anaesthetists, some of them I can ask anything of them. (Myrtle)

Myrtle has learnt to work comfortably with secondary services by placating the individual practitioners to achieve this even though it reinforces poor work place behaviour; so the "Queen" goes on being coerced into fulfilling her paid professional role by submissive behaviour. Heidegger (1962/2006) discusses how we relate to Other. He suggests our interactions set out to align ourselves with Other by evaluating difference; he describes the hierarchical system when one "already has some priority over them and sets out to keep them suppressed" (p. 164). The reality of some workplaces is that the midwife is subordinate to all these professionals while the midwifery ideology expects a facilitation of women's care from a position of equality. The dogma which participants describe presumes the midwife and woman stand fast as a combined entity, further strengthened by the woman's rights of choice. The reality for some of the participants is that most women are almost always coerced by a persuasive argument from an obstetrician as their authority carries more

weight than the midwife's. The nature and manner of the relationship midwives have with their peers is found to be more significant than the professional role itself. The charge midwife, anaesthetist, paediatrician, obstetrician's or registrar's willingness to be supportive becomes the essential information rather than their official role.

The obstetricians were an important aspect of it. I had a very bad experience with one in a situation that just devastated me. I already didn't relate to this obstetrician because he was so arrogant. He didn't relate to midwives and he didn't work with midwives, he oversaw midwives and took over from them. He wrote comments in the clinical notes commenting on my practice and what, in his view, I had not done or done wrong. I was attending a woman in labour where there were some issues but everything was calm and progressing well. Then this bastard came into the room and the whole dynamic changed – the whole dynamic changed. Because of his mismanagement the woman was seriously compromised. It was the catalyst for an ongoing very traumatic relationship for me with him. I had problems working with him from then on. It actually affected my practice because I made really stupid decisions about not doing things because if I brought him into the picture I knew what was going to happen. I held on and didn't refer to the obstetrician at times when he was on. That was a really bad time, a really low time. When he was on duty I knew I just couldn't have anybody go into labour. It was a dreadful time. I wouldn't sleep for days around when he was on duty; it just filled me with terror. (Jemima)

Jemima's account shows us that interfacing with secondary services may involve negotiating around an entrenched professional perception of midwives as both inferior and subordinate. Because there is an in-balance of power between midwives and obstetricians within the reality of their shared work world, conflict within it has a potential to be unchecked and become destructive. Jemima describes having to cope with an obstetrician critiquing her care in the women's clinical notes which then become a permanent record that can be accessed by her client and viewed by other involved health professionals. Jemima's story reveals the reality of her powerlessness to negotiate for the women for whom she cares in that hostile environment. She resorts to avoiding his involvement in care, at times inappropriately. She becomes anxious and fearful when he is on duty; her feelings are so extreme she describes them as being "filled with terror". Jemima describes a situation where it is the authority of "they," in this situation embodied in a particular person, that is the source of her fear; there is nowhere for her to flee to. The extreme of Jemima's terror reveals the extreme of the situation she has been placed in. Her

account shows a lack of any facility to address the destructive work relationship she has become embroiled in. Often these encounters occur when midwives are deeply concerned for the wellbeing of a woman in their care as well as feeling tired and vulnerable. Fear of a particular obstetrician, or charge midwife, transfers to the possibility that any other person in authority could act in such a way, at any time. Fear of the specific becomes a non-specific dread.

King (1964) discusses Heidegger's analysis of dread, "The everyday familiarity with and at-homeness in the world is suddenly broken in dread" (p. 134). In dread the security of the world is disrupted, the response to which is to flee from the not-at-homeness "to the reassured at-homeness made public in the explanations given by "them" (p. 135). King tells us that this mode of retreating to what is familiar is not an accidental or occasional event but a constant and basic way of maintaining ourselves in the world. To understand this is to understand the power of "they" to have an authority over us as it is by that authority we define ourselves and feel at home in the world. When authority per se becomes dreaded, a mood pervades that brings heaviness and despair. The worst is imagined, and goes before every encounter. Dread dulls hope, optimism and resilience.

The midwifery philosophy embraces the perception that the midwife works in partnership with the woman; thus she is responsible for creating a functional partnership which empowers the woman to control her experience of pregnancy, birth and mothering from the essential perspective that childbirth is a significant and normal life event. Interfacing with other professional services is expected to be timely, competent and in a co-operative and collaborative manner (NZCOM, 2002). The lived experience of midwives uncovers the complexity of upholding the philosophy of partnership with women and effecting professional interfacing, some of which difficulty is a significant factor in burnout. Difficulties of effective working relationships also occur within the midwifery culture.

I was too proud to phone my mentor because I knew what she would say to me (laughs) so I just toughed it out. When I spoke to my colleagues about it later they had deliberately left me alone so that I would learn a lesson. They knew I was there and they knew what was happening, and they both said you needed to learn that you say no to doing a surgical

induction with syntocinon. I had tried to get help, but the staff had said "no," and I just accepted that it was no. But if I had been a bit more pushy and assertive they probably would have found someone to baby-sit her. I came to dread it if someone phoned me and told me that their waters had broken. (Anne)

Anne describes a situation where her mentor and her mentor's practice partner decide to teach her a lesson by deliberately leaving her to manage an induction of labour over an extended period of time. They believe that she needs to be more aggressive in the work place in order to access support in a short staffing situation. In this way learned aggression is taught to new practitioners as a survival mechanism and endorsed as an acceptable part of normal practice. She learns her lesson - "*if I had been a bit more pushy and assertive*" then "*probably*" she would have had help. Yet Anne expresses thereafter dreading having to manage an induction of labour, revealing that the lesson she has really been taught is that within midwifery you may not be helped by anyone. Angela also comments that she "*felt so vulnerable at the hands of specialists and even my mentors. I realized that at the end of the day you are on your own*". Liz recounts:

I felt incredibly isolated. Some of the charge midwives made life very difficult. Years later I realised that I wasn't the only one who used to shudder in my boots when they would say that a particular person was on. When I rang to say I was bringing in a women in labour my first question was who was charge midwife on because it made a huge difference as to how you would be treated. It would affect the level of support that would be there should you need it. Some of them came out with amazingly nasty stuff. I was incredibly naive about the profession believing that it was full of good intention and integrity and I have to say that it is not. I worked in a poor area with women, who because of their social circumstances were unwell. Their culture was to self-present, then the hospital would ring me and say get here now! I had an incident report made against me because I took longer than twenty minutes. At the time I thought it was to do with me rather than about the way they behaved but later I saw very clearly that they were just bullies and abused their power. (Liz)

Liz discloses situations amongst midwifery colleagues where the manner of the individual person is also more critical than their official role. Who the person is affects the level of support a midwife can access regardless of the position that they hold, the restriction of which then impacts on client care. Just as midwives are shown to create boundaries between themselves and their clients through their

manner, charge midwives are similarly revealed to create a barrier between them and the midwives whom their role is to support. Such behaviour may also reflect excessive workplace demand. Liz shows us her feelings of powerless by submitting to the need to work in a hostile environment if particular charge midwives were on because she is unable to effect change. When such behaviour is without trigger, vulnerability is created as there is no ability to avoid conflict as anything or nothing may incite it. Within that hostility there is a lack of acknowledgement of Liz's provision of care for a high need client and the extra demands such care entails. The punitive attitude compromises woman by the withholding of care until Liz can personally attend her. Angela comments:

Not being safe to say, look I am really too tired because there was no one to handover to. That whole power thing at the hospital, 'where's her partner, she can't handover to us.' They say of the case loading practitioner that 'she is autonomous so if she needs any help she should be asking her practice partners.' I hate it. (Angela)

Angela uncovers the dilemma of feeling unsafe to say that she is unsafe through fatigue because of the lack of opportunity to hand care over and unwillingness by core staff midwives to assist. The assumption that the midwife is autonomous so if she doesn't ask for help she doesn't need it is erroneous because we are shown that fatigue impairs discriminatory judgment. Two participants tell of being momentarily horrified by the possibility of having injected an anaesthetics agent intravenously because the syringe is the same size as the antibiotic medication when they were exhausted. Amelia comments, *"I have been in situations where I have been coerced to keep working. I find bursting into tears works well"*. Her words show the degree of stress midwives can be exposed to and the levels of fatigue they work with while giving what may have become complex care. While Amelia has learned tears procure help, her tears reveal the extreme her distress must reach before help can be obtained, help which a less open midwife who masks her exhaustion may be denied.

I started at eight o'clock that morning and it was ten o'clock at night. I said I am starting to feel that I am not okay. It was, 'oh we are far too busy right now, but we will keep you in mind.' Then comes four o'clock in the morning, the woman is on syntocinon and we are getting nowhere and they say 'well are you going to need a little break soon?' No, I am

beyond having a break. If I stop, that's it; I am going, so I kept working.
(Myrtle)

Fourteen hours of unrelieved work without a meal Myrtle voices her lessening ability to work but her approach is dismissed. After twenty hours of continuous work, she is offered a break in a scenario she describes as obstructed labour where a baby can become critically distressed with an exhausted midwife as the sole caregiver. Myrtle recognizes that a break is no longer sufficient but her recognition that she needs to handover care is also now impaired so she doesn't stop - and she isn't stopped by those around her. The Midwives Handbook for Practice (2008) criteria is that the midwife "recognises that she is an autonomous practitioner, regardless of setting, and is accountable for her practice" (p. 14). In this scenario the accountability of the autonomous practitioner is skewed by her autonomy making her unsafe by the lack of support and appropriate intervention.

My practice partner had been at a birth there all night without a break while I was attending a birth at a different hospital. She had gone out at one point for help and they had said they were too busy; they were looking at houses on the computer! I rang Steph at six in the morning to see what was happening as I had got home at two and she was still there and she told me. I walked into that place at handover and said to this whole room full of core staff 'you didn't support my mate. She hasn't had a break and she started at work at eight o'clock yesterday morning you bastards and she hasn't had a break. And somebody was out looking at houses on the computer telling her they were too busy!' There was just this deadly silence. I said 'you made her really unsafe, you put her in a situation where she could have done something dangerous and you were all here not caring and I just want you to know that I think it is really, really bad.' The manager was there, she didn't have a lot to say that day (Laughs). I couldn't have spoken up like that for myself. When you haven't slept all night and you start trying to say I need help you are so beyond it you could be embarrassed by falling to bits in front of everyone.
(Myrtle)

Myrtle's story shows that help can be withheld as well as be unavailable because the midwife is a non core staff midwife. It tells of the divisions within midwifery where an insider/outsider mentality puts women at risk. Myrtle's perception of Steph being unsafe reveals 'being unsafe' is about midwives as well as women; "*she could have done something really dangerous*" considers midwifery culpability as well as compromised care. Grace speaks of having a serious road accident on her way home

from giving extended care. Lynch (2002) believes that "hospitals are organized as corporate workplaces overseen by managers whose job is to economize health care" (p. 180). Senior management remains silent in the face of Myrtle's words; words she tells us are hard to express on your own behalf. Change is not implemented; showing us that anger is not easy, it may go unexpressed and when expressed it may be ignored.

Linda, who now works as a staff midwife concludes that: "*Midwives are exhausted in every single area and are mean to each other because they are all pushed! They are all stressed to the limit!*". She feels this leads to a lack of empathy amongst core midwives because they themselves are struggling to meet their own expectations of service and have no reserves left to reach out to help a colleague. She does not see this as indicative of a lack of collegial goodwill but a direct reflection of the current work load midwives carry. Jemima endorses this when in her new role as a core midwife she sees a former case loading midwifery colleague at her limits of tiredness, "*There was nothing I could do to help her because I was so busy but I could see she was desperate. It was... awful. I think about it a lot and I feel so guilty...*"

Heidegger (1962/2006) says of guilt that it arises from feeling that "One can owe something to another" (p. 327). Collegial goodwill invites an empathetic response of help to a midwife who is exhausted through her giving of professional care. Because Jemima and Linda have experienced burnout they have a greater awareness of this need where other midwives may not. Linda moves beyond the midwifery interaction to critiquing the system under which midwives work. Within collegial dynamics the system which endorses understaffing which impacts on the ability of individuals to offer each other professional support is often overlooked.

In a working environment of divisive behaviour the midwife is isolated with her difficulties in providing extraordinary care. The midwifery focus on working together to achieve the best outcome for women is nowhere to be seen, nor is there any recognition of the ideology of continuity of care in supporting the midwives who meet its expectations. Difficult of interfacing in some areas is known and despite a

zero tolerance of work place hostility it often goes unchallenged. Thompson (2004) suggests that "Midwifery needs to refocus its ethical 'gaze' from the abstract to the particular and from right or wrong 'action' to the nature of relationships" (p. 174).

Summary

Van Manen (1990) reminds us that "phenomenology does not problem solve" (p. 21). To explore the lived experience of these midwives opens up a fuller understanding and knowing of burnout which a focus on solving it would close off. Areas of vulnerability were identified by participants within the philosophy of care and the understanding of it which is bought to practice. Participants believed that the continuation of the promotion of an unmodified service expectation to women further compounds this and it is not easily addressed by brokering boundaries with the individual women. They also showed that practice can involve unsafe care that occurs in part because of an understaffed or hostile work environment. The failure to acknowledge or address these areas within the profession both isolates and alienates midwives who reluctantly abandon their work out of painful needs of self preservation while the nature of that work remains unchanged.

Heidegger (1962/2006) tells us of lived experience that just as the theories of Newton governing gravity always existed and were not altered by becoming known, so are the entities we encounter. That: "Once entities have been uncovered, they show themselves precisely as entities which beforehand already were. Such uncovering is the kind of Being which belongs to 'truth'" (p. 269). He informs us that the truth that is exposed was always there but was simply unavailable because it was hidden. Harman (2007) comments that, "what Heidegger always opposes is the traditional concept of truth as an equation between mind and reality" (p. 82). Instead Heidegger believes that truth is only revealed by its pursuit through mixtures of light and shadow and the numerous levels of understanding.

Throughout her case loading practice a midwife is exposed to such complexities of light and shadow in the multi layered experiences of her work. Her working environment fluctuates around the clients she engages with, the complexities of their care, the influences on the levels of support exerted by the particular professional

staff on duty, the various cultures of different hospital settings and differing levels of staffing availability. Her day-to-day personal circumstances further impact on how she assimilates what she is exposed to. It may be as simple as whether she begins to provide labour care in the morning, or at the end of a long working day and will then need to continue to work through the night without sleep and access to sustaining food. Within her lived experience her original vision of midwifery may be upheld, altered, lost, and rediscovered until it ultimately reflects the truth of her own reality. Interviewed midwives set out to share the truths of their lived experience and possibilities of why it was able to become so severe. In my next chapter midwives offer an understanding of the reality of their world of work, the indicators they began to experience of burnout and the process of reaching their decision to leave practice.

I thought burnout was the abandonment of joy
but it was words seared into
the inside of your eyelids.
Tattooed there from the stories
of pain and abuse
so sharply etched
that the images seeped
through the perforations into your sleep
and eroded the sanctuary
of yourself
until even if peace was
gift wrapped in death
it was preferable
to now.

Chapter Eight: Hearing the pain

Introduction

In the previous chapter an understanding was sought of how burnout occurred and was able to become so severe within midwifery. The personal passion midwives brought to their work and the nature of their philosophical understanding was considered against the realities of their practice experience. The participant midwives lived experience of burnout was measured against the professional perception. Boundaries have been suggested as a tool for containing burnout, the difficulties of establishing these in the face of a promoted consumer expectation was studied. The frailties of professional relationships and their potential to create detrimental working environments were visited through the stories of participants.

This chapter seeks an understanding of the nature of on call work and how it is experienced within case loading midwifery practice. Interviewed midwives showed that there was an analogy between escalating burnout and an accruing antipathy towards their phones. The impact on family and social life is contemplated, and the potential for the manifestations of burnout to escalate its development.

Participant midwives shared the nature of their leaving case loading practice and tell of the repercussions that burnout has had in their lives. They have done so in the hope that others will achieve an understanding of providing this midwifery care and its potential for burnout through the knowing of their experience. Heidegger (1962/2006) tells us "by 'Others' we do not mean everyone-else but me - those over against whom the 'I' stands out. They are rather those from whom, for the most part, one does not distinguish oneself - those among whom one is too" (p. 154). 'Other' is not isolated out from self but is part of that to which we ourselves belong. The midwives who burned out were not 'other' within the community of midwives, they belonged to us and are part of us. Gadamer (1975/2004) says of understanding that ultimately "openness does not exist only for the person who speaks; rather, anyone who listens is fundamentally open...Belonging together always also means being able to listen to one another" (p. 361). These midwives stories ask to be heard.

The nature of being on call:

Harman (2007) suggests that "the only way to get at the depths of the world is through interpretation, not direct vision" (p. 48). The nature of on call availability is not present to those who have no experience of it and its meaning must be uncovered. 'On call' cannot be measured by the number of calls or whether they announce the giving of care. The tension lies within the continuous potential for the disruption of everyday life.

Even now when I have stopped practicing when the phone rings my response is still... if I am home or even out somewhere relaxing as soon as the phone rings I click into a different mode. It is like I have been suddenly pulled out of where I was; I am taken elsewhere. Definitely some of my sense of pending burnout is still there whenever the phone rings. (Candy)

Candy describes the affect on her 'when the phone rings.' Years after giving up case loading midwifery practice the conditioned response is still there: the metamorphosis of a private person with personal rights into a midwife with professional obligations continues to be triggered by the sound of a telephone. She is disrupted in her being; snatched out of one mode and catapulted into another. She becomes a caregiver who is defined by that role; 'Candy' is abandoned in whatever moment she is in. Candy captures this unpredictable instant disruption of 'Being' when she talks of being 'pulled out' of wherever you are.

I think there is an inability to plan your life. There are quite a few things around that. Everyone else can plan things up to a point, even if they didn't do it well, but she just couldn't. You loose control of your everyday life. (Rowan)

The feelings of loss of control of everyday life which Rowan, as the husband of an on call midwife also experiences, are generated with the ringing of the midwife's phone. For the midwife there is an immediate potential of a night without sleep, anxiety over a woman's or baby's wellbeing, irritation over an ill timed call, the reassurance or concern of incoming results, an abandonment of personal plans or the re-scheduling of a busy planned day. For the family their family life may be thrown

out of kilter. The phone rings and life alters. The meaning of being on call is this constant potential of disruption - whether the phone rings or not.

Candy draws attention to another facet of on call midwifery: "*When the phone rings in the middle of the night you have to be alert from the beginning so I come to very quickly*". The midwifery response to a night time phone call is a trained one. She must rapidly reach a level of alertness to process information, elicit questions to make a sound decision and initiate appropriate action or give advice that she is then assured her client understands. Even if the phone call is brief and involves trivial information, to return to sleep from a state of full alertness is difficult.

In describing Van Gogh's painting 'shoes of the peasant' Heidegger moves beyond the visual description to the contemplation of the world that was lived by the peasant who wore the shoes. "*From the dark opening of the worn insides of the shoes the toilsome tread of the worker stares forth*" (cited in Steiner, 1978, p. 134.) The life that was lived within the worn shoes of the worker is announced by that wear. The life of the midwife is announced by her wearied reaction to her phone. George Myerson (2001) discusses the impact of cell phone technology on modern communication. He suggests that cell phone communication is based on the principle of want; "it gets you things" (p. 25). Of text messaging he comments "you say as little as possible to make sure you get what you want as fast as you can" (p. 42). The cell phone / pager became the symbol of client demand for interviewed midwives.

Candy, as did other participants, comments "*It is exciting to begin with; you can't wait for the phone to go.*" The cell phone for the newly autonomous midwife taking up case loading practice is the proud symbol of her chosen role and her willingness to be of service. Yet every midwife interviewed then adds, akin to Candy, "*I can't stand my cell phone now! Truly, it is hardly ever on, I hate it!*". Years after giving up her practice Candy comments that a response of dread is still triggered by the sound of a phone. When midwives spoke of their relief to be off call their feelings were tangible.

To turn the cell phone off, oh it was lovely! When it was my holidays the only way I could be completely sure it was going to be 'off' would be to go overseas for a holiday. To be not contactable... to get away from the phone. (Brenda)

Brenda worked with midwifery partners and had structured time off, but tells of the pure relief of turning her phone off. She describes an extreme of leaving the country to ensure she was unreachable. Her experience reveals the constancy of women's high expectation of accessibility; their midwife being on leave does not deter their calls to her cell phone. Jemima adds another dynamic: *"To be off on holiday was absolutely (starts laughing) bloody fantastic! It was incredible! Even on holiday sometimes I was sure I could still hear my pager going off. It was just absolutely fantastic to get away!"* The burnout induced anxiety of on call causes Jemima to imagine she can still hear her pager even though it is not with her. Her transparent joy when she recollects the relief she felt in being on holiday is poignant in that her interview took place five years after she ceased practicing. Her words *"to get away"* disclose that what she has been able to leave behind her is an important component of her happiness of being on holiday; she has escaped the professional demand. To uncover the feelings generated by phone calls is to uncover the feelings of burnout.

The announcing of burnout within the phone response

I have done the long walk and now I feel no, even if I am at home I do not want the phone ringing – I don't want to know! I want time out, I want the phone off, I want my mobile off; we have got to do that to survive. (Grace)

Grace describes her emerging need for no contact from clients. Her emphasised aversion to phone calls mirrors her underpinning aversion to professional demand. Her need is more explicit than time off; it is about *'survival.'* She doesn't want to know anything about things midwifery; she doesn't want to hear a phone ring because it calls up feelings she recoils from strongly. Celine also tells us: *"I hated my cell phone - It wasn't just the cell phone it was any phone"*. As burnout progresses any phone call triggers an escalating response of angst.

I would want to throw my cell phone off the harbour bridge at times; that is what is going to happen to it when I retire. And the land line too. When it rings more often than not you will hear me saying "Oh fuck" and "Oh shit!" Yeah, my husband noticed a difference in that – he would say it used to be when the phone rings you would leap up with a smile on your face, but these days he worries that if he answers it before I open my mouth they might hear me swearing! (Laughs). (Amelia)

Amelia fantasizes, as did other participants, over not just switching off or disposing of her phone in the future, but of destroying it. Through the words participant midwives use to express their animosity towards phone calls, the truth of their practice reality is revealed. The phone has been so destructive on their lives, that, when it can no longer hold them to ransom, it will itself be destroyed. Gadamer (1975/2004) tells us that: "...experience of itself seeks and finds words that express it. We seek the right word -i.e., the word that really belongs to the thing - so that in it the thing comes into language" (p. 417). He suggests that we choose the words that will best fit the experience we seek to relate; through those words it then enters into language in way that conveys the understanding of it. Tellingly, interviewed midwives often use expletives specific to their comments on excessive client demand. Crowe (2006) suggests that "we use words without knowing what we are saying at the deepest level" (p. 107). There is a hidden language within language; here the venomous response calls attention to the burden of demand and the choice of language insists that the anger and stress that is generated is noticed.

Family dynamics around client calls

Candy tells us:

It used to upset me at times; I would feel my partner wasn't very supportive of the demands that were being made on me. The phone would ring and I would come away from the call and say there was no need for that call. He would say, but you know she's ... and he would make some excuse. Or the phone would ring at nine o'clock at night and I would say why the fuck are they ringing at this hour, and he would say 'it's only nine o'clock!' (Candy)

Candy's relates feeling her partner lacked empathy when he defuses her irritation with logical rationale. For him "it's only nine o'clock!" But for Candy, it is "why the

fuck are they ringing at this hour.” Her response shows us the narrowing her world in burnout as she retreats from the demand of on call midwifery and client expectation. Candy does not want logic from her partner, she wants empathetic understanding of how impinged on she feels. She shows us through her words that her work demand is not understood within midwifery by her seeking of an understanding of its difficulty outside her profession. Transferring her work related frustration to her primary relationship further reveals a lack of facility to process it within her work setting.

Dorstal (2002) comments that "Gadamer would have us see that the act of speaking and conversing is not so much us, using language, but language working its way with us such that truth happens" (p. 254). Anne comments: "*My son does the cruellest imitations of women ringing up*" (Anne). Anne description of her son's response shows his exposure to a frequency of calls that allows for mimicry, and a significant animosity underlying his humour from that intrusion. Myrtle relates:

My pager went off at eleven o'clock last night and my partner is the one who is over the pager right now. I get that little sick feeling, that yuck, what is it going to be? All I get from him is 'I can't wait for this to be over! I am sick and tired of this fucking pager.' (Myrtle)

Myrtle shows us that disruptive phone calls are invasive for the midwife and also impact on her primary relationships. These comments show us the dynamics of anger, disharmony and resentment generated by out of hours calls, which the midwife then has to process as well as attend to the incoming call.

Telephone aversions impact on socialising

As burnout progresses the aversion to phone calls becomes indiscriminate.

It has got to the point where I don't want to hear from family. If the phone is ringing I don't want to deal with it. If it is my sister or my Mum ringing, I don't want to know. It is quite hard for them to understand that. (Grace)

With the appearance of a resentment of all calls from all people burnout begins to show itself for what it is, rather than being announced by what it is not. No longer

hidden within a generalised resentment of work calls, burnout begins to declare its seriousness with the shutting down of social interaction. Yet Grace does not identify the seriousness of what is happening. Harman (2007) tells us that we are mostly preoccupied with others and pay little attention to our own lives, that: "Dasein does not see the world directly, because Dasein has a historical structure, and generally interprets things in the same way others interpret them" (p. 59). Grace therefore continues to see her work demand as acceptable because her role is publicly defined and promoted as being acceptable. She is told it is her responsibility to make that role manageable. To achieve this she alters her personal living to sustain her professional role as it exists, showing us that she believes it is easier to adapt her life to the difficulties of her work, than to adapt her work to her life. She claims personal time therefore by the strategy of withdrawing from personal relationships not modifying client relationships. While Grace recognizes it is difficult for family to understand her alienation from them, she does not see that it is indicative that something is wrong in her world. The significance of her aversion extending from work calls to family calls is unnoticed by her. For Candy it becomes even more isolating:

When it rang, especially in the evening, my heart would sink. If one of our friends called at an hour that I thought was late, even if it wasn't, I would think "what are they doing calling now!" This is my time, even though it was a friend. You don't realize that you are limiting your social world and those of the people you live with. I am aware of that response as an indicator as to how I felt now. It is one of the things for me to be aware of because it is still there even now... which shows how serious it was. You feel overdosed on people and overdosed on meeting need. It starts to spill over into your life so you don't socialise. I would use my job as an excuse to get out of things. (Candy)

Candy, now recovering from burnout, is able to understand the implications of her social withdrawal and recognize it as an indicator of her well being. She shows us how rationality becomes altered in burnout. What was late, intrusive and alienating in burnout she is now able to see was a timely call from a friend. In burnout Candy cannot distinguish between client demand and social interaction; she pulls back from both in an attempt to protect what has become most precious, "my time." Her defensive response shows how eroded her personal time has become.

"You would go out and not want to talk to people; I would think I have been talking to people all day!" (Anne). In burnout Anne also shows an inability to distinguish between professional and personal worlds; all conversation is the same. Other midwives interviews reveal a similar normalizing of the dysfunctional behaviour of burnout and a progressively isolating of themselves. They do not realise that this coping strategy boxes themselves in alone with their work and without life balance. Angela recalls, *"booking a hotel room once to escape and be brain and demand dead,"* while Amelia tells us that, *"what I treasure most in my life is curling up in bed with a book... alone! (Laughs)."* Midwives in burnout do not recognize what is happening adding to the complexity of setting boundaries. Participants become unable to identify the different areas in their lives and describe themselves as being "eaten up" in terms of themselves. Brenda recalls wondering *"where is me in all of this?"* while Anne tells of feeling *"I don't even know who Anne is any more."*

Steiner (1978) discusses angst as a primary means of causing us to question our being-in-the-world, that "angst is a mark of authenticity, of the repudiation of 'theyness'" (p. 94). Distress forces us to confront the realities of our life; the power of "they" to control what we see is overturned by the urgency of the stark reality of what is actually there. These midwives stories show us that midwifery role can become so embodied that the differentiation of personal Being from professional Being becomes impaired.

The beginning of understanding through cell phone aversion

The midwife in burnout initially focuses on her cell phone / phone as the centre of her angst, as when Amelia describes her intention to *"throw it off the harbour bridge"* when she stops practicing. The phone takes on a persona and becomes the symbol of all that is wrong in the midwife's world. Brenda tells us: *"I hated it... I dreaded that mobile phone ringing. I hated the thought of it and I resented the fact that it was making me dislike midwifery."* The phone has become an antagonist; Brenda states that *it* is making her dislike midwifery then stops her analysis. The redirection of her angst to a passive technological instrument reveals the extent of the covering over of burnout within midwifery. To move to the recognition that it is the

professional demand the phone conveys she hates is to confront the unthinkable reality; that it is midwifery that is making her hate being a midwife.

Heidegger (1962/2006) discusses the fear of something that is drawing closer, "if it is still far off, its fearsomeness remains veiled" (p. 180). When something is distant we are screened by that distance, but as burnout draws closer its potential for destruction begins to be realised. Brenda begins this transition:

The mobile phone going all the time... I hated it, I hated the women, I hated midwifery... that was very frightening, finding myself hating to be a midwife when I have always been exceedingly proud that I was a midwife.
(Brenda)

Brenda describes moving to the recognition that it is not her phone she hates, it is the women who ring her phone, and it is midwifery which makes her receptive to those calls. To have such feelings surfacing within the covering over of her deep commitment to midwifery she describes as being "*very frightening.*" Heidegger (1962/2006) tells us; "That to which our concern refuses to turn, that for which it has 'no time', is something *un-ready-to-hand*" (p. 103). Brenda's words disclose how un-ready-to-hand her knowing of her burnout is; its emergence is unexpected and therefore fearful. Heidegger (1962/2006) tells us fear is around the threat to Dasein itself, the presence of fear discloses its entity as "endangered and abandoned." That; "Fear always reveals Dasein in the Being of its 'there', even if it does so in varying degrees of explicitness" (p. 180). He advises us that fear arises from what is fearful and frightening. That what frightens us is that which threatens our very being and leaves us feeling at risk and alone. Brenda's fear makes the unknowing of burnout present and ready-to-hand; it calls for her to address what is threatening. It shows us that burnout threatens our essential being through its ability to generate such fear. Through her fear Brenda becomes aware of her loss of love for her work and what this new knowledge now means, whether or not she acts on it.

Burnout and family

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 (laughs). We have a really strong relationship, but I know that amongst people she works with there are a lot of marriage break ups. You are living two different lives really. That is the nature of the job. I think the hardest thing was thinking she is going to be home and she is not and getting pissed off. You have to carry on with your own life and do your own thing; you can't plan anything because you never know when she is going to be back. I am sure it is an adrenalin rush for midwives out there doing something amazing, making a positive impact on someone's life and sharing an experience that makes you close. Not many people experience that, but the family doesn't have that. (Max)

Max and his partner have a mature established relationship yet it is still significantly impinged on by her work. His comment that “*you are living two different lives*” evokes the two different partnerships a midwife engages in; the partnership between the midwife and the woman which is as strongly upheld within the profession as society upholds the partnership of wife and husband and their parental roles. Within the professional relationship the woman holds the power and the midwife must endeavour to meet her self perceived needs on her terms. The midwife's ability to do so is ultimately evaluated by her client and she is expected to answer to any complaint that the woman makes around her care. Failure to recognize and act on clinical aspects of care may carry serious implications for the woman and her baby, and ultimately the midwife. The relationship of a life couple is more negotiable, therefore more likely to be impinged upon in order to maintain the professional partnership, yet the level of support a midwife has in her personal situation is a critical factor in her ability to remain in practice. The midwife is compensated for the disruption of her life by the joy she finds in her work, something that her family does not have.

If I was talking with someone whose wife was going to do case loading midwifery, I have so much admiration for case loading midwives and what it is all about; I would say that is fantastic. But I would put out some warning messages. That it is going to impact on you and your family and that you need to be aware of that from day one, more than what I was. (Rowan)

Rowan tells us that, despite his respect for self employed practice, it has elements that husbands need to be warned about from the onset of practice, something he was not. Angela talks of how “*It affected my marriage profoundly. My husband hated it,*

he hated the job! Hated the job with a vengeance.” Midwifery exerts a high level of ask from family and friends akin to few other professions, Angela's words reveal elements of the affect of that ask on a marriage. Brenda comments *“It ended my marriage.”* while Celine observes, *“I saw a lot of case loading midwives who were all single, they were divorced or had moved on. I don’t want to be like that.”* Midwives have a highly developed professional expectation to place their client’s needs first which can prevent them from stepping back, as Celine did and recognizing if their family’s wellbeing is being impinged on. Other interviewed midwives also disclose the significant strain their work placed on their relationships.

I think my work definitely impacted on my life, I am sure my husband would agree I was hell to live with; it just wasn’t a good time. I was always tired. That we never did anything together – he would say there is a movie on let’s go, and I would say no I can’t because I have got somebody who might go into labour. We would be invited out for dinner and I would say that I couldn’t go because of my work commitments. It really affected our relationship. It took months after I stopped practicing for the tensions to go between us. My job was the only problem we had together. (Jemima)

Jemima’s account reveals how the ability to maintain a healthy life balance and perspective is difficult when on call and how it becomes further eroded in burnout. As fatigue becomes chronic the weight of unpredictable twenty four hour on call obligation becomes increasingly oppressive and begins to affect personal life through restricting socializing. Jemima believes her inability to be spontaneous and flexible had serious implications for her marriage. Linda tells us, *“I talked about going back to case loading practice with my husband and I said it means more money – a couple of hundred dollars more a week – and he said I will pay you two hundred dollars a week not to.”* The partner, while free of both the professional sense of obligation and the exhaustion of burnout, through the restrictions on their shared quality of life, also pays a price for burnout. Linda's husband even puts a monetary value on that cost.

It impacted on my relationship with my partner. At first it was my inability to commit to doing stuff together and then interruptions with people in labour – not being able to go too far away and all that stuff. Then it was things like Christmas and birthdays. It was always stressful; when I stopped I realized how demanding it had been on our relationship. (Candy)

Midwives consistently fail to recognize they are in burnout and how it is affecting them or those around them. Similarly partners disclose that they did not understand the phenomenon of burnout or its impact. As Candy shows us, accumulating stresses are absorbed in their everydayness and only in hindsight is their full impact understood. Rowan draws attention to supervision within midwifery:

I actually asked her to what extent was there support for case loading midwives; is there someone who takes that role? When you think of the amount of support counselors get in a tiered layer, each having their own support network, it is appalling. I did a lot of listening to her stories, anonymously and professionally, because there was no one else. It is a real indictment on the profession. There are some terrible situations out there. (Rowan)

Without an external overview the midwife is isolated with her practice difficulties and her processing of them. Rowan draws our attention to the situation that there are few messages from midwifery to the midwife that she matters, not just as an appropriately functioning midwife, but as a person. The burnout indicators that she is unable to self detect are professionally hidden within the anonymous nature of her practice while the personal distancing as symptomatic of burnout is not understood within her tiers of personal relationships. The majority of participating midwives reveal this pattern of increasing withdrawal from both family and friends as they try to regain a sense of self as burnout progresses. Midwives interviewed commonly expressed guilt over their latter recognition of how their burnout impacted on their families, including their children, further complicating their recovery from it.

Children

I can hold it together for the very demanding woman and then come home and my kid wants something really basic and I tell him to piss off, and then I feel like a bad mother. You know... my kids have grown up with this. My youngest has grown up knowing that I may not be there a lot of the time, he knows he comes second. (Myrtle)

The participant midwives believe, as Myrtle does, that their children pay a price for their work. The same phrase 'he/she knows they come second' Myrtle uses was also used by other participants. The urgency of labour care often leaves a midwife with

few options; her private life must accommodate this. The child's perception of the world is shaped by what is modelled to them. Myrtle's story reveals the reality of her life in-balance when professional obligation depletes life tolerance. She shows us that she contains and copes with "demanding women" then transfers her anger to her child in a way which she knows is unjust. It illustrates the extent of the obligation she feels she carries to tolerate demanding women. She does not address the difficulty at its source but transfers its frustration to her personal life and an easier relationship because of its different power balance. She was not alone with this.

My children were still small, my daughter was a pre-schooler and my son was just at school. Your heart is always with them but physically you are with someone else. I was driving my son home after I had picked him up from somewhere; he said 'Mum, I don't mind if we don't have McDonalds, I just want you at home.' It was pretty horrible. I became the old bitch honestly. All these women would get the best of me and then there was nothing left for anyone else, or for myself. I can't keep doing this – I am not treating my family right. (Celine)

Celine's son tells us of the extent to which he misses his mother and the scattered lives children lead when a parent is on call. It was apparent from other participants that some midwives felt obliged to channel their best into their professional lives while family suffice on what is left over. There is a flexibility to make concessions within their private lives that is not present in their professional lives. While she knows that it is her work causing her to compromise her family, Celine describes herself as "becoming the old bitch" further condemning herself. This self denegation is a common theme. Grace, who believes she is at a professional crossroad and *may* be experiencing burnout, reflects:

I was always trying to juggle everything to be everything. But I can see now the damage that I have done being everything for the woman. I have denied my kids. All that they see is that you are gone again. I will come home from a birth and there might be a houseful of teenagers. I just want to go into a dark room and shut everything off and say don't talk to me, don't even look at me! My daughter will come along, and say are you alright Mum? I will say 'well not really, I don't want to hear anybody'. She'll say 'oh, okay.' Sometimes if she really wants to talk to me she'll just sort of slam the door and say, 'Oh God you are not in one of those moods are you?'

It is not that I am in a mood... I think case loading midwifery has a shocking impact on your family. My son would say when there were

school sports on "well okay if you don't come, you don't come." Or in the school holidays we might be heading out and a client calls, "oh well this is normal". He would just be very quiet but he has separated himself out from us. At the time I felt he accepted it, but now I know he didn't. Even when he decides to come home for something he will say, "the chances are you are not going to be there anyway." Or if I have to go out – "oh well, that is what I expected." (Sighs). He is a wonderful, wonderful lad, but now I can see the cost there has been. I think it has damaged our relationship as we were very close. You can't be an case loading midwife and there not be costs. I know my daughter says you always put your women first, we never come first. (Grace)

Grace's talks of a necessity to remove herself from family need even when she is home. Heidegger (1962/2006) informs us that mood does not reveal who we are but the world in which we are in. When Grace wants to retreat from all demand to a dark room, to neither hear nor be looked at by anyone, she expresses an intense need to withdraw from all obligations to Other. The extreme of her need shows the weight of her burden of obligation; her need to be publicly visible and to hear everybody. Her daughter's response reveals that she is familiar with Grace feeling like this; it is "*one of those moods.*" Grace realizes that this is something other than 'mood' and links it to her work, but not to burnout. On reflection she identifies that her work has been damaging to her family, the affects of which are evident in her now adult children. This view is expressed by other participants. Derryn tells us:

It was not good for my family, they got on without me. I think my on call affected my son badly, maybe generated feelings of abandonment at times. There is no choice; the woman in labour has to take priority over family. It is too hard to revisit the impact on your family, midwives just can't go there, you have given it all out to these women and there is nothing left for your family. It is too painful to consider what it may have done to your children. (Derryn)

Derryn reflects on the impact of her practice on her family and sees the difficulties that were there for them. She concludes with Grace, that families are also victims of burnout but resists visiting that because "*midwives just can't go there.*" Heidegger (1962/2006) says; "That with which one's concerned dealings fail to cope, either by producing or procuring something, or even by turning away, holding aloof, or protecting itself from something, reveals itself in its insurmountability. Concern resigns to it" (p. 407). Derryn shows us when she resists considering the affect her work may have had on her family she does so because it is too hard for her to

contemplate; the situation is insoluble. *“My children don’t talk about it. I think they were okay. I think... they knew I couldn’t be left alone”* (Angela). Angela similarly does not want to consider and explore the impact her burnout may have had on her children. Gadamer (1975/2004) has advised us then when nothing is said it is because there is too much to say. He suggests that certainty only occurs when doubt has been passed through, which Angela has not evolved to. Her contemplation jumps over the painful consideration of the impact on her children to what is the essential aspect of that time - she can't be left alone, her children know that, so whatever occurs it is justified - there is no energy for anything else. As a father Max tells us:

It is quite disruptive for the family life in that you never know when Jane is going to get called out and the long hours. I took up the short fall though. I am lucky because I am self employed so I could work the hours I needed to or work around Jane. If she needed to sleep I could take the kids out on the weekend, or I would take and pick up the kids from school. But yeah, I did feel resentful sometimes. Of course the family missed out. Jane feels guilty about that as well. She feels at times she has been a bad mother but they haven’t known anything different, so it is just normality for them. They don’t feel resentful and they don’t hand out guilt trips, but you can never replace a mother – you can only do so much. The children accepted it because it was how we lived. (Max)

Max reveals the extent to which the on call midwife's family must accommodate the unpredictable nature of her work, the extended hours worked and her recovery from those hours. His own work allows this, but he believes that as a family they are still compromised. While he feels their children accept it as a normal part of their living, he knows that Jane carries an onus of guilt, feeling she is a poor mother despite his own belief that their children feel differently. He concludes, however, that *"you can never replace a mother"* showing that he sees gaps in their family structure that he could not fill. King (1964) discusses Heidegger's concept of care; "since man inhabits the world by way of care, each of his fundamental relations must have a specific care-character: he is near to things by 'taking care' of them (*besorgen*)" (p. 89). The frequent disruption of the traditional expectation of the hands on care giving nurture of motherhood may lead to a self perception of being a poor mother. Cornelius, however, believes:

It is destructive, for relationships that aren't solid it could be completely destructive. It is incredibly disturbing for a family's way of life and children's care with its lack of continuity. It is quite difficult to quantify but there is definitely acute anger and disappointment involved. When the midwife is on call the whole family is on call, and when she is finally home the family has to be shut down so she can sleep. Children look for their mother. (Cornelius)

In Cornelius view children do not normalize and accept their disrupted home life. He believes it is extremely destructive when work that is encompassing and stressful unpredictably removes a mother from her family for unknown extended periods of time. Burnout then fractures the family further through the sufferer's continued self imposed withdrawal. The experience of burnout is not lived by the midwife alone.

The leaving

I said to my midwifery partner I have got to finish. She said when? I said I have got to finish really quickly, within a month. We just got on the phone and said I am sorry you are going to have to change your midwife. We kept women really close to having their babies, but handed on the others. I recognized I needed to stop practicing as soon as possible. I had to finish; it took too long as it was. I had to finish. (Derryn)

The severity of Derryn's burnout is expressed in the urgency of her need to stop practicing; she *has* to finish, there is no choice. Heidegger (1962/2006) talks of authentic being, believing that the more we align ourselves with other and take on the choices of 'they' as our own, the less authentic our lives become. He believes that: "This process can be reversed only if Dasein specifically brings itself back to itself from its lostness in the 'they'" (p. 312). It is only by drawing back from the external influences that mould us to identify with their own perception that we are able to regain an authentic sense of our own potential for Being. Derryn is the only midwife who is able to set aside her sense of professional obligation and connect with the urgency of her own need to be released from it. Liz tells us:

I wanted to stop, but I had to keep on, I had women booked for the rest of the year. I was just not mentally okay. Unbelievably stressed. I was... just not coping. In my personal life it was shocking. It was terrible. Just getting through each day was fearful... really, really down. I was tearful. I was ... I didn't know how I would get through the day. I don't like admitting to it, but I was pretty close to suicide at the end of that year. You see I had to keep going. I had taken on these women... I had to keep

going. Now I think it was... ridiculous, I should have actually handed them over. To stop practicing was an absolute relief, an unbelievable relief! It was like peeling off stuff... It probably took quite a long time to feel like myself again. (Liz)

Liz's words convey desperation. She pauses frequently, searches for words, visibly struggles to speak of her experience. Gadamer (1970) tells us "when speech deserts us, what this really means is that one would like to say so much that one does not know where to begin" (p. 14). Liz has previously told us that there are gaps in her memory and memories she does not wish to revisit. Van Manen (1990) suggests that "language speaks through silence" (p. 49). Sometimes what is not said has a louder voice than what is said. Yet Liz continues to practice through a time that she is still unable to find the words to convey its level of difficulty. There are many layers to why she keeps practicing; practitioner integrity, honouring commitment, philosophical persuasions, legal obligations, economic realities. But overriding all of this is the evidencing of the difficulty of self recognizing severe burnout. Liz describes being stressed, tearful, severely depressed to an extent where she is fearful of getting through each day, yet each day she gets up and goes to work. Heidegger (1962/2006) says of fear that every possibility and impossibility offers itself and we leap from one to another without taking hold of any, "his 'environment' does not disappear, but it is encountered without his knowing his way about in it any longer" (p. 392). He suggests that when we are overwhelmed with a situation we grow fearful. Our world doesn't change, but our rational thinking is compromised so that we lose our way within the world we know. Liz's story shows us that she is so incapacitated by burnout that she can't negotiate her way within midwifery to reach a safer way of being. She is unable to re-structure her world, so she just keeps going with the status quo. It is only in retrospect she sees that her decision to complete care for booked women was flawed; bookings take eight months to fulfil the obligation of care. Her words "peeling off" convey a sense of onerous weighty layers being slowly escaped from followed by a long recovery time. Angela comments:

Three years later I was starting to burnout, I was getting really tired. I was trying to make a decision as to whether to leave my job. I got no support from my husband. It was like, 'no... you've got to keep going, you've only just started practicing, you are fine, you are just tired, ask for

some time off,' from my husband while I had this boss at me 'are you leaving? Are you leaving? Are you leaving? I need to know' while my husband was saying to me 'you can't leave.' It became severe. Knowing I had to stop practicing, and getting more desperate, but knowing that my husband and my boss were down playing it, so who was I to say that it was something more? I was a person who was just moaning a lot and no one likes a moaner. My brain did not want to make those decisions. I knew I was getting so sick I had to leave him to be able to leave my job. So that is what I did. I left him. I moved out. Burnout impacted hugely on our relationship. I came back because I was so sick. Five weeks later when I should have been fine, I burned out. It still happened; it is almost like removing myself from the stress gave me the peace to let my body crash. I came home because I had to be looked after. (Angela)

Angela's experience of burnout is severe. She tells us of 'zoning' out in the face of confrontation and decision making – the conflict around her decision to stop practicing escalates her burnout symptoms to where she no longer feels able to trust her feelings, *"my husband and my boss were down playing it, so who was I to say that it was something more?"* Okrent (2000) concurs with Heidegger's assumption that people are motivated by achieving goals and fulfilling self expectation, that: "One acts in order to accomplish some end, but one also acts for the sake of being a certain sort of person" (p. 191). Here Angela shows us how this creates a dilemma where she cannot make a decision; her need to leave practice conflicts with her need to honour her commitments and please those around her. Burnout continues to escalate until she becomes seriously unwell; her story shows us that even when midwives leave practice the ramifications of burnout are not halted. For other midwives it is less decisive:

I think for me burnout it was gradual it wasn't sudden. It was very, very gradual for a couple of years before I gave up. It was sort of feeling; get me out of here (laughs). Resentment that the job had taken over my life and there were times when it was worse than that if I felt abused as a midwife... I felt guilty about giving up. I angst about it, but I really didn't have anyone to talk the whole process through with. My husband was there for me if I made the decision, but I had to make the decision. When I decided that there was no way I could keep going it was such a relief. I couldn't wait to get rid of the woman booked with me. Looking back, now that I am out and it just felt like shit! I was so angry that it had come to that. It was made out to be a wonderful job; you're a midwife so you should be this wonderfully relaxed, empathetic, coping... (Cries again). (Jemima)

Jemima's experience resembles Angela's in that she struggles with making the decision because she no longer trusts herself to decide appropriately. There is a slow realisation of how she is being affected; she uses words of resentment, angst, guilt, anger and abuse. King (1964) comments that:

Moods and feelings rise from man's thrownness and bring him face to face with it. By "thrownness," Heidegger does not mean that man is cast into the "natural universe" by a blind force or an indifferent fate, which immediately abandons him to his own devices, but means: his own "real" existence is manifest to man in the curious way that he can always and only find himself *already* here, and can never get behind this *already* to let himself come freely into being. (pp.77-78)

The "thrownness" of human existence means that we arrive at a knowing of our feelings only as they manifest; we are always already in the situation that precipitates those feelings. We are led to our way of Being by what approaches us from the world to which we respond with "attunement" to those possibilities. In this way Jemima only discovers the degree of her relief to give up practice through the intensity of that relief. She discovers her eagerness to be free of her work in the intensity of her feelings that she can't "*wait to get rid of the women booked with me.*" Yet her authentic being still struggles with non authentic being and its conforming to the expectations of "they" - her decision to cease practice is therefore linked to guilt.

Heidegger (1962/2006) discusses guilt:

Everyday common sense first takes 'Being-guilty' in the sense of 'owing', of 'having something due on account'. One is to give-back to the Other something to which the latter has a claim. This 'Being-guilty' as 'having debts' is a way of Being with Others in the field of concern, as in providing something or bringing it along. (p. 327)

Heidegger's interpretation links guilt to the sense of owing. Midwives chose to take up a duty of care to women; interviewed midwives believed they could best fulfil within self employed practice, that it would be their life work. To withdraw from this commitment was a major life decision for many of them. Midwives have shared

with us their further feelings of guilt with regard to the disruption of their families. Now their work which justified that disruption is also in question. Linda tells us “*the feeling of guilt is incredible. You just think why can't I do it?*” She continues:

It was a huge – huge thing, it was like a death... I mourned it. I considered going back to case loading practice on a small scale, but there is such a high cost of professional compliance you can't. Giving up was very difficult. I really mourned it... it has taken me months to get my head around it. (Linda)

As Linda shows us midwives not only experience guilt because of their struggle to practice in the face of the promoted belief that only lesser midwives experience such difficulty, they then have to process the intensity of their emotions arising from their decision to give up practice. Despite previously telling us that ‘*the job was not worth dying for*’ and ‘*it took me a year to heal from the stress,*’ Linda's pain over ceasing practice is so severe she equates it with death and mourning. (Linda left case loading midwifery practice has since left midwifery).

The husband's stories

Essentially it has been like a slow down hill slide. I couldn't say that either of us recognized it as burnout. We both knew that she wasn't well. I worried like hell about her, constantly. I saw it as very serious; it was completely destructive...completely. She was in a situation where she could have probably just dropped dead from a heart attack or something like that. There was just... no sleep (pauses) and not being able to handle situations, her body just falling apart and body systems falling apart. I saw burnout for her becoming borderline life threatening. In her situation it definitely was. Her blood pressure just went off the dial and there was so much other stuff; what you might call adrenalin fatigue and neurological depletion, everything just completely run down and so she stopped doing the case loading thing. (Bob)

Bob describes the stress of watching his wife becoming increasingly unwell while neither of them understand why. He tells us that he ‘*worried like hell about her, constantly.*’ The ‘*unknowing*’ of burnout allows it to go undetected until the accrued damage is significant. In Bob's opinion his wife became seriously compromised through its destructive process. Recognizing that burnout as a dangerous and

debilitating phenomenon, for which midwifery carries a high risk, enables ways to be evolved that will protect those exposed to that risk.

I never saw it as being as bad as she did, and she has told me that. I never understood why it became so bad she had to give it up. I clearly didn't realize... it was much worse than I had thought. I think for someone who had loved the continuity of care aspect to see how she got to absolutely hate it was quite shocking. I said what is the matter with you? Surely you can just reduce the number of clients that you see? But that wasn't actually the issue. It was the on call; it was the twenty-four hours and all of that. I don't think I am a totally insensitive person, but I know I didn't understand it. I thought what a dreadful way to finish a thirty-four year career. It took 'Eve' quite a while to make the decision to stop. She was not excited about going back to the hospital setting; she even looked seriously at doing something completely different, like others have. My intuitive feeling is that her passion for midwifery has reduced considerably; it is just a job now. She just does her shifts. Once her case loading practice came to an end the strength of her feelings to the profession she had been so committed to were impacted on enormously. I think it is sad because she was very committed... I don't think I would want her to return to case loading practice again... no. (Rowan)

Rowan's story shows us the difficulty to recognize and understand burnout. Jeff comments that *"he didn't see this coming before she did."* (Jeff). Without realizing it Rowan adds to Eve's difficulty in making her decision to give up practice when, just as the midwifery profession itself does, he asks *"what is the matter with you?"* It is only with hindsight that he recognizes that burnout has many aspects related to the on call nature of the work and it is not just about client numbers, while the profession maintains it is about client boundaries, not the nature of the work. As midwives show us, it is the on call availability, symbolized in their hatred of the phone that is most erosive. The shock Rowan expresses over Eve's shift from loving her work to hating it reveals the intensity of that change as well as his non-anticipation of it. The loss to the women she now cares for of her former dedicated care is hidden within the loss of Eve's joy in her work that is evident to Rowan. Such loss is not just Eve's loss; it is midwifery's loss. Partners concluded with Max's words *"I think the price is too great."*

The aftermath

I feel I have been on the brink of depression at times. The loss of joy, the frustration with the demands of the women, I can feel all of that happening to me, including the ... like the 'what if I crashed my car on the way to the hospital then I wouldn't have to go.' I hope I will recover because I think I am in the early stages of it, I don't think I am so stuffed I can't cope with my job anymore. But I think if I ignored it long enough I would turn around and walk away and not come back, but I don't want to do that. (Myrtle)

At the time of her interview Myrtle believes she is in recovery from burnout but tells us of thinking '*what if I crashed my car on the way to the hospital then I wouldn't have to go.*' Yet she regards herself as being in the early stages of burnout and continues to go to work. There is no recognition that she can choose not to go to work without needing to have a car crash. Heidegger (1962/2006) tells us of choice, that Dasein:

...interpret's itself in terms of the world by its reflected light... it simultaneously falls prey to the tradition of which it has more or less explicitly taken hold. This tradition keeps it from providing its own guidance, whether in inquiring or in choosing. (pp. 42-43)

He reminds us that what we believe to be personal choice is shaped by the criteria of the world in which we live. Myrtle's failure to exercise a choice to not attend work reveals that the strength of what drives her to attend work is able to override her self knowing of the extent of her fragility. Within this we see the power of the midwifery commitment. Her words reinforce the perception of burnout as personal failure. She is not '*so stuffed*' that she can't cope with her job; she needs to have a road accident therefore to legitimize not working. Myrtle shows us the assumption that burnout is not sufficient grounds to stop work.

Gadamer (1970) tells us that "Language contains a self-protecting and self-concealing power, such that what happens in it is protected from the grasp of one's own reflection and remains hidden in the unconscious" (p. 26). He describes how the depths of what we express can be concealed from us protecting us from a conscious knowledge of what we unwittingly disclose. Here Myrtle discusses her feelings of depression, her angst with the women for whom she cares, how engineering a car

accident would legitimize her not presenting for work, but concludes that she believes she is still coping with her job. She has no conscious awareness of the seriousness of what her words tell us. Severe burnout continues to be downplayed by both the midwife inflicted with it and the profession in which it occurs, fuelling its capacity for destruction. (Myrtle left case loading midwifery practice and midwifery.)

I have developed a fear of flying; I used to fly all the time when I was a teenager. It might be something to do with getting older, it might be hormonal, I don't know. As a teenager I used to often fly in little planes, but from 2001 I developed this terrible fear of flying that is absolutely ridiculous. I have to drug myself to fly. It may or may not be related to burnout but the anxiety is the same kind of anxiety. It has got worse. I have these terrible palpitations and excruciating feelings that my head is going to burst. It has left me vulnerable in my practice and in my personal life. (Liz)

Liz believes burnout may have left her with on going anxiety that now affects her in other areas of her life. She falls into the trap of the assumption that anxiety may be induced by menopause, something that was shown to be an appearance of burnout. Heidegger (1927/1962) says of anxiety that it directly discloses the world as the world: "that about which anxiety is anxious reveals itself as that in the face of which it is anxious – namely Being-in-the-world" (p. 189). The symptoms Liz now experiences when flying parallels her feelings of burnout. She has an inability to deal with it and must self medicate to dull down her reaction. To consider this in the light of Heidegger's insight is to contemplate what is familiar to flying and burnout that could trigger the same degree of anxiety? As a passenger there must be trust in Other for the lack of control over personal safety; in burnout participant midwives express feelings of anxiety around safety of self and of their clients. It is possible to hypothesise that it is the damaged trust in Other to keep her safe that now haunts Liz in her personal life when she is again in a situation where she cannot control her environment. (Liz has left case loading midwifery practice and has since left midwifery.)

It was a hard experience, a full on one, but it wasn't a negative experience that destroyed something that I could never get back, or that it destroyed my relationship. Definitely some of my sense of pending burnout is still there. (Candy)

Candy believes she has recovered from burnout; that despite being a hard experience it did not cause permanent damage. Yet she still carries some of the adverse feelings of that time. There is an apprehension and caution in her choice of the word 'pending' - her language tells us that she still feels vulnerable despite her conclusion that she has recovered. (Candy left case loading midwifery practice and now works elsewhere in midwifery).

It took me eighteen months to feel okay, but three years later I still think I will never be right again. My patience has gone big time and I don't have the trust. I feel it will always affect me... I am just angry, I am horrible! I still feel very vulnerable and that I would fall very quickly and it is more likely to happen. I don't feel I will ever be one hundred percent. (Angela)

Angela, three years after her experience of burnout, believes she is still, and always will be, affected by it. She relates feeling vulnerable, having a lack of trust that is perhaps paralleled in Liz's new fear of flying. She self denigrates, she is impatient, untrusting, angry and horrible. Burnout still has her in its grasp. (Angela left case loading midwifery practice and works elsewhere in midwifery). Anne tells us:

I got up early yesterday morning to finish my reflection on my practice for my peer review and my husband and I went for a walk together to walk the dog. I found I was so wound up and so cross and angry and snappy that he said what is wrong with you? I said I have just finished my practice reflection and I just been reliving it all and I can't believe that it still brings up those feelings in me. I think it comes from being devalued and abused on many levels. (Anne)

Anne shares the feelings she is left with after her experience of burnout that still persist after giving up practice. She shows us the intensity of an anger that still travels from her past experience to now and impacts on her everyday living. But Anne has made the transition that Angela is still to make; it is not the anger of an angry person but an angry response of a person who was made angry by the circumstances of her midwifery world. (Anne left case loading practice and has now left midwifery).

Summary

Participant midwives and their partners show us that the nature of midwifery on call work is exacting and invasive of self and family and that few midwives begin practice with that knowledge. The response of the midwife to client calls captures the progress of burnout, but the awareness of this is lost in the unknowing that surrounds it. The concealment of burnout occurs within this unknowing of both the midwife and the midwifery profession. It can be so covered over that even the family of the midwife, who are removed from the midwifery philosophical and ethical culture of care, do not see burnout manifesting until its symptoms are so severe they declare themselves in their seriousness. Because of this midwives can be brought to the brink of suicide. Such a high rate of depression and suicidal tendency was disclosed by participants it is possible to speculate that some midwives may have even taken that final step.

The dynamics of leaving case loading practice are complex. To do so requires the overriding of the original passion, the shaped self perception of failure, and the dysfunctional perspectives induced by burnout. There is an altered awareness in burnout that impedes clarity, isolates the sufferer, negates choice and compounds the distresses that are associated with it. Midwives stories show us that it is a profound experience, often gauged by them as the worst one of their lives. There can be ongoing repercussions that carry over into their lives after leaving practice.

Until burnout is addressed within midwifery, midwives are placed at risk and women's care contain the possibility of compromise. Midwifery will continue to hold the possibility of losing good and experienced midwives from the profession, while the midwives themselves will continue to pay an unacceptable price for their love of their work. In the final chapter I have considered the findings emerging from this study and what their implications are for midwifery.

I found burnout was made of flames,
of ice and silent fear,
of tears of joy's abandonment
and words and images
that burned and scarred
and breathed of hopelessness.
I draw out the threads of them
to weave the cloth
to create the tapestry
to tell the story of burnout

Chapter Nine: Discussion

Introduction

Out of the day and night, A joy has taken flight...

(Shelley, 1956, p. 68) : A Lament.

The joy that calls midwives to midwifery and sustains them through the rigours of their practice is destroyed by burnout. The stories participants shared spoke of a profound joylessness that permeated their lives and cast a shadow over those who lived alongside them. To reach a knowing of their experience has required me to make a long journey, the nature of which seems appropriate to disclose within this discussion as it is closely interwoven with the study I have undertaken. As with all long and arduous journeys there are times of pausing to question why we make them.

Forty years ago I tramped across the southern alps in days of such long arduous hiking that many times, despite the lure of the mountains and the rush of rivers, in the pull of mud, the jar of rock and the slow of trudge, came the thought - 'why am I doing this?' Towards the end of my trek I wandered into a forest clearing. It lay in sunlight; a long soft sweep of meadow grass made more precious in amongst the gnarl of wild alpine flora and rock faces. It still stands clearly in my memory while the rest of the journey has dulled with time; an enchanted glade in which new thoughts were possible. Its unexpectedness took me to another place of contemplation; I no longer asked 'why am I doing this?' - I had my answer.

Heidegger (1993) speaks of such a moment in our journey to knowing: "The quiet heart of the clearing is the place of stillness from which alone the possibility of belonging together of Being and thinking, that is presence and apprehending, can arise at all" (p. 445). In our search for the knowing of the phenomenon we are focused on, there is tangle of information through which Heidegger suggests "we toil to the foothills of thought" (p. 377). We reach places of knowing where in that moment of stillness amidst all the possibilities when there is a piercing clarity of assimilation of what it means to be.

The experience of burnout that midwives shared reveal that it is a life event that is seldom understood by those who have not suffered it. I set out to know that experience through their stories. Dorstal (2002) refers to Gadamer's concept of conversation achieving mutual understanding through talk which flows in an opening up to each other in a game of give and take until the conversation proper begins. Then "in talking to each other we pass over into the imaginative world of the other...the elevation of conversation is experienced not as a loss of self-possession, but even without ourselves actually attending to it, as an enrichment of ourselves" (p. 186). For participant midwives the sharing of their stories so we could know their experience plunged them back into trauma. Their courage to re-enter such intense personal pain has sustained me through the long journey towards a knowing of burnout.

Gadamer (1975/2004) describes prejudice as "a judgement that is rendered before all the elements that determine a situation have been finally examined" (p. 270). My pre-understanding prejudiced me to believe that burnout was less than it is because it is hidden within the shadows of shame and camouflaged with a pretence of coping.

The ferocity of burnout is difficult to capture on paper. 'Tiredness' is the heart stutter within the cold fist of the phone call with its potential for a night without sleep, demand induced weeping, the near miss of clinical error through exhaustion, the wish to have a minor car accident on the way so 'you wouldn't have to go', or the reality of such an accident on the way home. 'Anxiety' is sleep disrupting feelings of terror, heart palpitations, knotted stomach with the excruciating worry of how to safely accomplish what needed to be done; then another night of broken sleep because of the fear that you may not have done the right thing. 'Loss of confidence' is overwhelming feelings of utter professional worthlessness, of being a failure in every domain of your life while being further demeaned by the belief you are the only one who was so afflicted. 'Overwhelmed' is shutting yourself away from family and friends, withdrawing to a place so emotionally removed that you 'see them speaking but can't hear their words.' To enter that place of such despair that the final oblivion of nothingness begins to feel preferable to the unbearable pain of being.

Through my participant's stories I came to understand that burnout is a phenomenon with a terrible capacity for devastation which is concealed from those central to it.

I began my search encapsulating burnout in hackneyed words that anticipated it as being 'a serious and significant life event.' Heidegger (1927/1962) tells us that our interpretations are founded on what we bring to our study, it is "never a presuppositionless apprehending of something presented to us" (p. 191). We therefore need to identify the suppositions we bring with us, to expose the threads that we will weave into our interpretations both to ourselves and to others. I looked for something unlovely, of perhaps medium build? As I caught glimpses of burnout through the words of my participants it began to look bigger.

Then I entered a clearing of knowing just as unexpectedly as that former alpine forest glade. Burnout stilled my heart with its huge malevolent presence. It blocked out sunlight, it killed bird song, it stole joy, it destroyed good people, it shattered families. It wounded and, I suspect, at times left people for dead. Burnout was more than 'a serious and significant life event'; it was a thing of dread. Burnout was more than my pre-assumption of 'a serious and significant life event'; it was a thing of dread. I had not anticipated that it so damaged self image that sufferers could become suicidal; nor that stopping practice did not make those feelings go away.

I came to see that unexpectedly burnout has its own momentum yet its presence is disguised. Burnout reinforced its destructive potential through such extreme feelings of personal failure that it obscured external solutions, such as modifying practice. This loss of self worth was compounded by the isolation that was shown to occur in burnout as the sufferer progressively withdrew from all social demand and interaction.

Neither had my pre-assumptions anticipated that there were safety issues for both women and midwives within burnout. Not only does the midwife begin to disassociate from her client, there is the further difficulty in self recognizing the point at which the exhaustion compounded by burnout makes her unsafe. While there has been a study of how the hospital environment, e.g. staff shortages etc,

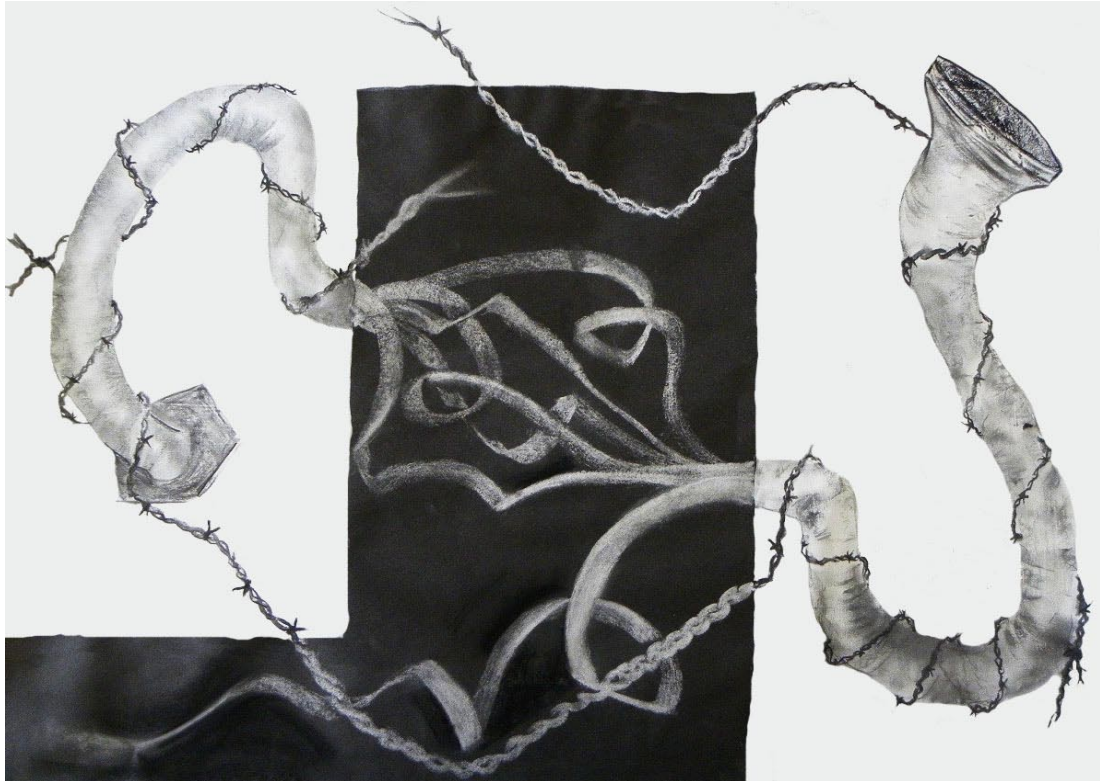
contribute to burnout and impact on patient care (Spence Laschinger, Leiter, 2006), there has been no study of the way in which burnout itself impinges on the quality of care. Hidden within the everydayness of practice was the reality of midwives working long hours without meals further impacting on their ability to give good care.

I had not expected to find that bullying was wide spread with facets of isolation as well as hostility or that it linked so strongly to burnout.

The strong correlation between the antipathy felt towards the source of the call to care, in this study the midwife's cell phone, and the degree of burnout was not anticipated. Nor has this been evidenced in existing studies.

I also came to understand that until something is known there can be no blame.

Yet it has an invisibility. Daphne Du Maurier describes the burnt ruin of the once beautiful homestead of Mandalay. Although ravaged by fire, in a trick of moonlight it seemingly "lived and breathed as it had lived before." But the unspoiled image is only an illusion created by distance and the expectation of seeing what once was there. When the trickery of moonlight is dispelled by cloud, the fire consumed Mandalay is revealed as "a desolate shell..." (Du Maurier, 1938, p. 7). Such is the illusion of burnout. Casual glance assumes nothing has changed but the essential core of being is hollowed out. The fire of burnout is not selective. It does not choose "them" it chooses us. Jemima, a participant in this study who is also an artist, sketched a picture in the depths of the despair of burnout called "pipe dreams" which she has granted me permission to reproduce. In it the extraordinary shaped pipes she sketches have their exquisite shapes crudely wrapped in harsh barbed wire.



Pipe Dreams - sketched by Jemima in burnout

This chapter sets out to discuss the findings that have emerged from this study and to consider the implications they may have for midwifery and midwifery practice. Through the years of study to reach the heart of the clearing of the knowing of burnout, I have never needed to ask 'why am I doing this?' Knowing good midwives have been devastated by its destruction has kept me writing.

At the heart of the matter

What this study has shown is that at the heart of burnout lies individual powerlessness because of the erosion of self. Participants' stories were uniformly of a crippling loss of self rule and self sufficiency. They spoke of the loss of joy, of passion, of self, of family, of friends and of the loss of their ability to alter their situations within the existing framework of care giving. Without the tools to recognize the potential for burnout amongst midwives engaging in the high demands of continuity of care, midwifery opens the door to invite it in. Burnout is made dangerous because of its insidious nature. It is a master of illusion through

semblance and appearance which dulls down alarm bells until a midwife can no longer maintain the pretence that she is alright.

This study suggests that within the strategy of power-through-unity lies the potential for individual powerlessness. The expression of individual concern and difficulty that differs from mainstream opinion is stifled. The terms and the nature of 'autonomous' practice are rigorously dictated to the case loading practitioner by external sources but when they burnout in its service it is only they who are held culpable. Midwives struggling to understand their experience may carry ongoing feelings of guilt and failure that spill over to contaminate their private lives. Great midwives continue to be lost to case loading practice and to midwifery itself through burnout while its complexity and causes go unrecognised and unaddressed.

Powerless to get needed support

Participants shared stories that exposed many layers of animosity within the world of midwifery which was expressed through indifference as well as hostility. One participant spoke of help being deliberately withheld from her exhausted colleague overnight by staff midwives who were filling in their work time with personal internet searches. Even within established systems of collegial networking midwife participants disclosed differences in the quality of support that was on offer; that only some of their colleagues could be trusted to respond willing to a request for help. Every midwife interviewed consistently related stories of being abandoned to a protracted labour care with no offer of relief or support when they could not access help from their practice partner.

Participants voiced their belief that there was failure by management and their professional bodies to address the difficulties of their working situations. Myrtle described a recent managerial memo saying they were to have a break after twelve hours work and retorted "*but where is the midwife to handover to? There is no one available and its bullshit, it's a lie!*" (Myrtle). Heidegger (1927/1962) speaks of how mood reveals the world of the person. Myrtle's anger shows us her sense of injustice over documented offers of help where there is no practical help to be had. It exposes her sense of powerlessness to effect change to address such injustice.

Disempowerment was shown to occur at points of interfacing. Some approaches by case loading midwives for charge midwifery assistance were responded to with hostility and help was withheld. The individual charge midwife was shown to be able to re-define the nature of their professional role through their personal willingness or unwillingness to help thereby creating an inconsistency of support. Participants were resigned to this, accepting the fluctuating levels of support linked to the personality of the interfacing professional. Such resignation exposes their perceived powerlessness to address work place bullying. Myrtle also tells us of how the animosity of core midwives interfered with her decision to handover care despite her own exhaustion because she did not trust that the woman would be looked after empathetically.

It was apparent that a learned behaviour is developing of countering perceived hostility with increasing aggression to get what is needed, normalising workplace animosity. Participants recounted breaking down in tears and publicly displaying their extremes of distress to elicit help when it was being withheld despite their exhaustion, something which the midwife who retains her composure under similar duress may not receive. Help that can only be sourced by extremes of distress is not timely or safe.

One participant believed that the assumption is "they're autonomous so if they need help they should ask for it" - yet this study revealed that when help is asked for it is not always forthcoming. The expectation is that case loading midwives should have practice partners whom they can call on, but participants disclosed situations when they were unable to call on their practice partners because they were also providing care or exhausted from birth attendance. The most significant affect of this divisive behaviour was one of isolating the midwife from support when it was most needed to ensure safe care in a prolonged complex labour. There was a history of an uneasy alliance between core staff and case loading midwives with a poor understanding of the demands of the differing roles. Understaffing was identified by many participants as a factor that contributed to this. The need for supportive interfacing

between case loading and core midwives and the addressing of inadequate staffing levels by management was made apparent within this study.

Division was also apparent between primary and secondary services despite the promotion within the District Health Boards of a zero tolerance of bullying. It was evident that bullying does occur within the hospital environment which both undermines the individual and the quality of care that they are providing creating both an unsafe work environment and unsafe care. Such incidents of hostility were identified as a source of stress by participants that contributed to their feelings of isolation. The 2010 Medical Conference hosted by Otago University considered burnout. It concluded that New Zealand hospitals are rife with bullying and that this was an important factor in burnout. This study has also found that incidences of bullying was common amongst the participant population and the mechanisms for addressing this appeared inadequate.

Impracticalities of the workplace

Participants spoke of the unavailability of food within some of the hospital facilities, and of the lack of option of meals breaks, when they were called in to provide care before having a meal. Because the time of birth is unpredictable, the midwife may not always be leaving to attend from her home or during usual business hours, so taking food with her or purchasing it en route is not always possible. Equally the nature of birth is unpredictable and the call may imply an urgency of response that does not appear to allow time to prepare food, but the reality of the birth may become long hours of working with low blood sugars compounding the affects of fatigue.

Power-drained in enacting the philosophy

Participant midwives spoke of their struggles with aspects of the philosophy of partnership. The affect of a perceived professional resistance to such critique was one of disempowerment. Participant midwives felt unable to express and seek solutions for the commonly voiced difficulties.

Liz suggested that partnership, as prescribed within midwifery, presupposes that women have an identical interpretation of partnership and realistic expectations of their entitlement of care. Participant's stories showed that some women abused their availability and saw them as a resource to be used without restriction or courtesy.

Participants revealed partnership dilemmas when working with client's who wanted the midwife to 'take care' of them in keeping with the traditional medical model of care. They spoke of trying to craft care plans through a process of informed consent in partnership with women who countered it with an increasingly irritated "I don't know, I'm not a midwife! You should know what's best!" Other interviewed midwives felt some of their clients had an impaired ability to decision make effectively because of their compromised life styles and dislocated focus induced by drug and alcohol abuse. They did not believe that all women were able to be motivated to put good self care in place in their pregnancies. Derryn spoke of "*the women who don't give a rat's arse!*" There was also a belief that women from other cultures may have a differing perception of what constituted good care.

Palmer (1969) discusses Gadamer's interpretations of the I-thou relationship. In the first version "the other person is seen as something specific within one's field of experience, most often something which can serve as a means of achieving one's goals" (p. 192). In the second version 'other' is seen as a person but in context of self, and in the third version there is an authentic openness to the 'thou'. Women are coached to see midwives as a provider of a professional service, the legal and philosophical definition of which must revolve around their personal needs, their own interpretation of entitlement and their own perception of the urgency of that entitlement. Within the promoted framework for the provision of care there is no recognition of any need for 'other' to be perceived as other than as a utilitarian human resource to be used at will; "*there is no understanding of the fact that you have a life outside of midwifery or any other client*" (Jemima).

Within the philosophical framework of service provision and availability, all participants acknowledged taking "partnership too far" giving "too much" when they first began to practice. This was so strongly evidenced that it revealed a lack of

understanding of the practical application of the partnership model of care by both women and midwives within the study population. The midwife is expected to achieve partnership with every woman in her care regardless of circumstances. It was clearly shown that women are coached to have a high expectation of midwifery care and its constancy of availability; that they interpreted this as part of midwifery partnership. Access to midwifery input in practice may be uplifted inappropriately with non urgent calls outside normal working hours. The need for a non scheduled consultation and assessment would be deferred until evening when the woman had completed her own work obligations which she expected her midwife to accommodate. There were occasions when women expected the midwife to make house calls around their own convenience and transport decisions. Such expectation was initially upheld by participant midwives, their compliancy to unrealistic high availability at first being attainable because of their low case loads. This established a pattern of service provision that the midwife later struggled to extract herself from.

The uneasy brokering of boundaries

The recognition of the need for boundaries and the subsequent modifying of an established mode of practice were shown to only evolve in the face of difficulties when philosophical ideology is worn down by the service demand. Once recognized, the need to establish boundaries is left to the individual midwife to broker in private. Women continue to have a high expectation of the case loading midwifery service that is promoted to them with no awareness of their midwife's work load outside their own experience of her. This study shows that for midwives reshaping that expectation to something which is sustainable can be a painful process laced with guilt because of their philosophical ideology surrounding midwifery service provision.

It was shown that within the dynamic of woman focussed care midwives lose sight of their own needs until their willingness to provide unconditional care begins to conflict with their ability to do so. Establishing their need for personal space then became divisionary. Hostility and distancing was shown to be used to create boundaries to curtail demand within the midwifery / client relationship, just as it was shown to be used within the midwifery / collegial relationships. This study exposes

strong evidence of the need for continuing dialogue within midwifery and the greater community to realistically define the midwifery role as a professional service.

Fatigue that unravels the quality of care

The reduced ability for midwives to provide care safely because of their personal exhaustion is of concern. The visible hours that the midwife has worked within the facility does not recognize the hours that may have been worked before commencing care. Again the visible hours worked does not reflect the degree of sleep deprivation experienced as midwives recounted sleeping poorly when they knew there was a woman in labour or being disturbed by reassurance seeking calls through the night. This study showed that midwife's own judgment becomes impaired by fatigue and she does not self recognize the extent to which the safety of her care has become compromised. There were also times when participants did recognise they were no longer safe to work but chose to continue to do so because of their loyalty to their client. There was little evidence of any recognition or response to a midwife's excessive fatigue by colleagues working around her. The ability of a case loading midwife to handover care to core staff after giving extended hours of care when her practice partner was unavailable was limited; some participants spoke of being coerced to keep working despite stating they felt unsafe to continue to provide care. It would appear from this study that the affect of caregiver fatigue on the safety of the care that is given is regularly dismissed and its inherent dangers little understood.

Losing discernment of safe practice

There is a painful honesty when midwives told us of *"just wanting them to have a caesarean so I could go home to bed."* Such honesty reveals the anomalies in the midwifery philosophy that "continuity of midwifery care enhances and protects the normal process of childbirth" (Midwifery Council of New Zealand, 2010a, p. 3). Within other occupations there are restrictions on how long a person is permitted to work continuously because of the recognition that excessive fatigue compromises safety.

Current proposals within civil aviation seek to address what they call 'the silent killer' of fatigue within their industry of pilots being on duty for extended hours. They cite independent research into pilot fatigue that suggests that there should be a maximum of 12 hours day duty and 10 hours night duty permitted to be worked after which there is a need for a compulsory stand down time (The Associated Press, 2010). The New Zealand Land Transport Agency (2010) also identifies driver fatigue as the major cause of heavy transport accidents. Drivers are restricted to a maximum of 13 hours work in a 24 hour period, during which they are expected to take a half hour break after every 5 1/2 hours, following which they must have a stand down time period of a minimum of 10 hours.

The maximum shift hospital employed nurses and midwives are expected to undertake is twelve hours, which should include set meal breaks. In the provision of continuity of care with the unpredictability of birth midwives may work far in excess of this. Midwives who were interviewed spoke of working at times with a level of fatigue that compromised the safety of their care. Fatigue does not exonerate a practitioner from giving unsafe care within the legal medico framework. Why do they continue working then? Interviewed midwives offered reasons in addition to the difficulties of accessing help. *"If your brain isn't functioning properly then you can't make decisions"* (Linda). This study revealed that there is a further impaired ability in burnout to recognize the impact of fatigue because the midwife has become accustomed to working when over extended.

Excessive fatigue impairs judgement, including the ability to self assess whether you are safe to continue to provide care. The midwife also becomes torn between her commitment to care for the woman and the practical realities of the safe provision of that care. *"I wanted to both hang in with the woman but also to escape. I felt sick; so tired I didn't feel safe"* (Angela). Angela shows us the complexity of handing over of care, even when it is an option. Her decision making is skewed by her commitment to the woman she is caring for with the juxtaposition of her own tiredness, her decision making capability and her ability to evaluate the impact of her fatigue on the quality and safety of her care. A survey of midwives identified that there was "a tension for midwives providing continuity of care because of the relationships that

are formed, and working in a sustainable manner through having regular time off" (Wakelin & Skinner, 2007, p. 13).

How safe is 'unsafe'? Participants told of incidents of near error when exhausted from prolonged labour attendance. Unsafe within the fatigue of burnout was shown to have the potential for grave and lethal error in the care of women and their babies, the terrible cost of which will always echo through the lives of all who were central to such event. For the midwife who provides such care there is also a potential for devastating life time trauma. The assumption that a midwife always has the ability to identify when her practice is becoming unsafe because of extremes of fatigue is not borne out in practice.

It was shown that there are gaps in the support of midwives creating a lack of safety for both women and midwives. Fatigue has become such an accepted part of practice that it is lost in the everydayness of case loading midwifery and the dangers of working with high levels of fatigue become minimised. One midwife told of crashing her car because of her levels of fatigue when driving home after giving labour care. In a recent unrelated incident a midwife was killed in a car accident returning home after giving extended care. Inappropriate levels of support for over extended midwives created gaps in safety through which both women, babies and midwives may fall.

Within the worldhood of midwifery

Sandall (2006) suggested that the changes within midwifery care could lead to a "feminist-inspired paradigm of partnership with women and/or the creation of a new midwifery elite with the associated casualisation of employment for those midwives on the periphery" (p. 201). Sandall's proposal that case loading midwives could become viewed as an elitist group within midwifery may in part explain some of their collegial interfacing difficulties. While collegial support was evidenced within the practice partner relationships, it was shown that there is a wide range of both demonstrated and covert hostility with little understanding of the tensions of the differing midwifery roles.

Heidegger (1927/1962) refers to the being of entities that are encountered within our environment as part of our worldhood and it is through these entities that the character of that world announces itself. The character of the world of midwifery that announced itself within this study as one in which there could be an isolating lack of support in meeting the stress and fatigue of protracted labour care. It exposed a fractured and sometimes dysfunctional collective responsibility for the wellbeing of women within the indifference to the wellbeing of the caregiver and the related safety of their care. Sometimes this occurred because of an over extended workforce but it was also from a lack of collegial empathy that could extend from indifference to hostility. While it is likely that there were also times of strong collegial support and supportive interfacing with both primary and secondary services, it was the stories of feeling hurt and vulnerable that came forth in the stories told.

Strong enough safety nets to rescue

The presence of severe burnout in practicing midwives reveals that the current safety nets within midwifery are not enough to rescue midwives from its affliction. Conversely participant's stories showed a lack of celebration of good practice. Amelia commented that *"I don't know that I have ever said to someone that they have done a great job except to a student"*. Nor could she ever recollect anyone acknowledging her own good practice. Amelia's words reveal a silence around exemplary work in an environment that pays robust attention to critique of lesser practice. It is a combination that led to many participants feeling undervalued and unsupported.

The midwifery professional processes focus on the maintenance of professional competency and achievement of standards of practice. The Health Practitioners Competence Assurance Act (MOH, 2002) requires the New Zealand Midwifery Council to set standards of clinical competence, cultural competence and ethical conduct and to review and maintain the competence of midwives (May, 2008). These processes create safety nets for the public around professional competency.

The New Zealand College of Midwives offers a Resolutions process for addressing dissatisfaction with care for consumers while the New Zealand Public Health and

Disability Act (MOH, 2000) has mechanisms for addressing more serious concern through Health and Disability Advocacy services or the Health and Disability Commissioner. Again this process focuses on client need.

The New Zealand College of Midwives also oversees a Midwifery Standards Review process that includes individual optionally anonymous evaluations by women of the quality of the care they received from the midwife. The midwife presents her work statistics, evidence that she has met her competency requirements and attended relevant educational workshop, her response to the women's evaluations of her care and addresses how she meets the standards of practice and philosophy of care. She builds this into a reflective overview of her work which is then presented to a committee composed of a reviewing midwife and a consumer representative and formulates a professional development plan with them to guide her future practice.

The review is seen as the midwife's own process and is designed to be supportive of her and of assistance in her identification of areas for future practice development. The Midwifery Standards Review "strives to be a positive and effective process for all parties" (Guilliland & Pairman, 2010, p. 411). It became a compulsory requirement from 2005 for midwives to participate in a review process at the end of a midwife's first year of practice, and thereafter minimally every two years in order to be issued with an annual practicing certificate without which a midwife cannot practice (Midwifery Council of New Zealand, 2008). During this two hour bi-annual process the midwife presents her practice statistics; demonstrates how she upholds the midwifery standards of practice within her work: confirms that her required midwifery competencies have been met, responds to the evaluations women have submitted around her care and constructs a professional development plan.

Interviewed midwives gave mixed accounts of their review experiences, the single process that focuses on the midwife and therefore has the potential to act as a safety net for midwives. Candy spoke of finding her review positive. Jemima found her review so destructive she resigned her New Zealand College of Midwives membership. Other participants also felt as Jemima did. One participant followed up her review with a resolution process because she felt so distressed by the

perceived unfair hostility experienced. Others felt they gained very little from the extended amount of time they had invested in preparing for the review, the cost of which is borne by the midwife if she is working independently.

Within the study population reviewers engaging in this one midwife focused process did not identify that any of these midwives were in severe burnout. Safe care of women and babies has highly emotive connotations against which the well being of the midwifery practitioner can seem a secondary consideration. Yet for women and babies to receive safe care, the midwife must be able to provide safe care and she herself must feel safe in providing that care. The safety nets for these midwives were shown not to be strong enough to identify burnout in time to rescue midwives or to allow timely intervention in fatigue induced compromised safety of care.

Drawn into tensions of power

Powerlessness was a theme that emerged strongly, not only within the dynamics of midwifery but within the practice model. This study showed that some interviewed midwives felt 'unsafe' within the partnership model of care when women ultimately chose care that was outside the perimeters of accepted standards of safe practice. The supposition is that with women's power to make decisions and be in control they assume responsibility for those decisions. It is contended that while midwives are always professionally accountable for their midwifery judgements and actions, in midwifery partnership women also take responsibility for outcomes of decisions jointly made (Pairman, 2010).

However participant midwives felt that the practice reality was one of providing care on the woman's terms and then endeavouring to keep her and her baby safe within her choices for which they carried the professional responsibility. They voiced a belief that the women they cared for seldom assumed responsibility for their decisions and allocated blame elsewhere if those decisions resulted in a less than favourable outcome. The common belief that good documentation was as much about keeping the midwife safe from the woman's decisions as it was about keeping the woman safe within the midwife's care revealed a basic distrust of the midwifery partnership.

Participant midwives also believed that they lost professional credibility when women flouted protocols and guidelines of safe practice for having failed to guide the woman's choices appropriately. They believed that midwives retain a level of responsibility for whatever the woman decides. Interviewed midwives revealed that when interfacing with secondary services they could experience condemnation because they had not manipulated their clients into compliance despite this being contrary to established midwifery philosophical care and statutory rights of informed consent. This study revealed a need for a stronger linking of the consumer rights of informed consent with the obligation of self responsibility for the outcomes attributed to those decisions. There is a further need for recognition within secondary service interfacing of a shared legal obligation to uphold informed choice without allocation of blame to the midwife for her client's choice when it falls outside recommended care of guidelines and protocols.

Feeling powerless and alone

Participant midwives frequently referred to the loneliness of practice. They shared stories of processing traumatic events in isolation; of wondering how other midwives had coped and continued to practice after similar experiences revealing there was little dialogue around it within midwifery. It was felt that informal debriefing with a practice partner who was distressed on their behalf and dealing with their own issues of practice did not suffice. They frequently commented that "*there was nowhere midwives can go with these experiences*"(Derryn) and used words of being "devastated," of feeling "terrible," of being "no use to anyone" to capture the extent of their trauma and their powerlessness to access appropriate help with which to address it.

In times of such stress interviewed midwives commented that their spontaneous sources of support came from obstetricians not midwifery colleagues. They spoke of how they wept profoundly without resolution after being exposed to incidents of stillbirth and infant death and how, in the absence of any other support they turned to friends and family for comfort. Some still felt affected by what they had been exposed to years later and believed that they were no closer to resolution and closure

despite the passage of time. For some participants such an event was the final factor in their leaving practice.

Derryn also drew attention to the *"Reliving dreadful histories that the uncle abused her, her father abused her, the partner is in prison and then she is raped and the other kids are under CYPs care..."* (children and young persons services) that can be involved with history taking and the ongoing provision of care for some women. While the midwife is not involved in an incident directly related to the woman's current pregnancy and birth, she can still be impacted on by the histories and domestic situations her work exposes her to. She is bound by the ethics of client confidentiality in what she can disclose to others in processing such information. All this falls outside the general perception of what midwifery work involves in the idealisation of the planned and wanted baby by united and happy parents. It is only within the profession that the challenging realities of midwifery are understood and within the frame work of confidentiality the impact of such experience stays hidden within the profession.

Participants compared their systems for support with other professions (social workers, counsellors, mental health workers, allied health workers, fire services, police and teachers) where there was professional supervision and readily available debriefing, feeling that there was a lack of effective support available to midwives. Candy discussed her previous work experience within teaching where there was supervision with a debriefing component that *"allowed other people to help us to come to an understanding of what we experienced and clarify issues"* (Candy). They believed this would be helpful as an ongoing process for practicing midwives because of the stresses their work entailed and not just a resource for new practitioners who are now supported through the Midwifery First Year of Practice programme.

Liz told of her attempt to seek private counselling for her on going distress over the death of a baby, but found she was so diminished by grief and burnout that she was unable to see it through. Myrtle shared her story of seeking counselling within the health system for trauma she experienced and finding it inadequate because there

was no understanding of midwifery and her role within it. The recent NZCOM (2010) publication "unexpected outcome?" now guides midwives through such an experience and goes part way towards addressing this. It was evident that midwives within the study population felt isolated with such difficulties of practice.

What is the cost of burnout?

The cost for midwives

Smythe and Spence (1999) tell us of phenomenological hermeneutic research that "How it was' for that person is 'how it was'" (p. 1). How was burnout for the midwives who burned out? They have shown us within this study that it was many different things.

All midwives described a wide range of stress related physical symptoms e.g. low level illness indicating an impaired immune system, weight gain, headaches, hypertension, depression escalating in some participants to feelings of *"I woke up one morning working out what I could do to kill myself"* (Derryn). One participant midwife believes her subsequent development of melanoma was linked to the adrenal exhaustion she developed in burnout. A recent article in the New Zealand Sunday Star Times (Pepperell, 2011) drew attention to the levels of burnout amongst New Zealand health professionals and a study which showed that nurses had a higher than normal suicide risk.

Strathern (2002) talks of Heidegger's belief that "instead of concentrating on his own being, man ignored himself and faced out-wards" (p. 51). To do so meant seeing himself in terms of those around him and measuring himself against his society. Participants supported Heidegger's assertion; they all commented that they had no understanding of what was going on for themselves in their focus on the women in their care. Derryn commented that *"part of the danger is that it is not talked about"*.

Participants revealed the extent of their isolation in burnout as they talked of wondering how other midwives dealt with the death of a baby, how they kept practicing after a significant event, how they maintained practice, how they resourced help when they needed it, how they dealt with fatigue, how they dealt with

bullying, how they appeared to be coping with what they themselves struggled with. The words showed a void of unknowing within the conversations around midwifery practice of how to cope with practice. There was a marked silence for these midwives that surrounds practice difficulty in which it is hard to voice vulnerability. Within this void midwives develop a perception of being "*the only one*" and feel shamed into covering over their difficulties. Anne told us that for her burnout was "*pretending to be something that I once was*". The result was a damaging loss of self esteem. Jemima describes feeling "*I was useless, a no good midwife, a failure!*" Similarly impoverished self images were held by other participants. Low self esteem extended into feelings of loss of self where participants described not knowing "*who I was anymore*" (Brenda). For some interviewed midwives there was complete withdrawal; Angela told us that burnout "*felt like being removed.*" But this study shows us that while each midwife is alone with burnout, they are not alone in burning out. The constructive conversation that was shown to be missing from midwifery for these midwives is an omission which fuels the fires of burnout.

Midwives shared their stories of entering midwifery with joy and passion, of their total commitment to the midwifery ideology of partnership and women centred care. They spoke of their initial pride and professional fulfilment in offering continuity of care and then told of their alienation from all that they had once cared so passionately about and the disintegration of the pride they had once had. This study reveals that burnout creates chaos in the lives of midwives and their families. Participant midwives have shown us that it is a phenomenon with a potential to inflict such damage it can precipitate life threatening crises with levels of depression that become suicidal. For midwives burnout unravels who they are as midwives and as people. It forces them out of the work to which they bought total commitment. For some they are so diminished it is simply a "relief" to walk away, while others describe the abandonment of their work as "being like a death". Amongst participants, midwives at times expressed feeling that they "*would never recover*" (Angela).

The cost for midwifery

The history of midwifery shows us that over the last two decades New Zealand midwives have evolved as a strong autonomous profession with excellent leadership

and a clear capability of fulfilling the midwifery obligations of maternity care. Heidegger (1927/1962) says that what arises from history is monumental. Our history has taught us that midwives are strong, idealistic, passionate and capable of achieving their goals against the odds. But Heidegger informs us that: "authentic historiology becomes a way in which the 'today' gets deprived of its character as present" (p. 449). We need to shift our focus from a history of strength and achievement by toughing through the huge challenges that have been faced and met to see what lies around us in the 'now' of today to shape our future effectively.

The midwifery focus for interviewed midwives fell predominantly on the New Zealand College of Midwives. Participants uniformly identified this as their negotiating professional body which then set the ground rules for practice; the New Zealand Midwifery Council was seen as a regulatory body and was seldom referred to. Interviewed midwives consistently looked to the College of Midwives as their source of support and expressed feelings of betrayal when they did not perceive it as forthcoming.

The role that the College of Midwives fills is a demanding and complex one. Two participant midwives who had sought legal advice via their professional body spoke highly of the availability and quality of that support. Otherwise there was a consistent feeling amongst participants of having been trivialised through the lack of acknowledgement or understanding of the trauma of their experience leading to a distancing in their loyalty and expectations from the New Zealand College of Midwives. Amelia was direct in expressing her opinion, "*I don't feel particularly supported by the College of Midwives. In what way are they supporting me?*" Her words show she is so removed from her professional body that she has lost sight of the enormous amount of important ground breaking work that it has done and all that has been achieved. Other participant midwives believed that the College had accomplished positive change, but were hesitant over the intention and positive influence it has had within their own roles as case loading midwives. At times the participant midwives words contained a sense of abandonment by those who "should know better". Celine comments that "*You would think the College would push our barrow because some of them have been there and done it*".

The difficulty of those who are no longer working on the 'factory floor' maintaining an understanding of what the reality of the workers world has evolved to is an ongoing problem in all walks of life. The study revealed that participants did not believe that the everyday world of the practicing midwives was understood by those who were making the decisions governing the provision of that care. It was shown that distance grew between midwives in burnout and their profession revealing that not addressing a situation, or dismissing it, drives it underground but does not make it go away. The perception of indifference compounded existing damage and in the survival mode of burnout unless the decisions made by the professional bodies ease the midwife's practical world they become irrelevant.

What is survival mode? In burnout midwives become reduced to "*just getting through each day*" (Liz), of trying to hold themselves together when they sense that their whole being is unravelling. Myrtle described feeling as though she was in a car surrounded by a deluge and even though the wipers were going full speed she simply couldn't see the way ahead. She had previously fantasised about having a car accident on the way to work to escape from the obligation of care. Survival mode is to journey through a bleak and desolate landscape devoid of all anticipation of joy.

The study has also shown that when the struggle to provide a professionally upheld ideology of care within practice is believed to be unheard, the midwife who is in burnout begins to implement something of her own in her attempt to survive. She sets up practice boundaries in her own way, the staunchness of which may not always be appropriate. She 'nips and tucks' partnership until it begins to become unrecognisable and the principles that keep women and midwives safe are lost. She condenses informed consent processes to ones of expedient paucity. She learns to manipulate woman's choice so it conforms to expectation and she does not have to muster the energy to run the very real gauntlet of upholding controversial decision making within an established criteria of care provision. Through all this she holds on to her original integrity of commitment and constantly castigates herself for falling short of her own ideal experiencing guilt over each modification she makes to her original mode of practice. Becoming unrecognisable to her self, she pushes herself harder to be the midwife she once was and still wants to be while not understanding

that she is in the grip of the destructive phenomenon of burnout, a relentless process she cannot outrun.

The 'now' of midwifery shows us that midwifery, as does every profession that seeks to maintain an essential integrity in the world of modern health care, has issues to address. The world continually evolves; solutions continue to need to be found for the problems that present within the process of that evolution. Partnership has been shown to have practice difficulties. Interfacing within midwifery and differing professions can be fraught with difficulty. There are elements of bullying, alienation and indifference within the midwifery culture and an animosity that is sadly evident within some factions of the midwifery relationship with women. Women's care can be compromised by midwifery exhaustion. There can be an inability to handover care appropriately because of staffing shortages or an unwillingness to intervene. The midwife's own inability to accurately gauge when she has reached the point of being unsafe to provide care can become impaired by fatigue. Burnout is invisible and some of the compromised care that may occur within burnout is also invisible.

Midwives have burned out at the coal face of midwifery. There is little understanding of what their so called 'dropping quietly out of practice' means in human terms. The trauma of the reality of burnout and an appreciation of the loss to midwifery of that midwife's depth of experience is invisible. This study has shown that these midwives still carry the trauma of their experience with them and continue to feel unheard by the professional bodies that they once looked to for support and guidance. There seemed to be little expectation amongst participants of ever being 'heard' by anyone in authority. They shared their stories, re-experienced their original pain and shed their tears to provide a direct bridge to future midwives to protect them from their own devastating experiences of self employed practice.

The cost for women

An article published in the New Zealand Herald drew attention to the midwifery workforce shortages creating stress amongst women who began a frantic search in early pregnancy to find a midwife to provide their care (Johnston, 2008). Burnout has contributed to a midwifery shortage. One midwife related being phoned by a

woman pregnant with her first child who said "I have rung thirty-four midwives so far and no one wants to look after me. Really, I am a very nice person; I promise I won't be any trouble." The woman's words show us the rejection she feels and the need to placate the professional so that she can assess the care she needs; an uneasy beginning to her first experience of midwifery and childbirth. They also show us the pressure that can be applied to midwives to over extend themselves in taking on the care of women. This midwifery shortage is no longer apparent in many geographical areas.

The boundaries the individual midwife devises to try and contain this expectation may not always be done skilfully. It can fracture an essential trust in the client / midwife relationship after one after hours phone call too many, which the woman believed she was entitled to make. In burnout such distancing becomes part of a survival mechanism. As this study has shown, midwives in burnout become hostile to the women for whom they care, seeing them as their adversaries in their own quest for a sense of self and respite from the burden of care. Participants spoke of "*never caring if another women ever rang them again*", "*coming out of delivery rooms hating women*". They told of a hidden world of midwifery complaint and denigration of the women in their care.

This study exposes a disquieting knowledge that a midwife's need for sleep or respite dominates her ability to provide both empathetic and competent care. Provision of continuity of care through prolonged labour and can skew the midwifery relationship with women. Unvoiced it becomes covert. The woman has no knowledge of the midwife's working world outside the meeting of her own need. She may know that something has entered into their relationship that is detrimental, but in the all encompassing focus of her labour she may not recognise that the quality of their partnership has been impaired at the time when she needs to trust it the most. Heidegger (1927/1962) has informed us that we do not notice what is missing until there is an awareness of its absence. Women recount changing midwives and having a better birth experience subsequently. In the subsequent 'easy' birth they are able to see the quality of care that was absent in their first birth and may applaud the virtues of their current attendant midwife. What is not noticed is the absence of the extra

hours of continuous midwifery care that may have accompanied their previous birth and impacted on their care.

For the women, who are the recipients of prolonged care they may feel emotionally unsafe but the extent of the impact of their midwife's excessive fatigue on the safety of their care may not declare itself to them.

Recommendations from this study

By uncovering the meaning of the lived experience of burnout a knowing of the phenomenon is enabled. From such knowing arises opportunities to address what has been previously concealed. To begin to understand burnout there must be a recognition that the midwives who have suffered burnout are not lesser midwives who were unsuited to the demands of practice. They are but ourselves having been placed under extremes of work induced stress which eroded their wellbeing. Their loss to the midwifery profession is a loss not only of valuable experience but of integrity, commitment and passion; to burnout you must first feel the fire of dedication.

What could be addressed within midwifery education?

The findings of this study would suggest that there is a need for an understanding of burnout, its severity and its prevention, to be strengthened in the undergraduate education of midwives. Such an awareness is already being evidenced in the Midwives First Year of Practice programme. Further consideration as to how to best address this within the educative midwifery process is indicated.

The consistent unknowing of the case loading practice reality amongst the participants also suggests that there is a need for graduating midwives to enter such practice with a greater understanding of its realities. While students have placements with case loading midwives many of the participants voiced protecting their students from the reality of the 'after hours' work load because of their awareness of the student's study commitments. How to bring that reality to the student experience calls for the deliberation of educators. Perhaps it is also a call for midwives to take

cognisance of the manner of practice they are role modelling to students, and consider its long term sustainability.

Within their understanding of midwifery philosophy the participants brought to case loading practice was a consistent idealistic selfless prioritizing of the woman's entitlement of need. It would suggest that there may be a need to revisit the original philosophy of care so that midwives are empowered to offer women led and women focused care in a way that does not rob them of their professional voice or impact on their personal wellbeing. The reappraisal of how these premises are interpreted and enacted could ensure that within the giving of safe care the midwifery practitioner is equally safe.

Within the midwifery professional structure

This study has revealed a lack of knowing within midwifery of burnout. As a world recognized destructive phenomenon that occurs in professions such as midwifery it calls for a professional understanding that extends past the inappropriate blaming of the individual midwife for making poor practice choices. The finding of pathways that enable burnout to be addressed promptly as well as prevented will heal the rifts that have been created between the participants and their professional body and disable the environment that predisposes to burnout. The evolving of a professional understanding of burnout as a recognized phenomenon to which no one has immunity protects all midwives.

Difficulties of setting boundaries around practice in the face of consumer expectation to achieve sustainable practice were voiced so frequently by participants that this study has indicated a need for open discussion between women and midwives. By evolving clearer boundaries around the giving of care in consultation with consumers, women are also able to be aware of such a need if continuity of care is to be a sustainable model within midwifery. This is preferable to leaving such difficulties to be resolved by the individual midwife as her practice disintegrates around her. Philosophical truth can withstand scrutiny, and such scrutiny is needed if truth is to remain truth. This study suggests a need for revisiting how these essential philosophies are interpreted in the world of practice.

Gaps in the supportive processes for midwives were also made evident within this study. Some midwives appeared to have few resources to deal with trauma and because pregnancy and birth is a normal life event in healthy women, there is an 'unexpectedness' of adverse outcomes which exacerbates their impact. More effective supportive services would help midwives address distress arising from incidents their work exposes them to in a timely and appropriate way. The ability to recognize the need for and instigate counselling is reduced in times of great distress and what was available through the public system was not always found to be helpful. The profession and its governing authorities have an onus of responsibility to keep the professionals who work within it safe. Future study and evaluation of the support systems available to case loading midwives would appear appropriate.

It was made visible that there was a need to consider within the midwifery processes a further option that simply focuses on the midwife's wellbeing rather than her competency and practice integrity. The belief that an ongoing supervisory process would be helpful in maintaining practice wellbeing rather than seeking temporary and limited counselling input when not coping was voiced by participants.

Smythe and Young (2008) undertook a three month trial of midwifery practice supervision to evaluate its benefits to a midwifery practitioner. Smythe, who was participating in a master's paper on supervision, engaged in a supervisory process with Young, (myself), who was working as a case loading midwife and engaged in this study on midwifery burnout. We investigated supervision from the premise that supervision is a supportive process that listens, supports and when necessary sensitively challenges the midwife to enable her to take stock of the impact of her practice on her personal life and ensure her ongoing practice is safe. We concluded that professional supervision created a safe place for a midwife to reflect on her practice and her own wellbeing within it. We believed that supervision has many positive facets. It nurtures and values the midwife-as-person affirming her own rights to personal space and care; celebrates great practice that may otherwise go unnoticed; problem solves difficult situations and allows insight in future dealing with similar events and allows the midwife to move on from practice events. We felt

it was a process that would reveal the early warnings of burnout. Proctor (1986) concluded that clinical supervision has three levels of function, normative (organisational responsibility, quality control), formative (development of skills and knowledge) and restorative (supporting personal well-being). The model of supervision visualised was one that was an informal supportive and enabling one as described by Proctor. In a study by Teasedale, Brocklehurst and Thom (2001) it was reported that there were significant differences between supervised and unsupervised nurse practitioners. The supervised nurses reported feeling more listened to and supported, subsequently coping better at work and feeling that they had better access to support than unsupervised nurses. It was seen as a valued form of support for nurse practitioners. It was felt by the study group that further evaluation of the benefits of such a system within midwifery was indicated.

Participants identified the safety nets that they believed to be missing within midwifery. They believed that remuneration rates were needed to allow case loading midwives to take regular time off or to call in a colleague to help with prolonged labour attendance without being financially penalized. Despite the concept that they are self employed, therefore self responsible, midwives are providing an essential health service which they are contracted to the New Zealand government to provide. There is an onus of responsibility at governmental level through the Ministry of Health to ensure that such care is provided safely by all who are involved in its implementation by realistically monitoring what is asked of them as well as what they give and making time off and appropriate support affordable within the fee structures. A rural midwifery support scheme now funds locum relief administered by the New Zealand College of Midwives and the Midwives and Maternity Providers Organisation (Guilliland & Pairman, 2010), but the criteria for eligibility leaves the majority of midwives working within the existing structure. Future consideration as to fee structures and whether a second birth fee should become payable when labour care becomes prolonged to facilitate engaging a relieving midwife without penalising the primary midwife may be indicated.

Within midwifery

To retain the considerable experience of home grown midwives lost to the profession through burnout by appropriate supportive intervention is preferable to the short term solution of overseas recruitment of midwives new to continuity of care. Overseas recruited midwives are statistically shown to remain in midwifery practice here for a shorter time than midwives who are trained and registered within New Zealand. Increasing the workforce through a greater intake by the schools of midwifery only increases midwives who are new to practice and therefore vulnerable; it does not offset the loss of midwives with years of practice experience and wisdom.

This study has shown that there needs to be the capacity to say when help is needed, the capacity to hear and to see such need when the request for help is unvoiced. Where there is no ability or willingness to appropriately intervene when the primary caregiver is exhausted, women and midwives are placed at risk. Fostering a supportive collegial environment which makes the midwife who is struggling visible and the turning of backs on her struggle unacceptable was identified within this study as a basic need within midwifery. The soil in which a culture of caring can flourish requires adequate staffing levels. Jemima, having now begun working as a core midwife, shared her distress over not being able to help a former case loading colleague who was clearly exhausted because of the extended level of commitment within her new role. Knowing how it felt to be in such a situation deeply upset her, but despite Jemima's desire to intervene supportively she did not have the time to do so. A need to address the fluctuating staffing levels within maternity units because of the unpredictability of demand was made apparent. The most appropriate way of meeting such variability of midwife/client ratios, such as having an on-call midwifery pool, invites future investigation.

Within the participant's experiences work place bullying was evident. Hastie (2002) tells us that the first step in addressing work place hostility is to break the silence and acknowledge its existence. She further suggests that we should deal with the work situations that give rise to it. This study has identified that there is division between some midwives who work in different areas of midwifery. Hastie believes that to change the culture of workplace violence there must be on going education and

managerial involvement and prevention in every level in which work place violence occurs. Midwives need to individually embrace the concept that within the ability to effect change lies 'the power of one'. This study would suggest that there is a need for further research to promote midwifery unification through the understanding of what enhances or erodes collegial goodwill.

Within the care of women

Women were shown to be are the innocent victims of burnout. They are given to understand an entitlement of care and ease of constant access to that care that invites them to precipitate an unsustainable level of demand. While it was revealed that there were incidents of lack of consideration amongst the women being cared for by participants, it is likely that there are also times when animosity is innocently induced within their relationship with their midwife. Women were also shown to struggle within the model of partnership within the study group's clients. At times they appeared to mistake the intensity of the professional focus for a personal relationship. They felt it allowed evening and middle of the night phone calls for trivial concerns. There would appear to be a need to publicly reinterpret the parameters of continuity of care so that women present for care with a realistic knowing of what is fair and reasonable. Within the extended care of prolonged labour it was shown that danger can lie because of impaired judgement induced by fatigue. It invites a further investigation of how to safely offer such episodes of care to women within the continuity of care paradigm.

What ever enriches midwifery enriches women and their babies, for whom midwifery cares.

Key principles

The key principles that have emerged from this study as needing robust thinking and questioning are:

- Case loading midwives have the right for a manner of practice that is sustainable and therefore less likely to lead to burnout
- Women have a right to care from a midwife who is not burnt out
- Families of case loading midwives have a right to have protected family time

- Every midwife, be they case loading or core, has a right to work in an environment free from bullying

Linking into existing research

Linking this study into existing literature first draws it back to Maslach (1982) and her identification that the stress of burnout arises from the interaction between the helper and recipient. Schaufeli and Enzman (1998) further conclude that the service professions are at high risk of burnout because of the daily emotional demands of their work. An article evaluating burnout amongst New Zealand psychiatrists by Kumar, Fischer, Robinson, Hatcher and Bhagat (2007) revealed concerning high levels amongst two thirds of their professional colleagues and called for further research into what factors predisposed to or could protect health professionals from burnout.

There was an assumption that through continuity of care midwives would regain professional autonomy that had been lost by working in a hierarchical setting dominated by medicine (Sandall, 1995). Within this study it was evident that a medical hierarchical system is still inherent in some of the interfacing with secondary services, that while the rhetoric has changed the reality may stay the same.

Stock and Wraight (1993) found that midwives traded increased autonomy with greater intrusion into their personal lives as evidenced within this study. It was conjectured that with the establishment of midwifery continuity of care and autonomy, job satisfaction would increase correspondingly (Sandall, 1995). Sandall believed that these assumptions needed critical evaluation within the practice reality that was emerging. Providing continuity of care requires a radical change in the way in which midwives work. The participants stories revealed that the stresses related to that work carry a high potential for burnout.

The relationship between the midwife and the women for whom she cares was shown to be fraught with potential difficulty in the tightrope that must be walked between an idealistic self expectation and the realities of the practice world. Sandall (1995) believes there was a further assumption that a "female dominated occupation such as

midwifery will provide more nurturant 'woman-centred' care than has been the case in the past" (p. 203). This study showed that the ability of the individual midwife to provide nurturing care fluctuates; that the quality of nurturing woman-centred care is variable and links to the wellbeing of the practitioner rather than their gender.

The midwife is expected to place the woman at the central focus of care and maintain a respectful and supportive relationship with her and her family (NZCOM, 2008), yet she must evolve a professional distancing that enables her to sustain the weight of this role. An excerpt from the poem of 'The Good Physician' captures this difficulty:

"If I care too much
Yours and all the other's pain will drain, weaken and kill me.
My love must be shallow enough
For both of us to survive". (Brown, 1995, p. 59)

Recent literature around the New Zealand midwifery LMC experience (Cox, 2008) tells of how this tension plays out within the case loading midwifery practice. When the midwife cares too much the weight of that care becomes erosive. The call to care is described by Smythe and Spence (2008) as one which primarily connects to who we are in our Being. Amelia tells us "*I don't just work as a midwife, that is who I am*". The seeds of burnout lie within that perception and the understanding of what it is to be a 'good' midwife may create unreal expectations that invite comments such as Derryn's "*we are doomed from the start, they set us up to fail.*"

The findings of this study also link into the new complexity of practice introduced through modern technology which dominates practitioners. Heidegger (1971) asserts that people have become enslaved by technology. The scope of midwifery practice has moved from normal pregnancy and birth to one of the provision of guided care in complex situations. Normality, once assumed, is now regularly asked to be proven through technology by women and their caregivers. What is known through the wisdoms of experience is dismissed and only evidence based practice is deemed to be valid.

Participants told of their worry that they had omitted a procedure of technological care that may place a woman at risk and described on going levels of anxiety around routine care that disturbed their sleep. Yet there are doubts about the contribution high technology makes to health. A study conducted within New Zealand over 2006-2007 suggests that low risk women who choose to birth at home are more likely to birth their babies normally and without intervention than low risk women who birth in hospital (Davis et al., 2011). The implication is that when technology is available it is used and such intervention may interfere with the normality of birth outcomes. An analysis of the high rate of intervention in childbirth provided evidence that many interventions were unnecessary and caused harm, (Chong & Kwek, 2010). Reviews of place of birth suggested that planned home birth for women at low obstetric risk had similar or even better outcomes than those of a woman at equally low obstetric risk delivered in an obstetric unit (Janssen, Saxell, Page, Klein, Liston & Lee, 2009). A further study by Olsen (1997) showed that home birth is an acceptable alternative to hospital confinement for selected pregnant women and leads to reduced medical interventions. Participant's stories show the domination of a normal life event by evolving technology creates an anxiety that increases caregiver's stress and likelihood of burnout while the demonstrable benefits of that technology are in doubt.

Opening the conversation to other

Robert Frost (2002) captures the choice we make when we choose one path over another in his poem 'The Road not taken.' The road that was travelled "has made all the difference" to the travel and the traveller. Within this study there are other possibilities, other considerations, and other paths that could have been chosen. I know that I will return to this study and with time see new things. In my study lies roads not taken, and roads not seen as well as interpretations that differing eyes will see in a different light of knowing. There is a welcome as well as the room for more travellers, new eyes and new knowing. To reach the end of a study is to arrive at the beginning of new study and new enquiries.

Since engaging in this study I have been regularly approached by midwives wishing to debrief from practice stresses. They also seek advice on sustainable practice

because of the difficulties surfacing within their practices and their midwifery partnerships. There is a reaching out by midwives for a knowing of burnout. Participant midwives shared their stories in the hope of creating such awareness, for which I and other midwives thank them. It seems I have become a person to whom it is safe to tell stories of burnout to. While there are limited numbers in this study there are many other midwives who could perhaps tell similar stories. Who will listen? And how will we/they respond?

Recommendations for future research

This phenomenological study of burnout amongst case loading midwives providing continuity of care points to a need to understand the environmental context in which it occurs. Continuity of care is believed to be increasingly necessary as care now extends across different fields of expertise and a lead co-ordinating caregiver provides the client with a consistent link. Guilliford, Naithani and Morgan (2006) refer to continuity of care as the centeredness of care. There is no distinction between the centeredness of the principle underpinning continuity of care and the unique continuous care that occurs in prolonged midwifery labour attendance. It is an option of care valued by both women and midwives but it is poorly defined (Murphy-Black, 1992). There is limited evidence of what continuity of care actually means to both groups (Lee, 1994) and why it is important to them. What makes a midwife 'known' to a woman? What enables a woman to feel she has received continuity of care within the increasing recognition that such care must of necessity accommodate the midwife's need for personal time?

This study contributes to a better understanding of the lived experience of the autonomous case loading midwife and the factors that may play a role in precipitating burnout. It sheds light on the particularities of New Zealand case loading midwifery and the participants' experience of burnout. While it upholds some of the findings of existing research on burnout, it brings a new knowing to it from a hermeneutic phenomenological perspective. The findings of this study show many new paths that lend themselves to future investigation.

The voice of the core midwife is seldom heard within this study with its focus on case loading practitioners. A lack of empathetic understanding of the tensions of the different roles within midwifery was shown to exist. Research which uncovers the lived experience of differing midwifery practice would allow their stories to be heard and their roles to be better understood.

Fatigue has been shown to be very present and cumulative within the burnout study population. This lends itself to further study on the impact of fatigue on the quality and safety of care. The common difficulty that was shown for both the case loading midwives themselves and the colleagues working alongside them as to when their level of fatigue compromises safety invites further investigation by future research projects.

The experience of these participant midwives revealed a gap in the support that is available for processing adverse events and maintaining good midwifery practice by directly supporting the midwife. Study to gauge the extent of such need and whether this could be more appropriately met within midwifery is a further possibility to consider.

Within the phenomena of burnout there are opportunities to see if there are clear indicators specific to each profession that indicate its presence. This study showed a strong correlation between the progression of burnout and the increasing antipathy towards cell phones. There is a safety for midwives in knowing that this that may be transferable to other professions, but further research may show that different professions have differing burnout indicators.

The limitations of this study

This study represents a group of participant midwives from one geographical area in New Zealand with a diversity of cultural population. There are always implications that what occurs within one setting within a country may not transfer to another locality; that what occurs in one country will not transfer to another. But this must be also considered in the context of does the phenomenon of burnout have a

geographical terrain, a cultural bias or political agenda? Or is it the lived experience of a study group wherever it occurs

Qualitative research is increasingly recognized and valued and its unique place within nursing research is highlighted by many. Despite this, some researchers continue to raise epistemological issues about the validity of qualitative research findings. Qualitative studies can not be judged by quantitative criteria but by criteria that is developed for the qualitative paradigm, (Cutcliffe & McKenna, (1999).

Phenomenological approaches are good at surfacing deep issues and making voices heard. It can cut through assumptions, prompting actions and challenging complacency, (Lester, 2005). Twelve midwives were interviewed and four of their spouses. While this is in keeping with a phenomenological study, it does not represent a large research population but nor did it seek one. Lester (2005) continues that phenomenological studies are not always understood with regards to sample size to which a quantitative parameter may be applied; a common misunderstanding is that if the sample size is increased the results should be statistically reliable.

The focus, in keeping with hermeneutic phenomenology, was always on an intensity of the exploration of the lived experience of another to learn what that experience meant within the life of the person. A higher participant number and a more peripheral knowledge was never sought. The size of the research population therefore reflects the desire to confirm a consistency in the intensity of that experience, the meaning of which brings weight to the findings, rather than seeking weight through a numerical value. McAra-Couper (2007) speaks of phenomenological study "adding flesh and bones to the statistics" (p. 227); burnout needs such a way of knowing if it is to be understood. Amongst the existing research on burnout such an understanding is only just emerging and is recognized as extending the existing knowledge of burnout.

A common criterion used to judge quantitative research is the generalisability of the findings. Quantitative researchers use large, random samples to enhance the generalisability of statistical findings. In qualitative studies, however, the goal is never

generalisability. Rather, transferability is used to judge the extent to which the findings can be applied to other contexts. Specific strategies used to achieve transferability include thick descriptions and purposive sampling (Bryne, 2001). Within this study the specific lived experience of a case loading midwife who had worked exclusively within a hospital employed framework was sort to discern if her experience resonated with that of non hospital employed case loading midwives. It did. Similarly, midwives partners were approached to enable a different perspective and greater understanding of burnout. Thick descriptions are richly described data that provide the reader with enough information to judge the themes, labels, categories, or constructs of a study (Bryne, 2001). They provide enough information to judge the appropriateness of applying the findings to other settings.

Even though the study focused on one particular practice setting, transferability of findings to other comparable settings, (e.g. other geographical areas within New Zealand, and other professionals experiencing burnout) is regarded as high because of the detailed disclosure of findings in relation to the primary investigation.

The process of interpretation used within the study methodology may also engender critique despite always being acknowledged for what it is, the interpretation of the researcher. However it is a process that always seeks to uncover what was always there, not to implant it, or see what was not there, despite always remaining a process of interpretation. As a phenomenologist I see that as an attribute, allowing a freedom to search for meaning that may not be otherwise seen or brought to the light of day. Van Manen (1990) reminds us that hermeneutic phenomenology is both descriptive because it wants things to appear and speak for themselves, and it is interpretive because phenomenon is always interpreted.

Harman (2007) draws attention to Heidegger's comment that "...every moment is an event, and an event is never fully visible, definable, or describable. The only way to get at the depths of the world is through interpretation, not direct vision" (p. 48). The two concepts of allowing things to appear and speak and to interpret what is said through such appearance are united in the belief that lived experience is already

meaningful and the essence of it is captured in language, which is in itself an interpretive process.

In accepting the liberation of a philosophy that does not pretend to both know and hold all the answers to the questions, or to even know all the questions that need to be asked, the potential for the continuous revelation of the human experience is embraced. New thinking is generated and invited in; there is an expectation of challenge, a willingness to be shown a new or better way in the pursuit of knowledge. The intensity of the encounter with the lived experience being studied allows a depth that could never be captured if spread thinly over a large study population.

The journeys end?

The contemplation of lived experience has no finish, for to arrive at what was thought to be the end is but to arrive back at the beginning because our new understanding then alters our pre-conceptions of what needed to be learned. Heidegger (1927/1962) talks of the "remarkable 'relatedness backward or forward'" of the meaning of our Being (p. 28). This is not to say that we stay static, returning to the same place over and over again. We go forward with a different knowledge born of the new understanding of our original question. The nature of that question is constantly redefined by our evolving learning when we return to revisit it in the light of what we now know.

Malpas (2006) says of this concept; "The path along which Heidegger's thought moves is a path that constantly turns back towards this place, and in which the place-bound direction of that thinking, sometimes in spite of itself, becomes even clearer" (p. 17). The "place" changes as our question changes; new paths leading away from it are seen, or not seen, but there is a knowing to be had within it.

Heidegger believes that this circle of understanding can limit the acquisition of random knowledge if we narrow our focus to only see what we believe we are seeking. But if we enter the circle in the right way he then suggests that, "In the circle is hidden a positive possibility of the most primordial kind of knowing" (p.

195). The understanding he refers to is the understanding that is arrived at through the knowing of the things themselves rather than through supposition or popular conception. This is the clearing in which we arrive through the toil up long and arduous paths and weighty contemplation; the place where meaning may occur. Each visitation is dappled in the mix of light and shadow that both conceals and reveals. We choose one path over another, but may not even see the possibilities of all the paths that lie ahead.

Gadamer (1975/2004) concludes that "It would be a poor hermeneuticist who thought he could have, or had to have, the last word" (p. 579). Hermeneutic phenomenology does not set out to travel in a black and white world of absolutes; it travels in a world full of the rich complexities of human experience that continually evolve. There can be no last word without the last human, nor can that final word ever claim to encompass all that it may mean to be that last human.

Yet within this context of ever evolving knowledge I have sought a greater knowing of burnout through the lived experience of the midwives who have suffered it. Within the words gifted to me by my participants lies another possibility of the knowing of burnout and the showing of another piece of the ever evolving jigsaw.

Sifting through burnout's ashes...

Seeking knowing in the weaving
of the threads
of the darkness
of the being
of burnout.

Two ply hanks of loss and alone,
care worn,
pain hued -
the colours
of burnout.

A swarm of words,
twice barbed,
sting to utter
sting to hear
of burnout.

A flurry of tears, salted with hurt
peppered with rage
and dead dreams,
the larva flow
of burnout.

In the hollow of fled joy
echoes lie
telling of
the being
of burnout.

Carolyn Young.

I thought burn out
was invisible
and made of flames
but it is ice
made of
frozen feelings.
Blinding icicles
in which
the world cracks
into ice islands
fracturing families
fracturing self.
Freezing women
until warmth
breaks through
in a sad
melt down of
self.

I thought burn out
was made of ice.
but it is made of
silence
sound dying in a
conspiracy
that renders
families speechless
colleagues blind and
deaf.
A silent isolation
in which
the inner voice
is muffled.
Self quelled
until in a startled
sob
physical self
breaks.
I thought burn out
was made of
silence
but it is made of
fear
well fed
growing plumper
while self
grows smaller
and dies
and dies
and dies
each day.
Until hollowed out
to almost nothing,
only heartbeats
away
from disappearing,
pain, careful and
deliberate
draws you back.
Reminds you
to breath.

I thought burn out
was made of fear
but it was made of
uninvited,
unexpected
tightly held tears
that suddenly seep
in an over flow
of sorrow.
That even years later
still cannot wash
away
those barbwire
memories
of the pain
that comes from
the death of dreams
I thought burn out
was made of tears,
but it was made of
awfulness.
Such awfulness
that it had to be shut
away
from self
with seals so strong
that if they were ever
broken
and the steel doors
prized open
you would blind
yourself
so you could not see
what was there.
Only your heart
would betray you
in quiet moments
continually remind
you...
it was the worst.

I thought burn out was
an awfulness
but it was the
abandonment
of joy. The
shedding of self
knowledge
learning to pretend
first to others,
then to self
unknowingly,
that it was
the woman
the day,
the difficulty
the demand
steadily shutting doors
on insights.
Becoming whom
you did not recognise
until even when
that woman
that day
that difficulty
that demand
has been abandoned
you still did not know
that joy had
abandoned you
or why it did.

I thought burn out was the
 abandonment of joy
 but it was words seared into
 the inside of your eyelids
 tattooed there from the stories
 of pain and abuse
 so sharply etched
 that the images seeped
 through the perforations into your
 sleep
 and eroded the sanctuary
 of yourself
 until even if peace was
 gift wrapped in death
 it was preferable
 to now

I found burn out was made
 of flames
 of ice and silent fear
 of tears of joy's
 abandonment
 and words and images
 that burned and scarred
 and breathed of
 hopelessness.
 I draw out the threads of
 them
 to weave the cloth
 to create the tapestry
 to tell the story of burn out

Sifting through burnout's
 ashes...
 Seeking knowing
 in the weaving
 of the threads
 of the darkness
 of the being
 of burn out.

Two ply hanks,
 loss, alone,
 care worn,
 pain hues -
 the colours
 of burn out.

A swarm
 of words,
 twice barbed,
 sting to utter
 sting to hear
 of burn out.

A flurry of tears,
 salted with hurt
 peppered with rage
 and dead dreams,
 the larva flow
 of burn out.

In the hollow
 of fled joy
 echoes lie
 telling of
 the being
 of burn out.

Carolyn Young.

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Appendix A: Ethics Approval



MEMORANDUM

To: Liz Smythe
 From: **Madeline Banda** Executive Secretary, AUTECH
 Date: 23 June 2006
 Subject: Ethics Application Number 06/56 **Independent midwifery practitioners' experiences of burnout: an interpretative phenomenological study.**

Dear Liz

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTECH) at their meeting on 10 April 2006 and as the Executive Secretary of AUTECH I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTECH's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTECH's meeting on 10 July 2006.

Your ethics application is approved for a period of three years until 23 June 2009.

I advise that as part of the ethics approval process, you are required to submit to AUTECH the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through <http://www.aut.ac.nz/research/ethics> including a request for extension of the approval if the project will not be completed by the above expiry date;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/ethics>. This report is to be submitted either when the approval expires on 23 June 2009 or on completion of the project, whichever comes sooner;

You are reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTECH for approval before that change is implemented.

Please note that AUTECH 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.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us.

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 Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely



Madeline Banda

Executive Secretary

Auckland University of Technology Ethics Committee

Cc: Carolyn Mae Young bernard.y@xtra.co.nz

Appendix B: Ethics Approval Amendment



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Liz Smythe
 From: **Madeline Banda** Executive Secretary, AUTEC
 Date: 26 September 2007
 Subject: Ethics Application Number 06/56 **Independent midwifery practitioners' experiences of burnout: an interpretative phenomenological study.**

Dear Liz

I am pleased to advise that as the Executive Secretary of the Auckland University of Technology Ethics Committee (AUTEC) I have approved a minor amendment to your ethics application permitting the involvement of the participants' partners. This delegated approval 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 8 October 2007.

I remind you that as part of the ethics approval process, you are required to submit to AUTEC the following:

- A brief annual progress report indicating compliance with the ethical approval given using form EA2, which is available online through <http://www.aut.ac.nz/about/ethics>, including when necessary a request for extension of the approval one month prior to its expiry on 23 June 2009;
- 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 23 June 2009 or on completion of the project, whichever comes sooner;

It is also a condition of approval that AUTEC is notified of any adverse events or if the research does not commence and that AUTEC approval is sought for any alteration to the research, including any alteration of or addition to the participant documents involved.

You are also reminded that, as applicant, you are responsible for ensuring that any research undertaken under this approval is carried out within the parameters approved for your application. Any change to the research outside the parameters of this approval must be submitted to AUTEC for approval before that change is implemented.

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. Also, should your research be undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all written and verbal correspondence with us. 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 Committee and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely



Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee
Cc: Carolyn Mae Young bernard.y@xtra.co.nz

Appendix C: Participant Information Sheet (Independent Midwifery Practitioners)

Participant Information Sheet



Date Information Sheet Produced: 23 June 2005

Project Title

What is the experience of Independent Midwives who burnout: An interpretive phenomenological study.

Invitation

You are invited to participate in my study that is part of the Masters of Health Science (Midwifery) qualification within the Auckland University of Technology, Auckland. My interest is in interviewing independent midwifery practitioners who have taken the role of Lead Maternity Carer. These midwives will have ceased to practice in this field because of self identified burnout that is believed to have been induced through meeting professional obligations.

What is the purpose of this research?

To examine the lives of independent midwives who have experienced burnout to discover what impact this has had on them. To make the professional responsibilities required of the independent practitioner more visible. It is anticipated that the research findings may be an information source in the formulation of future policy around the expectation of services provided by the independent midwifery practitioner. As the issue of a viable and sustainable independent midwifery service concerns both women and midwives publication of findings will be sort within both Midwifery Journals and Parenting Magazines. Presentation of findings will be sought at Midwifery Conference. The research will form the thesis by which I seek to gain a Masters of Health Science (Midwifery).

How are people chosen to be asked to be part of this research?

Midwives who self identify with the research question will be directly invited or recruited through advertisements in Midwifery Journals, local newsletters and notice boards. The choice of participating in the research will always be that of the individual midwife.

What happens in this research?

If willing to participate in the research, with your consent you will then be interviewed by me at a place and time nominated by you. The interview will be between 45-90 minutes long and will be audio taped. In addition some notes may be taken during the interview. Your interview will then be transcribed and a copy of this will be sent to you along with

my analysis of it for your comment and return. You may be asked to have a follow up interview to seek your opinion of the ideas that are emerging about independent midwives experience of burnout. Between eight to fifteen midwives will be involved in the research.

What are the discomforts and risks?

I anticipate that burnout and leaving a professional field you once choose to work is an experience that you may have many mixed feelings and emotions around. I appreciate that revisiting those feelings may be painful and leave you feeling unexpectedly vulnerable during and after the interview.

How will these discomforts and risks be alleviated?

The interview will take place at a venue of your choice where you feel comfortable and at a time that is convenient for you. Your right to privacy will be respected and only I will be interviewing you. The interview will be halted should you request this and there will be an opportunity to debrief with me after it has been completed. I will re-contact you a day or two after meeting with you to ensure that you have not been left feeling distressed by any feelings the interview may have left you with. Should you feel unsettled a free counselling session can be arranged if you felt this would be helpful to you. You are able to withdraw from the study at any time and have your audio tape and information returned to you or destroyed.

What are the benefits?

I hope this study will create a greater understanding of the complex role independent midwives have in the provision of maternity services. I believe such understanding may lead to better support for independent midwives and ensure that the valuable service they provide to women continues to be a viable option of care.

What compensation is available for injury or negligence?

I appreciate that there may be some distress over revisiting a difficult life experience and therefore sensitivity of interviewing, debriefing and counselling services if requested will be incorporated into my research. Concerns you may have over risk factors within the research can be discussed with my project supervisor or the Executive Secretary of AUT Ethics Committee.

How will my privacy be protected?

All participants will be protected by strict confidentiality criteria. Your identity will only be known by me and any information linking you to my study will be kept in a locked filing cabinet. You will only be referred to within the research by a fictitious name chosen by you. Any identifying information will be edited out of your interview and the transcript of your interview will be given to you so you can re-evaluate the information you have given me before it is incorporated into my study.

What are the costs of participating in this research?

It is not anticipated that there will be any actual costs incurred however should any expenses arise for you as a consequence of being interviewed you will be reimbursed appropriately. The giving of time to the study is voluntary and you should nominate to have your interview take place at a time that is least inconveniencing for you. The time involved will be in the vicinity of two hours with a possibility of a further two hours being involved should you be re-interviewed. Your generosity in making this time available is appreciated.

What opportunity do I have to consider this invitation?

After receiving full information following my preliminary contact your verbal consent will then be sought approximately a week later. At this point of contact you will have a further opportunity to ask for any further clarification of issues or concerns you may have. A final written consent will be obtained from you prior to the interview commencing.

How do I agree to participate in this research?

A consent form will be mailed to you with the information sheet so you may peruse it. Two copies of this will be signed and one retained by you should you wish to participate in this research prior to your being interviewed.

Will I receive feedback on the results of this research?

I would value your continued involvement with the research and be delighted to provide you with feedback.

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.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, *madeline.banda@aut.ac.nz*, 921 9999 ext 8044.

Researcher Contact Details:

Carolyn Young, Telephone 021 612 7778: Email Bernard.Y@xtra.co.nz

Project Supervisor Contact Details:

Liz Smythe: Auckland University of Technology

liz.smythe@aut.ac.nz

Ph 917 9999 ext 7196

Appendix D: Participant Information Sheet (Hospital employed case loading midwives and independent midwives who have returned to practice after experiencing self identified burnout)

Participant Information Sheet



Date Information Sheet Produced: 6 September 2007

Project Title

What is the experience of Independent Midwives who burnout: An interpretive phenomenological study.

Invitation

You are invited to participate in my study that is part of the Doctorate of Philosophy (Midwifery) qualification within the Auckland University of Technology, Auckland. As part of my research I have previously interviewed midwives who have taken the role of Lead Maternity Care with a focus on independent midwifery practitioners. These midwives have ceased to practice in this role because of self identified burnout that they believe to have been induced through meeting professional obligations. I would now like to interview independent midwives who have experienced burnout and since returned to practice to seek their perspective on what they have needed to change. Also hospital employed midwives who work as a case loading midwives who self identify as experiencing burnout to consider their experience alongside that of independent midwives.

What is the purpose of this research?

To examine the lives of independent midwives who have experienced burnout to discover what impact this has had on them and their families. To make the professional responsibilities required of the independent practitioner more visible. It is anticipated that the research findings may be an information source in the formulation of future policy around the expectation of services provided by the independent midwifery practitioner. As the issue of a viable and sustainable independent midwifery service concerns both women and midwives publication of findings will be sort within both Midwifery Journals and Parenting Magazines. Presentation of findings will be sought at Midwifery Conference. The research will form the thesis by which I seek to gain a Doctorate of Philosophy (Midwifery).

How are people chosen to be asked to be part of this research?

Midwives in independent practice who self identify with the research question will be directly invited or recruited through advertisements in Midwifery Journals, local

newsletters and notice boards. Similarly midwives who have been able to sustain or return to independent practice after experiencing burnout will also be recruited. Non independent practicing midwives working in other midwifery areas that self identify with the research question will be recruited to compare the processes they have experienced. The choice of participating in the research will always be that of the individual midwife.

In order to explore the impact of burnout on the independent midwife's family, partners of midwives will be recruited initially through the participating midwife then, having obtained the midwife's consent to do so, a direct approach will be made to their partner to ascertain if they would also be willing to participate in this research. Partner's interviews will be separate and confidential from their spouses and the choice of participating in the research will ultimately be that of the individual partner of the participating midwife.

What happens in this research?

If willing to participate in the research, with your consent you will then be interviewed by me at a place and time nominated by you. The interview will be between 45-90 minutes long and will be audio taped. In addition some notes may be taken during the interview. Your interview will then be transcribed and a copy of this will be sent to you along with my analysis of it for your comment and return. You may be asked to have a follow up interview to seek your opinion of the ideas that are emerging about independent midwives experience of burnout. Between ten to fifteen midwives will be involved in the research and between three to five partners of midwives will also be recruited.

What are the discomforts and risks?

I anticipate that burnout and leaving a professional field you once choose to work is an experience that you may have many mixed feelings and emotions around. I appreciate that revisiting those feelings may be painful and leave you feeling unexpectedly vulnerable during and after the interview.

How will these discomforts and risks be alleviated?

The interview will take place at a venue of your choice where you feel comfortable and at a time that is convenient for you. Your right to privacy will be respected and only I will be interviewing you. The interview will be halted should you request this and there will be an opportunity to debrief with me after it has been completed. I will re-contact you a day or two after meeting with you to ensure that you have not been left feeling distressed by any feelings the interview may have left you with. Should you feel unsettled a free counselling session can be arranged if you felt this would be helpful to you. You are able to withdraw from the study at any time and have your audio tape and information returned to you or destroyed.

What are the benefits?

I hope this study will create a greater understanding of the complex role independent midwives have in the provision of maternity services. My belief is that the impact on both the individual midwife and her family of meeting the demands of her professional obligation is currently invisible. I believe such understanding may lead to better support for independent midwives and ensure that the valuable service they provide to women continues to be a viable option of care.

What compensation is available for injury or negligence?

I appreciate that there may be some distress over revisiting a difficult life experience and therefore sensitivity of interviewing, debriefing and counselling services if requested will be incorporated into my research. Concerns you may have over risk factors within the

research can be discussed with my project supervisor or the Executive Secretary of AUT Ethics Committee.

How will my privacy be protected?

All participants will be protected by strict confidentiality criteria. Your identity will only be known by me and any information linking you to my study will be kept in a locked filing cabinet. You will only be referred to within the research by a fictitious name chosen by you. Any identifying information will be edited out of your interview and the transcript of your interview will be given to you so you can re-evaluate the information you have given me before it is incorporated into my study.

What are the costs of participating in this research?

It is not anticipated that there will be any actual costs incurred however should any expenses arise for you as a consequence of being interviewed you will be reimbursed appropriately. The giving of time to the study is voluntary and you should nominate to have your interview take place at a time that is least inconveniencing for you. The time involved will be in the vicinity of two hours with a possibility of a further two hours being involved should you be re-interviewed. Your generosity in making this time available is appreciated.

What opportunity do I have to consider this invitation?

After receiving full information following my preliminary contact your verbal consent will then be sought approximately a week later. At this point of contact you will have a further opportunity to ask for any further clarification of issues or concerns you may have. A final written consent will be obtained from you prior to the interview commencing.

How do I agree to participate in this research?

A consent form will be mailed to you with the information sheet so you may peruse it. Two copies of this will be signed and one retained by you should you wish to participate in this research prior to your being interviewed.

Will I receive feedback on the results of this research?

I would value your continued involvement with the research and be delighted to provide you with feedback.

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.

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.

Researcher Contact Details:

Carolyn Young, Telephone 021 612 777: Email Bernard.Y@xtra.co.nz

Project Supervisor Contact Details:

Liz Smythe: Auckland University of Technology (Primary Supervisor) liz.smythe@aut.ac.nz Ph 921 9999 ext 7196 : Judith McAra Couper: Auckland University of Technology (Additional Supervisor) jmcaraco@aut.ac.nz Ph 921 9999 ext 7193

Appendix E: Participant Information Sheet (Partners of Midwives)

Participant Information Sheet



Date Information Sheet Produced: 6 September 2007

Project Title

What is the experience of Independent Midwives who burnout: An interpretive phenomenological study.

Invitation

You are invited to participate in my study that is part of the Doctorate of Philosophy (Midwifery) qualification within the Auckland University of Technology, Auckland. As part of my research I have previously interviewed midwives who have taken the role of Lead Maternity Care with a focus on independent midwifery practitioners. These midwives have ceased to practice in this role because of self identified burnout that they believe to have been induced through meeting professional obligations. With the consent of the midwife involved I would now like to interview some of their partners to seek their partner's perspective of what has been shown to be a profound event in the individual midwife's life. I believe that because of the level of commitment midwives have to their profession they may not recognize the beginnings of burnout. By interviewing their partners who are not locked into the professional ideology and therefore have a different perception of events a broader understanding of the phenomenon may be possible. In adding this dimension into my research I also hope to reveal the impact that burnout may also have on the families of the midwives who were affected by it.

What is the purpose of this research?

To examine the lives of independent midwives who have experienced burnout to discover what impact this has had on them and their families. To make the professional responsibilities required of the independent practitioner more visible. It is anticipated that the research findings may be an information source in the formulation of future policy around the expectation of services provided by the independent midwifery practitioner. As the issue of a viable and sustainable independent midwifery service concerns both women and midwives publication of findings will be sort within both Midwifery Journals and Parenting Magazines. Presentation of findings will be sought at Midwifery Conference. The research will form the thesis by which I seek to gain a Doctorate of Philosophy (Midwifery).

How are people chosen to be asked to be part of this research?

Midwives in independent practice who self identify with the research question will be directly invited or recruited through advertisements in Midwifery Journals, local newsletters and notice boards. Similarly midwives who have been able to sustain or return to independent practice after experiencing burnout will also be recruited. Non independent practicing midwives working in other midwifery areas that self identify with the research question may be recruited to compare the processes they have

experienced. The choice of participating in the research will always be that of the individual midwife.

In order to explore the impact of burnout on the independent midwife's family, partners of midwives will be recruited initially through the participating midwife then, having obtained the midwife's consent to do so, a direct approach will be made to their partner to ascertain if they would also be willing to participate in this research. Partner's interviews will be separate and confidential from their spouses and the choice of participating in the research will ultimately be that of the individual partner of the participating midwife.

What happens in this research?

If willing to participate in the research, with your consent you will then be interviewed by me at a place and time nominated by you. The interview will be between 45-90 minutes long and will be audio taped. In addition some notes may be taken during the interview. Your interview will then be transcribed and a copy of this will be sent to you along with my analysis of it for your comment and return. You may be asked to have a follow up interview to seek your opinion of the ideas that are emerging about independent midwives experience of burnout. Between ten to fifteen midwives will be involved in the research and between three to five partners of midwives will also be recruited.

What are the discomforts and risks?

I anticipate that burnout and leaving a professional field you once choose to work is an experience that you may have many mixed feelings and emotions around. I appreciate that revisiting those feelings may be painful and leave you feeling unexpectedly vulnerable during and after the interview.

How will these discomforts and risks be alleviated?

The interview will take place at a venue of your choice where you feel comfortable and at a time that is convenient for you. Your right to privacy will be respected and only I will be interviewing you. The interview will be halted should you request this and there will be an opportunity to debrief with me after it has been completed. I will re-contact you a day or two after meeting with you to ensure that you have not been left feeling distressed by any feelings the interview may have left you with. Should you feel unsettled a free counselling session can be arranged if you felt this would be helpful to you. You are able to withdraw from the study at any time and have your audio tape and information returned to you or destroyed.

What are the benefits?

I hope this study will create a greater understanding of the complex role independent midwives have in the provision of maternity services. My belief is that the impact on both the individual midwife and her family of meeting the demands of her professional obligation is currently invisible. I believe such understanding may lead to better support for independent midwives and ensure that the valuable service they provide to women continues to be a viable option of care.

What compensation is available for injury or negligence?

I appreciate that there may be some distress over revisiting a difficult life experience and therefore sensitivity of interviewing, debriefing and counselling services if requested will be incorporated into my research. Concerns you may have over risk factors within the research can be discussed with my project supervisor or the Executive Secretary of AUT Ethics Committee.

How will my privacy be protected?

All participants will be protected by strict confidentiality criteria. Your identity will only be known by me and any information linking you to my study will be kept in a locked filing cabinet. You will only be referred to within the research by a fictitious name chosen by you. Any identifying information will be edited out of your interview and the transcript of your interview will be given to you so you can re-evaluate the information you have given me before it is incorporated into my study.

What are the costs of participating in this research?

It is not anticipated that there will be any actual costs incurred however should any expenses arise for you as a consequence of being interviewed you will be reimbursed appropriately. The giving of time to the study is voluntary and you should nominate to have your interview take place at a time that is least inconveniencing for you. The time involved will be in the vicinity of two hours with a possibility of a further two hours being involved should you be re-interviewed. Your generosity in making this time available is appreciated.

What opportunity do I have to consider this invitation?

After receiving full information following my preliminary contact your verbal consent will then be sought approximately a week later. At this point of contact you will have a further opportunity to ask for any further clarification of issues or concerns you may have. A final written consent will be obtained from you prior to the interview commencing.

How do I agree to participate in this research?

A consent form will be mailed to you with the information sheet so you may peruse it. Two copies of this will be signed and one retained by you should you wish to participate in this research prior to your being interviewed.

Will I receive feedback on the results of this research?

I would value your continued involvement with the research and be delighted to provide you with feedback.

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.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, madeline.banda@aut.ac.nz, 921 9999 ext 8044.

Researcher Contact Details:

Carolyn Young, Telephone 021 612 777: Email Bernard.Y@xtra.co.nz

Project Supervisor Contact Details:

Liz Smythe: Auckland University of Technology (Primary Supervisor)

liz.smythe@aut.ac.nz Ph 921 9999 ext 7196

Judith McAra Couper: Auckland University of Technology (Additional Supervisor)

jmcaraco@aut.ac.nz Ph 921 9999 ext 7193

Appendix F: Consent Form (Midwives)**Consent to Participation in Research**

Title of Project: Independent midwifery practitioner's experiences of burnout: An interpretative phenomenological study.

Project Supervisor: Liz Smythe

Researcher: Carolyn Young

-
- I have read and understand the information provided about this research project (information sheet dated June 23 2005.)
 - I have had an opportunity to ask questions and to have them answered.
 - I understand that the interview will 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 all relevant tapes and transcripts, or parts thereof, will be destroyed.
 - I agree to take part in this research.
 - I wish to receive a copy of the report from the research: tick one: Yes
 No

Participant signature:

Participant name:

Date:

Approved by the Auckland University of Technology Ethics Committee on 21st April 2006, AUTEK Reference number 06/56

Note: The Participant should retain a copy of this form.

Appendix G: Consent form (Midwives Partners)



Consent to Participation in Research

Title of Project: Independent midwifery practitioner's experiences of burnout: An interpretative phenomenological study.

Project Supervisor: Liz Smythe

Researcher: Carolyn Young

-
- I am the partner of a midwife who has self identified as having experienced burnout and has participated in the above named research "independent midwifery practitioner's experience of burnout: An interpretative phenomenological study."
 - My partner has consented to me also being invited to participate in this research with the understanding that my perspective may provide further insight into this phenomenon and the affects that it may have on a family unit.
 - I understand that my interview will take place in a confidential setting and I will be interviewed as an individual participant separate from my partner with the opportunity to use a pseudonym to further protect my identity.
 - I have read and understand the information provided about this research project (information sheet dated June 21, 2007.)
 - I have had an opportunity to ask questions and to have them answered.
 - I understand that the interview will be audio-taped and transcribed. I will have an opportunity to read the complete transcript and the actual information the researcher wishes to work with, subject to my consent, will be identified. This information can be further modified at my request.
 - 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 all relevant tapes and transcripts, or parts thereof, will be destroyed.

- I agree to take part in this research.
- I wish to receive a copy of the report from the research: tick one: Yes
 No

Participant signature:

Participant name:

Date:

**Approved by the Auckland University of Technology Ethics Committee
on 26th Sept 2007, AUTEK Reference number 06/56**

Note: The Participant should retain a copy of this form.

Appendix H: Proposed Advertisement for recruitment of participants if required



Research aims to discover the experience of midwives in independent practice who burnout

Increasing numbers of independent midwives are ceasing to practice because they feel unable to sustain the high professional demand that is made of them despite this having been their preferred option for their provision of midwifery care.

My research seeks to draw attention to this by making the experience of burnout amongst independent midwifery practitioners more visible. Participants would be involved in a 45-90 minute confidential interview for which ethical approval from Auckland University of Technology Ethics committee has been obtained.

If you identify with this experience and are interested in participating in my research please contact:

Carolyn Young,
Ph 021 612 777
Email Bernard.Y@xtra.co.nz

Appendix I: Semi-structured Interview Questions

These questions are a guide only and may not be used at all or discarded as the data collection expands.

1. Tell me why you decided to give up independent practice?
2. How did the reality of independent practice compare with your prior understanding of it?
3. What were the most difficult aspects of it?
4. How did these difficulties impact on you and those around you?
5. What was your experience of burnout like?
6. How did you know you needed to give up your practice?
7. Was it a difficult decision?
8. What is it like for you now?
9. What would you tell a midwife newly entering independent practice?
10. What would need to be different for you to practice independently again?