

Working towards being ready

**A theory of how practising midwives maintain their ongoing competence to
practise their profession**

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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

Date

Abstract

Every year in New Zealand midwives must declare that they have maintained their ongoing competence to practise their profession. There are a number of mandated activities undertaken which are aimed at maintaining public safety. Midwives work in a range of different roles in areas with varying access to resources that support development. There is no current documented research that explains what it is that midwives must do in order that they meet these mandatory requirements and self-identified areas of development.

Grounded theory was the methodology used in an attempt to understand the process that midwives engage, in order that they maintain their competence to practise. Twenty six midwives from around New Zealand, with varying degrees of experience, practice type, current role and qualifications were interviewed.

The finding of this study has led to the development of the theory “working towards being ready”. This is a continuous process in which midwives engage. The component parts are professional positioning, identifying needs, strategizing solutions and reflecting on practice. The process is contextual, diverse and is impacted on by practice setting. It is also dependent on salient conditions of resourcing, availability and opportunity for engagement in activities.

The consequence of this process is that midwives maintain their ability to continue to practise and also maintain their self-assessed competence. However midwives manage a plethora of obstacles some imposed by themselves, others by their practice environment in order to do this. What we see is that midwives start to place boundaries around the practice in which they will engage. Not only that but they develop expertise in certain areas and discard skills that have no relevance for their current clinical context. Ultimately across the profession of midwifery we have midwives working in different areas in different ways all working above the minimum requirement for safe practice and all under the umbrella of midwifery practice. Midwifery practice it seems is far more than just clinical practice and through the process of working towards being ready we see that there is depth to practise but at the consequence of breadth.

This study makes the recommendation that an evaluation occur of current mandated processes for midwives to ascertain if they are effective. Midwives it appears self-manage their practice in order to keep themselves and women that they care for safe and in order to be ready for the moment, whatever the moment may be.

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To the Midwifery Council for their support to engage in this process one that questions and critiques a number of your processes and that explores and calls for a need for change. As the guardians of the safety of childbearing women and their babies please review and hear what is being said and act from a position of evidence to strengthen and sustain our profession.

To my family

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Chapter One: Introduction

Well it is all tied up with being a good practitioner. It's being accountable for your actions. By that I mean you are accountable to be able to provide the women with the best care possible. So the only way that you can do that is to keep up to date. (Megan)

At the commencement of their professional careers midwives in New Zealand are required to demonstrate that they have the required knowledge and skills to enter the Register of Midwives. The competencies that provide the baseline level of competence, the boundaries around which practice is based (scope of practice), and the ongoing requirements placed on midwives are mandated by the Government appointed Midwifery Council of New Zealand. The Council is charged with ensuring public safety by making sure that midwives are competent to practise their profession.

As the Midwifery Advisor, employed by the Council, I am involved in all aspects of Council process premised around public safety including: accreditation of pre-registration education programmes, management of processes where a midwife's competence is found to be below the required standard, and reviewing and approving components of the programme for midwives to demonstrate their ongoing competence to practise. I, therefore, have a thorough understanding of the theoretical mandated requirements. Armed with this theoretical and experiential knowledge, I wanted to understand how a group of midwives working in New Zealand actually engaged in required and self-directed activities in order to maintain their competence to practise. This became the aim of my study.

In this chapter I will introduce the reader to the requirements that are in place to protect the public and that go towards ensuring that health professionals are competent to practise their profession. I will briefly look at national and international definitions and comparisons of competence as I introduce the concept of ongoing competence.

Requirements to demonstrate competence

The Health Professionals Competency Assurance (HPCA) Act (New Zealand Government, 2003) provides the legal basis for practice. It also requires Councils and regulatory boards to ensure the ongoing competence of practitioners. Prior to this Act there had been no formal requirement for

midwives in New Zealand to demonstrate ongoing competence. Therefore, prior to 2003, once practitioners qualified, they were not required to engage in any on-going education or professional development and could make no further effort to update their knowledge and skills. There was no protection in place in relation to public safety.

Post 2003, Registrars of Professional Councils were charged with ensuring the competence of practitioners in the issuing of an annual practising certificate that allows the practitioner to continue to practise. The need arose for a mechanism to enable the Councils to make this judgement. In order to meet its obligations, the Midwifery Council commenced a mandatory Recertification Programme in 2005 (Midwifery Council of New Zealand, 2005b). All midwives in New Zealand holding a practising certificate are required to engage in the Recertification programme and to demonstrate and declare annually to the Midwifery Council that they have maintained currency of practice knowledge and skills, and therefore competence, through completion of the required activities.

The activities of the midwife and the requirements in which they engage are encapsulated in the midwives' scope of practice. Scope of practice is defined as: "any health service that forms part of a health profession" (New Zealand Government, 2003, p. 13). The scope of practice further describes the practice of a profession, including the location and level of responsibility attributed to the professional. The scope of practice originally gazetted by the Midwifery Council in 2004 was republished in 2010 (Midwifery Council of New Zealand, 2010). While founded on the International Confederation of Midwives (2011) definition of a midwife, the scope of practice is defined as the broad boundaries around which practice is based.

It is as follows:

The midwife works in partnership with women, on her own professional responsibility, to give women the necessary support, care and advice during pregnancy, labour and the postpartum period up to six weeks, to facilitate births and to provide care for the newborn.

The midwife understands, promotes and facilitates the physiological processes of pregnancy and childbirth, identifies complications that may arise in mother and baby, accesses appropriate medical assistance, and implements emergency measures as necessary. When women require referral midwives provide midwifery care in collaboration with other health professionals.

Midwives have an important role in health and wellness promotion and education for the woman, her family and the community. Midwifery practice involves informing and preparing the woman and her family for pregnancy, birth,

breastfeeding and parenthood and includes certain aspects of women's health, family planning and infant well-being.

The midwife may practise in any setting, including the home, the community, hospitals, or in any other maternity service. In all settings, the midwife remains responsible and accountable for the care she¹ provides.
(Midwifery Council of New Zealand, 2010)

The scope statement, therefore, defines the relationship that the midwife has with the woman and the time span and practice boundaries through which care is provided. It describes the work that the midwife completes which includes making referral to other health professionals, providing emergency assistance and health promotion. It explains where a midwife can work and, most importantly, makes the clear statement that regardless of her context of practice a midwife is accountable for the care she provides.

Since publishing the statement in 2004, the Council have provided additional interpretation regarding the scope statement which made explicit the requirement for midwives in New Zealand to work across the scope of practice in order to maintain a practising certificate for their role (Midwifery Council of New Zealand, 2005a). This is further reinforced in the Council Recertification policy that states, "The Midwifery Council expects that over each three-year recertification period, each midwife will make sure that she has worked across all aspects of the Midwifery Scope of Practice. That is across antenatal, labour, birth and the postnatal period" (Midwifery Council of New Zealand, 2014b, p. 16). Behind this statement is the recognition that any midwife with a practising certificate can set herself up as a Lead Maternity Carer (LMC), thereby taking responsibility for care from early in pregnancy until 6 weeks postpartum. Engagement in this activity was to be through self-declaration and evidence included within the midwife's portfolio. Such evidence was to be reviewed either through Midwifery Standards Review² or Council audit.

The HPCA Act also required the Midwifery Council to define the "*Competencies for Entry to the Register of Midwives*" (Midwifery Council of New Zealand, 2007a). In New Zealand there are four overarching competencies, all of which have a number of underlying performance criteria. The first competency, partnership, is defined first and foremost as a professional relationship that occurs between the woman and her midwife during pregnancy and childbirth (Guilliland &

¹ In this study the pronoun "she" is used to describe the midwifery population. In this instance it includes the few males (<10) practising in New Zealand.

² A peer and consumer review process provided by the College of Midwives and required as part of the Recertification Process.

Pairman, 2010a). The second competency identifies the parameters supporting the technical knowledge and skills that are the specific tasks performed to a level of proficiency by midwives as part of their clinical practice (International Confederation of Midwives, 2010). The third competency refers to the midwife's role with regard to health promotion and education that will enable the woman to be an active participant in her health care. The final competency refers to the midwife's professional responsibilities, including the midwife's behaviours towards the woman and her colleagues, as well as the midwife's commitment to participate in on-going education (Midwifery Council of New Zealand, 2007a).

To practise in New Zealand health professionals must be granted a practising certificate by the relevant regulatory authority. Regulatory authorities can only issue a practising certificate if they are satisfied about the clinician's ability to practise. To be able to hold a practising certificate, in 2015, midwives must demonstrate their initial competence which allowed them to gain entry to the register and their on-going competence to the Midwifery Council (Midwifery Council of New Zealand, 2005b).

The Competencies for Entry to the Register of Midwives (Midwifery Council of New Zealand, 2007a) are the baseline level of practice. Over time there are advances to knowledge which lead to changes to practise. The flow on effect is that the required theoretical knowledge and skills that underpin each competency will also change. The onus is on each individual registered midwife to ensure that her knowledge and skills continues to meet the requirements for the competencies.

The challenge for midwives in New Zealand is that if they are required to hold a practising certificate in order to work in their role, then according to the Council requirements over each three year period they are required to work across the midwifery scope of practice. This means that the midwife is expected to work clinically in the antenatal, intra-partum and postnatal areas of practice to ensure that they update their knowledge in care provided. This is a requirement for midwives working in clinical practice and for those who hold positions in teaching, education or strategic development by virtue of their midwifery registration. New Zealand midwives practicing across the full scope as LMCs and case-loading midwives comprise 37.3%, leaving 50.6% whose practice is more likely to be predominantly focussed to one particular aspect of care. The remaining 12% of midwives are employed in education, research, management and other aspects of clinical practice (Midwifery Council of New Zealand, 2015).

New Zealand has a unique maternity system. Midwives are the main maternity workforce and are supported by medical and allied health professionals in the delivery of care to women. In New Zealand women chose a lead maternity carer to provide their care during pregnancy, birth and the postnatal period. Most women choose a midwife to be their LMC. Midwife LMC's aim to provide continuity of care through a negotiated partnership with women. When a midwife or doctor works as a LMC they are required to ensure that the woman has access to pregnancy care either from the LMC or their back up 24 hours per day. Birthing women call on their LMC (if she is a midwife) or the back-up to provide intrapartum care at a planned place of birth. To be able to offer these services midwife LMC's re contracted with the New Zealand ministry of health and have an access agreement with facilities in order to be able to provide client care within that service. Midwife LMC's are not employed by the facilities they access. Additionally, midwives working in the LMC capacity have access to referral services for women from conception through to six weeks postnatal. While the care provided is the scope of midwifery, quality practice must also be achieved. This means that for most midwives the recommended size of their caseload is 40-50 women per year. Consideration therefore must be given to the needs of LMC midwife as she works to keep herself up to date and competent.

Superimposed on the need for demonstration of clinical competence is the reality that in the clinical workplace there is change. Every day midwives can be confronted with new knowledge or changes to practice protocols that recommend or require them to change aspects of their clinical practice. The volume of research and reference materials is beyond the reach of the individual midwife. Indeed the MIDIRS reference database, which is a source of information on all aspects of midwifery practice, updates with approximately 100 new reference items daily across all aspects of midwifery (MIDIRS.org, 2015). As midwives are accountable for their practice, there is an expectation that midwives will keep abreast of the research evidence (International Confederation of Midwives, 2010; New Zealand College of Midwives, 2008; Sackett, Rosenberg, Muir Gray, Haynes, & Richardson, 1996) and ensure their practice is maintained at the entry level of competence required by Midwifery Council of New Zealand (2007a). This is demanding, as midwives must incorporate the need for up-to-date theoretical and clinical competence in a complex context where there are numerous demands and constraints. Time may be one very real limiting factor. Yet, lack of time to maintain competence is not considered a valid excuse for a lack of competence that places consumers of health care at risk. The New Zealand College of Midwives, as the professional organisation, has a role in updating members on research findings through publication and presentation of New Zealand research and development of national

midwifery and multidisciplinary consensus statements. Although such information may be provided directly to the midwife, this does not mean that findings are integrated into practice.

Obligations to consumers

Consumers have the right to expect that the health care they receive from clinicians is of the required professional standard (Health and Disability Commissioner, 1996). Maternity consumers have the right to expect that they are receiving a high quality and safe maternity health service (Ministry of Health, 2011). Consumers want to trust their clinicians and they want to believe that the clinician has the required knowledge, skills and attitudes when they attend for care or when they make a decision about care options (Calvert, 1998; Howarth, Swain, & Treharne, 2013; Paterson, 2012). The law that regulates health care professionals, the HPCA Act 2003 (New Zealand Government, 2003), is designed to protect the health and safety of members of the public. Further, the Code of Health and Disability Services Consumers Rights (Health and Disability Commissioner, 1996) clearly describes what consumers can expect when they receive health care. Within the Code, Right 4 refers to consumers receiving services of a required standard. Right 4.1 states “Every consumer has the right to services provided with reasonable care and skill” (Health and Disability Commissioner, 1996). As Godbold and McCallin (2005, p. 125) discussed, “the terminology in Right 4 is ambiguous” and it has, therefore, been left to the Health and Disability Commissioner to decide how care that is provided, as described in a complaint, is assessed and further, for the nominated professional expert to clarify the expected level of skills as part of their review. Right 4.2 also states that “Every consumer has the right to have services provided which comply with legal, professional, ethical and other relevant standards”. The requirements that regulate midwifery practice and that underpin Right 4.2 are those developed by the Midwifery Council which have a legislative basis as required by the HPCA Act. They include

1. Competencies for Entry to the Register of Midwives (Midwifery Council of New Zealand, 2007a)
2. The Midwives Code of Conduct (Midwifery Council of New Zealand, 2011a)
3. Statement on Cultural Competence for Midwives (Midwifery Council of New Zealand, 2011c)

Additionally, there are professional standards developed by the College of Midwives. These do not have a legal basis but were developed to guide practice before the formation of the Midwifery Council.

4. Midwives Standards for Practice (New Zealand College of Midwives, 2008)
5. Code of Ethics (New Zealand College of Midwives, 2008)

Although there is some overlap, the competencies, codes and statements indicate that midwifery practice is to be reviewed using what is agreed by peers as current standards competencies and reasonable practice for the time the event occurred. Midwives, therefore, are expected to keep abreast of changes to ensure that the care they provide is of the required standard of the time. Reference to what one was trained to do or taught to do may well be irrelevant in the context of current care. Consumers have the right to expect professional currency.

Recognising the complex expectations of maintaining competence implicit in a health service that promotes high quality and safety for consumers, the focus of this research was to ask the question: “How do midwives maintain their on-going competence to practise their profession?”

Aim of this study

The aim of this study is to discover how midwives working in New Zealand maintain their competence to practise their profession. The methodology chosen to do this is grounded theory. The output of this study is a substantive theory that explains the processes that midwife participants followed as they worked to achieve the legislative requirement to maintain their practising certificate³. The theory was developed from interviews with 26 midwives who work across the scope of midwifery practice (Midwifery Council of New Zealand, 2010) in various roles in New Zealand. The midwives came predominantly from the Central Region of New Zealand that is the area bounded by Wanganui, Hawkes Bay and Wellington; however, through the process of theoretical sampling the need for midwives with specific characteristics who lived outside the geographical area was identified and they were included in the sample as necessary.

Purpose of this research

With the aim of the study being to develop a substantive theory of how midwives maintain their competence to practise, the purpose of this study is to inform those involved with regulation, education, workforce planning and continuing professional development, of the choices,

³ In New Zealand midwives are registered for life. They go through the process of applying for a practising certificate on an annual basis. To be able to apply for a practising certificate midwives are required to declare that they have maintained their competence to practise.

consequences, challenges and processes that occur for midwives as they attempt to meet this requirement. This is so that those involved in overseeing the midwifery workforce can understand the reality of maintaining competence for a group of clinicians with a perceived scope of practice defined as midwifery. It was also to develop a theory that may be of use and benefit to other clinicians and midwives as they attempt to maintain their on-going competence to practise. In the process of the development of this substantive theory it became apparent that interpretations of the midwifery scope of practice differed across members of the profession. This is a professional doctorate that aims to inform current local midwifery practice. The aim is to develop insight that will generate change that impacts on midwives practising in New Zealand (Rolfe & Davies, 2009). However, it is likely that the findings will also be relevant to those charged with assessing on-going midwifery competence in other countries, and other health disciplines.

Significance of the study

As previously mentioned, in 2003 there was a significant change in regulation of health care practitioners in New Zealand with the passing of the HPCA Act. The purpose of the HPCA Act (2003) is “to protect the health and safety of the public by providing for mechanisms to ensure that health practitioners are competent and fit to practise their professions” (p. 7). The implication is that the midwife who is competent to practise has maintained her knowledge and skills across the entire scope and that she is “up to date”. As noted previously, prior to 2003, within the context of the Nurses Act (New Zealand Government, 1971) and Nurses Amendment Act (New Zealand Government, 1990), there was no requirement for midwives (or nurses) to formally demonstrate their on-going competence to practise. Although it is suggested that the reasonable midwife would engage in professional development, there was no compulsion for her at that time to do so. The reality is that the safety of the woman and her baby at that time could have been compromised because clinicians had chosen not to engage in any professional development. This is the first research that has asked the question “*How do midwives maintain their on-going competence to practise their profession?*” within the context of the New Zealand maternity system.

This study is important in the context of current practice and society. Over the past few years midwifery practice has been the subject of intense media scrutiny (Matenga, 2012; Powell, 2015; Press Association, 2015; Twentyman, 2012; Wilson, 2015a, 2015b). Paterson (2012) discussed the trial by media of the medical profession when cases are brought against individual clinicians. Midwives too experience the same public exposure. Clinicians, regardless of their profession, must, therefore, ensure that their practice is at the required standard in order that they can

demonstrate to their peers and the public that they have the necessary knowledge and skill to practise their profession competently. It is suggested that the mechanism that clinicians use to achieve this is engagement in the recertification programme. There are approximately 3000 registered midwives in New Zealand who hold a practising certificate and, therefore, must maintain their knowledge and skills in order to practise (Midwifery Council of New Zealand, 2005b, 2011b, 2014a, 2015) and to provide care every day to the pregnant, birthing and postnatal women of New Zealand.

The concept of evidence informed practice is entrenched in midwifery education and the competencies for entry to the register of midwives. This has been a major change that has been introduced into clinical practice over the last almost 20 years (Midwifery Council of New Zealand, 2007c; Sackett et al., 1996; Tracy, 2010). Yet little is known of how midwives actually incorporate evidence into their clinical practice, how they utilise and access research and then process it into individualised care for women and their babies. Although not the major focus of this study the implicit assumption when questioning how midwives keep up to date in order that they provide safe care asks about the processes that they have used to incorporate practice evidence, how they differentiate which evidence to incorporate and how they have acquired such knowledge and skills to do this.

Assumptions underpinning the study

As researcher, I bring my own set of assumptions to this study. First and foremost, I am a midwife. I have practised midwifery for more than 20 years. My fundamental belief has always been that as healthcare practitioners we have an obligation to maintain our competence to practise our profession so that we provide safe effective care. Further, that we have an obligation to ensure that the information and care we provide to consumers is based on current evidence that allows us to make wise decisions that do not place the woman or her baby at risk. This is in line with the Competencies for Entry to the Register (Midwifery Council of New Zealand, 2007a) and the Standards for Midwifery (New Zealand College of Midwives, 2015b) practice. I believe that as practitioners we have this obligation to maintain our competence regardless of whether we are working in health, finance or indeed any industry. I believe that on-going development is each midwife's professional obligation and that the reality of being a midwife today is that we work amidst practices that are constantly changing and evolving. I am scared when midwives tell me that nothing has changed!

My own experience and employment as the midwifery advisor working for the New Zealand midwifery regulator requires that I demonstrate my on-going ability to practise within the midwifery scope of practice. I am required to hold a practising certificate by my employer, even though I am not currently involved in extensive hands-on clinical practice. My role includes but is not limited to the following, approval and accreditation of both pre-registration education as well as education in support of midwives ongoing development, assessment of competence for registration and management of midwives under Council competence processes. This is where gaps have been identified in an individual midwife's knowledge and skill base. Despite working in an advisory capacity I am required and is essential that I keep up to date with changes and advances in clinical practice and to maintain my competence. This means that at the minimal level, in addition to maintaining and developing my professional specialised knowledge and skills for my employed role, I have booked and attended a series of mandated courses, maintained my involvement with my professional colleagues, read and reviewed policy and guidelines, and worked clinically as either a locum LMC or as a core midwife within a facility. In this time the amount of nature of the experience that I obtained varied, when I was working as the locum LMC I would schedule visits before or after work throughout the entire pregnancy and postnatal period for the small number (less than five) of women in the caseload. Births would occur when they did and would need to be accommodated. Of course clinical eventualities could mean that the woman required an elective caesarean section. By working as a core midwife for one or two weeks at a time I was able to ensure that I met mandated requirements placed on me. Working in this way, although stressful and with the impact on my work-life balance kept me familiar with the reality of clinical practice. Competence is a statutory declaration based on the midwife's self-assessment as the Council has no minimum clinical practice hours or births requirement.

As a midwifery advisor I bring to this study the knowledge that when competence is questioned then it is also 'judged'. Midwives can be held to account by society when professional misconduct occurs (Health Practitioners Disciplinary Tribunal, 2008, 2014), by consumers or their advocates when a complaint is laid (Health and Disability Commissioner, 2014, 2015) and by other health professionals providing a formal or informal opinion about practice (Godbold, 2010; Lawton et al., 2014). Clinicians judge their peers and their competence based on each individual profession's belief of what is correct or acceptable practice. Society expects safety in birth. Midwives practise in an environment where competence is judged when the birth outcome is unexpected (Perinatal and Maternal Mortality Review Committee, 2015; Twentyman, 2012). Clinicians can be labelled

good, bad, competent or incompetent, depending on the care that they are perceived as providing in any given situation.

To engage in a study without holding some assumptions, when one works in the field of enquiry, is extremely difficult. I consider it is important therefore that I list the assumptions that I have brought into this study. The main assumption I have made is premised around symbolic interactionism (Charon, 2010) and is that people interpret the situation that they find themselves in, from their perspective. That is, they make meaning out of a situation from their own point of view, influenced by their context. There are, therefore, multiple perspectives held by the individual participants that indicate the meaning they give to a particular situation. As a midwife, while I acknowledge my personal motivation to maintain my competence to practise, I assumed that all midwife participants in this study wanted to maintain their knowledge and skills for two main reasons: 1) to ensure that the women for whom they provided care, received midwifery care based on current evidence and up-to-date skills, and 2) more pragmatically, to ensure that they were able to continue to practise their profession. My assumption was that midwives want to provide the best care that they can and that there is personal motivation for them to engage in this activity beyond legislative requirements.

Midwives with whom I had a working regulatory relationship within my employed capacity were excluded from the study. These were midwives who currently have identified knowledge deficits and who were working to address them. While these gaps may have been identified I do not believe that the midwives involved made a personal decision to cease engaging in learning and development. It is more likely their learning needs arose through factors that stopped them from accessing education and development opportunities or from personal factors that inhibited their understanding. At the commencement of my study I made the arbitrary decision to exclude such midwives to reduce any conflict of interest; however, my assumptions regarding the cause of the knowledge gaps changed as I progressed through the study. As the picture started to unravel I began to see the complex and challenging factors that impact on individuals, making exposure to learning opportunities difficult and hence limiting their ability to engage in development.

However as an advisor to the midwifery regulator I was upfront with any potential participants. As certain midwives with specific characteristics were identified any approach was made by a third party who acted as an intermediary. After the initial approach it was up to each individual participant to contact me if they wanted to be part of the study. I was very aware and did not want

to be perceived as using my role as a means of influencing participation and I did not want any participants to feel that they were coerced into participation. If I did not hear from a potential participant no further action was taken.

In addition while my direct manager knew that I was undertaking work on the topic of professional competence, very little day to day conversation occurred about my university work. I was very clear that when I was interviewing or analysing data I was a researcher and when I was working I was a midwifery advisor. Despite the nature of the topic and my work, boundaries had to be maintained at all times to support the midwife participants and me as a researcher.

Definitions of competence

An understanding of what it means to be 'competent' is a key component of this research. This section provides a number of definitions of competence; a somewhat nebulous concept. Indeed Eraut (1998, p. 127) advised the reader that "the usage of the term is no less diverse than the usage of such familiar terms as 'knowledge' 'skills' and 'ability'". In that it is often hard to accurately and concisely state what people mean when they refer to competence or to someone being competent without reference to checklists of tasks and knowledge that individuals are required to demonstrate. The Collins Concise Dictionary (Sinclair, 2001, p. 302) defined 'competent' as "having sufficient skill, knowledge etc... capable; suitable or sufficient for the purpose." Similarly the online business dictionary defined 'competence' as

A cluster of related abilities, commitments, knowledge, and skills that enable a person (or an organization) to act effectively in a job or situation. Competence indicates sufficiency of knowledge and skills that enable someone to act in a wide variety of situations. Because each level of responsibility has its own requirements, competence can occur in any period of a person's life or at any stage of his or her career. (Businessdictionary.com, 2012)

Competence has, for long, been implied or expected in professions (Goode, 1963) and in many facets of life, not just in professions that are related to health. For example competence is required to protect the public when someone is issued with a drivers licence (New Zealand Transport Agency, 2014) or when an individual is required to demonstrate that they have ability to meet required expectations so that they may achieve a credit towards a qualification (New Zealand Qualifications Authority, nd). One of the key components of the second definition of competence is that it can change depending on circumstances. That means that competence may change due to responsibility or to new roles. Although competence is described in generic

terms it is an identified requirement for professions and one that they are advised to “ignore at their peril” (Eraut, 1998, pp. 128-129).

New Zealand Definitions of Professional Competence

Within New Zealand, the HPCA Act (New Zealand Government, 2003) refers to the required standard of competence. This implies a scale of measurement and criteria against which competence is measured. The Act (New Zealand Government, 2003, p. 12) states that the “required standard of competence, in relation to a health practitioner means the standard of competence reasonably to be expected of a health practitioner practising within that health practitioner’s scope of practice.” The New Zealand Midwifery Council (akin to other regulators) defines the minimum standard of competence within the Competencies for Entry to the Register of Midwives. This level of skills and knowledge is that which would be reasonably expected for a health practitioner to gain registration and to be able to practise in 2015. The required competencies are gazetted (Midwifery Council of New Zealand, 2007a), the performance criteria are listed within the competencies, and the skills and knowledge required to be able to meet these criteria are clearly defined in the Standards for Pre-registration education (Midwifery Council of New Zealand, 2007b). The Council states that “By defining the minimum competence standards for registration as a midwife in New Zealand the Midwifery Council has established the minimum standard that all midwives are expected to maintain in their ongoing midwifery practice” (Midwifery Council of New Zealand, 2007a, p. 1). The statement assesses clinicians in terms of their newly qualified counterparts and does not take other identified factors such as experience, context or level of experience (Eraut, 1998) into consideration. In New Zealand there are four competencies for entry to the Register of Midwives; these focus on the knowledge, skills and attitudes that are required for midwives to practise and are listed in Appendix A (Midwifery Council of New Zealand, 2007a). In line with requirements other regulatory authorities in New Zealand have also made statements regarding the competence of health professionals within their remit and developed minimum standards for competence.

The New Zealand Psychologists Board describes the core competencies or skills and attributes that a psychologist is required to hold. While the core competencies are divided into nine different areas of competence, the foundation is the competencies that relate to discipline, knowledge, scholarship and research.

This set of competencies is concerned with the knowledge base in the discipline of psychology required for adequately investigating, describing, explaining,

predicting and modifying behaviour, cognition and affect. They cover the possession of knowledge of psychological theories and models, empirical evidence relating to them and methods of psychological enquiry, as well as an understanding of the interplay between the discipline and practice. They are concerned with basic understanding of, and respect for, the scientific underpinnings of the discipline (i.e. knowledge gained and/or tested by the scientific method). They cover knowledge of research principles and methods, to ensure psychologists are good consumers of the products of research. They are the foundation upon which the other competencies depend. (Psychologists Board of New Zealand, 2014, p. 5)

Underpinning this statement is a definition of competence that relates the requirement to hold knowledge and skills required to practice one's profession. The Psychologists Board have expanded their definition to state that "Competency is a developmental process and evolving process beginning with the novice and leading to the advanced and expert stages" (Psychologists Board of New Zealand, 2014, p. 15). The statement thereby provides a notion that competence is not static and that it does change depending on practice and experience.

The Pharmacy Council bases its definition of competence on that of Epstein and Hundert (2002, p. 226), "Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values and reflection in daily practice for the benefit of the individual and the community being served." Again, the Pharmacy Council describes the notion that competence changes across the professional's career. The Pharmacy Council is very clear that while the standards "may be expressed as entry level competencies and behaviour" it expects that "all pharmacists should look to build on these, as the behaviours expected of an experienced practitioner will exceed this level" (Pharmacy Council of New Zealand, 2015, p. 1).

It is clear that definitions of 'competence and competency' across these three New Zealand based professions appears to have a number of common characteristics which include the skills and knowledge related to the individual profession in order to work within the scope of practice, as well as the ability to practise at the required standard as expected by that profession at any given time. The way that these statements are presented focuses on knowledge; and the demonstration and enactment of skills places them very much into the knowledge and performance discourses of competence (Hodges, 2012) which can be linked to the requirements within legislation that guides these regulatory boards. Recent work by Austin (2015) explored existing and emerging discourse of competence in an attempt to provide understanding and clarity on the topic. This review indicated that competence, although often articulated in line with expression of knowledge and skills, is indeed a more diverse topic – the measurement and

understanding of which is fundamental to safe health care. With this notion that competence is an evolving topic, it is of value to examine international definitions relevant to midwifery to ascertain the focus of international standards.

International comparison

Originally published by the Australian Nursing and Midwifery Council, the National Competency Standards for Midwifery (Nursing and Midwifery Board of Australia, 2006) outline the minimum standards expected of all midwives practising in Australia. The Board writes that the standards “provide the detail of the skills, knowledge and attitudes expected of a midwife to work within the midwifery scope of practice... standards provide the detail of how a midwife is expected to practise and his/her capacity to practice” (Nursing and Midwifery Board of Australia, 2006, p. 3). Language used within the standards is similar to the New Zealand equivalent including reference to partnership and woman centred care. However the Australian standards appear to be more of an amalgamation of the New Zealand ‘competencies’ and ‘standards’. The Australian standards are presented as four domains of practice with a number of competencies that sit under each domain. Chiarella, Thoms, Lau, and McInnes (2008), in their paper, provide background discussion into the development of competency standards for both nursing and midwifery and present results of a survey describing the need for such standards and their acceptance and use. The key recommendation from this paper was for the need for ongoing research into competency standards and for a literature review to ascertain if the standards translate into safe practice and patient outcomes.

The Nursing and Midwifery Council in the United Kingdom has standards of professional practice for clinicians which includes the requirement to deliver care “on the basis of the best evidence available” (Nursing and Midwifery Council, 2015a, p. 7) and further requires clinicians to “recognise and work within the limits of their competence” (Nursing and Midwifery Council, 2015b, p. 11). Competence in this situation is couched around preserving the safety of the person receiving care. The Midwives Rules and Standards (Nursing and Midwifery Council, 2013, p. 7) state that midwives “must be capable of meeting the competencies and essential skills clusters set out in Standard 17 of the Standards for pre-registration midwifery education (Nursing and Midwifery Council, 2009) that are within your scope of practice”. The competencies are listed within the pre-registration standards and link the knowledge and skills of the practising midwife to that of the student entering the profession. The competencies have subsequently been developed in their own stand-alone document in which the Nursing and Midwifery Council state that the goal

is to make it clear that the standards are those that “midwives must meet when they qualify. This will also reinforce that all midwives must maintain these standards by keeping their knowledge and skills up to date as long as they are on our register” (Nursing and Midwifery Council, 2015b, p. 3). Failure to do so can result in the midwife’s fitness to practise being investigated (Nursing and Midwifery Council, 2015b). The Midwives Rules and Standards also refer to practice that is “outside of your current scope of practice” (Nursing and Midwifery Council, 2013, p. 7) implying that the scope of practice of the midwife has time and contextual boundaries.

Sitting behind the definition and standards for individual countries are the International Confederation of Midwife (ICM) standards and guiding documents. The ICM (2011b) provides a statement on the role of the midwife and the scope of practice of work that she engages in. The work by the ICM is seen as “guiding principles” that lead to the development of education programmes (Nursing and Midwifery Council, 2009, p. 4). The UK, Australia and New Zealand regulatory authorities have accepted almost verbatim the ICM international definition of a midwife (International Confederation of Midwives, 2011b); yet regulators in the UK and Europe also have a European Parliamentary directive (European Parliament, 2005, 2013) which, under sections 40-43, outlines the education and practice of midwives across the European continent. New Zealand and Australia, while not bound by the European legislation, have also adopted the ICM standards as a basis from which their education and practice develop (Australian Nursing and Midwifery Council, 2009; Midwifery Council of New Zealand, 2007c, 2010). It seems that even when countries have accepted a consistent definition of a midwife there is also the potential for variation in practice to exist due to the practice environment in which the midwife works. The clinician’s competence will, therefore, be measured against the local standards and accepted practices in their country of practice. However, changes to knowledge and clinical practice will affect the midwife regardless of the environment of her practice. The following section briefly introduces the concept of evidence that leads to change in practice and how that can impact on competence.

Evidence based practice

It is ever changing evidence that calls on-going competence into question. Developed in the 1990s, and originally targeted at the practice of medicine, evidence based or informed practice and the use of ‘evidence’ to guide decision making has become one of the key concepts that underpins and guides clinical practice in society. Evidence based practice uses ‘best practice’ research knowledge applied to a specific individual in a specific clinical context (Sackett et al.,

1996). Evidence based midwifery incorporates this into the framework of midwifery practice and the partnership relationship that exists with the woman (Page, Corkett, & McCandlish, 2006).

Evidence based practice impacts on midwifery and on-going professional development. Texts on evidence based practice refer the practitioners to quality of research and hierarchies of evidence that should be incorporated into practice as part of the process of evidence based practice (Sackett, Strauss, Richardson, Rosenberg, & Haynes, 2000; Tracy, 2010). Indeed, time and money is spent on manuals of policy, guidelines for practice that control and direct what practitioners should and should not do when caring for women (Ministry of Health, 2013, 2014; New Zealand College of Midwives, 2014). The evidence based dogma and discourse runs across all areas of practice and all disciplines. The need for an evidence base arose through the need to control health care through the rigor of academia and science. Clinicians are now expected to be able to understand what happens, what is required and what should not be practiced. Further, evidence based practice ensures that there is a standard practice that is practised by all and that clinicians, across the whole spectrum, work using the best evidence available.

However, there is a contradiction with the evidence based discourse. One of the key components of evidence based practice is that clinicians must rely on both research evidence and their clinical skills. Further concern is that despite 20 years of evidence based practice there are delays in utilisation and implementation into practice (Bick et al., 2012). Further, there is the potential to create new challenges once implementation occurs (Bick, 2011). Indeed implementation of research itself can be problematic and fraught with challenge (Hunter, 2013) regardless of profession and knowledge of evidence based practice (Ubbink, Guyatt, & Vermeulen, 2013). In addition to the growing body of research are the reviews and research that discuss safety and implementation of quality initiatives into practice. Quality is identified as being the responsibility of the individual clinician (Donabedian, 1989) and practice is now further impacted by this work (Lee, Allen, & Daly, 2012; Macrae, 2014). While such information aims to improve the care that is provided by reviewing examples where there have been severe outcomes or by implementing changed communication techniques, their presence and need to be incorporated into practice needs to be disseminated to clinicians.

The concept of safety is identified as being key to all services, (Vincent, Burnett, & Carthey, 2014) and institutes such as the Health Quality and Safety Commission are created in order to provide oversight and to review and analyse serious events, in order to support practice through the

development of a learning culture within New Zealand health care services. The Health, Quality and Safety Commission provides consumers with a degree of reassurance that another agency is watching over clinical services to ensure that when systems and processes are in place, safe care will be provided to the consumers of health care services. In support of a safety culture the National Maternity Monitoring Group has been established as an advisory group to oversee national maternity standards and to provide advice to stakeholders on priorities for improvement in maternity services (www.moh.govt.nz). Clinical governance and risk management processes and frameworks guide the implementation of quality programmes within local clinical practice. Risk management processes include risk assessment and subsequent identification of risk factors with associated referral through the use of nationally approved and endorsed referral guidelines and the use of clinical guidelines and protocols to support practice.

The concept of risk and risk management within practice has developed as a way of promoting safety within health care services. However there has been some debates about its implementation. Skinner (2008, p. 53) states that “risk seems to have become the core force to be reckoned with in maternity care”. In addition Mackenzie Bryers and van Teijlingen (2010) discuss the dilemma that clinicians face when research findings recommend one course of action but when policy change is hindered by delays in translation into practice. Such delays are impacted it would seem by differing perceptions of risk that exist, for example from the medical model where birth is only normal in retrospect and safe when it occurs in hospital, through to midwives who understand birth as a normal life event that occurs where the woman chooses (Mackenzie Bryers & van Teijlingen, 2010, p. 491). Even with risk management standards and processes implemented throughout health care, ultimately the midwife remains accountable for ensuring that her practice knowledge and skills are current (Kenyon, 2009; Midwifery Council of New Zealand, 2005b).

The reality is that the health care environment is changing and that such change is multi-factorial. All clinicians, regardless of the profession, face the challenge of keeping abreast with such change.

On-going competence

Measuring on-going competence is challenging in a world where changes in knowledge and technology create a movable dynamic target. While the competencies form the basis for 'current' practice and the standards for pre-registration education describe what skills and knowledge clinicians are required to have, they do not define what it means to be up to date and competent.

The Recertification Programme (Midwifery Council of New Zealand, 2005b) is the way that the Midwifery Council has decided it will measure how midwives demonstrate their on-going competence to practise. Recertification programmes are defined in Section 41 of the HPCA Act and are "for the purpose of ensuring that practitioners are competent to practise within their scope of practice" (New Zealand Government, 2003, p. 37). In addition, they may apply to all or a subgroup of practitioners, and may include any of a number or type of assessments or courses of study (New Zealand Government, 2003). The Council programme requires midwives to engage in a series of educational workshops and activities aimed at ensuring participation in professional activities, a quality assurance process and clinical practice.

Midwives must engage in this process of on-going professional recertification and demonstrate to the Council that they have engaged in what is required. It is suggested that engaging in recertification programmes whereby clinicians must only complete tasks, when the measurement of activity attendance is more an audit approach of ongoing competence than an assurance approach, does not necessarily imply or guarantee competence (Paterson, 2012). The question posed in this study looks beyond attendance as an indicator of engagement in prescribed activities in order to understand how competence, professional behaviour and attitudes influence midwives to engage in efforts to maintain competence from one year to the next.

The components of the Recertification Programme in 2015 are listed in Appendix B. Midwives in New Zealand have their practice boundaries framed around one scope of practice. This describes the nature of clinical practice, what skills a midwife must have, the tasks she is required to complete and where she may practice. One of the key requirements imposed by the Recertification Programme is the requirement for all midwives who hold a practising certificate, regardless of their context of practice, to work across the midwifery scope of practice. This is a requirement of midwives who are employed in education, research and advisory positions and must retain their practising certificate. The requirements to take part in on-going learning and work across the scope of practice are the two changes from the HPCA Act (2003) that potentially

have had the biggest impact on all midwives. Before these requirements midwives could choose to engage or otherwise in an area of practice. In addition educators and other non-clinical midwives must also engage in some degree of clinical practice over and above their daily role. As the Midwifery Council of New Zealand (2014b, p. 12) states “participation in the recertification programme requires a commitment by midwives to professional development”. Due to the mandatory nature of the programme midwives who engage in this process are merely complying with the Council’s requirements; the risk being that there is no consequential development.

Explanatory terms used throughout this thesis

The following provides explanation for the way that the data is presented:

- All participants have chosen their own pseudonym which is different from their personal names. Any reference to practising midwives with the same name as the pseudonym is purely coincidental.
- The names of all facilities have been removed or replaced with a general explanatory term in brackets; for example [a hospital], [a university].
- Participant quotes end with the participant’s pseudonym. A spread sheet with actual interview and line numbers has been maintained but is not provided. Some midwives were interviewed more than once.
- [Square brackets] have been used to provide clarity to quotations.
- ... indicates that words within the quote have been edited to provide clarity.

As with any health profession, acronyms and abbreviations are part of the everyday culture of midwifery. Where possible explanations have been provided throughout the text. The following table lists the main abbreviations used in this study:

Table 1: Main abbreviations used in the study

Abbreviation	Meaning
ACC	Accident Compensation Corporation
HDC	Health and Disability Commissioner
HPCAA	Health Practitioners Competence Assurance Act
HPDT	Health Practitioners Disciplinary Tribunal
HQSC	Health Quality and Safety Commission
ICM	International Confederation of Midwives
LMC	Lead maternity carer
MCNZ/MwCNZ	Midwifery Council of New Zealand
MFYP	Midwifery First Year of Practice Programme
MOH	Ministry of Health
MQSP	Maternity Quality and Safety Programme
NMBA	Nurses and Midwives Board of Australia
NMC	Nursing and Midwifery Council (UK)
NZCOM	New Zealand College of Midwives
PMMRC	Perinatal mortality and morbidity review committee

Structure of the thesis

The final section outlines the structure of this thesis.

Chapter one Introduction

This chapter has provided an overview of the content of this thesis. It has situated the study within the context of modern midwifery practice and the requirements placed on practitioners to maintain their competence to practise their profession. It has provided definitions of competence and placed New Zealand's on-going competence standards within the context of international best practice. The concept of evidence to inform practice has been briefly discussed as this concept, and its integration into practice, is a strong driver of change in modern health care.

Chapter Two Literature Review

Chapter two will place this study in the context of literature that supports and underpins the research question. It is acknowledged that historically in a grounded theory study a literature

review was not undertaken until during the data analysis whereby the researcher reviews the concepts that are developed. However, Strauss and Corbin (1998) argued that the researcher does not come into a project totally free of experience and ideas. In this case I acknowledge that I come to the project as a midwife who works within the regulation area with ideas and experience that shape my view around the demonstration of ongoing competence. I also undertook a literature review before the research started. The literature provided in this section situates the project within the context of knowledge around the topic of ongoing competence. This section will discuss midwifery practice and the concept of professionalism as a driver to engagement in continuing development. I also critique the notion of professional development as a key strategy to address knowledge gaps and the professional requirements to engage in this process. Literature that is reviewed as part of the data analysis will be incorporated in later chapters.

Chapter Three Methodology and Methods

Chapter three describes the philosophy of knowledge that has been used to guide and direct this study. I present the grounded theory methodology and then the actual method that was used in this study to obtain the data and guide the analysis. I will address the quality aspects of this study and the rigor of the findings.

Chapter Four Overview –Working towards being ready

The key finding of this study has been the development of a theory that describes how midwives maintain their ongoing competence to practice. Chapter four presents an overview of the grounded theory that has been developed. It is a summary chapter that provides a theoretical depiction of the conditions, strategies and consequences of actions that occur as midwives work towards being ready. The four components of the process of working towards being ready “professional positioning, identifying needs, strategising solutions and reviewing practice” are introduced.

Chapters Five – Eight: Working towards being ready

These four chapters provide the findings from the midwife participants in this study. The chapters are divided into the different contexts of practice. This occurred because analysis showed that the actions that the midwives took and their needs and responsibilities, whether mandated or otherwise, were contextually mediated due to the nature of their place and type of practice. Such contextual factors were influenced by the salient conditions of resourcing, availability and opportunity for education. The contexts are as follows

- Core (or hospital employed) midwife
- LMC(or self-employed community based) midwife
- Rural midwife
- Midwife employed in research, education and strategic development

Chapter Nine Discussion and conclusions

Chapter nine presents the research findings and the conclusions that can be drawn. It discusses these findings within the parameters of literature. Throughout the study I have listened to the voice of the midwives. I have heard the challenges that they faced as they attempted to engage in an activity which they believe is key to practice. I have considered the nature of the requirement to engage in development and the data identifies the engagement is a continuous and largely responsive process – responsive to need, responsive to requirement.

This chapter considers recommendations that can be made from this study to assist those midwives in practice who are faced with practice change and with practice need for learning that is based around the context of their practice. I include recommendations that consider the varied and diverse nature of practice and challenges if a “one size fits all approach” is effective. The findings discuss the nature and requirements that sit around the scope of practice when it is evident that midwives define their own boundaries and parameters for their practice. The chapter makes suggestions for those involved in regulation and policy to assist with decision making. Limitations of the study are presented, as are suggestions for further research.

Chapter 2 Literature Review

Literature review in a grounded theory study

Literature review in a grounded theory study is undertaken in the initial part of the research in an attempt to place the study in the context of current literature. Although historically literature was not usually reviewed in depth at the beginning of a grounded theory study, Strauss and Corbin (1998) argued that researchers cannot come into a study without acknowledging what they already know; "We all bring to the inquiry a considerable background in professional and technical literature. We may have acquired this background while studying for examinations or simply through efforts to keep up with the literature in our field."(pp. 48-49). Literature is used in an acknowledgement of what is already known about a topic, it is reviewed to search the field prior to commencing the study, and is further drawn upon as part of the analytic process when there is a need to read conceptually in relation to theoretic sampling. Finally, a literature review is a method of critiquing findings (Strauss & Corbin, 1990). Additionally, there is the on-going quest to search for new knowledge related to findings. Charmaz (2014, p. 308) discussed how the place of the literature review has moved in grounded theory and advised researchers to "use the literature review without letting it stifle your creativity or strangle your theory." McCallin (2003, pp. 64-65) similarly advised the reader that:

It is timely to remind ourselves that all research begins with an idea albeit a fuzzy idea and usually the researcher is sufficiently interested in that idea to pursue it further in order to focus the research and provide a rationale for the study, which will withstand academic review.

Further Giles, King, and de Lacey (2013) concluded and advised that initial review is beneficial but the researcher must identify his or her preconceptions as part of the research

To claim that I did not come into this study without any knowledge or interest in the topic would be incorrect. I had an in-depth working knowledge of the clinical and competence requirements within midwifery and within New Zealand. The literature presented here, therefore, is a critique of the literature which was undertaken in the formative stages of this study. I also identify the gap in literature with regard to knowledge of how individual midwives maintain their on-going competence.

Literature search

Literature was searched between the years 2011 and 2015, using the key words competence, competency, continuing professional development, workforce, quality, professions, midwifery, health professional, and regulation. Databases used for this search included Medline, MIDIRS

and Cinahl. Additional literature was accessed from reference lists, reviewing old professional journals, policy documents and current professional and regulatory websites. Older literature was accessed to track notions and traits of professionalism, professional behaviour and the process of professionalisation.

Professional practice

The characteristics of a profession, as described in some of the early writing by Goode (1963), include, but are not limited to, a determination of educational standards and legal recognition through some degree of regulation or licensure. Further included is the development of a code of ethics that provides guidance on behaviour and expectations of members of the profession. These tools, it is argued, were used by members of the profession to “assert their social utility, to further regulate the incompetent [out of practice] and to reduce internal competition” (Abbott, 1988, p. 11). Being in a profession, therefore, provides certain privileges. Although historically the professions were limited to medicine, law and theology, in recent times many occupations have rebranded/emerged/developed into professions themselves and today cover many aspects of society. However historically many professions worked under the auspices of medicine and were allowed to act under the parameters set by medicine (Freidson, 1985). In their book Ehrenreich and English (1983) state that control over female healers by medicine is part of both a sex and a class struggle, advising that medicine “owes its victory not so much to their (doctors) own efforts, but to the intervention of the ruling class they served” (p.5). Midwifery within New Zealand was no exception and at various times throughout its existence there have been many controls imposed on midwives which allowed for medical domination of childbirth. It was not until the formation of the New Zealand College of Midwives in 1988 and the passing of the Nurses Amendment Act (1990) that the opportunity arose for the formation of the midwifery profession.

A United Kingdom based regulator, the Health and Care Professionals Council (2014), recently engaged in research that explored understanding of professionalism and identified aspects of professional practice . In this study 20 focus groups explored the topic of professionalism amongst three regulated health professions (chiropractors/podiatrist, occupational therapists and paramedics). Group representatives included those from educational institutes as well as practitioners. The purpose of the study was to gain an understanding of how professionalism was interpreted, what indicated a professional person from the perspective of those groups involved, where people gain an understanding of the concept, the idea of professional practice and when someone is deemed to be professional. Findings from this study indicated that professionalism

was linked to the individual's behaviour, communication and appearance. However, the researchers also acknowledged that context plays a role in the definition of this concept stating that from their data they observed that "there is no single definition of professionalism; rather it is a concept that means different things to different people in different contexts" (Health and Care Professionals Council, 2014, p. 13) This statement is not surprising. However, it reinforces that there are multiple interpretations of professionalism; thus implying that judging if someone is behaving in a professional way, or otherwise, is not straightforward.

Previous analysis undertaken by an expert group (Hodges et al., 2011) suggested that professionalism was a concept that varied across time and culture, and that there was a need for an operational definition of this term. In their analysis these authors reviewed 50 articles that referred to the concept of professionalism using discourse analysis. They suggested that there are three main discourses that have evolved. The first takes the perspective of the individual and his or her personality and traits; the second describes professionalism as an interpersonal process that is constructed through interaction of which context is a significant component. The third discourse relates to professional groups and their role within society. The way in which professionalism is constructed and discussed would once again appear to be dependent on the context in which it is being used. Translating concepts and ideas from one profession and one context to another may not be as simple as it appears.

Midwives and professionalism

Regarding midwifery, the concept of professionalism or being a member of a profession has not always existed in New Zealand. The Nurses Act 1971 (New Zealand Government, 1971) removed the autonomy of the midwife to provide care to pregnant women, requiring medical supervision of midwifery practice (Guilliland & Pairman, 2010b). However, since the Nurses Amendment Act 1990 was passed, midwives in New Zealand regained their right to autonomous practice and over the past 25 years, within New Zealand, midwifery has developed or reviewed all components necessary for professionalisation. The book "*Women's business*" provides a historical account of the professionalisation of New Zealand midwifery before and subsequent to changes to the Nurses Amendment Act (1990) through the eyes of two key players in this process. One, the CEO of the College of Midwives (Karen Guilliland) and the other a Head of School of a midwifery education programme and former education advisor to the College of Midwives (Sally Pairman). The book provides their perspectives on the processes that were used to create the midwifery profession as it stands in New Zealand today (Guilliland & Pairman,

2010b). In addition, Pairman (2002) provided further discussion and description on the processes that were used to separate midwifery from nursing including reference to legislative, educational change and the development of a separate professional identity for midwives. In her account she described midwifery as exhibiting a new form of professionalism whereby the midwife and woman work in partnership with one another. This new professionalism identifies that both the midwife and woman are equal and both are expert in that they are both “making contributions that are essential to a successful relationship and to positive outcomes for the woman and her baby” (Pairman, 2002, p. 14). Both accounts, that of Guilliland and Pairman, and Pairman alone, present the perspective that the move towards the professionalisation of midwifery had been strategic, with purpose, and was enabled further through HPCA legislation which allowed for the creation of a separate Midwifery Council. The legislation required regulatory processes for midwives to be separate and distinct from other health professions. The development of the midwifery profession from the organisational perspective has been strategic within New Zealand society; the notion of professionalism of the individual is focussed around the relationship that the midwife builds with the woman for whom she provides midwifery services and is referenced in midwifery professional documents including the standards for practice, code of conduct and code of ethics.

The topic of professionalism in midwifery practice, and the defining of the professional midwife, has been reviewed in a small number of research articles. Halldorsdottir and Karlsdottir (2011) described an evolving theory of professionalism in midwifery. In their paper the authors discussed the need for theory development to be part of the body of evidence that supports a profession. These authors used a technique known as theory synthesis to bring together unrelated scholarly work in an attempt to develop midwifery related theory. Using theory synthesis a review of midwifery literature was undertaken to examine midwifery concepts that have been developed; those concepts were then organised around a key topic or concept of interest. The authors reviewed findings from nine studies undertaken over a period of 12 years between 1996 and 2008 to develop the theory that described “the positive contributions of the professional midwife” (Halldorsdottir & Karlsdottir, 2011, p. 809). From this they presented “five principal factors: professional caring, competence and wisdom, empowering interaction and partnership, together with the midwife’s personal and professional development combine into a whole” (Halldorsdottir & Karlsdottir, 2011, p. 810). The whole, in this case, is midwifery professionalism. Using theory synthesis techniques, these researchers have created a framework that presents the characteristics of the concept of professionalism. Under each of the factors, the researchers have

presented a list of attributes that are then associated with the good midwife. As expected in this research, professionalism includes that the good midwife “is information literate, e.g. is alert to the constant development of knowledge, and thus pursues continuing education and lifelong learning” (Halldorsdottir & Karlsdottir, 2011, p. 813).

Morgan et al. (2014) undertook a Delphi study to again understand professionalism. In this study perspectives from a panel of expert Welsh nurses and midwives were considered in order that an understanding of the behaviours and attitudes that constitute the concept of professionalism could be identified. Data collection occurred over 10 months; there were three rounds in this Delphi study. Statistical testing was used to ascertain the significance of the various attributes and concepts that were identified as relevant to the study focus. Consensus was achieved for 71 attributes which were then divided into attitudes or behaviours that were identified as being professional or otherwise. These were then reduced to eight themes with four under each category (attribute or behaviour). Within the attitudes “a commitment to the development of self and others” (Morgan et al., 2014, p. 38) was identified due to the need to ensure practice was evidence based. A behaviour described as continual development was also seen as essential as it retained the focus on evidence based care and learning. What Morgan et al. have provided is a list of concepts that, within this context, have been agreed as being important in professional practice. Within the categories of attitude and behaviours the need for the professional midwife to engage in, and be aware of, practice change is identified; the underlying premise being that the need to maintain currency and competence is part of the makeup of the professional midwife. Nevertheless the authors do not go on to discuss how such competence is best maintained.

Nicholls, Skirton, and Webb (2011) undertook a Delphi study with an expert panel comprising 226 midwives, women and educators, with the aim to answer the question “what makes a good midwife?” The researchers evaluated statements using a likert scale on characteristics of a good midwife. Statements were then assessed for mean and standard deviations. Responses indicated that for this group of experts a good midwife continued to learn, provided women centred care and had good communication skills. The requirement to continue to learn was the most valued quality. Within the statements were two further qualities that were identified by others as being qualities of professional practice; these statements which were ranked highly by the panel were “use research to inform practice and use reflection to enhance professional practice” (Nicholls et al., 2011, p. 233). There was no discussion on ‘how’ the midwife was to incorporate these on-going learning strategies within her life/practice.

The study by Nicholls et al. (2011) concurs with that of Morgan et al. (2014) and Halldorsdottir and Karlsdottir (2011); midwives are seen to be practising with a sense of professionalism when they demonstrate that they continue to engage in learning throughout their careers, as valued by women. However, while the study by Morgan et al. provided a conceptualisation of professionalism for nurses and midwives practising in Wales, it could be that midwives practising in New Zealand, because of the different context that enables them to work autonomously, see professionalism in a different way. It appears, therefore, that context is highly significant. While these studies identify, describe and define the behaviours required within the professional context they do not explore the on-going behaviours, activities and choices of the individual within that profession that underpin how they act in what is being described as the professional way. One factor that all studies highlighted consistently was the notion that the professional clinician is also a competent clinician suggesting that the clinician that ensures that his or her practice is current and up to date is acting in a professional way. It is argued that maintaining competence is a characteristic of a professional midwife.

Consumer safety

Safety of maternity consumers is a key influencing factor in healthcare (Ministry of Health, 2011, 2015) and is the premise around which health practitioner regulation is based. Safety within a framework of quality is described in a commentary by Arulkumaran (2010) as being essential in maternity care. From a service perspective the author wrote that there is a need for, amongst other things, audit of practice to ensure compliance with guidelines and monitoring of complaints to understand their basis and thereby address appropriately. Safety is, however, a nebulous concept. It has been described as being “concerned with the myriad of ways in which a system can fail to function, which are necessarily vastly more numerous than the acceptable modes of functioning” (Vincent et al., 2014, p. 670). Safety is required to be provided in the service specifications for maternity services as made explicit by the New Zealand Ministry of Health

The service will provide each woman, her partner and her whanau or family every opportunity to have a fulfilling outcome to the woman’s pregnancy, labour and birth, and postnatal care by facilitating the provision of services that are safe, and appropriate to the woman’s and baby’s needs” (Ministry of Health, 2015, p. 3).

The assumption that underpins safety within a service is that those who deliver care are competent to do so.

Safety in childbirth can be viewed through a number of different perspectives other than regulatory. Howarth et al. (2013) undertook a qualitative study, using a phenomenological approach, with 10 New Zealand mothers. The researchers wanted to understand what made the women feel safe about their childbirth experience. Using thematic analysis the core theme that emerged was the “safety-net” that women create to protect themselves and their child. Feeling safe was important for all the participants and it influenced decisions that they made and actions that women took. Important subthemes within the ‘safety net’ included self-help and lifestyle choices that the woman could make, and the need to ensure that the midwife had the required knowledge and skills to support safety and the availability of resources, technology and intervention if required. “The trust women placed in their midwives’ abilities to do all of this, gave the women a sense of safety that they relied on during pregnancy, labour and birth and in those first weeks of post-birth care” (Howarth et al., 2013, p. 27). Women, therefore, when choosing caregivers need to identify that the person in whom they place their trust is able to act in an appropriate professional manner. Clinical competence was essential to the women in this study.

Surtees (2010) interviewed and observed 40 practising midwives in New Zealand. In completing a Foucauldian discourse analysis she presented work that described how the notion of risk and a fear of litigation is impacting midwifery practice. Surtees described how midwives “must work to keep themselves safe, at a time when they are also concerned with keeping the women in their care safe” (p. 82). Surtees went on to explain her findings that despite evidence that does not support certain practices, midwives described how they practised in ways that were defensive. In order to defend themselves from possible action in the future they completed tests and screening so that they could be seen to leave a visible picture of care. For the midwives in this study, professional safety impacted on the care women received. It seems there are many factors that impact on practice and that there are many interpretations of safety.

Smythe (2000, p. 18) asked the question “Being safe in childbirth: what does it mean?” In this phenomenological study, the researcher interviewed six midwives and four doctors asking them about being safe in childbirth. She also listened to the childbirth stories of 10 women “paying particular attention to times of feeling safe or unsafe” (Smythe, 2000, p. 18). In interpreting the words of the participants Smythe drew attention to the fact that an unsafe phenomenon may already be present in the pregnancy, birth or indeed the birthing context; but has not yet revealed itself. She described how being safe is not assuming that what you think you see is how it actually is, and then presented characteristics of safe practice. These include mindfulness, watching,

anticipating, going and judging. What Smythe presents is the complex nature of safety, by making explicit the idea that unsafe may already exist, but that through what she calls a 'spirit of safe practice' clinicians can enable the situation to be as safe as it can be; just as in a moment of forgetfulness, stress or tiredness, they can miss seeing something that matters. This study questions the idea of the 'obvious' safe/unsafe dichotomy and with it the safe/unsafe practice or practitioner. It highlights that safety and ultimately public safety are not clear cut concepts nor are decisions black and white. A midwife may be deemed competent but that does not necessarily mean that on a day by day basis she is always safe in her practice.

A review of safety in childbirth was undertaken in the UK in 2006 (Kings Fund, 2008). Key conclusions from that review were that:

- most births in the UK are safe, but that some are less safe than they can be;
- that safety is the responsibility of every person who provides care for the woman
- the key to safety is effective teams.

While the study was undertaken in the UK, many contextual items discussed in the report are relevant to practice in New Zealand, including older mothers giving birth, greater access to fertility treatment, women with obesity giving birth and rising rates of intervention. The changing risk profiles for pregnant women calls for further knowledge and skills development. Furthermore in some instances, it requires a revision of staffing and skill mix for the safe provision of care.

To ascertain what clinicians believed were key challenges for the safe provision of maternity services within the United Kingdom, Smith, Dixon and Page (2009) conducted an email survey of practitioners involved in maternity services (midwives, obstetricians, GPs, neonatologists, hospital doctors and neonatal nurses). The researchers wanted to gauge opinions about what impacted on the health professionals' ability to provide safe care and to further identify what solutions could be suggested to rectify problems with services. The majority of responses were from midwives (474/591). A number of recurrent themes were identified from within the data. These included the need for more midwifery and obstetric staff with better skills, different ways of working together including different models of care, more resources and guidelines to direct practice. The authors also recommended that there is a need for clinician education around the principles of patient safety as they saw this being essential for successful guideline implementation. The assumption here is that having guidelines and protocols will impact on patient safety from an operational perspective.

In their 2011 review of maternity staffing in the UK, Sandall et al. (2011) conclude the midwife led models of care should be deployed for low and medium risk women and that continuity of care should be encouraged. Both continuity of care and primary led models of care are key elements of the New Zealand maternity system. Within their report, the authors discuss that skill mix, experience and deployment of staff is more important than the actual number of staff that are available to provide care. Supporting the LMC model within New Zealand are core midwives. Midwifery staffing standards for New Zealand maternity facilities clearly articulate that women need one-on-one care and that the staffing and skill mix must be set at levels to support safe continuous care (MERAS, 2014)

Yet there are other vectors or components of safety. Bingham (2010) discusses different approaches to the establishment of quality and safety processes within organisations identifying that adopting different approaches can lead to improved outcomes. In her article she recommends that quality improvement should strive towards perfection through the elimination of defects in the care that is provided (Bingham, 2010, p. 483). To do this Bingham argues that problems can be resolved through scrutiny of clinical performance measures and through thorough analysis. Obtaining robust data is seen as a key component of a quality process that can be then used to elicit change.

Measurement of the relative safety of birthing within New Zealand occurs through an analysis of morbidity and mortality outcomes and statistics. Over the past nine years the Annual report of the Perinatal and Maternal Mortality Review Committee has provided clinicians with a review of cases. (Health Quality and Safety Commission, 2015) Key findings in 2015 demonstrate that among other things for example the New Zealand rate of stillbirth has fallen significantly since 2007, that the majority of deaths from spontaneous preterm birth occurred prior to 24 weeks gestation and that in 2013 there were 12 maternal deaths (Health Quality and Safety Commission, 2015, pp. 5-6). These findings are one representation of the safety of services. Of equal importance with the report are the findings and recommendations that are made around practice, of identification of risk factors and barriers that prevent women from receiving appropriate care. Quantification of birthing outcomes and analysis of poor outcomes can provide assurance or otherwise of systems and can guide and target areas for practice improvement.

What the writers in these papers present are the different interpretations of safety that are evident within modern health care. They also provide discussion on the various ways in which safety can be measured and consequent improvements put in place. Midwives in practice are impacted by the reality of evidence based practice and how that translates into safe care; by the woman's need and interpretation of a safety net that will assist her towards safe passage through her pregnancy and childbirth; by the midwife's own interpretation of what it means to be safe, to practise defensively; and ultimately by their regulators role and the responsibility and interpretation of statutory requirements placed on the regulator. If safe practice is competent practice then by maintaining competence midwives ensure that their practice does not place the public at risk. But what does this mean and what are the boundaries and parameters that sit around public safety? It would appear that safety and public safety is a complex phenomenon impacted by decision makers, differing perspectives, the context of the moment and individual propensity for risk.

Changing practice

Sitting alongside safety in practice and public safety is the changing nature of clinical practice and the impact that has on practitioner on-going competence. Understanding of on-going competence, while seemingly simple on the surface, is complex. For example, on-going competence can also be referred to as continuing competence or continuing professional development. The International Confederation of Midwives (2011) defined midwifery continuing competence within its *Global Standards for Midwifery Regulation*, stating that this is "the on-going capacity to demonstrate the knowledge, professional behaviour and specific skills necessary to work within the Midwifery scope of practice" (International Confederation of Midwives, 2011a, p. 10). Having a standard of competence makes the need for competence explicit and indicates its dynamic nature. It further suggests that midwives must adapt and change their practice if there is evidence that supports the practice in order to enhance care for women and their babies. The process of incorporating new knowledge into practice is referred to as transferring knowledge into action (Bick & Graham, 2010). A midwife is said to be acting in a professional manner in ensuring her on-going competence through the integration of research into practise (New Zealand College of Midwives, 2008).

Over recent times the world of clinical practice has also gone through a number of changes that have influenced the individual's ability to maintain on-going competence. One of the most significant changes that has occurred since the 1990s has been the introduction of evidence

based practice (Cooke & Sackett, 1996). Evidence-based practice is defined as “the integration of best research evidence with clinical expertise and patient values to facilitate clinical decision making” (Sackett et al., 2000, p. 1). Constant advance in science has led to change in practice through the evaluation and implementation of evidence (Bucknall & Rycroft-Malone, 2010). Evidence based practice is based on the premise of using ‘best practice’ research knowledge applied to a specific individual in a specific clinical context. The principles and processes of evidence based practice have been adapted into a framework for midwives and midwifery practice and integrated into midwifery education (Page & McCandlish, 2006; Tracy, 2010). Page and McCandlish (2006) described the process the midwife initiates when utilising the evidence based framework. They identified that the midwife talks to the woman about what is important to her, and then discusses the evidence in order that the woman can make an informed decision regarding her care. Not surprisingly, discussion of the evidence requires previous knowledge of the evidence and this is, therefore, seen as an indicator for maintaining clinical competence. Tracy (2010, p. 86) also discussed and used the term “evidence based everything” to describe how the evidence-based term has been incorporated into research of all aspects of clinical practice across the board. A review of the literature provides a vast range of articles from a variety of disciplines that discuss how evidence should be and has been incorporated into practice.

Yet, there are challenges to research implementation and unintended consequences. Authors have discussed some of these. In an editorial to midwives Bick (2011) briefly discussed the change in practice of episiotomy largely driven by research and how this has potentially led to new challenges regarding confidence to perform the skill when required. Bick urged consideration of consequences, intended or otherwise, to practice changes.

In another discussion article Hunter (2013) reflected on some of the challenges that were discovered when implementation should occur and identified a disconnect between publication and implementation of research into practice. This article suggested that personal as well as organisational factors, including the quality of the evidence, the context of the study, the relevance of the issue and who the users of the evidence are, may need to be understood and negotiated in order that midwives and other health professionals integrate changes into practice. Ideally, Hunter argued, research dissemination occurs through active strategies on the researcher’s behalf. The onus, therefore, is not only on the midwife to ensure her practice is current and in line with research evidence but for researchers to make their evidence known. With

the growth in research there is a need for midwives to remain current in their knowledge so that they can be clinically competent. Midwives need to be strategic about what and how they need to update.

An Australian study (Murray & Lawry, 2011) described how a group of practising occupational therapists gave meaning to the concept of professional currency providing a description about participation in activities aimed at achieving this goal. Four focus groups were held with 17 occupational therapists. While it is acknowledged that the researchers stated that the findings of this study are not able to be generalised it may be that there may be similar issues faced by midwives as they attempt to maintain their competence.

The themes developed in Murray and Lawry's (2011) study identified personal as well as structural factors that affect an individual's ability to remain up to date with clinical practice. Personal factors included self-determination and knowing where to start; while structural factors included the impact of the workplace and support for therapists. However, this study identifies a number of factors that explain how occupational therapists maintain their competence to practise. One key issue was that competence was impacted by evidence based practice.

There were common difficulties expressed about knowing where to start with some activities that were unfamiliar, including using evidence based practice, undertaking research, making formal professional presentations, critiquing article quality, getting onto list serves, writing journal articles and using information technology. (Murray & Lawry, 2011, p. 264)

It seems logical to ask if midwives are faced with similar challenges incorporating evidence into practice as they attempt to maintain their competence. Are these challenges that are faced by all health practitioners? Mahmood (2010), in another discussion article, suggested that demonstration of maintaining competence by obstetricians can be assessed by ensuring that there is "evidence of cognitive knowledge – that they are up to date with the current developments and that clinical practice is evidence based" (p. 811).

It seems that assumptions of maintaining competence are related strongly to the incorporation of evidence into practice. For example, the Midwifery Council expects midwives to incorporate recent and relevant research into their practice (Midwifery Council of New Zealand, 2007a); which is partly how midwives demonstrate they maintain competence. There are a number of questions that arise because of this requirement including: what evidence does the midwife decide is important? Do midwives incorporate all evidence into practice or do they use their discretion and

guidance from the profession? If so what guidance is available? And ultimately, how do the midwives demonstrate their on-going competency in a clinical world that is constantly evolving and changing?

While there is need for professional development to maintain knowledge, there are likely to be times when a midwife will not be up to date in all areas of practice because of change. Even the most competent midwife could, at one time or other, be deemed to be lacking in competence in a specific area, because she has not read the right article or been exposed to new learning. This raises questions for the midwife in practice such as, what is the line that is drawn between the need for up-skilling as part of usual practice and not being deemed as a competent practitioner? Is this to do with the midwife's professional engagement and her own professional development or are there other factors that impact on competence?

Professional development

Professional development has been identified as an important aspect of the individual's professionalism. Continuing education is one component of professional development. Cervero (2001), in a critique on the rise of continuing education, provided background into its development. The author wrote that the business of continuing education and the number and types of courses offered has grown substantially since 1980. Continuing education has been incorporated into a number of professions and has been identified as a major expense for employers and individuals. Indeed, within the New Zealand context there are provisions in the employed midwives multi-employer collective agreement that gives midwives paid time to attend professional development activities (Meras, 2012). Cervero (2001) argued that since the introduction of mass professional development, there was a lack of demonstrable change in competence. This suggests that coordination is required with evaluation of effectiveness to see if change and improvement in the quality of practice has occurred. The search for educational and development programmes leading to effective practice change continues to the current time.

Cervero and Gaines (2015) provided a synthesis of systematic reviews published since 2003 that look at the effectiveness of continuing education with regard to professional performance and patient/client health outcomes. This review was primarily focussed on research that explored medical continuing education and was an update of articles previously published (Robertson, Umble, & Cervero, 2003; Umble & Cervero, 1996). In the recent synthesis the authors reviewed eight systematic reviews that had been published between 2003 and 2013. Their key finding was

that continuing education delivered in an interactive way, with multiple exposures to participants and using more methods of delivery, do have an impact on both physician performance and health outcomes to patients. However, the impact is greater with regard to the knowledge of the clinician. The authors identified that there has been a vast number of systematic reviews (39) that support continuing education as an effective tool for health professional development and that future research should focus on other factors that have the potential to impact on development. Such factors include the socio-political context of practice as well as organisational parameters.

In a study looking at the psychology profession, Bradley, Drapeau, and DeStefano (2012) argued that the relationship between continuing education and the professional's sense of competence remains unclear. In this study the researchers surveyed 418 psychologists practising in Quebec in order to explore what activities they engaged in that led to a sense of professional competence and in which psychologists received professional value and professional support. This study is somewhat different to a number of studies that just address outcomes of education in that it specifically asked clinicians what activities they see as providing them with personal value. Activities identified as improving competence included reading literature, which it is argued has been a dominant means of maintaining competence within psychological practice. The authors argued that "the wide accessibility of literature and the explosion of online knowledge may be allowing psychologists to access information tailored to their practice needs more quickly and efficiently" (Bradley et al., 2012, p. 35). What this study adds to current literature is those activities that give psychologists' feelings of professional value and support. These activities were dependent on the age of the clinician and included networking with other psychologists as well as participation in case discussion and supervision groups. The authors concluded that such activities should be acknowledged and valued by regulators as part of the development process because of the intrinsic value that they bring to clinicians.

Neimeyer, Taylor, and Cox (2012) described and divided elements of continuous professional development into categories: formal learning (formal postgraduate education), informal learning (reading research) and incidental learning (that acquired from reviewing transcript) or non-formal learning (attendance at Grand Rounds). They argued that only attendance at formal education, where there is independent verification, assessment, evaluation and organisational accountability, can be directly linked to maintaining competence. While it is a desirable outcome, the subsequent learning is often not assessed. Indeed, in that paper, the authors reported that assessed outcomes most often included "only the documentation of attendance, ratings of participant

satisfaction and self-assessed ratings of learnings” (Neimeyer et al., 2012, p. 479). In order to obtain a picture of what activities American psychologists engage in, so that policy could be developed around inclusion in development frameworks, and further to understand the relationship between such frameworks and competence, a survey was undertaken amongst 1606 psychologists. Participants were asked to indicate their engagement in 10 activities over the period of one year and their opinion on how these activities had contributed to their on-going competence. Results showed that psychologists were spending many more hours than mandated engaging in activities and that the main activities that psychologists believed contributed to professional competence were self-directed learning, peer consultation and formal continuing education (Neimeyer et al., 2012). Such findings are consistent with those of Bradley et al. (2012). Limitations of this study include sample characteristics; that is, average time in practice for many of the participants was 25 years and many had obtained board certification (a formal qualification in a speciality). Questions remain regarding the ability to generalise findings to the population. What this study does provide is a quantitative baseline that describes the amount and type of activities in which psychologists engage to maintain their competence to practise from which comparisons can be made. Further it asks the question, is this indeed the same for midwives in practice?

In an attempt to understand the impact on Canadian pharmacists, following the introduction of a programme of continuous professional development, Austin, Marini, Glover, and Croteau (2005) undertook a qualitative study using 42 focus group participants. Those invited to participate in the study had been randomly selected for additional quality assurance activities that formed part of the Canadian pharmacists quality assurance and continuous professional development processes and were, therefore, already in the process of having their practice scrutinised more than their peers. Data from the interviews was analysed for identification of themes. General themes that arose related to the concept of continuous professional development as opposed to continuing education; pharmacists changing from the continuing education to a continuous professional development approach, workplace learning as the vehicle for continuous professional development and peer support as a major enabler of continuous professional development. Participants in this study appeared to value structure and understanding of the requirements placed on them; for example, the concept of attending a predetermined number of hours of education was seen as being preferable to self- assessment of needs and development of learning goals. It is interesting to note the finding that speed of change within the clinical environment was described by pharmacists as impacting their ability to integrate new knowledge

into practice and further to share this with their colleagues. The participants also identified that a lack of skills and ability in self-reflection, and a lack of visible role models, impacted on their ability to understand and grasp the change into a continuous development model. While this research is some 10 years old it does raise questions regarding implementation of programmes and the needs of those for whom change is made. It identifies that without structure the processes that people initiate to engage in these activities vary and can, potentially, impede change in practice.

In an attempt to understand the impact of post-registration or continuing education of midwifery practice, Webster-Benwell (2014) undertook a small pilot study interviewing four midwives to obtain their views on the impact of such education on their practice. She identified the noticeable absence of research into the topic of professional development on and by midwives. While it is claimed that the study is phenomenological, the approach taken in the pilot was general thematic analysis. Her findings suggested that midwives valued practice based learning and that accessibility and cost, as well as employer priorities, impacted on midwives' ability to engage in development. Webster-Benwell argued that there is a need for further research into the effect of continuing development on midwives. A statement I support.

Another study explored the values held by midwives and the way these values influenced decisions regarding on-going competence to practise. Gray, Rowe, and Barnes (2014) interviewed 20 midwives as part of a longitudinal case study that sought to discover how midwives in Australia have been challenged by changes to their regulation and the requirement for them to demonstrate on-going competence to practise. The key finding in this paper was that motivation was the midwife's key driver to engage in education. Further, it was the relationship that they had with women, and recognition and validation that they received from them, that influenced their decisions around continuing professional development activities. It was admiration of their peers that led individuals to evaluate their continuing professional development needs in order to reflect the nature and practices of others. It is interesting to note that a concern was held regarding how midwives who were no longer practising as midwives but practising as nurses could retain their ability to practise midwifery. While this appears challenging to the authors, the Australian Regulatory Board has clearly signalled through different competencies and standards that nurses and midwives are separate professions. This issue is perhaps more philosophical and dependent on professional maturity and acknowledgement. One wonders if over time this challenge will remain or if it will become an historical issue.

Frameworks for on-going competence

Saita and Dri (2014) undertook an evaluation of continuing medical education requirements across Europe. This project was undertaken to ascertain if online education was included as acceptable continuing education; however, in the progress of ascertaining that information they reviewed systems in 27 European Union countries. These systems included review of the medical regulatory body website, and analysis of the Health Act for each country. The researchers reviewed the mandatory status of the education, the type and amount required, the unit of accreditation i.e. time spent, the type of activities that were included as continuing education and the scope of professions covered. While many countries within the European Union required participation to some degree, and while there were some similarities between systems, the authors concluded that there was a lack of standardisation and that development of a protocol for consistent application of e-learning could be warranted. The authors also acknowledged that this study was fundamentally focussed on medical education and should inter-professional learning be required there needed to be further consistency with application. It was interesting to note that in some countries the researchers noted the applicability of policy on continuing medical education to all or to listed health professions including midwives (Netherlands and France). As stated, the authors have not reviewed information provided by regulators for other professions which could potentially have made this a multidisciplinary study and could have provided greater understanding.

In another article Tran, Tofade, Thakkar, and Rouse (2014) undertook a literature review and website search as they reviewed international requirements for continuing professional development and continuing education for a number of professions (medicine, pharmacy, nursing, ophthalmology, public health, psychology and dentistry). In their search the authors were looking for status of continuous development requirements that is mandatory versus voluntary, the type of requirements (education alone versus a degree of reflection and performance development), as well as amount of development in which the individual was required to engage. The findings in the review by Tran et al. (2014) were similar to that of Saita and Dri (2014) in that the reviewers found there was a degree of similarity with regard to the way that continuous professional development may be organised but there was a lack of consistency with regard to terminology used, the mandatory nature of requirements, and the number of hours of development required. Of note, Tran et al. (2014) stated that many of the requirements of clinicians are without an evidence base and, further, from the literature there is little evidence of effectiveness of activity and any impact on patient safety.

While these studies suggest that there is a lack of consistency with regard to definition and requirements, and demonstration of on-going competence, it is acknowledged that continuous development is part of the work life of a health professional. There is a need for evaluation of effectiveness of such activities and it is the implementation of learning that occurs as a result of development that is essential for public safety.

In a survey of New Zealand nurses and stakeholders that explored perceptions and understanding of the New Zealand Nursing Council continuing competence framework, which included a self-declaration of competence and verification of hours of practice and continuous development, Vernon, Chiarella, and Papps (2013) found that the survey participants (n=1157) strongly agreed with the statement that they were responsible for maintaining their on-going competence to practise. However, 10% of respondents indicated that they were confused about their own, their employer and the regulator's role in the process. Some even stated that it was their employer's responsibility to ensure they were competent. In this research nurses also agreed that the Nursing Council's continuing competence framework, combined with the ability of the Council to manage the process of granting practising certificates for those nurses who did not meet requirements, was "an appropriate mechanism to ensure nurses are competent and fit to practise" (Vernon, Chiarella, Papps, & Dignam, 2013, p. 64). Further, that the combined requirements of self-declaration of competence with clinical practice and evidence of on-going education was the best measure of competence. As with midwifery, while nurses in New Zealand were a regulated profession prior to the HPCA Act, there was no requirement for clinicians to demonstrate their competence to practise. What Vernon et al. has provided is a survey that confirms that clinicians are largely aware that they must take responsibility for their on-going competence to practise and that the system that has been initiated is seen as meeting their needs. There are two key matters here. Firstly, the nurses surveyed have only had this one type of framework and do not have a comparator; and secondly, as stated in the paper, "CCF (continuing competence framework) processes may infer competence but they are not a guarantee that a nurse is safe to practise on any given day" (Vernon, Chiarella, Papps, et al., 2013, p. 59). This is a valid statement and the fact remains that engagement in activities of development does not confer competence to practise.

Change of approach

Recent changes in the United Kingdom have seen regulators move away from an audit approach to ensuring competence to an assurance approach. In the United Kingdom both the General Medical Council and the Nursing and Midwifery Council have reviewed and replaced their original frameworks for on-going competence with that of Revalidation (General Medical Council, 2015; Nursing and Midwifery Council, nd). A major change with these frameworks is the requirement for third party confirmation through formalised appraisal in line with requirements of the regulator in support of declaration of on-going competence.

In a qualitative study designed to evaluate the impact of the change to revalidation on the behaviours of doctors in the United Kingdom, Nath, Seale, and Kaur (2014) undertook a series of semi-structured interviews with doctors and telephone interviews with others affected by the process of revalidation. When introduced in 2011, it was agreed that the change to the revalidation process would occur over a period of five years; it is, therefore, still in the implementation stage. The researchers' findings reinforced this situation, stating that a lot of effort had been placed into establishing processes of implementation rather than the effects on doctors. The researchers identified two key factors that were coming out of the process; one being that there was a mixed message given to clinicians regarding the purpose of revalidation. Second, that already there was, in some instances, evidence of focussing on compliance with process through tick box behaviour rather than evaluation of quality. The researchers concluded by stating that further attention needs to be paid to implementation and communication for doctors to ensure that the process is implemented effectively. The process of implementation is key in such change.

The Nursing and Midwifery Council has also changed its on-going competence process to that of revalidation (Nursing and Midwifery Council, nd); which again requires third party conformation of competence and has gone through the process of piloting in a number of sites across the United Kingdom. Professional leaders identify that the change will not be onerous for midwives in the United Kingdom (J. Griffiths, 2015); further, that there is an expectation that the revalidation process may lead to increased professionalism in the clinician. Revalidation includes "a number of reflective accounts based on a number of CPD activities, practice related feedback and the code (of practice). Revalidation will need to be signed off by a line manager – a 'confirmer'" (J. Griffiths, 2015, p. 55). This framework incorporates a number of activities designed to maintain competence but includes an endorsement to the regulator of competence. The idea that third party sign off could be seen as removal of autonomy and the ability of the profession to regulate

itself is raised by one writer (Spendlove, 2013); such an idea is countered with evidence showing the history of regulation of practice. Revalidation, it is argued, will occur regardless of philosophical position and could be a positive opportunity for change that may enhance the public's perception of midwifery professionalism. Indeed, in a discussion article, Bolsin, Cawson, and Colson (2015, p. 142) debated that "an ethical and professional commitment to reducing errors, adhering to best practice and improving quality of care should be reflected in the training and practice of competent doctors"; adding that "the obvious mechanism to embed such competent professional practice is through the process of revalidation once doctors have completed training." Within their discussion paper the writers proposed that there are other mechanisms that can be used to enhance and scientifically demonstrate competence. Such mechanisms include use of statistical testing to produce high –quality procedural outcome data confirming competence. It appears that there is a move towards some type of third party assessment be it in the form of appraisal or statistical analysis of practice clinical outcomes that supports maintenance of knowledge and skills.

Quality assurance within individual practice in New Zealand

In the New Zealand midwifery recertification context there is a quality assurance mechanism included within the programme. This is known as Midwifery Standards Review (New Zealand College of Midwives, 2015a). Originally introduced by Domiciliary Midwives Society in the 1980's in an attempt to ensure that practice review for midwives was relevant and based on midwifery standards for practice, (New Zealand College of Midwives, 2007) Standards Review was made a College of Midwives process before being integrated into the Recertification Programme in 2005. The purpose of the review is to give the midwife the opportunity to discuss her practice, review feedback from peers and women, to demonstrate her commitment to on-going professional development and to examine her practice. It includes an element of reflection and discussion of practice statistics. It is provided by the College of Midwives. While it has been mandatory since 2005 for midwives to engage in this process, to date, apart from a clarificative evaluation study that was undertaken when the process was introduced into core midwifery practice (Barlow & Lennan, 2005) and an evaluation on the educational aspects of the review which occurred before it became mandatory (Barlow, 2001), there has been no published evaluation of this process that demonstrates its effectiveness as a component of the recertification programme. Indeed, while in the case study research undertaken by Barlow (2001) participants acknowledged that the review process helped them keep up to date and provided some degree of safety net around their practice, there has been no supporting research. The study by Barlow and Lennan (2005), that

looked at barriers and enablers to successful implementation of the process within employed practice, was undertaken before the process became a mandatory requirement. In reviewing implementation within one DHB the reviewers found attitudinal, cultural and organisational factors impacted on implementation. Their recommendations included the need to engage key players, for dialogue about the review and to provide support.

Skinner (1998) undertook a case study evaluation to review the Midwifery Standards Review process in Wellington. Through interviews with stakeholders, reviewers, reviewed midwives and analysis of documentation, she found that Midwifery Standards Review was a unique innovative method of peer review that supported and endorsed reflective practice. At that time Skinner recommended further research to ascertain whether midwives found the process useful, especially with regards to their professional development. Skinner's findings and recommendations were made at a time when Standards Review was optional, primarily focussed on community based LMC midwives and not the mandatory activity that is required of all midwives today. The recommendations she made for further research remain valid.

The mandatory requirement for standards review has been in place for 10 years and, while it is hoped that barriers as explained by Barlow and Lennan (2005) will have been overcome, the question remains regarding how the review provides reassurance of the practice of the midwife. Further questions remain regarding its effectiveness as a component of recertification when it is managed by the professional body. It appears that there are systems and processes in place to support midwives to engage in development and to provide quality assurance but their effectiveness remains largely untested.

In addition, there has been no published review of the effectiveness of the New Zealand recertification programme on the on-going competence of the midwifery profession. The Council argued that by "engaging in the recertification programme midwives demonstrate their continuing competence to practise and therefore their competence to be issued with a practising certificate" (Midwifery Council of New Zealand, 2014b, p. 14). Although midwives are required to make two declarations that state they are engaging in the programme and practising across the scope, there is no measurement of this process. If on-going competence is measured by audited attendance, as is stated in the programme documentation (Midwifery Council of New Zealand, 2014b), then the premise would be that by recording attendance regulators know that competence is retained or updated. However, does attendance at education sessions translate

directly into change in practice and is the education provided of value to clinicians? It seems that there are a growing number of questions around the effectiveness of components of the recertification programme. Further, while the regulation measures attendance, it cannot articulate what further activities midwives engage in, or answer questions regarding barriers to engagement and other contributing factors that undermine effectiveness.

Midwives and maintaining competence

There is a small body of research that discusses the impact or understanding of regulatory requirements on maintaining competence of midwives (Gray et al., 2014; Webster-Benwell, 2014). Yet, there is a requirement for midwives to maintain their competence. It is also acknowledged that there can be barriers that individuals face when maintaining competence to practice. This literature review found evidence of research that identified learning needs related to specific areas within practice; for example a recent study by Hauck et al. (2015) identified midwives learning needs in the area of perinatal health. No articles were found that discussed how midwives went about the day to day business of maintaining their competence.

Through the process of this literature review it seems that within society, and within practice, there is a need for accountability and a call for clinicians to remain competent within their field of practice. This has led to the introduction of systems that are designed to ensure some form of competence is assessed and recorded in order to maintain some degree of safety for consumers. Yet 'how' clinicians do this is largely silent.

While this review indicates that within a number of professions there has been a body of evidence that assesses and evaluates the effectiveness of continuing professional development activities, it seems for midwifery, at least, this is an area in which there is little research. It also appears that there is little published research that describes activities in which midwives engage in order to maintain their competence. The process of identifying how midwives maintain their competence in a world that demands safety is largely un-researched. The current study hopes to add to the body of evidence that describes how a group of midwives working in New Zealand meet the requirements placed on them that confirms their ability for on-going professional practice.

Chapter Three: Methodology and Method

Introduction

The aim of this study was to use a grounded theory methodology to uncover how midwives working in New Zealand, from 2012 -2015, maintain their competence to practise their profession. The substantive theory that has been derived explains the processes and strategies that midwives used as they worked towards achieving this legislative and professional requirement. This study will add to the literature that explores, describes and explains how New Zealand midwives maintain competence as they work in a complex world that is constantly changing, where new evidence is discovered and introduced into practice on a regular basis (Bick, 2011; Byrom & Downe, 2010; Fullerton, Thompson, & Severino, 2011). The research question asked was, "how do midwives maintain their on-going competence to practise?" The purpose of this chapter is to explain and present the methodology and the method used within this study. I begin with a discussion about pragmatism and symbolic interactionism, two philosophical positions that underpin grounded theory, and then move onto discussion around the development of grounded theory, and finally the variant of grounded theory that has been used within this study. Finally I present my method of data collection and analytic approach, and discuss the implementation of grounded theory and its application to midwifery research.

Constructionism, pragmatism, symbolic interactionism and grounded theory

Constructionism is the epistemology that underpins how understanding occurs. Constructionism is the belief that, for individuals, meaning is constructed (Crotty, 1998). Within the constructionist epistemology there are the theoretical perspectives that overarch the grounded theory methodology. Grounded theory, as presented by Corbin and Strauss (2008), is based on the sociological principles and philosophy of pragmatism, as initially developed by Dewey (1922) and Mead (1934) (Corbin & Strauss, 2008; Crotty, 1998; Shook & Margolis, 2006), and of symbolic interactionism as developed by Mead (1934) and as documented by Blumer (1969) (Corbin & Strauss, 2008; Strauss & Corbin, 1998). These perspectives, and their relevance to this current study, will be briefly discussed in the following section.

Pragmatism

Pragmatism is one of the philosophical perspectives that informs grounded theory and is described as "an approach to understanding and explaining society and the human world" (Crotty,

1998, p. 3). Pragmatism (Corbin & Strauss, 2008) is a theory of knowledge interpretation and generation, in that pragmatists believe that knowledge is created through individuals as they act and interact with their environment. To the pragmatist, the individual responds to challenges or problems within his or her environment by a process of self-reflection aimed, ultimately, at changing collective knowledge. The way that an individual will react is focussed on resolving a problem which is useful for practice and practical affairs (Corbin & Strauss, 2008). "To be pragmatic, in the general use of the word, indicates a concern for the practical matters; being guided by practical experience rather than theory" (Robson, 2011, p. 27). Because individuals process challenges through their own self-reflection, what this means is that there can be multiple realities for individuals that lead to multiple perspectives; people, therefore, take note of what they perceive as being relevant to them within the context of their situation.

With the recertification programme, well education wasn't a problem because I was doing university studies, but also I went to workshops, local workshops, and as a result of some of the research that I did, I enrolled in papers to follow on some of the outcomes from there. So as far as education was concerned it wasn't an issue. As far as professional activities are concerned I was involved with a lot of things through the New Zealand College and I also attended forums and conferences, and I can't think of anything else. But I have never had a problem with points the whole of the years that recertification has been going.
(Megan)

Megan has explained how she met the requirements for education that are mandated as part of the recertification programme. This showed me that at the basic level there was a certain understanding of the need to meet requirements. How Megan met these requirements depended on her interpretation of what she needed to complete. Thus, from one perspective, the midwife would consider how she meets the education requirements of recertification and then consider what actions she must take in order to derive a practical solution that meets her needs. The midwife would reflect on issues related to maintaining competence. She would attempt to resolve challenges through a process of action and interaction within the environment that she practised and within all the constraints and challenges that she faced. Yet, from another perspective, the midwife could consider that her children and family are her priority; hence, while acknowledging the need to engage in the process or recertification, the actions that she takes are focussed on meeting the minimum requirements. As individuals make sense of their actions, consequences are considered; that is, pragmatist philosophers believe that "knowledge is created through action and interaction" (Corbin & Strauss, 2008, p. 2). Therefore individuals act and respond in different ways to different situations based on their interpretation of what is going on, with such

interpretation being based on reflection which is influenced by the individual's past experiences (Corbin & Strauss, 2008).

It is argued, therefore, that the way a midwife responds and then maintains her competence is based on her interpretation of what the requirements are. This interpretation is influenced by experiences that have occurred in the midwife's career to date.

Symbolic Interactionism

It was Blumer (1969), documenting the writing of Mead, who named the sociological perspective of symbolic interactionism. Charon (2010, p. 31) explained that "to understand human beings, we need to understand their actions, the cause of their actions, the consequences of their actions, the perceptions of our actions and the perceptions of other people's actions". That is, people are seen as being actors within their society who actively "do" things in order to make sense of their everyday situations. Blumer (1969, p. 2) one of the key writers around symbolic interactionism asserted that there are three premises around which symbolic interactionism is based. "Firstly that the individual acts towards things on the basis that they have meaning to them, secondly that meaning is derived from social interaction with peers and thirdly that meanings are interpreted and then modified". At the basis of symbolic interactionism is the notion of the symbol and the specific meaning that society places on symbols. Symbols, which are described as "social objects" (Charon, 2010, p. 48), include language and, for example from within this study, registration as a midwife and practising certificate. The way that the symbol is interpreted is due to values and beliefs that are embedded within a cultural group (Bluff, 2006). Specifically, an understanding of the culture and symbols within midwifery enables the behaviour of clinicians to be predicted within the context of their practice. Therefore, midwives engagement in on-going competence, in order to maintain their practising certificate, is influenced by the culture and symbols of midwifery which includes the language that is spoken and the importance that is placed on ideas such as on-going development by the profession.

In her role as a midwife it is argued that there is a defined set of expectations of what a midwife is and what she does. People perceive the midwife through a process known as "taking the role of the other" (Charon, 2010, p. 104), whereby they create an image of their expectations of what a midwife is and how she behaves as they attempt to see the world from the midwife's point of view.

I was fascinated that there were so many people who were on interim practising certificates⁴ because to me, again, it's actually about being professionally responsible. You know you have to do certain things and you know that you have to make sure that you do them. (Mary)

The practising certificate is seen as being a symbol linked with practise. The interim practising certificate has been interpreted as being of lesser value by Mary who interprets the requirement for a practising certificate to be directly linked with her interpretation of professional practice. Midwives act in the context and culture of midwifery practice.

Grounded Theory

Developed originally in 1967, grounded theory is a sociological methodology that was developed and published by Glaser, a social researcher with a background in positivism, and Strauss, another researcher with a background in symbolic interactionism (Bryant & Charmaz, 2007a). Their book, *The Discovery of Grounded Theory* Glaser and Strauss (1967) articulated the methodology and the method that they developed and used in order to generate, as well as verify, theory from social research.

Over time there have been a number of interpretations made of the original method which include dimensional analysis (Schatzman, 1991) and constructivist grounded theory (Charmaz, 2000). However, the first variation occurred between the original developers themselves. Authors (Birks & Mills, 2011; Bryant & Charmaz, 2007b; Charmaz, 2014) discuss a division between the two authors arising from different perspectives on analysis originally presented in *Qualitative Analysis for Social Scientists* (Strauss, 1987). Despite the differing interpretations and methodological developments the underlying basis of the methodology remain, and include, but are not limited to, coding and categorisation of data, concurrent data generation, memo writing, theoretical sampling, constant comparative analysis and theoretical integration (Glaser & Strauss, 1967).

I came somewhat naively into this study with a desire to use grounded theory. I had, in my opinion, "used" this method when undertaking my Masters research. After considering other methodologies and the question that I wished to address, grounded theory seemed to be the most fitting approach because a grounded theory study "seeks to generate a theory which relates to a particular situation forming the focus of the study" (Robson, 2011, p. 146). Other methodologies were considered when developing this research project; for example, I considered

⁴ Short term practising certificates are issued when compulsory components of the Recertification Programme are not up to date.

the use of action research and critical social theory. These were considered and then discarded as I wished to develop a theory that describes group patterns of behaviour as they currently exist in the context of practice. I did not want to implement a project that may change what currently happens when the consequences of current actions are unknown. It could be that such a project of change arises as a consequence of this research. While the power structures that are prevalent in the practice of midwifery and their interplay may be a factor that is taken into consideration, I struggled at the start of the project to be critical of a system in which I am fundamentally a key player; something that changed during the course of my research. However, at the start the use of critical social theory methodology was abandoned as I felt too closely connected to the key stakeholders.

The grounded theory used in this study

The grounded theory method used in this study is that based on the writing of Corbin and Strauss. Grounded theory is described by Glaser (1998, p. 3) as “the systematic generation of theory from data acquired by a rigorous research method”. Grounded theory is not findings but rather an integrated set of conceptual hypotheses (Glaser & Strauss, 1967). A grounded theory aims to develop theory for social processes that occur within groups of individuals. In this study the group of individuals specifically refers to midwives.

When reviewing the methodological literature, at the start of the research process, I was somewhat biased towards traditional or Glaserian research. It was not until I reviewed *Basics of Qualitative Research* (Corbin & Strauss, 2008) that I discovered the Conditional Consequences Matrix. Thinking about the topic of ongoing competence, and especially the consequences of a lack of ongoing competence, I was somewhat compelled towards using this framework. While I acknowledge there has been some debate about its usefulness (Bryant & Charmaz, 2007b), it has been helpful in guiding the development of theory. I acknowledge the work of other grounded theory writers, such as constructivist and dimensional analysis frameworks, and although these were not considered as part of the development of this study it has helped me to develop further depth of knowledge.

Essentially grounded theory as articulated by Corbin and Strauss (2008) was the best fit with me for my chosen question and the goal of the project, which was to develop a theory of how midwives maintain their on-going competence to practise as presented through an analysis of group patterns of social behaviour. My belief and reading reinforced the symbolic interactionist frameworks, especially the multiplicity of beliefs and how individuals are driven to construct

meaning within their lives and situations. Wright Mills (1959, p. 6) advised “the sociological imagination enables us to grasp history and biography and the relations between the two in society”, thereby enabling the understanding of how the midwife’s history and how she sees herself in practice has led to her act in the way that she does. For me, as a practising midwife, any notion that I could enter the study completely divorced of any thoughts or opinions on this topic was unrealistic. It was therefore important to utilise a methodology that acknowledged that my perspective, although managed through this process, would, in some way, be interpreted within the findings. This study considers the perspective of midwives working within the context of New Zealand practice and the social process that they use to maintain their competence and their ability to continue within practice.

Grounded theory and midwifery research

It is only in relatively recent times that grounded theory has entered the realm of midwifery research. Further, within New Zealand, midwifery scholarship has only developed over the past 20 years and the number of midwives engaging in research of any type only now appears to be gaining momentum. While my own Masters research, as stated earlier, used a grounded theory approach (Calvert, 1998), publication was not actively encouraged and occurred more on an opportunistic basis (Calvert, 2002). Other colleagues engaged in research but did not publish at the time of completion (C. Griffiths, 2002; C. Griffiths, McAra-Couper, & Nayar, 2013).

While developing the initial literature review finding midwifery research proved to be somewhat challenging, as very little published literature was available that discussed or disseminated findings from grounded theory studies in midwifery practice (Carolan & Hodnett, 2009; Kirkham, 1999; Lalor, Begley, & Galavan, 2008; Levy, 1999). Similarly, when research was reviewed that claimed to be grounded theory, what I found was that elements of the grounded theory method had been included as one part of analysis (Parratt & Fahy, 2004). While Bluff (2006) discussed grounded theory within the parameters of a research text, since the commencement of this study, Hall McKenna and Griffiths’ (2012) publication has encouraged midwives to utilise this methodology in order to enhance midwifery research knowledge and expertise. Further, published research whereby authors have utilised grounded theory methodology (Barry, Hauck, O’Donoghue, & Clarke, 2013, 2014; Edmondson & Walker, 2014; Hall, Griffiths, & McKenna, 2013; Licquirish, Seibold, & Mcinerney, 2013) is now available. While these studies were not directly related to the focus of my study, they proved useful as a guide to a grounded theory approach within midwifery related issues of which I was familiar.

Research design

This is a qualitative study using the grounded theory method. Data collection consisted of in-depth interviews with midwives practising in New Zealand. The grounded theory methods of concurrent data collection and analysis, comparative analysis and theoretical sampling were used. Additionally the Conditions/Consequences matrix provided a framework for interpretation of findings.

This study was undertaken primarily in the Central Region of New Zealand bounded by Wellington in the South, Hawkes Bay in the East and Taranaki in the West. The region goes as far north as the Central Plateau. It is a mix of urban, rural and remote rural localities.

These regions were chosen for pragmatic reasons because they are where I am located and because there was a variety and mix of practice and education facilities. For example, within this region there is a provider of pre-registration midwifery education, there are providers of post-graduate midwifery education. There are also primary and secondary maternity facilities and a tertiary referral centre. Areas are classified as both urban and rural. In 2015, there were approximately 480 midwives working as community based lead maternity carers (LMCs) or as core midwives in this region (Midwifery Council of New Zealand, 2015). Given the variation within practice type and location, and the number of midwives in this region, it was expected that this should have provided sufficient midwives for participant selection and recruitment. However, as the study progressed midwives were recruited into the study from outside of the central region due to midwives with characteristics identified through theoretical sampling and who agreed to participate being located outside of the original geographical area. There was a total of 31 interviews with 26 midwives from various locations, practice types and with difference levels of pre and post-registration education. All were women and all spoke English as a first language.

Data collection and recruitment

In this section the processes around data recruitment and selection are described. The Participant Information Sheets and consent form are included as Appendix C and D.

Ethical considerations

Ethical approval was required and sought for this study. Approval was given by the Auckland University of Technology Ethics Committee (AUTEK) on 27th April 2012. A copy of the approval

letter is included as Appendix E. The main ethical considerations in this study related to the process of informed consent and ensuring that conflict of interest was discussed and minimised. Additionally, it was important to maintain confidentiality for all midwife participants. It was decided at the time the study commenced that should any midwives be recruited into the study who had specific cultural or ethnic needs then this would be explored at the time. While theoretical sampling meant that midwives from different areas or with different work types were included in the sample, ethnicity of the midwife did not appear from within the data. Ethical research conduct is important in midwifery research; therefore, the ethical considerations in this study are presented and discussed below.

Treaty of Waitangi

The Treaty of Waitangi is the foundation document of New Zealand. The articles of the Treaty describe the principles of partnership, protection and participation which form the basis of New Zealand society and require consideration and action when research is designed. Regardless of the context of research it is vital that it is approached in an inclusive way. Although this study was not specifically about Maori and Maori midwifery I sought informal advice from a Maori midwife regarding recruitment and involvement of Maori midwives in the study and a further letter was forwarded in support of the study, from a prominent Maori midwifery elder. It is acknowledged that regardless of culture or ethnicity all midwives must complete the same requirements in order to retain their right to practise in New Zealand. There is a need for researchers to consider the impact of their findings for Maori and midwifery (Health Research Council of New Zealand, 2010; Hudson & Russell, 2009). Although the concept of cultural differences was not raised, through the process of theoretical sampling, it could be that through the process of caring for women of different ethnicities there is a need to refine the processes used in order to meet the requirements of cultural partnership within practice. One midwife raised the topic of cultural competence in relation to other midwives' technical skills and theoretical knowledge.

Informed consent

During the process of theoretical sampling researchers identify categories of participants that they wish to interview. Once a potential participant was identified, an intermediary, a midwifery colleague, raised the idea of participation in the study with the identified midwife. The potential participant was then given a copy of the information sheet and it was agreed that it was her decision to contact me if she wanted to participate. If I did not hear back from the potential

participant there was no further follow up and I assumed that the midwife did not wish to participate.

If the midwife did decide that she wished to participate then, after she contacted me, and before the interview began, two processes occurred. I discussed the study with the potential participant and, if she agreed to participate, she was asked to sign a consent form. Consent to participate also meant that the participant agreed to parts of the transcript being used in the thesis and potentially being used in conference presentations.

Conflict of interest

One of the key ethical considerations for this project related to that of conflict of interest. As the Midwifery Advisor at the Midwifery Council of New Zealand participants needed to recognise my link to this organisation. Competence is one key business function of the Midwifery Council. It was very important that those who agreed to participate in the study were aware that I was not undertaking this study as part of my employment. Midwives were advised in the information sheet that participation in this study would neither advantage nor disadvantage them with regard to Midwifery Council processes.

Maintaining confidentiality

All midwives were asked to choose a pseudonym. I chose a pseudonym for two participants. All references to the midwife interviewed are referred to by using the pseudonym. Signed consent to participate sheets were stored in a separate location to the list of pseudonyms. The only person who knows who is in the study is myself, the midwife researcher. In addition, the transcribers signed confidentiality agreements promising not to disclose any information about the research and any information regarding the participants. The transcribers did not have access to the actual name of the participant and, as they both worked outside of health care, identifying individual participants was minimised. Once the transcripts had been sent back to me they were deleted from the transcriber's computer. All interviews were stored on a CD in a separate location from the consent forms. Only the first few interviews were transcribed by a person outside of the study, with the majority being transcribed by myself.

There is a small midwifery community in New Zealand with approximately 3000 practising midwives, and an even smaller number involved in education and advisory positions. Therefore, it was made explicit to midwives before they agreed to participate in the study that something they

said during the interview could potentially identify them. In attempts to minimise this possibility name places and locations were changed and personal speech inflections or terminology used by the participants that identified them have been removed.

Researcher involvement

Midwives work in partnership with women; they also work in a way that is effective and supportive of their colleagues (New Zealand College of Midwives, 2008). The midwifery partnership (Guilliland & Pairman, 2010a) is based on a number of components one of which is trust. As a researcher it was important that the midwives participating in the study were able to trust me. I also needed to trust the information that they discussed with me.

I undertook interviews in a number of different places. For those interviews that were held face to face a personal safety protocol was developed and implemented. This meant that a third person who had no involvement in the research knew where I was during the interview. Contact was made with the third person before the interview started and once it was completed and I had left the meeting place.

Due to the topic of this study and my professional role there needed to be a number of inclusion and exclusion criteria for this study. These are described below.

Inclusion Criteria

They were as follows:

- New Zealand registered midwife with a current annual practising certificate
- Must be located and working in practice in New Zealand
- Must be able to converse in English

These criteria were selected because holding a practising certificate meant that the midwife was required to engage in the process of Recertification and therefore required to practise. As the aim of this study was to develop a theory about competence within the context of the New Zealand maternity system it was imperative that the midwives who were interviewed knew and understood this system. Therefore it was deemed appropriate that they were working in this system. It is a requirement for registration that midwives are able to speak and communicate effectively in English. In order to be able to participate in the study it was agreed that this should be a requirement of those midwives who were interviewed.

Exclusion Criteria

There were also a number of exclusion criteria that were developed to protect both me and the participants, and to minimise the potential for a conflict of interest. The exclusion criteria were as follows:

- Any midwife who was or had been under a competence, health or conduct process with the Midwifery Council
- Any midwife who was selected for Midwifery Council audit during the data collection phase
- Any midwife who had restrictions on her practising certificate i.e. a midwife working through an overseas competence programme or who had not practised in New Zealand for a minimum of the previous three years

Rational for Inclusion and Exclusion Criteria

The inclusion and exclusion criteria were developed to ensure that the midwives who were in the study were able to discuss the question with knowledge and experience. Due to a potential conflict of interest situation that could occur due to my employment some specific exclusion criteria were added. As the Midwifery Advisor at the Midwifery Council, I was and remain involved with those midwives who fall under the Council's competence review processes. This, it was believed, could lead to potential role conflict in both data collection and analysis whereby as a researcher I could potentially analyse data from a perspective other than that of researcher i.e. as a competence manager. I considered my role and any potential conflict that could occur at length. Midwives who I managed as part of my professional role were excluded from the study. Also there was a need to ensure confidentiality of information and I did not want to have prior information regarding my participants' efforts to maintain competence. It was important in this process that there were clear boundaries between advisor and researcher to avoid any potential role conflict and protect research participants and researcher (Asselin, 2003; McConnell-Henry, James, Chapman, & Francis, 2009). While at the start of the research I did not believe that any of the midwives under the council processes would want to participate, it was agreed that any midwife who was or who had been through a competence process would be excluded. Only two potential participants were excluded due to the criteria. As I wished to understand how midwives in New Zealand demonstrated their on-going competence to practise, those midwives who had restrictions on their practising certificate because they are completing a return to practise or overseas competence programme were also excluded. This was because they are completing

programmes of education designed to address already identified gaps in their skills and knowledge base.

As with any grounded theory study I did not know exactly how many participants would be recruited into the study. However, I considered that up to 30 midwives would be sufficient to provide an explanatory theory of the maintenance of ongoing competence. As noted previously, the eventual sample size consisted of 26 participants.

Sampling

One of the key components of any study is the method used to recruit participants. In grounded theory one of the main techniques is the use of theoretical sampling which is explained later in this section. While initial sampling was purposive, that is midwives were recruited that met specific criteria, once analysis of the data commenced, sampling changed to theoretical. The following section explains in detail the type of sampling used and the specific processes that were followed in this study.

Purposive sampling

In this study initial sampling that was undertaken was purposive; this means that I identified the characteristics required of an individual who I wanted to interview. These were midwives who I hoped would be able to articulate how they maintained their competence to practise, who had a number of years of experience in practice and who had worked in a variety of midwifery roles. At the commencement of data collection phase a total of five individual midwife participants were selected by purposive sampling. Identification of potential participants was through personal knowledge of the midwife's role and her practice type. In the first instance it seemed appropriate to interview midwives with experience and involvement in education both at undergraduate and continuing professional development level who were also practising within the clinical environment. A brain storm identified names of potential participants and my intermediary then contacted the midwives asking if they would agree to participate in the study. The midwives who were approached in this instance were identified as being knowledgeable around the topic of ongoing competence. The midwives sampled in this way comprised two midwifery undergraduate educators, who also worked as LMCs, one midwifery educator who also worked as a core midwife, a midwifery manager and a midwife engaged in strategic activities. All midwives had the minimum of 10 years midwifery practice and all were working towards or held a minimum of a Master's level degree.

Theoretical Sampling

Once the first interviews had occurred, further participant selection was undertaken using the method known as theoretical sampling. In a grounded theory study the first participants are those who “provide rich in-depth accounts and that can provide data that are conceptualisable” (Stern & Porr, 2011, p. 51). After the data from these first interviews were analysed, and initial codes and categories developed, I looked for participants who would be willing and able to discuss how they maintained their competence and whose experiences and actions may differ from previous participants. For example midwives who may work in a different work context or who may have different levels of work experiences. I was seeking those midwives whose experiences could enhance concepts that needed to be explored further. Identification of potential participant characteristics occurs through the process of data analysis as questions are raised when the codes are developed (Strauss & Corbin, 2008). Theoretical sampling, therefore, is designed to add depth to the analysis; its purpose is to guide what data needs to be collected next and for what purpose (Strauss, 1987). “Concepts are derived from data during analysis and questions about those concepts drives the next round of data collection” (Corbin & Strauss, 2008, p. 144). Further, the process of theoretical sampling means that as the researcher I was collecting new and relevant data that was adding to the theory (Glaser, 1998). Data collection continued until saturation was achieved which means no new categories emerging and the properties, dimensions and relationships of the categories had been fully developed (Corbin & Strauss, 2008).

As I was undertaking the analysis, through the process of theoretical sampling I identified the characteristics of further participants that were required. For example, because a many initial participants were very experienced midwives, I decided during the analysis that it would be beneficial to explore the concept of reviewing practice in more depth from the perspective of a relatively new graduate. Additionally because a large number of participants were based around urban secondary maternity units, I wondered if strategies toward maintaining competence were different for those midwives working in a different context; for example core midwives. Finally as analysis revealed different strategies for this group, I collected data to investigate the situation for midwives working as LMCs in rural practices. I also wanted to consider the perspective of those midwives who worked in tertiary or more complex areas within practice. As many of the midwives with whom I initially spoke held other roles, in addition to clinical practice, I considered it vital that I discuss this topic with midwives who were practising clinically on a day to day basis. Then, because all participants to date had engaged in advanced education and were cognisant with the

premise of evidence informed practice and the need to implement research into practice which was discussed in the initial interviews, I identified that it was also essential that I talk with midwives who had not engaged in formal post-graduate education. In this way theoretical sampling guided me in participant selection arising from my analysis.

During theoretical sampling I asked my intermediary to approach midwives through professional networks. It was imperative that the intermediary made the first contact and provided the midwife with an information sheet regarding the study. This avoided any potential sense of coercion. If the midwife wanted to participate in the study she was then able to contact me via email. Through the developing analysis the context of practice appeared to become a significant factor and it was therefore important to understand this perspective. A total of 21 midwives were identified and interviewed using the process of theoretical sampling. They were predominantly midwives who were engaged on a daily basis in clinical practice. When broken down further these were midwives working in urban and rural primary units, in secondary and tertiary units, as both core and LMC midwives. The majority of the midwives in this group had little formal postgraduate qualification, although some had completed postgraduate study. The theoretical questions for this sample focused on how they maintained their competence and eventually how they managed factors that potentially impacted on this process. During the interview process it became apparent that I needed to return to some of my original participants. This served a two-fold purpose, one being that there were concepts that were being raised in later interviews that I wanted to examine in further depth with the midwives who had been interviewed in the initial phases of the study and also to discuss with midwife participants the findings that were emerging. Returning to those participants was therefore a way of member checking. Data collection and interviews ceased after interview 31 as I believed I had reached data saturation as the concepts had developed depth and demonstrated recurrent patterns of participant strategies.

Participants were, in the majority of cases, interviewed face to face. For those participants living outside of the Wellington and Manawatu area, Skype was used to facilitate the interview. All participants agreed for the interviews to be voice recorded. Twenty six midwives were interviewed once, five midwives were interviewed a second time and the average length of time for each interview was approximately one hour.

Once the interviews were completed then the recordings were sent to a typist in order to be transcribed. Due to personal circumstances I was unable to use the first typist and a second was engaged. It became apparent to me that the most efficient means of transcription that assisted my analysis was for me to transcribe the interviews which was how the process proceeded. Eight interviews were transcribed by the first typist one by the second and 22 by me.

The midwives in this study

Using theoretical sampling midwives from diverse and different practice arenas within midwifery practice were interviewed. These practice arenas are presented below:

Core midwives: There were a number of core midwife participants who were employed midwives working in hospitals. These midwives worked rostered shifts in the facilities providing care to women for a predetermined period of time (between 8 to 12 hours). Some midwives only provided antenatal or postnatal care to women and their babies or were a second midwife present at a birth, should a woman birth, while they were on duty. Core midwives provided care to women usually from 20 weeks gestation through to five days postpartum.

Core midwife (primary services): Those midwife participants who were working in what is known as primary units were often the sole clinician in the facility. Should emergency assistance be required this was provided by other health professionals located nearby or by paramedics. Primary units were often located in small towns outside of the main urban centres. The units did not have onsite obstetric staffing; women were assessed for appropriateness to birth in these facilities. Midwives could provide some degree of assessment for antenatal women but referred to larger secondary and tertiary facilities if more diagnostic assessment was required. Women with risk factors were screened and discussion occurred over the most appropriate place to birth. Midwives working in these facilities provided postnatal care and were the second midwife at births⁵.

Core midwives (secondary and tertiary services): Other core midwives worked on shifts in secondary and tertiary level facilities. These were based in larger cities. There are requirements for these facilities to have obstetric and neonatal staff due to the complex nature of medical or obstetric needs of women or the infant. Midwives who worked in these hospitals often rotated throughout the entire obstetric unit; hence they provided some degree of antenatal, intrapartum

⁵ Although not mandatory it is seen as being best practice for two midwives to be present at the time of birth.

and postnatal care. Midwives could care for women with co-morbidity, medical disease or who suffered some degree of trauma. Women who gave birth in these facilities had access to caesarean section, epidural pain relief and premature or babies at risk were cared for in the neonatal units.

Community based midwives: can be employed by a District Health Board; however the majority of community based midwives in this study were self-employed. These midwives worked to what could be described as a fixed price contract from the Ministry of Health (Primary Maternity Notice, 2007). This notice provides the service specifications for midwives working as LMCs. Generally care was provided by the midwives in this study from booking, which should occur at less than 10 weeks, until discharge which was usually at six weeks postnatal. The recommended caseload for these midwives was between 40-60 women per year; however this varied depending on a number of factors, mainly practice location. Midwives working as LMCs provided full antenatal, intrapartum and postnatal care. They provided advice and information to women on all aspects of care throughout the pregnancy and birth continuum. This generally was not required by their counterparts working in hospital facilities. Midwives working as LMCs had access agreements which allowed them to make a booking for a woman into a maternity facility where the woman could birth. LMCs were paid by the Ministry of Health for services provided. While they could access education provided at maternity hospitals, there could be a user pays charge but this was variable.

DHB educator: The majority of secondary and tertiary facilities had developed roles and employed at least one midwifery educator. This educator provided in-service education for staff and community based LMCs. Such education could be theoretical teaching through to working side by side colleagues in practice.

Employers were required under the Midwives MECA (Meras, 2012) to provide a certain amount of paid education for their staff. There was an expectation that staff would be oriented to their role and the clinical environment.

Undergraduate educator: Although interviewed as part of the initial purposive interviews, there were some participants' selected using theoretical sampling whose role was in undergraduate education – who worked with students learning to be midwives. Their role in education required a mix of theoretical and practical teaching. Their day to day work sat outside the clinical practice

arena, although through the students they had relationships with facilities and LMC midwives who provided clinical placements for students. These lecturers were required to engage in formal higher learning and research. They had ready access to electronic learning resources and journals. To maintain their practising certificate they also maintained some type of clinical practice.

Postgraduate qualifications

Within the participant sample 14 held formal postgraduate qualifications. All the midwives working within education had a postgraduate qualification. The following table shows the type of practice the number of midwives in each work type that held a formal qualification.

Table 2: Postgraduate qualification by work type

Practice type	Number	Postgraduate qualification
Core midwife	6	1
Midwife manager	2	2
Employed case loading midwife	1	1
LMC	8	1
Undergraduate educator with LMC caseload	4	4
Professional and postgraduate education with core practice	4	4
Not currently practising	1	1

Those employed in education had the most postgraduate qualifications whereas those employed in clinical practice had the lowest proportion of postgraduate qualifications.

The midwife's entry to the profession

Within this study midwives had entered the profession via a number of routes which represented the education pathway for midwives at their time of registration. The following table shows the pathway for midwives into this study to become midwives.

Table 3: Qualification that led to registration as a midwife

Initial pathway	Midwifery Qualification	Hospital or tertiary	New Zealand or overseas	Timeframe	Number
Midwife	Hospital certificate	Hospital	New Zealand	1960s	0
Nurse	Midwifery hospital certificate	Hospital	New Zealand	1960-1980's	5
Nurse (NZ Or other)	Midwifery post qualification	Hospital	Overseas	1960s–1980s	9
Nurse	Advanced Diploma Nursing	Polytechnic	New Zealand	1980s	1
Nurse	Diploma in Midwifery	Polytechnic	New Zealand	1990s	4
Midwife	Bachelor degree	University	Overseas	1990s-current	1
Nurse	Bachelor degree	Polytechnic/ University	New Zealand	1992 – current	0
Midwife	Bachelor degree	Polytechnic/ University	New Zealand	1992-current	6

For some midwives entry into the profession had been as clinical based learning provided through a hospital; for others, entry meant obtaining a qualification through a formal education institute and the granting of a diploma or degree. The route of entry to the profession was dependent on the requirements in place at that time. Many of the midwives in this study had held other health professional qualifications before entering midwifery practice. More than half had obtained their midwifery qualification working directly in the clinical environment; whereas, as would be expected, more of the recent graduates obtained their qualifications from tertiary institutions.

Employment status and physical environment

The midwives in this study came from varying areas around New Zealand. Within New Zealand there are five main large cities. Other midwives lived and worked in smaller provincial cities and towns and others practiced in remote rural towns and areas.

In this study, of the 26 midwives, table 4 provides a breakdown of the number and “employment type” of midwife interviewed in this study. The cut off figures here are arbitrary; however, from the data midwives worked in the following areas:

Table 4 Practice location and area of practice

Practice location	Number of midwives	Type of unit employed at or accessed
Large city tertiary referral centre	4	Tertiary
Small City (30 km away from tertiary centre)	12	Secondary
Provincial city (Travel to tertiary centre more than 30 km)	5	Secondary
Rural town may have access to GP level emergency services	4	Primary
Remote rural travel to secondary unit can be in excess of 2 hours	1	Primary

Regardless of where they held access agreements⁶, most of the LMCs offered women the choice of homebirth.

The physical reality of the environment in which the midwives practiced and the access to resources and support differed in each area. As mentioned, a number of midwives worked in education and therefore had access to electronic databases, updated resources etc. Some of the midwives worked in larger hospitals where they may have had free access to a medical librarian, databases etc. Others may pay for access although it appeared that access to such resources could be variable (personal correspondence K Wakelin, T Thompson).

⁶ A contract allowing a midwife to access birthing facilities where women in their caseload birth.

Involvement with the midwifery profession

The midwives in this study were asked to describe any roles that they held which indicated involvement with the midwifery profession. Most of these roles were undertaken on a voluntary basis. Table 5 presents an outline of these roles.

Table 5: Midwife participants' professional roles

Role	Number of midwives
Preceptor – means in this instance that the midwife works with students	3
Mentor – means in this instance a mentor to a qualified midwife	6
Midwifery standards reviewer	3
Quality and Leadership Programme assessor	1
Expert advisor	6
Clinical Guidelines Group member	2
Midwifery Council Role (includes member Professional Conduct Committee, Competence reviewer or supervisor)	5
NZCOM role (includes regional chairs, Resolution committee etc.)	11
NZCOM membership (specifically stated)	21

Data collection

Data collection is a key component of any research and, in this qualitative study, there are specific methods and processes that were completed to obtain the data that was required. Corbin and Strauss (2008) identified interview as being a powerful method for data collection and this was the main method used in this study.

Interviews

The key method for data collection used in this study was participant interview. It became apparent early in the research process that people had pre-empted what I may want to hear and had prepared themselves in line with current policy and practice. Asking open questions about competence was therefore challenging to the participants and required more thought and consideration. Indeed, as Corbin and Strauss (2008, p. 27) stated, “our experience has

demonstrated that perhaps the most data dense interviews are those that are unstructured, that is they are not dictated by any pre-determined set of questions". I very quickly realised that if I wanted midwives to talk about how they maintained their on-going competence to practise then I needed them to think more widely than the requirements of the Recertification Programme. Although I had a number of cues and demographic questions with me, the question of maintenance of on-going competence needed to be answered by the midwives who were not afraid to speak their mind.

I also had to remember that I was not there to provide them with advice about how they are meant to engage in the Recertification Programme My role in the interview was that of researcher and I needed to be impartial and non-judgemental around the answers that they provided. My opening question in the early interviews asked midwives "how do you maintain your ongoing competence to practise?" This elicited a number of responses that were focussed around completion of the components of the Midwifery Council recertification programme but also elicited responses regarding knowing and understanding the role of a midwife and the scope of midwifery practice.

Well I work in the places that I work and I think that you need to be really aware of what the scope of practice is and what your boundaries are around it and stuff... So I feel that if I am faced with an emergency I can deal with it, and I have found that out to be true. I have sort of tested myself in emergency situations and because I do these things very frequently I kind of just click into the mode of what I have to do next. I am not fearful about what I do because I feel competent and I believe fear stops your ability to perform well in an emergency situation if you are too scared. So it keeps me up to date and I do it really. I identify that I reflect a lot about my practice. (Mary)

For my first few interviews I had a number of pre-determined questions that I used to engage the midwife in the interview process and to start the discussion on competence. As the interviews progressed and I began exploring concept development, before each interview I would refine the questions that I had in order to ensure that they were focussed on the concepts that I needed to explore. Often the questions were there as prompts because as the midwives talked further questioning that occurred at the time was in response to their statements during interview.

As the interviews progressed, through the process of coding and comparative analysis I began to identify how the midwife engaged in activities, what activities midwives engaged in and the opportunities that were presented to the midwife, were conditional on how the individual perceived herself as a midwife, her identified role and the limits or boundaries that were put on

her practice. This was influenced by the actual practice location. Some of the limits placed on the midwives were self-imposed and others were structural or employment barriers.

Memo writing

Another key element of the grounded theory method is the writing of memos. After each interview concluded I took the time to memo on the interview. The memo was not a description of the event but acted more as a conceptual reminder that described the concepts that had been discussed. That is I attempted to note conceptualisations of what had been discussed or to highlight processes that needed elaboration through further interviews. This was somewhat problematic and sporadic at times, and memos were sometimes more factual rather than abstract; however this is a part of the grounded theory method and something that I learned and developed as the project progressed.

Analysis and generation of the grounded theory

This section describes the methods that were used in the research process including coding and constant comparative analysis. The analytic Paradigm and Conditional and Consequential matrix as developed by Corbin and Strauss (2008), was used in this study to add richness to the data analysis and to guide the development of the theory. All data were coded by me and no computer software was used in the analysis. This made for a laborious process with large volumes of written data and paper. However, completing analysis manually meant that there was a sense of intimately knowing the data.

Coding the data

Coding is defined quite succinctly as “deriving and developing concepts from the data” (Corbin & Strauss, 2008, p. 65). The key subtlety is that it is about developing concepts not just presenting content during the process of analysis. First I sent the transcript to participants to allow them to delete any comments or make changes. Generally participants added small clarifying text to their transcripts and minimal changes were made. Most became aware of the imperfect nature of everyday speech but were advised that um’s and ah’s would be removed in the final quotations.

In this study data analysis began when the first transcript was received back from the participant. Data was coded using line by line analysis within each hard copy transcript. On the side of each statement I would note the concept that was being described.

For example, *updating* which was eventually identified as one of the strategies that midwives used to maintain their competence.

I also read the journals and the newsletters to make sure that I know about the consensus statements that the College puts out. I make sure I am up to date with the policies and guidelines of the facilities that I work in and also I work with students so therefore that ensures that I keep up my competence to practise just through supervising them. (Lydia)

The challenging part of the analysis was to keep it at the level of conceptualisation. Reading through the text it was easy to look at the data and to consider the action that was being undertaken. For example, in the above example it could be “reading” or “working with students”. These codes describe the actions that the midwives engaged in and eventually became properties of updating. By conceptualising these codes the actions are acknowledged but the activity of “updating” is used to describe these actions. Therefore, as an example, the concept of updating consists of the actions of reading or teaching. Appendix F presents two examples of data analysis, initial coding directly from interview and subsequent conceptualisation and category development.

Constant comparative analysis

Constant comparative analysis was used throughout analysis. This is defined as “the analytic process of comparing different pieces of data for similarities and differences (Corbin & Strauss, 2008, p. 65). I examined all interviews for similarities and differences between the codes and concepts. For example, Mary described how she keeps herself up to date with regard to attending education sessions: “I went to the NZAPEC⁷ course which was awesome and had much of what I wanted to know in it. It did reaffirm that I was on the right wavelength and that my knowledge was current” (Mary).

Here Mary is discussing the concept of *updating* but she is talking about attending a course, rather than, as Lydia said, reviewing and revising journals and policy documents. Constant comparative analysis led me as the researcher to identify the similarities, and can also lead to the development of the properties of a concept and how it relates to other emerging concepts. Using this example we see that midwives engage in a process of updating. This can include activities of reading, attending education or teaching. These actions were noted as part of the analysis and in the early phase of the research a memo was drafted regarding the concept updating. Early memos appeared to be more descriptive as demonstrated in this example

⁷ New Zealand Action on Pre-eclampsia.

Figure 1: Example Memo 1

Example Memo 5 26/4/2013 Concept Updating -planning
Causal conditions – knowledge changes indicators, practice changes, experiences and skills
Context: evidence based practice
Strategies for action – self-directed and mandatory education
Consequences: ongoing practice development

Explanation: One of the strategies that has been discussed by the participants is “planning”. Planning is one of the actions that must be completed if midwives wish to engage in updating.
Because of competing priorities and scheduling the midwives need to strategize to attend courses, these strategies includes deciding on times, places, and location for education. They just can’t attend at their own leisure they need to manage other aspects of their practice for example time off, course availability.

The above Figure 1 provides an example of the type of thinking and documentation within the memo. This memo was an early attempt to document the findings and as such made reference to the components parts (conditions, context, strategies and consequences). It ends with an example that describes how the midwife manages the competing priorities in order to plan to attend education. Later memos began to reflect the conceptualisation that was occurring and the ongoing thinking and analysis. Thinking and discussion became a key component of this work with continual thinking going on outside of the interview That was reinforced by supervision enabling sense to be made of the data as outlined in the next example in Figure 2.

Figure 2 Example Memo 2

Example memo 123 8/9/2014

“Midwives are talking about keeping women and their babies **safe**.

So “**conscientiousness**” is personal but it is also driven by the midwife’s desire to keep the woman and her baby safe

Within this level of practice there seems to be a one way **divergence** that is people who are viewed as barely meeting the minimum standards appear to be held in low regard however those who excel are not able to be identified as **developing expertise** i.e. there is no acknowledgment of the ability of these people to advance themselves but poor practice or poor engagement is not condoned.

So the midwives clearly stated that practising at lower standards or completing the bare minimum is not acceptable.

So levels of good practice is characterised by:

Talking about safe care

Engagement in ongoing professional development

Working with women so having a receptive professional relationship listening to women

Reviewing their feedback

Practising across the scope

Other levels of practice or stratification include

Developing different skills sets (primary care midwives versus secondary care midwives)

Core midwives versus LMC midwives

Midwives who work in labour ward versus those who remain in the antenatal/postnatal areas

Midwives who work in rural areas and those who work in urban areas

Constant comparative analysis also guided the data collection. As I was in the process of identifying similarities or differences within the data, I identified that there were other midwives who had certain professional characteristics for whom the process of updating may be similar or different. This led to the identification of midwives who I wanted to interview who had the required characteristics. Some of these characteristics included midwives working in similar or different practice contexts, midwives working in urban or rural contexts and midwives with or without formal advanced qualifications. They also included midwives who were new to practice and those who were reaching retirement.

Context

One of the main factors that potentially impacted and contributed to the findings within the study was that of context. Context is identified as a pertinent concept by Strauss and Corbin (2008). They defined it as “structural conditions that shape the nature of situations, circumstances or problems to which individuals respond by means of actions/interactions/emotions” (Corbin & Strauss, p. 87). Context itself is influenced by conditions and the consequences of actions of

those involved in the research. It became clearer during analysis that the context of practice affected and impacted on the process that was followed as midwives maintained their competence. Indeed this has been borne out by the findings of this study which have been divided into the individual practice type groupings because context made such an impact.

One of the key tools introduced and used for analysis by Corbin and Strauss (2008) was the Conditional/Consequences Matrix. There are a number of premises around which use of the Matrix exists (Corbin & Strauss, 2008, pp. 91-95). These include:

- Conditions and consequences are connected through the actions interactions and emotional responses of the participants. This means that change in an aspect of practice can lead to a desired outcome. But the way that this occurs and the way that the final outcome is expressed is dependent on the actions of the individual.
- Differentiating between micro and macro conditions is artificial as most situations that occur are a mix of both conditions that impact on the individual and on society.
- Individual participants do not always know or understand the full range of interrelationships.
- Conditions and consequences exist as clusters; however over time as the relationships between them changes, so do the clusters. Therefore this process is dynamic and not static in nature.
- Action interactions and emotional responses do not occur in individuals alone but can be by agents or in response to individuals. They are not just the individual participant response.

The analytic paradigm was used to explore and identify the context of the coded data. This meant that when the conditions, actions and strategies used by the midwives to address their situation were also taken into consideration, the actual consequences of the process could be understood. The Matrix required me as the researcher to consider the actions along a continuum and to look at both the personal consequences and the group, and then the potential national and international consequences. Use of this framework made me consider the implications for the midwife herself and those of her colleagues in differing contexts. It was important to consider the effects and actions of one group on another. For example, when one midwife indicates she will not provide an element of care, then another must do this. The consequent change in skill base has implications for the individual, the field in which she practices, her employer (if relevant) and the profession as a whole.

Use of the analysis paradigm became the key tool used to formulate theory and to integrate data. Using this tool I named the core category, the process used by the midwives as they worked to maintain their ongoing competence to practise, “**Working towards being ready**”. This was a four stage process which had the component parts:

- Professional positioning
- Identifying needs
- Strategising solutions
- Reviewing practice

The four stages were dependent on the salient conditions of resourcing, availability and opportunity, and very much on diverse contextual factors that impact the context of practice. The findings are described in detail in Chapters Four to Eight.

Quality features of the study

Every study, regardless of the methods employed, needs to demonstrate the quality processes and aspects that constitute the research and the findings. Corbin and Strauss (2008) presented criteria that are used to assess the quality of the study. While some of these are based on the work of Glaser and Strauss (1967) others have been added to and adapted into this framework. These features include fit, applicability, concepts, contextualisation, logic and creativity.

Fit

This first aspect of quality required me to consider if the research makes sense to those who are in the study and to members of the midwifery profession. In order to check “the fit” of the study I engaged in a number of interviews during the process of the research itself whereby I tested, through discussion, the concepts and the explanatory framework that I had developed. Although these interviews were beneficial, further areas or matters for discussion were identified which led to further data collection. They also led me to review some of my theorising and analysis which seemed to tighten the analysis and made the theory seem more relevant. Once the theory had been developed I went through a process of member checking where I discussed the theory with representatives of the different practice contexts highlighted within this study. Midwives across all groups identified with the findings that were presented. Midwives explained how they could see that diversity and differences would mean that people who needed to achieve the same requirements would do so in different ways due to different contexts and conditions. For example,

during member checking, urban midwives spoke about the challenges faced by their colleagues who worked in rural practice due to geographical matters and access issues.

In addition to the above, presentations have been delivered during the course of this study. Although some presentations occurred during an earlier phase of progress, the New Zealand midwives in attendance generally affirmed the findings.

Applicability

This study has led to the development of a theory of how midwives engaged in the process of maintaining competency in practice. This was a new and exciting area to explore as currently there is a lack of demonstrable evidence that describes and indeed confirms what is required to enable ongoing competence to be incorporated into practice. This research has asked midwives how they overcame some of the challenges that were placed upon them. The findings add to the knowledge base of the profession as it explored the strategies that midwives utilised in their attempts to maintain their readiness for practice. It also demonstrated the development of diversity within practice that is embraced within an umbrella term “midwifery.”

This research is grounded in the words of midwives who practise in New Zealand, those in direct clinical practice and other areas. It raises a number of questions around risk management and assessment of the current practices and requirements. Additionally the study provides documented evidence of the outcome of the process of maintaining competence which may be challenged but which demonstrates that there is a healthy professional stratification and diversity within New Zealand midwifery practice.

Concepts

The findings have been presented around the concepts that fit within midwifery practice today. Midwives spoke from their position about how they maintained their competence. The theory that has been derived describes the concepts that were developed. At times concept development seemed to be incredibly complicated. It was challenging to move from describing to achieve conceptualisation. Yet simply describing does not provide a robust grounded theory. As analysis progressed it became apparent that within the description were the concepts that together formed the theory and description. For example, “attending a course” became part of the concept known as “updating” which included attending education and practising or rehearsing skills and self-directed reading.

Contextualisation

To understand the findings it is important that the concepts are placed into the context of practice. A lot of time during analysis was spent examining the context of practice and the social context in which the midwives work. Further analysis was undertaken that looked specifically at the context of the midwives and how this impacted on the activities in which they engaged. Context appeared to be a very significant feature of the process of working towards being ready, so much so that when the time came to document the analysis, context of practice was recognised as a key factor that directed midwives in their activities.

Logic

When the data was being analysed it seemed that there was pressure on me as the researcher to find the problem and then to use the matrix to fill the gaps. What emerged through this study was a process of initial professional identification that led to a further three stage process of learning and reflection. Midwives in the study proceeded through the process in a logical progression – from when they identified where they sat within the world of midwifery practice to where they reflected on the care or the work that they undertook and how it impacted on their ability to practice, who they were in their world of practice and what changes they needed to make within their skill-set. This process was cyclical and continuous.

Creativity

The findings of this study demonstrate that while there is a core process in which midwives engage, the diversity of practice and the challenges that midwives work to overcome impact on their current practices. When I began my study a colleague said “won’t midwives just say they attend technical skills?” This worried me because potentially the participants could say that and this would mean that attendance at education was all that was deemed necessary. What became apparent was that there are a number of components of **working towards being ready** that are so much more than attending mandated workshops. Indeed, as I have progressed through this study I have seen a change in my understanding of the need for development and what it means to “be up to date”. The analysis led me to discover that the midwife’s professional identity, be it placed in time or space, directed what she did. Attendance at education is a small, arguably dubious part of an individual’s journey to maintain competence. The issue at hand is so much more complex than I ever imagined.

I acknowledge that I did hope that midwives engaged in some form of updating in order to maintain their competence to practise. What became evident was the different strategies they used and the challenges they faced in order to achieve this. What also became evident was that personal professional priorities were more often the driver for the direction in which the individual engaged in learning activities. It would have been easy after the first few interviews to state that the midwives engaged in education and practised certain technical skills and that was what they did in order to maintain their competence. Stopping the analysis at that time would not have shown the breadth of requirements and needs or the factors that were managed and juggled. It would have meant that theory development would have been incomplete.

Conclusion

This chapter has presented the methods that have been used in this study. The assumptions and method of a grounded theory study have been discussed. It has described the processes that were followed by me as the researcher during the phases of participant selection, data collection and data analysis. It has described the quality aspects of this study that demonstrate the methods that were followed ensured that the process was rigorous and therefore that the findings were representative of those involved in the study. Ethical considerations were also discussed as this was a major consideration for the way that participants were recruited and the way that data was analysed.

The following sections of the thesis will start with a presentation of the theory and process of **“working towards being ready”**. It will then move into an explanation of the conditions that impact on midwives competence to practise, the context within which they practice and the consequences of their actions.

Chapter Four: Working towards being ready

We are continually learning, we are always on that trajectory along with our intuition but we are getting somewhere that all builds in and develops your competence as a practitioner. (Mary)

Introduction

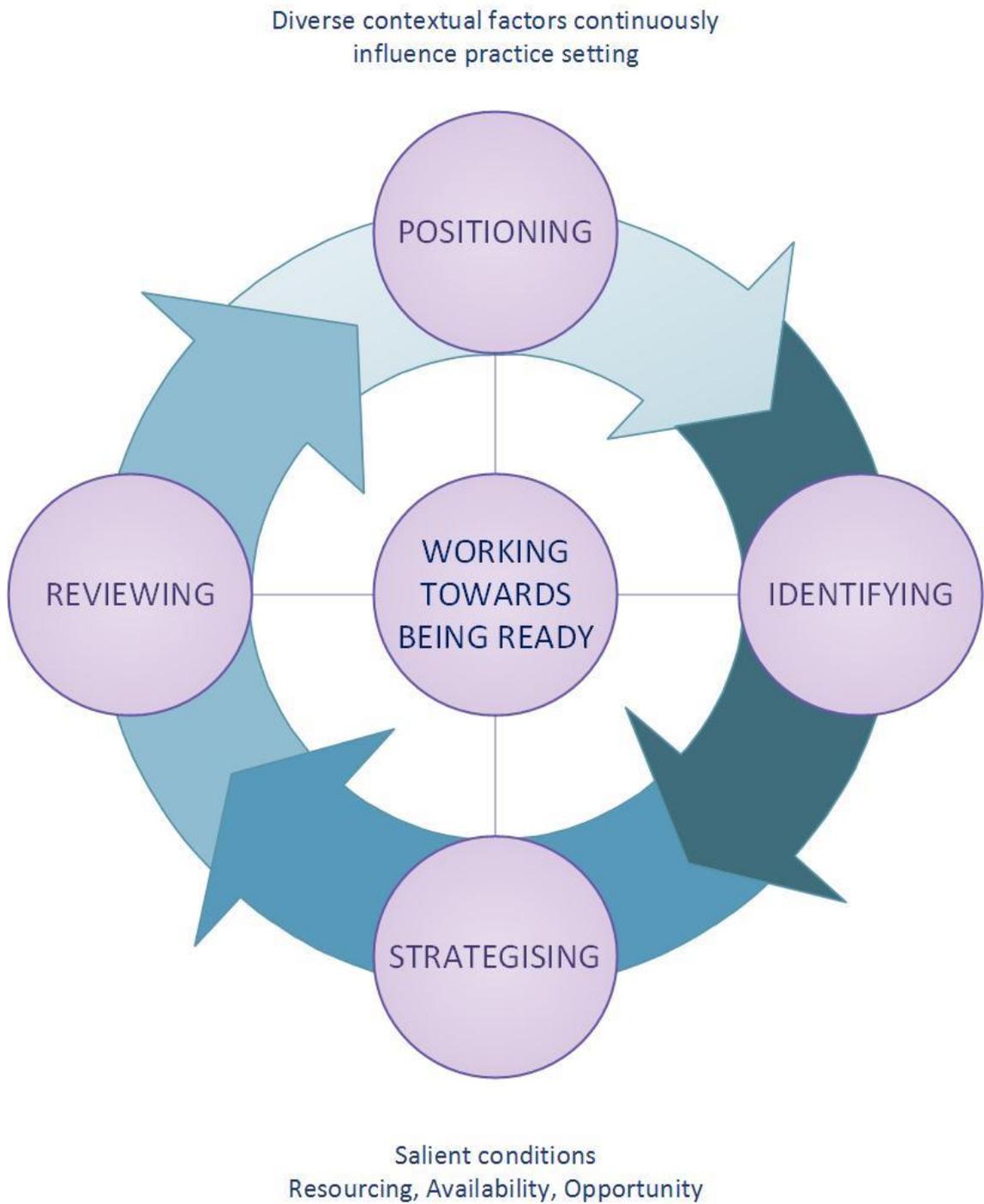
The midwife's work is centred on providing safe and effective care to women and their babies, yet midwives do not work in a vacuum. They work in a society that is affected by change and that has an aversion to risk. They work in a practice environment that demands accountability and professionalism. For all midwives, regardless of their place of practice, there are processes they have developed in order that they are ready to engage in clinical practice and that allows for informed decision making with women and their professional colleagues. This is not a static process. Midwives do not get to a place of professional readiness and then stop their learning or professional growth. Indeed, midwives are in a state of continually **working towards being ready**, for whatever the moment may be.

This section of the thesis will present the findings of the study. I will explain those conditions that impact on all midwives, regardless of their place or type of practice, and present the strategies that midwives use as they are **working towards being ready**. The consequences of these actions will also be shown. Chapters five to eight provide further analysis of the data based around the specific context of midwifery practice.

Working towards being ready

The theory of **working towards being ready** is a substantive theory that describes how a group of midwives in New Zealand maintain their ongoing competence to practise their profession. The components of **working towards being ready** are depicted in Figure 3 below.

Figure 3: Working Towards Being Ready



What does it mean to be working towards being ready?

Midwives in this study worked in a complex practice environment where there were multiple tensions and priorities that they negotiated. In order to maintain their ongoing registration and ability to practise they engaged in a process of **working towards being ready**. This was a dynamic process that involved the midwives engaging in a number of strategies so that they identified and managed the complex environment in which they lived and worked.

The components of the process **working towards being ready** are

1. Professional positioning
2. Identifying needs
3. Strategising solutions
4. Reviewing decisions

These components were dependent on the *salient conditions* of resourcing, availability and opportunity, and were impacted by diverse and continuous *contextual factors* which were influenced by the practice type and setting of the midwife, and by conditions that impact the midwifery profession as a whole. **Working towards being ready** was the core process that midwives engaged in regardless of differences in practice type or location.

Maintaining Competence

Maintaining competence was the purpose of **working towards being ready**. In order to continue to practice their profession, midwives are required by the Midwifery Council of New Zealand to maintain their competence to practise. The midwives developed a way in which they did this that met their needs, the needs of the woman, and the needs of other agencies involved in the midwife's regulation or employment. What was required in order to maintain an individual midwife's specific competence was unique and specific to that midwife and to the midwife-woman partnership. Yet, the strategies midwives used in this study, and the actions that they took, had many similarities across all groups within the midwifery profession. So to meet the need to maintain competence, the process of **working towards being ready** was enacted by midwives that ensured they had the appropriate knowledge and skills for practise enabling them to provide safe and competent care for women.

By **working towards being ready** the consequence was that there was a refinement in the midwife's knowledge and skills. That is, they had the current knowledge and appropriate technical skills that they needed to be able to work in the environment that they chose or in which they were required to practice. It also meant that because of the personal nature of each midwife-

woman relationship, and because of the personal choices made by each midwife as she was **working towards being ready**, there were midwives within the profession who had developed a specialist and enhanced knowledge of particular areas of practice. This does not necessarily mean that they were “technical subject matter experts”; rather, that they had knowledge and understanding of aspects of practice that differed from their professional peers.

Change impacting on how midwives practice

There have been a number of changes that have impacted on midwifery practice over the past 25 years. To recap, key legislative changes related to this study are:

1. The Nurses Amendment Act (1990) which granted autonomy to midwives and allowed them to practise without the oversight of a medical practitioner.
2. The Health Practitioners Competency Assurance Act (2004) which requires midwives to demonstrate ongoing competence in the assessment process laid down by the New Zealand Midwifery Council.

Further to these legislative changes, was the changing context of practice. For example, the rise of midwifery related research aligned to the evidenced based practice movement (Bick et al., 2012; Hunter, 2013; Tracy, 2010), the growing influence, importance and involvement of the consumer movement within health care (Hill, Elkin, & Road, 2013; Research New Zealand, 2015), and the risk aversion and accountability nature of society (Coxon, Sandall, & Fulop, 2013; V. Smith, Devane, & Murphy-Lawless, 2012).

Competency based practising certificates

The Health Practitioners Competence Assurance Act (2004) meant that, for the first time, regulators were required to ensure the ongoing competence of the workforce. Mary indicates how it used to be:

I suppose because I came from a system where nothing happened and I trained, I was trained and then for five years I just trundled along. Nobody asked me to demonstrate anything, nobody asked me to go on any courses [and] nobody asked me to re-evaluate my skills or keep myself updated. And then the world changed... (Mary)

The consequence of the change in professional regulation was that midwives had to declare that they were fit and competent to practise their profession; thus requiring them to engage in a series of activities of learning and professional development. Midwife participants in this study spoke at

length about the requirements that were placed on them by the Midwifery Council as their regulator and how this had impacted on the way that they were **working towards being ready**. The *consequence* of this change was that midwives devised strategies to ensure they were able to meet the requirements in order that they could demonstrate their competence, on paper at least.

Lydia explains that the statutory declaration that she signs for her practising certificate each year is her declaring that she is competent to practise her profession.

Every year I sign a declaration for my practising certificate saying that I am competent to practice and that I practice within the scope... What that means to me is that I am declaring that I meet the minimum requirements for entry onto the Register of Midwives which is the standard that the Council sets as being the minimum standard required for midwives to carry on and maintain [their] practice. (Lydia)

While the declaration and standards may be a minimum for practice, there are strategies that the midwife implements to ensure her practice is at, or above, that required. The actions that midwives took in situations, while ensuring that they were competent, were to ensure their practice could stand up if it was put under scrutiny. For example, Mary was motivated to maintain competence in order to keep out of the public eye:

I don't want my name appearing in the paper. If I have done something wrong I am happy to be held accountable for my actions and I am really happy, well it would make me really unhappy, but I am aware that I, as an autonomous practitioner, I have a certain set of responsibilities and standards that I have to keep. So I do think in depth about what the standards are and the decision points and the competencies and what I am required to do. (Mary)

Often the greatest critic of her practice was the midwife herself and audit or scrutiny of their practice was welcomed.

And so to me the auditors can look at have I met my competencies for practice, have I met the requirements of the recertification programme, have I kept my knowledge and skills up to date, all of that and my case study, exemplars and all that are in my portfolio. The only thing that is missing is the friendly chat and you don't need that to monitor if you are a good practitioner or not. (Megan)

While the midwives in this study engaged in activities to maintain their competence, their motivation was self-induced and aligned with the need to ensure that their practice could hold up to scrutiny. Further scrutiny or audit of practice was welcomed.

Professional positioning

Before midwives engage in any activities that enable them to work towards being ready, the first action they undertake is to position themselves towards being able to make their declaration as meeting the minimum standard to be registered as a midwife in New Zealand. Each midwife first identifies her role within the all-encompassing scope of midwifery practice, and then the standard and level of practice that she determines from her position to be acceptable. She then enacts her professional persona. This part of being ready is extremely personal to the midwife. It is how she expresses her professional identity and it leads her to act the way she does when she engages in practice. While the inference is that this is a static part of the process, in reality, due to engagement in the process of **working towards being ready** and potential change in the midwife's career and circumstances, the midwife redefines what she sees to be acceptable practice as she progresses throughout her career.

While midwife participants identified that the competence standards formed some part of the practice requirements, they acknowledged that these standards formed the minimum basis for how they identified as a midwife and what they expected themselves to be able to meet. In order to position themselves professionally, midwives set their own personal standards for practice. This involved the midwife knowing, acknowledging and understanding the standards for practice, and then superimposing her own values and standards on top of these. This became especially important when midwives were required to make a declaration that they were engaging in what was required and that they were competent to practise.

That's [the recertification programme] the minimum so I think it's being the absolute best midwife and you have to connect, you have to keep on improving, you have to keep on challenging, acquiring knowledge; otherwise how can you be the best, the best person for that role. (Jane)

The consequence in this situation was, from Jane's perspective, that her midwifery practice had to be above the minimum standard required for practice in New Zealand. Jane had identified the need for her practice to grow and to develop. She had set her own standards to ensure that she changed and improved her practice and knowledge set. To be a midwife, from Jane's perspective, was to be the best midwife – to do this required a commitment to personal and professional improvement and not, therefore, to settle for the minimum mandated standards. It also indicated that to be the best midwife, each midwife desired to be; there was a need to be continually **working towards being ready**.

Some participants set high personal standards which, they reported, created pressure. Lydia describes this pressure to practise at and above the required standard; however she admits this pressure is self-induced, and she positions her professional identity and practice standard beyond mandated requirements:

I feel a lot of pressure to be a really expert practitioner but also a lot of that pressure I put on myself 'cos that's what I want to be. And I guess that's the difficulty, the frustration I've had when I've seen other peoples practice and I think it's not at the level I think it should be at. And I guess over time I have had to realise that my level is not the level everyone else is at really but they are still safe and competent practitioners and that's been quite hard, a hard adjustment to make. (Lydia)

From the perspective of the midwives in this study, each midwife, therefore, defines her practice. As seen above, this standard may be judged by others. Practice standards position the midwife with regard to her professional practice, her understanding of practice and, ultimately, to the care that she provides to women. As discussed by the participants, there are different ways that the standards or levels of practice are portrayed. The minimum level that is expected would be the minimum level for safe practice.

Safety is a concept that underpins the need for midwives to be continually **working towards being ready** – safety of the woman and professional safety of the midwife. Competence and safety are seen as being integrally aligned as demonstrated by Lilyrose who identifies the links between safe practice and competence: *“Of course it impacts on clinical safety; if you are not competent you are not going to know what is safe that's the thing I think”* and by Jane who considers the central element of safety, *“Oh it's [safety is] the utmost that has to be at the forefront of practice. You know the women and babies are at the centre-point so their safety has to be utmost”*. For midwives maintaining safety means that the care provided by them is directed towards ensuring that the woman and her baby have a safe passage through pregnancy and birth. To do this, they aimed to ensure that their practice was competent practice because the implied understanding, as stated by Lilyrose above, is that being competent means that you are providing safe care.

Yet the need and motivation to maintain competence depends largely on the midwife; her understanding and acceptance that it is her responsibility to engage in what is required.

You're responsible for your own on-going competence. I mean the Midwifery Council at the end of the day is our regulatory body, but it is your responsibility to meet those competencies and if you don't meet them then the consequences are that you don't practice. So it is your responsibility to meet them. (Hermione)

Mary expands the concept further with the addition of her focus on women and families:

And for me that's ..., that's really bottom line we have to be safe because we have a responsibility to women and to families and to our regulatory body and to our profession and to ensure that we do what we are supposed to do. (Mary)

By taking responsibility for their own development the *consequence* is that midwives ensure that they are meeting the practising certificate requirements of their regulator and their own personal needs as they are **working towards being ready**.

Identifying needs

With the associated requirements of competency based practising certificates came the need for midwives to develop strategies that assisted them to meet any identified learning needs from within their practice and to manage the requirements placed on them by their regulator. One of the differences of competency based practising certificates was the need to demonstrate to an external body how an individual maintained their competence. The Midwifery Council decided that the technique it would use was measurement of engagement in a series of activities. The midwife participants discussed the requirements from their perspectives.

Identifying needs captured how midwives identified what actions they were required to take and then planned how to maintain readiness to practise their profession from their regulators' perspective. That is, apart from self-identified lessons from practice, midwives must attend to what activities they need to complete for their regulator as they were **working towards being ready**.

Well we have our compulsory education with our adult maternal CPR annually⁸ and your technical skills every three years and your breast feeding that's every three years. There's other workshops that we can attend all sorts, your domestic violence... smoking intervention workshops all over the place really, suturing IV [intravenous cannulation and therapy]. (Becky)

Becky explained the requirements that were placed on her by the regulator, the compulsory or mandated education which must be achieved in a required timeframe and other optional workshops provided for all midwives.

⁸ At the time of interview midwives were required to complete annual maternal and neonatal resuscitation updates with an update in maternity emergencies once every three years. This changed to be an annual requirement for all three components in 2014.

However, it was not only mandated activities that midwives needed to engage in. Midwives identified what was relevant and important for their development from their practice environment and personal interests.

There are some in-services for the core staff that we have to do and I do attend those, but I don't wait for the DHB to send me I just do it myself... There are areas of practice that bore me to tears... to be totally honest postnatal would be one of them. I have always had an interest in high risk things, pre-eclampsia, hypertension, that sort of thing sparks my interest. (Alex)

The consequence of identifying needs is that it enabled the midwife to understand what she needed to do so that she was able to update her knowledge and to meet requirements that were placed on her. In order to continue to practise, both Becky and Alex identified the requirements placed on them by their regulator and their employer, and also the areas of interest in which they wanted to develop their knowledge. However, it was not enough to know what must occur and what area one would like to gain greater understanding. The midwife then developed strategies that enabled her to engage in these activities.

Strategising solutions

Not all education or activities required by the midwife participants for engagement in the competency based practising certificate recertification process were provided in their local vicinity or on a regular basis. Therefore, once the midwives had identified what education or activities they needed to engage in, they strategised to develop solutions for participation or engagement in the required activities. Such strategies included identifying what they needed to do to enable participation. Depending on the type and location of practice, this could vary from simply booking onto a course provided on a regular day off, through to arranging transport and back up in order to attend a course in a distant town that required a midwife to take two days away from her practice.

Strategies that the midwives used were designed to enhance their professional capability. That is, their goal was to maintain their competence to practice and improve the care they provided to women and their families. Thus, at times, they needed to be strategic in order to plan and make sure that they met their obligations.

Some of it is strategic. That I need to do what I need to, to get my recertification organised alongside the other job roles that I hold. It's about time and fitting it in... Because I have two roles and one is of them is obviously on call and the other involves quite a bit of travel; it's a juggle. (Hazel)

Strategising solutions meant ensuring that the midwife planned her employment obligations around her recertification obligations, as explained by Hazel. Other times this meant managing work and life commitments as Catherine explains.

It's things like being a LMC, I've got to take time off, I've got to arrange for my colleagues to cover, you know I have got to do all this, this and this, in order to take the time to go and do my study. It costs me money, so I am juggling my life and my business and these factors as well. (Catherine)

At other times strategies included arranging for education providers to attend a local venue so that it was the educators that travelled and the participants that were able to stay in their local environment.

I think the College⁹ have done a wonderful effort, in coming to the areas. What actually happens is that our skills, technical workshops we actually organise those, they come to the <area>. And we get midwives coming from <other areas> and we get all the local midwives from here. Instead of us having to travel, it's a two day workshop as you know, its local we organise the morning tea and the lunches and people know about it.

I really have to say that the College has helped by coming to us. You don't have the cost of transport, you don't have the cost of accommodation. It helps keep the cost down [cover wise], it's more convenient for families and people with small children. So that is not a barrier ...that's a good thing. (Joy)

The consequence of this strategising is that the midwife was able to ensure that she engaged in the education or required activities. This means that midwives were active participants in their recertification processes. They acted and engaged in identifying what was required and then looked at ways of ensuring this could occur.

Strategising solutions was not only about attendance at workshops. They also included activities that enhanced the midwives capability such as rehearsing techniques whereby midwives practiced skills that they had learnt or believed that they needed to refine because of the change in their professional scope and identity. Maree explained how she ensured she was able to practice skills required if she believed they were necessary:

Things like suturing yeah I have done lots. So how do I maintain that? Suturing workshop. I did one about three years ago and I did that because I haven't done anything for a while on suturing. So I just did that myself. (Maree)

By ensuring that they planned and engaged in required activities, midwives strategised and were **working towards being ready**, for whatever that may be. However, once the education or

⁹ New Zealand College of Midwives.

activity had occurred the midwife did not stop the process of development, they then reviewed what they had learned in order to ensure it was effective and to identify if there was any further education that was required.

Reviewing practice

Reflection is considered a key activity in implementing change and learning into practice. Yet engaging in reflection is dependent on the individual valuing the process and understanding the benefit that can occur. *Reviewing practice* was more than reflection on learning. For the midwife participants in this study it incorporated activities that included unpacking care and decisions that had been made in order to understand outcomes and to consider the impact of such decisions. Reviewing practice was an integral component of the Recertification programme and this had an impact on the work of midwives. Reviewing practice could be an informal discussion with colleagues, a written reflection in a portfolio or it could be a formal Midwifery Standards Review¹⁰ undertaken with a peer and consumer.

Regardless of the method or degree of formality, midwives engaged in the process of reviewing practice as they were **working towards being ready**.

Well I did it [reviewed my outcomes] for my MSR at the end of last year and they were ok. But there is always room for improvement. So I have made some changes in the way that I practice so that to hopefully make some changes there, make a difference. (Carol)

Reviewing practice implied that the process of **working towards being ready** was not static. It was continual. Carol identified that while her practice outcomes were good, there was room for her to improve and she initiated change in order to achieve this improvement. To ascertain if there had been a difference she reviewed the outcomes at a later time.

As midwives were **working towards being ready** they were balancing the care that they provided against their understanding of the knowledge that they needed in order to be able to competently practise their profession.

I don't have a big practice so it is really easy to monitor my outcomes. So for every time I have someone who has a forceps or a caesarean section I go back

¹⁰ A quality assurance process provided by the New Zealand College of Midwives that involves discussion on the midwife's practice generally over the past two years. Midwives are required to provide their practice statistics feedback from consumers and a review of their work. The output is a professional development plan. This is a mandatory component of the Recertification Programme and midwives are required to undertake this process on a two yearly basis; although this can be shortened or lengthened at the discretion of the reviewers.

through it and will go, “oh what could we have done differently to change that outcome?” So that if I am faced with the same or similar scenario next time could we end up with a natural birth instead of this intervention and then in the end going back and getting some books out. And may have this have helped if I had done that and also talking about it with colleagues as well. I do have good stats so... it would be within the World Health Organisations recommendations about how many caesareans and how many vaginal births. (Samantha)

The consequence of reviewing practice was that the midwife identified the changes that she personally needed to make to her practice that allowed her to remain competent to practise. The challenge that this created was that the process of *reviewing* was specific to the midwife in her context and her circumstances. The consequence was that her professional capability was different to her peers.

So I think that having done Midwifery Standards Review for many years was a way of not only checking that you were maintaining a standard of care prescribed by your profession, but it would also help me have an understanding of being competent in terms of what an expectation of society is of a midwife. And my peers as well who you know will challenge you about certain aspects of your care. (Dora)

Finally, by engaging in the formal component of reviewing practice, the process of Midwifery Standards Review, which included ongoing reflection of learning opportunities, reflection of current practice against the standards for practice, analysis of practice outcomes and review of feedback from consumers and peers, the consequence was that the midwife was able to continue to practise her profession regardless of the degree of compliance with procedure or engagement in the process. For the midwives in this study however participation in standards review was just one way that they could ensure that their practice was in line with the requirements of their profession and of society. For the midwives in this study reviewing practice and all the elements in which they engaged acted as a quality assurance process that enabled them to be reassured about the care they provided.

Summary

Midwives work in a changing society; they need to adapt the care that they provide to meet the needs of women in order to ensure that they keep abreast of change. The introduction of competency based practising certificates and a mandated recertification programme, designed to require midwives to engage in professional development, has led to a number of changes within midwifery professionalism.

The process of continually **working towards being ready** was an attempt by midwives working in New Zealand to create their professional persona, to enable each midwife to complete the mandatory and self-directed requirements for her practice thereby ensuring that she was able to continue to practise and to adapt the care that she provided in response to feedback and identified needs. This was a process that was continual in that midwives did not get to a certain point within their practice and then declare themselves 'competent'. Rather they continued to identify for themselves, or be made aware of a need for change by others. **Working towards being ready** was about continually adapting according to prompts.

The consequence of this was that as she **works towards being ready**, the midwife herself grew and changed her professional practice, her professional identity and professional capability. She adapted to be in line with changes that were significant for her. This created a professional diversity as the need and changes in professional capability differed for those working in different areas and contexts of practice.

The next four chapters discuss the way in which midwives working in a number of different contexts adapted the way in which they were **working towards being ready** in order to ensure they were competent to practise. The chapters present the complexities and tensions that each group of midwives negotiated in order to provide safe effective care for women. The groups considered are core midwives, LMCs, rural midwives, and non-clinical practising midwives. Differences and similarities and ultimately the consequences of the decisions they made and the strategies that they utilised as they are continually **working towards being ready** for whatever the moment may be are presented.

Chapter Five: Working towards being ready – the core midwife

*Competence... what it means to me is that you are actually able to handle situations that come up and that you have enough knowledge and experience to be able to handle issues or know **where** to seek help and know **when** to seek help so that you are competent to care for women in labour... basically... or women generally ... or babies. So competence is actually skills and knowledge, and experience adequate to make you safe. (Ellen)*

Setting the Scene

This chapter shows the blurred practice boundaries, the tensions and the conflicts that can arise for the core midwife; and the dynamic interplay between employment conditions and mandated requirements. Additionally, it demonstrates that while all midwife participants reported the need for professional positioning, identification of learning needs and reflection on practice as continual processes towards being ready, environment and context shifted the ways in which they strategised to ensure practice competence.

Introduction

The core midwife is an employed midwife who may work in a variety of settings within the gazetted scope of midwifery practice. These settings include, but are not limited to, working in the community providing antenatal and postnatal care, in the ward situation providing elements of care across the full midwifery scope or in a specialist outpatient clinic. Wherever she works the core midwife has terms and conditions of employment which may place restrictions on the hours the midwife may work. In these settings her employer is required to assist in the provision of education and, further, to assist to address gaps in competence if and when they appear.

The core midwife works in partnership with women and with LMC colleagues to ensure the provision of care and the safety of women through the childbirth experience. From a regulatory perspective the requirements of the core midwife are the same as for any midwife. What differs is the way in which these are enacted and enabled conditional on the requirements of the employer. Depending on the location and services that are offered within her employment, the professional capability and maturity of the core midwife will differ to other colleagues. This is a consequence of the practice situation that she is exposed to and limitations or expectations that may be placed on her employed role.

Context of practice

For midwives in the core midwife role there are a number of specific challenges that need to be overcome to address issues that arise when they work towards being ready for the moment. However, within the context of attaining a competence based practising certificate, there are ready-made support structures that are in place that enable the core midwife to engage in this process with relative ease.

A midwife working as a core midwife positions herself from the perspective of this role and identifies the requirements or restrictions that are placed on her practice due to employment conditions. Such requirements can include the need to work in various clinical practice environments or to be confined to one. Consequently it can mean that her practice becomes limited to one area within the scope of midwifery practice. To meet regulatory requirements, she then negotiates to ensure that she is able to work in all areas.

Claire positioned herself as a core midwife and ensured that she took responsibility to know when education requirements of the recertification programme were due. However, instead of gauging where courses were that met her needs, she knew that compulsory components were provided by her employer. The onus on her was to ensure that the educator had booked her to attend a course in a timely manner within the parameters of the recertification programme. She also needed to ensure she was rostered away from clinical practice in order to achieve this.

Well, there's classes or you know, you have to attend certain sessions and it's making sure that I know when those are valid till and making sure that the educator at the hospital knows that I need to be on this particular course to maintain this. So, yeah, it's making sure that I am rostered to attend those study days to maintain it. (Claire)

The *consequence* for Claire was that she was enabled to attend mandatory education by her employer. Additionally, any attendance fee was employer funded, if the course was provided in house, and another midwife was rostered to provide clinical care to women in her absence. In order to engage in this activity there was (usually) no loss of personal income or time to Claire. Recertification requirements are contracted as the employer's responsibility to the employed midwife and became part of the routine of practice. But what are the complexities of practice and why is it essential that the core midwife is continually working towards being ready?

Working towards being ready

Midwives, regardless of their context, must ensure that they are able to practise and function effectively within the midwifery scope of practice. The first component of working towards being ready, professional positioning, describes how the core midwife makes sense of her position within her practice world; identifying the boundaries that she imposes and those that are imposed, as well as the supports that are in place to assist her to be ready.

Professional positioning – core midwifery practice

The core midwife can work across a range of work areas and in a complexity of roles that all sit within the midwifery scope of practice. Indeed the midwife participants, who identified that they worked as a core employed midwife, covered a range of clinical practice environments and contexts. These roles ranged from secondary care facilities in cities to sole charge midwives in rural primary birthing units. While the work in all units was often in support of, and alongside of, the LMC, the core midwives were autonomous and identified that they were professionals working with women. As articulated by Jane, *“I am passionate about what I do and I love what I do and its part of upholding that... you know, we are professionals ...we do this amazing job with women, and babies and families.”*

The challenges arise to the midwife’s professional positioning when there is conflict or potential misunderstanding about the role of the LMC, which raises questions pertaining to the professional scope of practice within which they work. Jane explains that there is confusion that now exists because LMC midwives are handing over certain elements of care; for example, induction or augmentation of labour that previously were the domain of all midwives. Her perception is that this is a change in practice that is leading towards different levels of practice within the midwifery scope. However, Jane states that from her perspective this can be negotiated and that there are ways to work in which both midwives can learn from one another in that by *working with* their colleagues they can acquire or refresh and retain their *professional capability*.

As an example, in some areas women who have diabetes are required to be handed over to obstetric services and the obstetric team is responsible for providing the LMC role and coordination. In this situation midwifery care can be provided by an employed midwife or the LMC may be involved. In other situations, the midwife remains as the LMC working in collaboration with the obstetric team and the role that she takes with regard to provision of complex care is negotiated on a case by case basis. So it can be that she hands over care to a core midwife if a

woman requires an insulin infusion to manage her diabetes or that she provides care with the support of, and while liaising with, the core midwife.

There are women who fall into high risk... and while that is out of the scope of a primary LMC midwife but if you are working with a core secondary care midwife then you are both learning and learning from each other and that way hopefully, your skills, you are picking up those skills over time so actually you might be able to deal with that [secondary care or women with complexity] more. (Jane)

Jane identifies that from her perspective there is *philosophical conflict* because midwives identify limitations on the scope of their practice. For example, the term primary LMC midwife is representative of a midwife whose practice is based around the Primary Maternity Notice (2007) and for whom secondary care or complex care is outside her normal practice. The issues arise for core midwives when there is transition from primary to secondary care and they need to understand who is providing care; both from a contractual payment basis and from a duty of care and accountability context. This has led to blurred boundaries. Conversely it provides the opportunity for growth and development of practice. Jane highlights that as the core midwife is working towards being ready she must be cognisant of her role and the way in which she works with her LMC colleagues.

Reflective of this, Audrey presents an example of handover of care because in this specific case the LMC does not provide care to women who are having epidural pain relief. This is the LMC's personal decision and means that her responsibility for the woman's care can end at that time. It can also mean that she stays and provides some aspects of care but another midwife manages the epidural pain relief. However, in this context, total care is handed over. The core midwife must be ready and able to take over care of the woman when such an eventuality occurs. The core midwife in these circumstances identifies that it is her role to be providing medically delegated¹¹ care and so the responsibility for care is negotiated on a case by case basis, the boundaries are contextual and philosophically can be conflicted.

It was a handover from LMC to secondary care with a woman who needed an epidural and so I carried on and did it and – formal handover – you know, she needs an epidural. Right! Fine! And I went in and met the woman and her family and as time progressed an hour later they said we want you to do our birth and I said “oh yes that's what will happen because you have been handed over to secondary care and I am the midwife working for the hospital”. (Audrey)

¹¹ Care of a woman with an epidural is deemed to be a medically delegated task. The anaesthetist takes responsibility and the midwife provides the prescribed care under that delegation.

In this situation we see two midwives accepting responsibility for different aspects and phases of the intrapartum care of women. One has positioned herself as a midwife who in this situation only provides primary care to women; and the other as a midwife who provides secondary or more complex care to women. When one reaches the end of her sphere of practice handover to a peer occurs. The philosophical conflict exists because of the lack of continuity of care. In addition the reason that care is being handed over is due to management of tasks that have historically been seen as the role of any midwife. This delineation is allowing for the development of different levels and the creation of different spheres of practice. One midwife works in complexity developing skills in complex care management and the other midwife with a primary focus is refining those skills and relinquishing her skills that relate to complex care.

The challenge arises in that in some situations, and in some contexts, there is no hard and fast rule that dictates who provides what care. Rather, care is negotiated in partnership with the woman on an individual case by case basis, depending on the LMC's choices and staff availability. These can be philosophical or pragmatic choices and can also be context specific. The tension exists when there are no boundaries as to what skills are required for competence. It seems any midwife can disregard or selectively abandon certain skills without redress¹².

Consequence –creating scope boundaries

The consequence of her employed position is that the core midwife is mandated and required to provide secondary care. She is required to be ready to provide care for, or with, her midwifery colleagues should the need arise. She is mandated to be ready to provide primary care to the woman should the LMC midwife not be in attendance. The LMC midwife additionally works to position herself within the boundaries of her practice, which impacts the work that the core midwife is required to undertake. The issue is that the core midwife is required to ensure that she maintains her competence to practise across the midwifery scope in order to retain her practising certificate. Because of the circumstances and the context in which she works, her professional capability will differ from her LMC colleague. In the core role, her skills and position focus can be in complexity but they can also be in primary care. While she may have expertise in an aspect of practice, the core midwife must also ensure that she has competence and experience in the full breadth of practice in order that she retain her ability to meet the needs of any given situation.

¹² Competency 2.7: the midwife provides and is responsible for midwifery care when a woman's/wahine pregnancy, labour, birth or postnatal care necessitates clinical management by a medical practitioner (MCNZ, 2007a).

Professional positioning – developing expertise in core primary care

There are other subgroups of practice which come under the classification of core midwife. These are midwives providing care to women in a primary facility. In this situation the midwife is usually the only clinician working in this environment; the midwife has to be able to act alone and to provide safe care to women knowing that she may be the only practitioner present. Becky describes her position on competence as a midwife working in primary care and identifies that she has to be skilled and safe.

Competence as a midwife [is] feeling confident that you're able to undertake the tasks that are required of you ...in your particular line of work... I'm in a primary unit, so there's certain things that I have to feel confident and feel like I'm skilled enough to work by myself and deliver out a high standard of midwifery care and be a safe midwife. (Becky)

Professional positioning in primary units also involves the midwife being able to engage in conversation with her LMC colleagues around matters that are pertinent to care that is provided. When a midwife positions herself within a primary care environment the decisions that are made are often to do with transfer to another facility when the care of the mother or the baby requires assistance or intervention. In this regard the midwife has to take into account the reality of being in the primary unit, of the time, distance and isolation that exists, and what needs to occur to assist with safe passage of the woman and her baby. *"A lot of our decision-making in a primary unit is based on those policies and discussion with the LMCs around transfers and labour and just neo natal jaundice - all those sorts of things"* (Mia). Although, for the majority of women in primary birthing units, the labour and birth is straightforward and the LMC provides all care under her own responsibility, for midwives in these environments there is a need to be aware and ready for the moment should assistance be required.

In this instance the core midwife is acting as a conduit; she is providing advice to the LMC midwife to support her in her practice and also to keep the core midwife and her environment safe. So the skills required here are more than being able to manage clinical incidents but also to negotiate and manage the environment in which she works.

Consequence – creating spheres of practice

The consequence of professional positioning, in this situation, is that the core midwife creates an identified sphere of practice within the boundaries of the midwifery scope of practice. This is partially derived because of the contractual role which is defined by her employer. This impacts

on her ability to work and may introduce unintended restrictions on her ability to practise across the midwifery scope. Hence, within the working environment, the midwife then creates her sphere of practice; in this instance primary care, that defines how she views and interprets the practice situation that she must negotiate. This sphere of practice is different to that of the LMCs with which she works providing advice and support and also from other core midwives employed in other areas of practice. Regardless of the context and how they professionally position themselves, in order to work towards being ready, the midwives identify needs that have to be addressed in order to support and enhance their professional capability.

Identifying needs

In order to retain their practising certificate and thereby practice, midwives identify their learning and professional needs that are relevant to them and that sit within their sphere of professional practice. One of the problems for midwives working in core practice is the requirement to provide antenatal, intrapartum and postnatal care when confronted with boundaries or challenges imposed by employment conditions and location of practice. Becky explains, from her perspective, the challenges that are faced and addressed in order to demonstrate that they practice across the midwifery scope:

I gather there is no particular requirement of time to spend in the areas [antenatal, intrapartum and postnatal care]. I know that some girls [midwives] that are a bit nervous about delivery may flit in and touch base occasionally. But then get out. So they in effect have worked across the scope of practise [but] does it really mean they're that confident in it? I don't know.

But where I work we do look after labouring women ourselves we are second at births and we do the postnatals. The antenatal, we see women at book in time.
(Becky)

Becky questions whether for some midwives the requirement for them to be working in labour wards can cause them to be nervous; yet they are required do this in order to retain their practising certificate. She questions the concept that there are no minimum boundaries for what is considered to be sufficient practice and then identifies that while these midwives have met the obligations of them in this regard, the benefit of this upskilling may be limited because of the fear that her colleagues possess about working in a certain environment. Further she states that risk may not be minimised due to lack of confidence from her colleagues. For Becky it appears that antenatal care consists of the "booking in" visit but that there is no ongoing antenatal involvement or even postnatal care after discharge from the unit. Becky identifies that she must practise across the scope of midwifery practice in what for her is the primary form. She decides that through her exposure on a day to day basis she is meeting this need; at no time does she

consider aspects of practice that are considered more secondary or tertiary focussed to be within her skill set and professional sphere of practice. A contrasting view is provided by Audrey who sees that because of employment conditions she is unable to retain some of the skills that she requires to maintain her ability to practise.

You see even at the secondary care there are some areas where I maintain them [my skills] very well. But we don't actually get fair rotation, so it is actually hard to maintain skills like perineal suturing is a case in example. Because I hardly ever do it I tend not to do it [suture]. And I really wanted to be good at that but you have got to be in delivery suite for more than one day every now and then.
(Audrey)

Audrey describes a structural barrier that impacts directly on her ability to maintain her competence to practise in one area. This is due, as she has described, to an unfair process of rotation into birthing areas. Therefore, despite the regulatory requirement for midwives to maintain their competence to practise within this area, structural conditions mean that this practice can be limited. The consequence of this is that the midwife loses her confidence to practise which appears in this instance, and in the instance referred to by Becky, to have a direct correlation to the time that they spend working in birthing unit. For Audrey the issue is wanting to work in that environment but not having the opportunity; whereas from Becky's perspective, the matter relates to midwives having to work in the birthing environment because they have to but not because they want too.

Ellen, who also works in a primary environment, *identifies the need* for her in her professional capacity to work across the scope. She therefore directs her learning and her practice to meet this requirement within her specific context:

And if a woman is having a baby I'll go in as backup. And if a baby needs a Guthries¹³ ...and if the midwife is off duty because she is sick then I might do a shift. So I do get enough for me to be comfortable with. But... it's very much primary maternity. I wouldn't even bother to refresh my epidural skills for instance because it is not relevant to where I am working and what I am doing and that's that whole thing about selecting what you need to have. (Ellen)

For Ellen identifying needs is about ensuring that she is able to work in her current context. For her, skills required for other areas of practice are not necessary in her clinical context and so can be removed from her skill set for the current time. As she is **working towards being ready** she can focus on what is relevant for her. What is relevant in this situation is that it is the midwife who identifies how she will meet the requirements and then who devises the strategies that meet her

¹³Newborn metabolic screening test.

needs. For Claire, by identifying that she is unable to complete one task she withdraws it from her clinical practice set.

I am not competent in suturing so I don't suture. I have had one teaching session ... it is not something that I am using on a daily or weekly basis that I need to do it so it is not a skill I have developed. I have observed. At the very best if it was a third world country then perhaps I would give it a go but I wouldn't take up that challenge on my own at the moment. I would certainly need to be skilled in that area. (Claire)

For Claire the issue is being able to practise this skill on a regular basis so that she feels confident in providing this element of care to women after they have given birth. She implies that there are differing expectations for women and that if faced with a situation in certain circumstances she would attempt this task. However in the context of her current practice where she is not required to complete suturing she does not.

Consequence - refining practice

When midwives reflect on their learning needs, they take into consideration the context within which they practice and any requirements that are placed on them by a number of agencies. This leads the midwife to identify areas for refining practice. The midwife then acts in ways to meet these needs, and practice is refined accordingly. As each midwife interprets her circumstances differently, the circumstances and professional parameters that they set also differ, with the consequence that there is variation in the skills and knowledge that they select to refine.

However the consequence of this role delineation, as described in chapter 6 with regard to the LMC midwife, is that there is confusion and uncertainty regarding the role of the core midwife and the boundaries placed on her practice by the LMC, for example:

I still think there is a little bit of core [midwife] versus LMC [midwife], so I think that is potentially a barrier there. Or there's an expectation "oh they are LMCs they can go and do that" ...We often have discussions as the managers ...that LMC will be really quick to hand over "no no that's secondary care we're not doing that "then what are they going to become at the end of the day. Are they just going to become glorified doulas and ...the secondary care aspects could be taken over by obstetric nurses? Are we as midwives going to lose our skills if we have to handover everything? (Jane)

Jane is describing how, from her perspective as a manager, if midwives define their role narrowly, they risk losing the ability to provide care. For Jane there are aspects of practice within the gamut of secondary care that she believes should be provided by midwives regardless of their role. Jane sees that LMCs who believe that such care is outside of their "sphere of practice" risk loss of

professional identity and that the challenge could arise from other professionals to provide necessary care to women. For Jane, as a manager in a secondary care unit, she then has to ensure that her staff are **working towards being ready**, which means that they have the knowledge and skills to provide care and take over from their LMC colleagues should the need arise. This further delineates the spheres of practice and leads to refinement in the knowledge and skills of both core and LMC midwives.

Strategizing solutions – enlisting the help of others

Core midwives identified that because of the location or the limits placed around their practice that they had lost their confidence with elements of practice. In addition, they also identified that they had a need for generic upskilling on matters that may not necessarily be within their day to day practice but nevertheless required awareness, knowledge and skill. Core midwives often had the luxury of the presence of an in-service educator who was able to guide and assist them after they had identified the needs that they had with regard to maintaining competence within their practice.

I would talk to [the educator] about specific midwifery things, I mean she is an excellent practitioner and her clinical skills are great and that can be a starting point to go off and find more. I mean you can do literature search and stuff like that, but just talking with other practitioners. (Alex)

Alex identifies that if she is uncertain about an element of practice that she will consult with the in-service educator within her place of work. She identifies that as a midwife she can review the literature or seek additional information but as a first point of reference she engages directly with the educator and enlists her help in that way¹⁴.

Claire has previously described her lack of confidence with the task of suturing. When asked to describe how she would develop this skill, she outlines the process that she would engage in should the need arise.

Well, I would go to the educator first off and demand practice and I would have to look at all the anatomy and physiology of what is required and practice and I think that it is practice, practice, practice and then I wouldn't do it unless I was overseen doing it by someone who was skilled in the task. Until I gained my confidence within myself that I could identify the landmarks and do it properly. And I think that would be one of the things that to date has held me back. (Claire)

¹⁴ Findings on how educators maintain their competence to practise are provided in Chapter eight.

For Claire **working towards being ready** in this environment starts with the need to seek assistance from the in-service educator within her practice. Claire considers the task that she is confronted with and then the strategies that she would need to put in place that would allow her to develop competence and to provide her with a sense of confidence to perform this repair. Such strategies include theoretical learning by reviewing the anatomy and physiology and being supported to practise the task by ensuring that she was overseen completing a repair. Finally she would rehearse the techniques through a process of repetition until she had the confidence that she is ready to perform this task on her own volition. Claire reflects that there is a clear process she would follow if it was identified that within her work place she must be competent to perform this task.

Utilising policy to support practice

The core midwife participants in this study all utilised the policy within their place of practice to support the work that they do. Often policy was seen as a mechanism to be informed about changes that had occurred and not just a mandate that must be observed. For the core midwife participants, utilisation of policy to support practice was one mechanism by which they informed themselves of changes in evidence for practice.

I guess emergency days are important for... updating like neo-natal resus. We have changed our practice over the last two years of the way we administer oxygen to babies for instance, from the neo puff back to the mask. Different pressures, different oxygen levels, they all change. So we rely on the educators from the base hospital for a lot of that change in policy stuff. The policies that the DHB put out are important too. Things change all the time. I found a new one yesterday that I never knew existed. So there are all those ways of learning.
(Mia)

For Mia participation in education is an important way to refresh and revise practical skills. She decides, in these situations, to rely on other educators to assist her to incorporate changes into her practice. However one of the other tools that she uses is review of policy; as Mia states, *"things change all the time"*. Therefore, review of policy is one of the solutions that she has developed to keep herself informed as she works towards being ready. Audrey too supports this stance. From her perspective, she openly admits that she cannot remember all things as there is too much to remember. The use of policy therefore supports her practice and allows her to be ready for the moment.

We have policies in place and guidelines and they are actually useful. They are very useful. I don't remember things, all the things. There is too much to remember. So you know to be able to give that competent care, safe care, keep my good standard of practice, I do follow those. (Audrey)

One of the issues that was raised by the core midwives was the diversity in policy and the need for a consistent approach. Claire, who works as a core midwife in a secondary unit, was seconded to assist in the development and communication of policy

A new unit opened up in the hospital ...I was part of writing one or two policies and making sure that they actually went through. So that we can show any new practitioners what is expected in this hospital and why, and this is the research that was used as a basis of that policy. And although it may differ perhaps slightly from where they have come from, at least there is a policy there that we can all try and be exact on using, you know, for the woman's benefit really.

You know there has to be some policies to produce a standardisation of how things should be managed and how the aim is safety and consistency so they are important... New Zealand is so small; we should have something the length and breadth of the country. Not individualised to a specific DHB and even a region ... and sort of using our common sense to the betterment of the whole area. (Claire)

Claire identifies there is a need for policy to assist and guide practice. From her perspective there is also a need for standardisation to support consistency of practice. What this would mean is that midwives would be able to work in different areas and be aware of the policy and guidelines and the research that supports aspects of practice. Policy is one way that midwives work towards being ready. However one aspect of this was the requirement for the core midwives to follow the policy that was produced by their employer. Even if, as it is stated by Becky, the policy is not valuable for her, there was a sense that she must follow policy as directed by her employer.

Well I mean there's lots of like policies and procedures and guidelines and the DHBs set their own policies and as a DHB midwife I have to follow that policy to cover them if I choose not to and there's a policy in place and something happens, I don't have their support, because I haven't followed the policy. Whether I happen to you know think that policy's good or not, if there's a policy in place really I, for my own safety, I feel like I need to follow it. (Becky)

The power of policy was questioned by Ellen who believed that the way that policy was written and documented, constrained practice and did not allow for women to make informed decisions.

... It actually worries me, at the moment I get very worried about the amount of policies and protocols that are trying to constrain midwifery practice. And you want some of it because you do need some sort of guidance. I would like to see things labelled clinical guidelines rather than policies and protocols. I am kind of involved with that side of it, so I try to use words like "may" instead of words like 'should' and 'must would' you know.

I think policies can be a very useful guide if they are up to date, maintained as up to date and have been set up with "some women will not want to do this" with the idea that actually informed choices override... you know what I mean? (Ellen)

For Ellen there is a need for policy and guidance for practice; however she sees that policy can constrain practice. This was mentioned by Becky who saw, as an employed midwife, the requirement to practise within the parameters of policy. Yet Becky stated, and this was reiterated by Ellen, that the clinician may not agree with the policy or the policy may be out of date. Midwives question where this leaves their ability to be ready for the moment. Yet the reality for these core midwives who are busy providing care to women is that they rely on others who have skills and time available to them to develop the policy that assists the midwife as she works towards being ready.

All those policies are based on an evidence-based and that's how it has to be. At a professional level we have to rely on other people's research and incorporate that into practice. We can't all do it ourselves so we have to rely on other people to provide that new information which is changing all of the time. (Mia)

For Mia being ready, therefore, requires her to be aware of policy that informs her practice. On a practical level she sees that evidence that informs aspects of practice changes on a regular basis. To keep herself ready for the moment she utilises policy to support her practice and in this way relies on the clinicians charged with developing policy to ensure that it is informed by recent and appropriate evidence for practice. Midwives working in core facilities rely on policy to keep them informed and to keep them ready for the moment. The policies are a solution to the need for knowledge and to keep the practice of the midwife safe.

Consequence - being ready for the context of practice

Through an iterative process of identification of practice boundaries, evaluating practice limits and requirements, midwives develop a perspective on the role that they are employed to provide. While midwives have the requirements that are mandated from the Midwifery Council which requires them to practise across all areas within the midwifery scope, at times there are barriers placed on the midwives which limits their skills and their abilities to work towards being ready. What is identified within this context, are the different expectations, experiences and options available to the midwives. As a result of barriers imposed on midwives through employment processes there is limited ability to engage in intrapartum care. This means that some midwives develop a lack of confidence with certain tasks or procedures involved in an element of practice when they are not able to utilise specific skill in a regular way. To resolve this matter, when they are working in the intrapartum environment, they seek advice and support from other midwives should the need arise.

Other midwives develop a lack of confidence to actually work in the intrapartum environment and the midwives themselves put limits around their practice. Some midwives consider their needs in relation to the practice environment within which they work; for example, Ellen and Becky strategise to meet their needs for their specific work context. They see that they meet the needs and requirements through their involvement in parts of the scope where they work and that they are supported to work with the use of evidence informed policy or guidelines. Midwives therefore strategise and implement solutions that allow them to work towards their practice reality. The tension exists when practice realities are different. The consequence is that these midwives are work ready for their work place – but this differs across institutions. This implies that the midwives are faced with different expectations and different requirements; as such their abilities differ because their experiences differ.

I think competence it is just not that you achieve goals that are set out by the organisation, by the profession, but your competence needs to be informed by the individual experience of the people for whom you care and you may see what you are doing as competent or what have you but they don't see it or what they expect in a situation then you are not meeting their needs. (Alex)

For Alex there is more to being a competent midwife than meeting the expectations of her profession or her employer. Alex has to work towards being ready so that she can meet the needs of the women for whom she provides care, both from the women's perspective and from her professional position perspective. Alex, and all the core midwives, need to be professionally capable within their context. Thus the reality is that Alex and Ellen may both be **working towards being ready** but the issues that they identify will be different because while there are some similarities on a day to day basis, the work that they actually do is different. The actions of **working towards being ready** for the moment, therefore is largely dependent on individual work context of the core midwife. The midwives are aware of this difference and variation and actively reflect to ensure that their practice meets the needs of the woman and keeps the midwife informed and professionally safe.

Reviewing practice

Midwives work towards being ready so that they can maintain their competence to practise. For core midwives there are employment constraints that impact on the work that they do. Core midwives were aware of the constraints and reflected upon and reviewed their practice in order to ensure that they were able to work towards being ready. Reflection on practice gave midwives the reassurance, or otherwise, to know that their practice was meeting their needs and that they had the knowledge to complete their job. This was not a practice that occurred occasionally.

A lot of it [discussion] happens around the staff room table, which is not a good place but I think that is where a lot of discussion as well happens, because people just sit down they have a cup of tea, it's probably time out cos often you're just so busy working in whatever field you are working in. So you sit down you have a cuppa and then often that provides an opportunity when something has happened and just people ... start talking and talking about practice .(Jane)

Indeed, written or formal reflection, while part of practice, was not a tool used frequently by the midwives unless they were preparing for their Midwifery Standards Review. Yet, as part of being ready for the moment they reflected, thought about and considered the care that they had provided to women to ensure that it met the woman's needs. Reflection was also an opportunity to consider their ability in that specific context.

For your midwifery standards review for competence we have to do that [formal reflection]... but more internal, just reflecting, your own thought processes and thinking. You know when you come out of a situation and think... that was a close call... Well it makes you think how could it have gone better or why was it such a close call. Was it because the organisation is falling apart and we don't have enough staff and things like that or like just the things that generally happen. (Alex)

For Alex, reflecting back on the care that she provides is personal and occurs while she is at work or after her shift ends. When she is reviewing her practice she is thinking about both her abilities in a specific context and if there is anything that she could or should have done differently, she also considers environmental factors and the impact they have on her competence to practise.

So it's trying to keep up with what trends are emerging or if someone has done an audit and said look this is what we have uncovered and perhaps you should really consider using this because what has come out of the audit is that this practice isn't necessarily a good practice that perhaps we need to reflect on what we did before and was that better than what we are doing now. (Claire)

For Claire, reflection also occurs in response to learning and directly in response to identified issues in clinical practice; it is focussed on what care is currently provided and what if anything may be changed. Claire identifies that she reflects on her practice all the time. Her impetus is to "Challenge myself. Challenge to do things better" (Claire).

For these midwives reflection on their practice is focussed around reviewing care directly provided to women and considering the appropriateness and need to improve this care. It occurs continuously and often is informal and can occur with their colleagues. Alternatively it can occur in moments when the midwife is alone and has the opportunity to think; as Audrey states, "Yes sometimes I will finish work and I will reflect on the way home. I live 25 minutes out from the hospital and I might reflect as it is easy to do." In order to work towards being ready for the

moment, the midwives consider the care that they provide during the shift that they work, and think informally about their practice.

There is, however, a legal and professional basis that sits behind this informal reflective process and that directs the midwife as she wants to be ready to ensure that her professional status is not compromised.

Like the first time I did my first Standards Review. I had no idea of what I was doing and there was fear. I suppose fear is a funny word to use but there is a heightened anxiety whenever you are having a Standards Review or whenever you are having - or even just going to tech skills - like I haven't been for a couple of years and you don't want to be the one in the group who is most annoying you know. (Claire)

For Claire, **working towards being ready** means being prepared, thinking about matters and taking appropriate action. She wants to be ready and wants to look prepared; she takes the time and acts accordingly. This sentiment was reiterated by Alex:

Well, just doing a bit of pre reading and just sort of thinking about it before you get there. It helps. But I think... unless you have no insight into your own abilities then maybe those people don't. But there are enough things put up by the profession that you have got to look at your practice against, like the competencies for practice you have got to sign a legal document each year to say I meet these and I have engaged in recertification and that must surely trigger internal reflection as to oh my god have I? (Alex)

For the midwife participants being ready is ingrained in their thinking and their reflection which leaves them questioning the practice of others; both the care practice and the professional practices of their colleagues and what this actually means:

The actual proving of meeting competencies I find actually quite difficult because I use case studies and reflections. But it always seems to me a very narrow and self-chosen way of proving that I am meeting competencies but I can't think of a better way. Case studies are quite narrow and to be perfectly honest could be totally fabricated. And there is no one, well I guess that's where the professionalism comes into it. It's up to each one of us to be honest and forthright and upfront about these things. But there don't seem to be many checks and balances in the way that I see meeting competencies of writing these case studies. With the MSR too, even the statistics that we provide could all be made up but that's where we as professionals we don't stoop that low I guess. (Mia)

For Mia reflection extends past the boundaries of her work into the processes that she and her colleagues complete as they work towards being ready. While Mia identifies that formal, professional, processes rely on the individual's honesty and integrity, she states that checks and balances do not appear to be present. The implication is that there is the potential for such

processes to be abused. Alex too clearly defines her thoughts and the thinking that she has when she makes her declarations. She questions if there are some midwives that do not reflect and consider if they have met their obligations.

For the core midwives in this study, reflection is a key component and strategy that is used as they work towards being ready. It is also a technique that they use as they work with their colleagues and it creates a sense that they become mindful of the practice of others. Such reflection allows them to question the work and ethics of their colleagues.

Being mindful of the practice of others

Working as a core midwife within the practice environment opens the potential to be the source of advice and support for colleagues. As part of their process of **working towards being ready**, core midwives developed an awareness and mindfulness of the practice of other midwives. Strategies were often developed to ensure that they were appraised of the care that women were receiving because as core midwives they could at any time be required to provide advice, support to their colleague or to provide clinical care. Alex describes how midwives come to her for clinical advice regardless of the place she is working in:

I am aware that when I am on the floor the LMCs will come and find me, some of them, even if I am not in delivery suite and they are not happy with what is going on, they will have a quiet word in a cupboard¹⁵ to check out what they are doing is right. And that isn't necessarily because it is me, it's because they haven't got any confidence in the person that they are supposed to be going too as the core representative in birthing suite. (Alex)

For Alex providing advice is part of her professional role and something she identified she needed when she was a new midwife. At that time she sought advice from her colleagues, "I used to [talk with other midwives] earlier in my practice when there were more experienced practitioners who I worked with" (Alex). Now midwives come to her for assistance. Alex tempers being mindful of the practice of others with concern and fear of a complaint being raised, the cause of the complaint not necessarily due to competence to practice but because of a lack of resources provided from within the environment.

Absolutely I am really worried at times that I will end up with an HDC¹⁶ and because I have been put at risk because of organisational ...because I really think that they do put us at risk, just because of the [organisational] constraints. (Alex)

¹⁵ Although not a formal meeting space this would be a storeroom in a clinical setting away from the main office.

¹⁶ A complaint made to the Health and Disability commissioner regarding care provided to consumers.

For Alex being ready is about ensuring that she provides women with care they need. She is aware that while she is working others come to her for advice and assistance with their decision making. She sees and accepts that this is part of the role of the midwife, being able and ready to share knowledge and skills should the need arise. A concern for Alex, however, is constraints that are outside of her sphere of influence and that impact on the care that she is required to provide

If it's a staffing issue you get "we can't employ at the moment", you are just going to have to work harder. They are relying on the staff's integrity to women. ...and you know what a labour ward is like, you are with a woman, you can't walk out with the staffing as it is, clinically it has been unsafe for people to leave and they haven't been paid and there is a lot of discussion over it. (Alex)

Being mindful of the practice of others extends beyond the actual clinical care provided by Alex's colleagues, to the environmental conditions in which they practice. While she does not comment on the physical care, she explores that the lack of staff can place her and her colleagues in a position of professional risk. Hence for Alex, being mindful means exploring boundaries and challenges that can occur and devising strategies to keep herself safe.

Core midwives work alongside other clinicians and through this process gain an awareness of their practice. They are at times the help that is called when there are situations for which midwives require assistance.

I mean there are people who you work with or observe. You don't necessarily work with them because they are independent of your work but you overlap a little bit, that you feel very nervous about their competency at times. And not always their knowledge, but the way they practice with that knowledge...

And often we are called into stressful environments when, that's when you see someone else's practice and therefore they are not necessarily at their best. You know the adrenalin rush affects everybody in a different way and so it is hard to judge how good a person actually is under those set of circumstances. You could be quite critical but in actual fact ..., certain people use certain techniques should we say or words whatever to cover up certain things that make you feel a little bit concerned at times about their competency. (Claire)

In clinical practice situations core midwives are the support that is called in times of need. They provide this advice and support willingly as they have a professional obligation to work in support of colleagues. They also have a moral and ethical duty to assist their colleagues should the need arise. As they are exposed to the practice of others they can and do judge it. This exposure to, and judgment of, practice leads the core midwives to develop strategies to protect their practice and to enable them to be ready for the moment.

Becky describes how she keeps a watching brief over practice that occurs when she is at work. She does this so that she is aware of situations that may arise and her need to be ready for the moment. While she hopes to receive information from the midwife so that she is apprised of the situation, and any requirements of her, when this information is not forthcoming she has developed strategies to ensure that she has a watching brief over the clinical environment:

Yeah one particular [midwife] that doesn't communicate at all... whenever her women are in there, I never get any progress on what's going on and that's a little bit tricky because I'm the midwife in charge for my shift and I need to know what's going on in that room and it's quite difficult to get any information. But what I have found I go to the family if I hear the family coming out I'll just go and introduce myself and say "hi how's it going in there, where is she at?"

So I found a way of getting information like that because I've been called in suddenly buzzers going off and I've had no idea if the birth's been... and then I walk in meeting this woman for the first time and well "are we doing an active third stage or doing physiological?" ...This particular person holds onto all information, always has done ... she's a tricky one to handle but she's not working much so I don't have to see her too often. (Becky)

Becky has developed an awareness of her colleague and the way in which she practices. In order to ensure that she is ready for the moment Becky has developed strategies that keep her apprised of birthing situations if the midwife is not willing to share information. Becky is mindful of the practice of this midwife and because of the context of her practice in a primary birthing area has developed strategies that provide her with the information that she needs. Becky wants to be ready for the moment and that means that she needs to have a good awareness of what is occurring in the clinical environment.

Consequence - being ready for the moment with others

Midwives engage in clinical practice in a number of different fora. They work alongside their colleagues who may also be employed and they work alongside colleagues who may be access holders. Through their work, and through their reflection and communication, midwives gain an understanding of other clinicians' practice. They become mindful of the work that they are employed to complete and the presence of others within the work environment. By being mindful they utilise different strategies to keep themselves apprised of the clinical situation so that they can be ready for the moment should they be required to provide advice or assistance. Thus, **working towards being ready**, for a core midwife, means having an awareness of the environment in which practice occurs and developing ways of protecting practice by understanding the needs of others.

Summary

Core midwives engage readily in the process of **working towards being ready**. As core midwives they are employed to practice within a certain specific environment and with various degrees of location and complexity of practice. They position themselves as core midwives and identify the boundaries that sit around their practice. By doing this however, and because of the boundaries conditional on employment requirements, they develop scope boundaries which leads to the development of differing capabilities within practice. The core midwife works to be able to, at any time, provide advice and assistance to her colleague and to take over care should the need arise. Midwives working in this role develop expertise in care situations that they are employed in. This leads to the creation of spheres of practice that sit within the midwifery scope of practice.

Midwives working in core roles identify their learning needs and engage in strategies that facilitate their work towards being ready. However because of the boundaries and parameters that are put in place the needs that they have are specific to their work context. As they strategise to meet these needs they often enlist the help of others in so much that they often have direct access to an educator who is employed to assist their learning needs. For core midwives, policy, process and guidelines were an integral part of their work and a mechanism that they used to be ready for the moment; however they were often policy users rather than policy developers. By incorporating these elements and using these strategies core midwives work towards being ready for their context of practice. Finally core midwives identify the need to consider, review and reflect on the care that they provide. They do this regularly in both formal and informal contexts. They also gain an understanding of the practice of their colleagues which creates situations where they are mindful of what might be developing behind closed doors. Being mindful leads them to develop strategies that will mean they are ready to act and to provide assistance should the need arise.

Core midwives work to be ready to face any situation and to provide advice and support within the context of their employed practice. The processes in which they engage allow for this to occur and lead to the development of skill and expertise within practice. Core midwives work to ensure that they meet the requirements of their regulator that enables them to continue to practise their profession.

Chapter Six: Working towards being ready – the LMC midwife

And I think, keeping the woman and her family safe is not just about the hands on, but also about... oh gosh what is the word I am thinking of... the interactions... you know and I just think it is more than “can I suture?”
(Catherine)

Introduction – the Lead Maternity Carer midwife

As she works towards being ready, the lead maternity carer (LMC) midwife positions herself within this area of practice and refines the parameters and boundaries, and the knowledge and skills that being ready entails. She accepts or rejects elements and tasks within general midwifery practice, that she believes forms part of her skill set, and as such creates her sphere of practice. The skills that she has and utilises are adjusted accordingly. The LMC midwife identifies that there are skills and knowledge needs that she must address which are based around her practice parameters, her own development and the clientele for whom she provides midwifery care.

By sharing knowledge with her practice colleagues there is reciprocal development across groups of practice. The main challenge faced by the LMC midwife, however, was the need to prioritise and balance the many costs of education alongside her personal and professional development. As the LMC midwife reviews and reflects on the care that she provides she analyses the birth outcomes and decision making that occurs. Through doing this she develops an awareness of both her practice and that of her colleagues. Part of **working towards being ready** is finding like-minded clinicians who support the clinician’s practice and identifying those whose practice one does not want to emulate. As a consequence there is diversity and a spectrum of LMC practices.

For LMC midwives, **working towards being ready** is an underlying premise of their day to day practice. It supports them to be identified as safe and knowledgeable woman-centred clinicians whose practice is supported by a group of like-minded clinicians.

Professional Positioning - LMC midwife

The LMC midwife is a community based midwife who holds a contract with the New Zealand Ministry of Health to provide maternity services for a caseload of women. She is a midwife who is self-employed; she provides midwifery care to women and runs a business. LMC’s are responsible for planning and coordinating care throughout pregnancy, labour and birth and the

postnatal period. As such their work is across the whole scope of midwifery practice. The LMC is paid by the Government for services provided under contract with a fixed price schedule of fees. Services provided are in agreement with the Primary Maternity Notice¹⁷ which forms the basis of their service contract. LMC midwives are on call or must ensure that women have access to care 24 hours a day, seven days a week. That is, they must be able to respond to women in a timely manner and resolve maternity care related issues whatever these may be. From a woman centred perspective, care provided to women is negotiated and individualised to meet the need of the woman and her family. The implications of this are that the nature and type of circumstances and requirements that LMCs may need to engage in, can be multiple and diverse. The LMC midwife must continually work towards being ready to ensure safe and appropriate care for women.

Similar to her core midwife colleagues, the LMC midwife decides to define the parameters that sit around her professional practice. She defines her role, her philosophy of birthing, the standard she sets for her practice and the care that she will offer to women, all within the expected competencies and standards laid down to maintain her practising certificate.

Judith is upfront with women and right at the start of the professional relationship informs women of her philosophy and practice so that both parties hold clear expectations of one another: *“at the booking visit we talk about you know the partnership and what that means, where I am going from, where they are coming from”*. She continues

I mean I have quite good relationships with my women, well I think and I always say whether I am being biased, particularly about my philosophy you know, I don't do elective sections kind of thing, depending on the situation, ...so being open and upfront at the beginning and expecting that from them so the communication thing. (Judith)

Judith seems to indicate that her competence as an LMC midwife is dependent on strong communication between herself and the woman so there is a shared understanding of expectations. While Judith no doubt seeks to practise within the standards or competence, she has her own boundaries of good practice. She will not take on women who want an elective caesarean section for no valid reason. Thus, for Judith, competence also has a philosophical, values base.

¹⁷ Primary Maternity Services Notice 2007

One fundamental difference of being a LMC midwife is the perceived visibility and accountability of the LMC as an individual midwifery professional working in the community.

When I hear good things said about me it makes me feel really good. But I am not doing it [midwifery] to get a reputation. So having said that I would not want to have a bad reputation. Because I know about how midwives talk amongst themselves and how they talk about the midwives that do have a bad reputation. I guess it is important... it is important. I think everybody wants to be good at what they do and I am no different from that. (Carol)

For Carol, it is important to maintain a good reputation regardless of her chosen profession. While it is not Carol's motivation, a negative reputation that would have ramifications throughout the professional community is seen as being something that she would wish to avoid. Carol therefore acts and strategises in such a way so as to ensure she has a good reputation as a LMC midwife.

While there is a clearly defined scope of practice for midwives, LMC midwives identified that for them to work effectively they had to decide what parameters they needed to put around their practice. This varied between each midwife and was largely dependent on their philosophy of practice and on individual context. Joy gives an example of deciding for herself where she needed to put the boundaries of her practice:

I think that our skills [hospital and LMC midwives] are very different and we should respect one another. When we have done everything that we can do and we transfer a woman in, we don't stay on with our women in secondary care. And I know that for some people that is not seen as professionally pure and I know with continuity of care you should stay through the long haul.

But you know when I first went out I did that¹⁸. I did 20 hour and 24 hour stints and I got cystitis twice, I've never had it in my life, we were not supported, it was ridiculous and it was unsafe. The other thing I noticed was that secondary care practice started to impact on my primary care practice. And I could see my colleagues around me you know, one ARM¹⁹ here, one getting on with the synto²⁰. So I made a conscious decision to focus on primary care and to do the best that I could... But once we have done everything that we can do, then we will go through to secondary care and we will respect the skills there... So what am I saying... we've got different skills sets. At the end of the day we have all got the best interest of the mother and the baby at heart. Generally there is a mutual respect for one another, for those who know us and know our practice. (Joy)

Joy is very clear that the roles midwives take means that they develop very different skills and that midwives should acknowledge and respect their differences. She has made a conscious

¹⁸ Provided continuity of care in labour which meant that she stayed with the woman until the baby was born

¹⁹ Artificial rupture of the foetal membranes

²⁰ Oxytocin augmentation to artificially stimulate labour to progress

decision to only offer primary care to women. This is a personal decision that was formed after she identified that her practice was impacting on her health. It is also a decision supported by the midwives in the facilities that she utilises and to whom she hands over when providing elements of care that are seen as being more secondary or when physiological birth is no longer a possibility and her care of a woman stops. This is how Joy has positioned herself within her sphere of practice. She has placed boundaries around her practice that, from her perspective, imply safety for the woman. Hazel, however, provides a different approach and describes how she has made the decision to remain involved and provide a degree of secondary or complex care for the women in her caseload.

For me as an individual I have always wanted to continue in the secondary role... That probably reflects a little bit about me in that as a user of the maternity services I needed secondary care and had a midwife who continued to provide that for me. So I went into midwifery knowing that was something I always wanted to do.

So that has definitely coloured how I practise and to be honest I think it is part of a midwife's role. So I have chosen to continue to do that. I know that some midwives in other areas may not feel as comfortable taking that role particularly if you are a rural midwife. That's not good use of their time to continue providing care for an epidural and staying for hours when they may have to go back to their rural community leaving their other rural caseload behind. (Hazel)

While Hazel identifies that she continues to provide these services, she acknowledges that in some situations, which are context specific, it is acceptable for a midwife to hand over care of the woman to another midwife; and that is acceptable to her from both a continuity of care and midwifery partnership perspective. It is her belief that these roles are part of the work of a midwife and that unless there are other matters that impact on the midwife's ability to provide such care that the midwife should stay with the woman until after she has birthed. Because Hazel has continued to provide this care she has retained her confidence and her self-identified competence to do so.

Joy and Hazel provide different perspectives about the same practice. Joy made a clear choice to stop providing aspects of secondary care; whereas Hazel made a decision from her perspective to continue to provide secondary care. This was a decision based on a pragmatic decision to place boundaries or otherwise around practice. But this decision was made based on the conditions within the different areas within which they practice and the support available to them. However the underlying premise of the midwives was their belief of the nature of care that they should provide in practice.

Consequence – Creating spheres of practice

The consequence of this delineation of role within a role is that there is a refinement in the skill set for these two LMC midwives. For Hazel, being able to maintain her competence and therefore provide secondary care, she needs to remain current and capable in these activities. Joy has decided that she will not retain this capability and so she does not need to engage in education or updates regarding these topics unless she chooses. Engagement in such education would be of little benefit to her professional practice. We see, therefore, a variation in skill-set amongst different clinicians and different boundaries placed around practice activities. This is very much dependent on the midwife and her professional position but the consequence is that there are different requirements decided by the individual in order to retain her practising certificate with a result that there are different levels of practice and creation of spheres of practice within the context of being a LMC midwife.

Professional positioning is about the midwife making decisions and a statement regarding her work and the care that she provides. The consequence of positioning is that within the midwifery LMC sphere of practice there is diversity in care provision that is decided by the individual given the physical parameters within which she works. After they have positioned their practice, LMC midwives ensure they retain their ability to practise by identifying development goals and practice needs.

Identifying needs

The learning needs of the individual midwife are based in and around her own professional development plan and the needs that she identifies from within her caseload. Learning needs are also dependent on the place in which she positions herself within her practice. Midwife participants spoke about how they had engaged in extensive education when they first moved from providing hospital based care to self-employed practice. Most hospital based care categorises skills into antenatal, labour and postnatal areas, meaning it is less likely for such a midwife to feel she has a wide breadth of competence across the full continuum of midwifery care. Furthermore, with medical staff on hand, some tasks were routinely handed over to the perceived expert as explained by Jane: *“Before we had the SHOs and registrar and it was just the consultants, I actually think midwives do more. Whereas now I’ve noticed... it’s like why are you getting the registrar to do that?”* Becoming an LMC midwife thus enlarges the updated professional skill set that the midwives require to ensure safe and effective care for women.

Maree explains her need to sharpen her skills related to the birth and her competence to practise, including clinical reasoning as well as technical skills maintenance:

I would be asking people would they do suture workshops with me and they would be going no [you] shouldn't be doing it [suturing]. Asking doctors to help us do things. We asked a paediatrician, who came out to our house and did resus with us as a group ...so then we asked people associated with the ambulance to [help in] terms of cannulation ...they came here and did a workshop. So now it feels like it is really easy to upskill. (Maree)

The challenges confronting Maree arose due to a major shift in role and practice context as she became a LMC midwife. In order to function effectively in this role she identified a number of technical skills that she needed to enhance. These were skills that may not have been part of her role prior to that time and included skills like cannulation²¹, phlebotomy²², perineal suturing²³ and neonatal resuscitation²⁴. These tasks may have been part of the midwife's competencies and skill set but due to contextual matters other health professionals, in the area where Maree practised, undertook them at that time. In this situation there was a conditional change that meant skills completed by others became part of the role of the midwife. This shift towards working in a new role took on a greater significance because as a consequence there was a shift towards the need for greater upskilling. Maree found that moving from one role to another requires an assessment of the skills required to complete another. She identifies her learning needs in this situation and acts in order to meet these needs. When Maree became a self-employed midwife she had been working for some time within a birthing facility; Catherine, however, was a newly qualified midwife who entered self-employed midwifery practice on graduation. Catherine was deemed competent in skills that were required for practice as a midwife regardless of the setting. As a newly qualified midwife she has to balance her academic and practical skills with the reality of being a midwife in clinical practice.

When I look at the degree... I mean I am coming from a very academic side of things, so if I look at the degree and if I look at what we have been taught in terms of skills and practical skills I think that the practical skills for me are an essential part of safe practice, being able to confidently and competently fulfil the hands on practical skills. You think of things like suturing, if I can't suture properly then how can I possibly say that I am a safe practitioner? Or if I can't manage an induction of labour how can I say that is safe? ...

I think from that perspective, for me keeping up with those sort of skills, keeping up with the latest research, being safe in that way and knowing, and having confidence in my ability to do those basic hands on practical things is very

²¹ A cannulae is placed inside a vein

²² Taking blood

²³ Repairing damage to the perineum that is caused due to the process of giving birth

²⁴ Specific resuscitation that is performed on the baby if required at the time of birth

important. But then on the other side to it, being safe also means communicating really well with women. And making sure that they have got all of the information to hand that they need to make informed decisions. (Catherine)

For Catherine being able to provide safe clinical care and ensure that she retains and enhances her knowledge and skills are key to being a midwife. While she acknowledges that through her education she has acquired skills for practice, she chooses to continue to learn and practise in order that she maintains her level of competence. For Catherine, therefore, identifying needs for practice is as much about the need to continue to engage in clinical work as it is about ensuring she has research to develop her practice.

Identifying needs depends on moving from one sphere within midwifery practice to another and identifying needs for learning when confronted with new and challenging medical or obstetric issues that impact on the care provided to women. Carol describes how she identified the need to engage in learning when she was faced with a situation that she did not understand and with which none of her colleagues could assist.

For example, the other day I had a woman with an abnormal blood result or something. It was something that I hadn't come across before, so, and no one in my practice could help me with that one, so I did some reading about that. (Carol)

The need to understand an unusual blood result was identified in response to a specific clinical incident and would be the same for both core and LMC midwives involved in the care of the woman. However, because the LMC midwife has the responsibility to ensure care coordination, to consult with and refer onto other services when required, her need to put strategies in place around her learning needs have, potentially, a more urgent focus.

At other times LMC midwives identify that they need to engage in education because of a change in the complexity of the population of women for whom they provide care. For example Sarah, an inner city based LMC midwife, discusses how she identified a need for education because the requirements of the woman were changing.

This last year I have been to a diabetic study day run by another hospital and so that was something that I knew I was looking after a lot of [women with] gestational diabetes and I knew there were changes in how they treated or what the blood tests meant. And so I knew there was a gap [in my knowledge] I hadn't done it for a long time. So that was a really good thing to sort of focus on and do. (Sarah)

As the medical and social needs of women become more complex, the midwife decides to *act* to ensure that she has the knowledge and skills required to provide safe and effective care to women. Whereas some core midwives may never be exposed to labour care of a woman with diabetes or they may be able to hand over care to a midwife who specialises in women with diabetes, the LMC midwife who negotiates with the woman to continue to provide care takes this responsibility on her own shoulders. For the LMC midwife then, there is a continual shift in learning needs due to the context of her practice and the need for her to be ready for the moment.

Once the midwife identifies the needs that she has for practice development, she then strategises solutions for resolution. For the LMC midwife there are many aspects of this action to be managed and manipulated in order that they are ready for the moment. As a *consequence* they are **working towards being ready**. This includes managing the practice, planning around requirements, creating opportunities, and rehearsing skills. Midwives then need to find solutions that assist them in this action.

Strategising solutions

For the LMC midwife to be able to engage in learning and development there was, at times, a need to rely on colleagues for advice and support. Whether it was actual practice cover of caseload or whether it was direct clinical advice in response to need for knowledge, the LMC midwives in these situations resorted in the first instance to their practice partners in order to be ready for the moment. While self-education was seen as being a personal matter, there were elements of group responsibility that allowed solutions to be formed and that kept the midwives ready for the moment.

Meeting personal needs

First and foremost, like midwives engaging in other practice contexts, the LMC midwife identifies and puts strategies in place to ensure that she meets her own professional obligation to remain current and up to date. Carol identifies that her own learning is a process that she chooses to engage in and describes how she will get a textbook or read a policy that allows her to do this activity on her own:

Continuing education, definitely I think it is invaluable, and reading the policies... and just being amongst it as well. Going to NZCOM meetings, I know I have to but I am not very good at that... It's a bad time of day with a young family. (Carol)

While she may want to engage in professional meetings and the education that is provided there, for Carol timing of these activities is poor. She therefore prioritises the time that she has, when she is not called to be with a woman in labour, to spend with her family rather than attend a meeting. Prioritising needs of family needed to be managed and negotiated, and at times presented a barrier to career change and development. For Dolly the reality was that although she had a supportive partner, meeting the needs of her family at that time had to take priority over her career aspirations, *“When I had small children, there’s no way I would have ... gone away for weekends for education. I say that for some people that is a bit hard especially if they are on their own and they have got children”* (Dolly).

For Dolly the challenges and requirements imposed through the need for competence based practising certificate and the reality of what it means to be a LMC midwife meant that she had to remain working as a hospital midwife for some time. The consequence for Dolly in her situation was that she delayed entering self-employed midwifery practice because her career needs were second to her family as she needed regular hours and rostered time off to be with them.

Dolly, unlike Carol, delayed entering LMC midwifery practice; Carol prioritises activities that she needs to undertake in order to be ready around her family. Catherine, in contrast, sees her family as being her motivator to remain current and engaged with practice and a support to her in this role. For Catherine to become a midwife and a LMC has meant personal sacrifice on her family’s behalf which means she believes that she cannot drop her practice standards as the impact would have many repercussions.

I have a passion for midwifery, so I don’t want to drop the ball in any way shape or form. And so I am my own motivator and my family is my motivator because this degree has come at a cost to them, not just financial but in many other ways, you know. So I know that I am doing it for a greater purpose. (Catherine)

LMC midwives negotiate the world of practice and manage the requirements for education and updating that are placed on them. To do this they meet their personal needs for education and work-life balance. For some this can mean delaying the time to enter LMC practice; for others it can be prioritising the way in which they engage in learning and relevant activities. Being a LMC, midwife however, did not mean that they necessarily worked alone. Indeed often it was the members of the practice who collectively supported the development needs of their partners.

Being supported by colleagues

Regardless of their practice context, LMC midwives negotiate the day to day reality of practice and the need to be ready for the moment by strategising solutions that mean they can address their needs for learning. One of the key ways they complete this is through the support of their colleagues. Being part of a practice LMC midwives are both giver and receiver of support that enables them to meet education and other learning needs. The way they do this is often conditional on the members of the practice and the ways in which they work together to support one another.

Zoe describes how her practice has realised that they needed to review and refine the resources that they provide to women. This has meant that they need to also revise what is current best practice to share amongst themselves. When time is limited they often find that if they do meet the focus is more on rostering and time off than on education. In order to support the new members of their practice they decide to share the workload between them and subsequently have each taken a number of areas and items to review and refine:

It does frustrate me at times that I do not leave enough time to do the updating [of knowledge], that I have got such a list at the moment. You know I never had such a long list of stuff that I want to update... As a practice we have decided to take a couple of subjects each and update the information that we are going to put on our practice website information for women about things. So it is a good way of speeding up the process as well. (Zoe)

By working together and *supporting colleagues*, this practice of LMC midwives has devised a strategy that will allow them to access and review recent information. It will enable them to update collectively so that they are able to provide evidence informed information to women.

Judith describes the benefit of working with colleagues who are also involved in midwifery education and how they can work together to support the midwives to enhance their knowledge and skills. Judith is competent in using evidence and databases to support the information that she provides to women. She believes the added benefit and support that she gets from her colleagues enables her entire practice to learn and to keep up to date.

I am the administrative person [for our practice]... I keep on top of the resources that we use and keep them up to date. And what's great is that of course we have two colleagues at a [school of midwifery] who have access to even better websites or database information than we do. But I think I am quite active, if someone asks me a question that I don't know then I will go and find out for them. (Judith)

For Judith, being able to access information is important for her professional growth and credibility in practice; she is an active learner and takes the initiative should a learning need be identified. From her perspective having colleagues with additional skills or resources that can assist at times of need is a benefit to her learning, to the care provided to women and to the practice.

Joy too identifies the ability to use the collective knowledge and wisdom within her practice, specifically the ability to utilise the skills that are available through one of her colleagues:

One of my colleagues is really good at bringing up [information]... if we ever have an issue ... She's got a doctorate and she loves research. Today she sent me some stuff on early cord clamping because I was having a conversation with [a person] about cord banking... so she is very good at keeping us up to date with the latest research. (Joy)

For Joy having a midwife who is able to provide research advice and assistance in finding information means that she is *being supported by her colleagues*. This enables her to be ready for the moment in that she has knowledge so that she is prepared for a meeting and discussion regarding an aspect of midwifery practice for which she is not familiar. Joy and Judith both identified that there was a midwife in their practice who took additional steps, who had developed roles and who supported midwives in their practice by actively disseminating research and resources for practice.

This type of LMC midwifery practice can provide support and advice that allows its members to be ready for the moment. The collegial network means that roles can be shared amongst colleagues and midwives can use their skills to assist others. When midwives do not engage in a formal practice arrangement then this level of support may not be readily available and this requires the midwife to negotiate other ad hoc arrangements that may not be to her advantage.

Consequence: Developing collective knowledge

By ensuring that resources are current for practice, or by assisting with the dissemination of knowledge regarding a particular case, midwives are working in support of one another as they work towards being ready. As knowledge is accessed, collected and shared there is an increase in knowledge across the group practice. Further the different skills that midwives hold and bring into the practice are used to support those with whom they work, be it research retrieval, updating resources or accessing additional information. This collaborative approach to knowledge upskilling is a solution that has been developed to assist midwives with their learning needs and with questions regarding practice. The skills that the midwives bring into their work place

differentiate them from their colleagues. While they are all LMC midwives with varying amounts of clinical practice experience, they have additional skills that mean their view of practice and the needs they have are different from their colleagues.

The issue, however, is that there is no consistency or routine availability of access to these resources or indeed midwives with these skills and abilities. Midwives were dependent on colleagues who may have access to additional information or who may have been educated in the use of research to enable them to include this within their practice. This may not be the case for other midwives who may struggle to find the information that they need or who need to look outside of their practice for this support. In this research the midwives were either located in urban centres or had access to resources provided through medical or midwifery schools. However, this raises the question as to whether access to this information is universal or if all clinicians have access to a colleague who is aware of this information or who has the necessary skills? These are some of the challenges that midwife participants chose to negotiate and managed. Absence of this support has the potential to leave the LMC midwife at a disadvantage to her peers.

Prioritising

For LMC midwives the need to attend and engage in education was a mandatory requirement that allowed them to continue to practise. Yet these midwives are self-employed and have an obligation to the women in their caseload to provide them with care should they need it. LMCs, therefore, need to ensure that they have systems and processes in place that allow them to be ready and able to provide care. When midwives are faced with a decision regarding attendance at education or caring for women, then they generally chose to provide care. Education was delayed until the next opportunity.

I think time when you are an LMC midwife in particular, that obligation to the woman that might be due that week that something is on and that commitment that you feel you have got to her, even though you can ask someone to cover for you. (Sarah)

For Sarah time to attend education was an identified need but it placed her with challenges. Even though she was aware that she could arrange a back-up midwife, which would allow her to attend, from her perspective she had a professional obligation to attend to the woman. This was more important than the need to attend education. The cost was another barrier that needed to be managed; however, she also believed that because of the unpredictable nature of midwifery practice, midwives should be able to pull out at the last minute without penalty.

I think courses that are run for midwives to attend, we should be able to back out at the last minute without having to pay for it you know. That's part of our practice ... I don't think we should have to commit I will absolutely be there.

Or maybe it is good to absolutely commit and let go for that woman. Personally I would think that the best is that when they are running courses that they say oh well you can't come this time then you can transfer over to next time. (Sarah)

As Sarah makes this statement she describes the decision making that needs to occur; does she attend pre-booked education or respond to the professional need to care for the woman in labour with whom she has made a commitment to be there? Or if the woman is in labour does she remain with her? If she has no commitments then she would most definitely attend education. She ponders this matter and then considers that maybe she should prioritise education over clinical care. The complexity here is that Sarah chooses to make a decision at the time; she weighs up the commitment she has with the woman to that of the education provider. She acknowledges that within her practice she can ask for back-up but in this situation backup is provided on a case by case basis. There are no confirmed processes which means that as a group support is provided without question and education is planned and takes priority. Hence for Sarah she must make prioritising decisions regarding education versus commitment every time that she plans to attend an event.

Sarah's experience was in contrast to the practice management that was in place within Dora's practice.

Getting cover for your women is a factor which is why having a group practice is really important because if you all agree that these things [education] are important then you cover each other and you look after each other. But for midwives working solo or maybe with only one other person I imagine that would be really, really difficult. (Dora)

Dora explains that by working within a group practice you can be supported by colleagues as you make decisions regarding attendance at education versus providing clinical care. Midwives in these circumstances develop negotiated practice arrangements that mean they can take scheduled days off. There is no need to make priority decisions because this is already achieved as part of the belief to support and look after one's colleagues. LMC midwives enabled themselves to attend education as required through having formal practice arrangements that allow this to occur.

One barrier to attend education that had to be negotiated, and that was an inhibitor for midwives, was that of the cost. LMC midwives often had to pay to attend education provided by the DHB in which they accessed facilities. This to them presented challenges that they needed to prioritise.

I think too the courses are becoming more and more expensive to go to and so you choose the ones that are most appropriate as opposed to in the past I might have gone to a lot of things for interest. (Sarah)

For Sarah the cost of education comes at a price to her professional development and inhibits her professional growth. She simply has to prioritise her needs, weighing up the cost rather than attending education that may be part of her development programme but more from an interest rather than requirement perspective. This too was reiterated by Joy when she was discussing engaging in education that ultimately would benefit students:

My other email was the preceptor training and we have now been told this is compulsory if you want to take students.

So we are giving all our time to take students and the first thing I look down and see is the cost. \$150 for non- DHB people. So they are wanting us to do this preceptor training so we will take on and pass on our skills as midwives and they are charging us for it. I mean that, honestly Sue, it just makes me want to tear my hair out. (Joy)

Joy sees the need to engage in this education if she wants to pass on her knowledge and skills to students; however this comes at a personal cost to her. Because she has to pay for education, for Joy the decision must be firstly if she wishes to attend this education. However, there are implications if she does not engage and what that means for her and any work that she may wish to undertake with student midwives. LMC midwives do not have the ability to pass on the cost of their education to the consumers of their services. Therefore, they must choose and prioritise what is important within the limited resources or budget they can accommodate from their learning needs.

For some midwives there are mechanisms in place that allow for course fees to be paid by another agency. Carol describes how her engagement with the Midwifery First Year of Practice²⁵ programme has assisted her with professional development in that the barriers imposed by the cost of education including travel and locum costs have been removed. She adds that with further negotiation with the midwifery in-service educator, courses that she may otherwise have had to pay for, have been provided free.

²⁵ A programme of development which includes mentoring and attendance at education for midwives in their first practice year. A budget is provided that funds attendance at education.

And it has been fantastic with the midwifery first year of practice [programme] that we have not had to pay for it [education]. And also in our DHB the educator has been fantastic, getting us into courses that we have not had to pay for.
(Carol)

For Carol education has been facilitated as part of her entry to practise as a midwife and as a LMC. This has meant that the decision she has made has not been with regard to attendance at education or otherwise, but the prioritisation of the education that she feels will benefit her and assist with her development in the profession.

Consequence: Equity of access

For all of the LMC midwives, regardless of the way in which they practised, there was an issue of equity of access to education. When midwives had to pay either for education or for a back-up midwife, then they had to make decisions that affected the education and development that they undertook. Prioritising education meant that they would attend what they deemed to be most important. When there were requirements for payment or when there were other mechanisms that enabled one group to receive education without the need for payment then this created access equity issues. The need for payment acts as an inhibitor and means that midwives may decide not to engage in some learning; not because they do not have an interest or a need, but because they cannot afford to attend. The consequence is two-fold in that firstly there are systems developed that support one group over another; and secondly, there is a delay in knowledge transfer of update which further accentuates different levels of practice and currency of practice knowledge.

Rehearsing for practice

Not all needs that midwives had related to theoretical education and learning. At times they identified that they needed to revise or review technical skills and emergency preparedness. While all midwives are required to complete an annual emergency update, for midwives working as LMCs they were often spurred to rehearse techniques. If they were anticipated that they had a woman in their caseload who might require them to have their skills heightened, then they needed to be ready to act. For these midwives, there was often no option to hand over aspects of clinical practice to another practitioner. These midwives were responsible for providing care across the entire scope, in a number of vast and different settings and they needed to be ready for whatever the situation might be. To be ready LMC midwives strategised and rehearsed the skills they needed for practice when given the opportunity. Maree is explicit in her rehearsal

stating quite categorically that in order to be ready for the moment she will rehearse the technical skills that she may require: *"I will go through the shoulder dystocia stuff, if I know there is there is a big baby coming up"*.

While rehearsal of techniques does not guarantee that a birth will not be without consequence, or that a shoulder dystocia will not occur, there is a sense of preparedness with the midwives because the skills and techniques that they may require are in the forefront of their mind. They rehearse what it is that they need to know and to do should any incident occur.

Rehearsing was not only in response to emergency preparedness. Zoe indicates that through practice or through rehearsal of skills and techniques there is a sense of preparedness that occurs as the midwife works towards being ready. Zoe takes the position that if midwives do not continuously prepare or practice then they will lose the comfort that they have with certain skills which leads to a position of not wanting to undertake or provide such care. For Zoe being ready includes being able to practise and whatever that entails.

There are skills that you just need to keep up to date but there are actually new skills that you can always introduce. But it kind of depends just what you want to take on. And I think when I look at some primary practitioners you know there is a bit of fear around up-skilling and so often they are the ones who will hand over to secondary services because I suppose we have always done the full realm of care I prefer to maintain those skills or keep updating myself.

So are you talking there about things like epidural management?

Yes and synto and you know even for pre-eclampsia and hypertension management. You know those sort of things you know, especially when they end up in hospital on which ever drip is the flavour at the moment or whichever medication. So it's always good to have a bit of an update. (Zoe)

LMC midwives work in a number of different arena and contexts. In order to maintain their competence to practice they identify what it is that practice is and from this philosophical, and at times pragmatic, standpoint identify the skills and knowledge that they need as they work towards being ready. As they identify their professional position they also develop strategies that will allow them to achieve that which is required. While there are some elements of practice that they engage in on an ad hoc or sporadic basis, the frequency with which they undertake these activities means that they develop strategies to rehearse and revise such skills. Doing this enables them to work towards being ready for the moment.

Reviewing practice

For midwives working as LMCs there was a need for reflection on care that was provided to ensure it met the needs of women and to enable the midwives to consider that they were prepared for the moment whatever that may be. This reflection could be formal or informal. It could occur following a specific incident or as a consequence of a formal review process.

Reflecting on care

Hermione explains the circumstances around a clinical matter. Although it was resolved at the time and the woman was well, there was the potential for catastrophic consequences:

At one of the last births I had, I had great problems getting a cannula in and I had to get three different people to put cannulas in. And you know even on kind of that level, it's kind of good to have some self-reflection and think do I need more experience in that ... you know. (Hermione)

For Hermione **working towards being ready** means that she has the skills to be able to cannulate a woman. While there are often circumstances that mean clinicians encounter difficulty completing the task of cannulation, for Hermione it is more than just conceding that the woman involved was difficult to cannulate. For her, through the process of reflection, Hermione identifies if it is indeed her skills that require rehearsal, so that she is ready for practice. In this situation, therefore, being ready requires an analysis of the event, a reflection and consideration of one's ability and a plan to rehearse skills if need be. This reflection occurred after the event as part of the midwife's thoughts about the care that she provided. In comparison Judith, who was relatively new to practice at the time of interview, used the formal process of standards review to consider what gaps she could identify within her practice that she could incorporate into her learning and development plan for ongoing learning

There is the regulatory stuff, obviously, standards reviews and things like that. We have set up our notes in a way that make sure that we go through all of the decision points and things like that. And then you identify - as you reflect you identify areas you are lacking... like with my first standards review I wanted to do that - my documentation wasn't that great, well I didn't think it was, so I wanted to do that workshop. So if there is a workshop that applies, then I go and do that.(Judith)

For Judith the process of **working towards being ready** compels her to ensure that she has met the requirements of her regulator; she then puts structures in place through her clinical notes to ensure that she meets her contractual and professional obligations with regards to care provided to women. Finally, through the formal process of reflection for midwifery standards review, she identifies that her documentation around practice was not at the level that she believes she

requires. It is apparent from the comment that it was Judith's expectations of her documentation, identified through reflection that led her to take steps to improve her skills.

The process of formal standards review occurs only once every two to three years. LMC midwives, however, identified that they provided reflection and review of care and, at times, opened this up to include learning from the parents and their experiences. Reviewing care and practice in conjunction with the woman and understanding how the care that was provided could have been improved all aid the midwife to identify what it is that she needs to change or develop as she works towards being ready. For Zoe this can occur at the completion of care whereby she engages with the couple and together they reflect on the care provided:

The other area that I use to check on competence is how I debrief with women and their partners as well. When women are getting into the skills thing I don't take it personally by actually ripping my practice apart, you know you actually need to be able to do it constructively. The woman and their partners are very good at doing that, you know this would have been helpful as we are going through the birth. What sort of things would you have found more helpful? What sort of things would you have wanted from me? And if you are not afraid to hear a few home truths then it is actually a very effective way of meeting their needs as well as competencies. (Zoe)

The fundamental midwife-woman relationship that is born out in continuity of care allows the LMC midwife to engage in meaningful discussions with the women in her caseload. Specific feedback can give the midwife very clear goals that can direct learning. The consequence of this feedback identification is targeted professional development and enhanced capability that serves the needs of the specific population of women. This is context specific and can be influenced by change in practice and through changes in time. The reality from Zoe's perspective is that care is reviewed as it is appropriate at that specific point in time. Each midwife-woman dyad or practice-caseload demographic guides and directs the midwife towards her own learning goals and objectives. Over time the reflection will lead towards a possible enhancement in aspects of care that are relevant to the LMC or to the midwives that she shares and works with, within her group practice.

Reviewing practice is a core component of being a midwife. For those who work as LMCs the opportunity exists to review care and to reflect on practice on a case by case individualised basis. This occurs because of the nature of the relationship that is built and developed over a period of months; a relationship based around openness and also the sporadic nature of events. A case loading LMC midwife may provide intrapartum care for a relatively small number of women per month. This gives her the opportunity for case by case reflection.

While the midwives worked towards their own goals, and with their own philosophy and professional positioning, there was a sense that they considered their practice in light of, and in conjunction with, other clinicians. That is, as they worked to be ready they identified that the care they provided and the support that they may receive was impacted by the presence of other clinicians. Hence, as they worked towards being ready they were mindful of the practice of other clinicians.

Being mindful of others

As midwives engage in clinical practice they identify that there are midwives who hold a similar philosophy who will support and sustain them and whose practice they wanted to emulate. They were also quite clear about those midwives whose practice they did not want to copy – be it from a philosophical or practical perspective. Often this mindfulness may have arisen as the individual midwife spoke of working toward being ready so that potentially within her practice she could avoid complaints as the practises that seemed to challenge her, she believed, may lead to that occurrence. Regardless of their practice context, as part of reviewing practice, the midwives in this study developed a sense or an opinion of practitioners and therefore were mindful of others.

As midwives reflected on their practice, they considered it in light of the practice of others. Midwives then made decisions about their colleague from their personal and professional perspective. For the LMC midwife, being mindful of others was an opportunity to be associated with likeminded clinicians as well as the opportunity to disengage from the practice of a particular LMC.

Joy explains that for her she needs to feel that she works with likeminded clinicians. From her perspective the midwives that she may need to call in to assist provide her with reassurance that they will provide the woman with good care

You know, I would have to work with midwives who are philosophically similar to me and also capable... When you have a relationship with a woman, a LMC relationship, well personally I have to feel that whoever is going to care for my women, (and to take leave), that they [the women] are going to get good care. I guess that's where it comes from.

And [as a practice] we debrief and we feel safe being able to talk to one another. So yes I think this has a lot to do with competence. If you have that expectation on one another who is not going to do it?

So what are your expectations of one another?

That we maintain a high standard of care and education. I guess, does like draw like though? Because I have to say all the people that I work with do ... are all involved in levels of education and being involved. Does like attract like? (Joy)

For Joy providing good care to women is more than her personal commitment; it is about a commitment from the people that she works with to adhere to the same standards of care and for personal development. That way Joy is reassured that the care that women receive in her absence would be of the standard that she herself would provide; and that should she need advice, then her colleagues are engaging in the same processes as she is herself so their advice is valued. This is a similar situation to Catherine who as a new practitioner receives the advice and support of her colleagues. This advice is offered by the midwives who identify the needs of the midwife who is new to practise:

I have to say my group, the two midwives that I am working with, they are very supportive and they are quite experienced and they have made it really clear that they understand the obligations of a... well not obligations... they understand the trials and tribulations of a graduate midwife and they have offered whatever I need in terms of support...

And do you reflect on cases and things like that or?

Yes, yes if there is something that is, that has cropped up and we are questioning a pathway we may have taken... Interestingly it's not just me that's having things that are coming from left field and "what do you think about this?" or so yes, yes we are. (Catherine)

For Catherine her practice partners have developed practice that is mindful of her needs. It appears that she works in an environment that supports her as a professional. Equally, her opinion is valued by her colleagues as they seek advice on matters relating to practice. Both Catherine and her colleagues are mindful and, like the midwives in Joy's practice, have respect for the knowledge and skills of others. With this respect comes the ability to engage in learning and to critique the practice of others.

However the practice of being mindful of others was not always performed in a positive light. Judith explains how she came to be a midwife and how because she is mindful of the practice of others she has developed an approach and a style of practice that differs from that of other midwives.

I wanted to work in women's health and it was about the ownership of something that is only ours, it [birth] is women's only and so we should claim it as ours and be as knowledgeable about it to make the best choices for each individual mum and baby and obviously that is obviously natural, normal, non-interventionist physiological birth wherever you choose to have it.

Whereas you see other midwives out and about who are taking eight to 10 women per month. I follow College guidelines about caseloads so that I can provide good care. You see other midwives who you know are interventionist and use medication and are very busy. I don't think they are competent because of my philosophy. But they haven't been struck off. Some of their women like them and they don't have adverse outcomes, on a maternal morbidity mortality neonatal [morbidity scale]... But I would consider the outcomes of their practice [high levels of epidural, or syntocinon augmentation] I would consider them adverse. (Judith)

Judith has a practice position that comes from a belief that for most women birthing is a normal life process and that women should be supported in their decision making around this process. For her to provide the quality of care that she wants, she places parameters around her practice and the number of women that she will care for in any given month. She is, however, mindful of the practice of others and she looks and reviews what she sees as the interventionist practice of other LMCs. She identifies that these midwives may practice with caseloads much larger than that which is recommended and that while she may not agree with their practice, she acknowledges that the women who attend these midwives appear to enjoy the care that they receive. In addition while they appear to engage in practices which are interventionist, and which she indicates support them in their busy practice, Judith acknowledges that on the whole the mortality and morbidity statistics that relate to these midwives are no different to the general population. Yet from her perspective, the large numbers of interventions that occur do not represent best practice. Judith therefore distances herself and her practice from theirs and acts in ways to ensure that her practice is not reflective of that of these midwives. Judith sees this as poor practice that she believes could lead to complaints. She bases her opinions on the conversation of others and from the women that she subsequently provides care for:

Yeah, I think definitely a different quality of care because, I haven't worked with them, so I am making a judgment from what you see and hear, or you get their ex-clients and what they tell you from their experience. But I think it's about neglect, which is not competent practice. (Judith)

Women relay stories that impact the opinions that midwives have of their colleagues. This adds to the opinion that they have or they create of one another. Judith has stated that clients advise midwives of their experiences of care, she was not the only midwife in this study who discussed the experiences of the women. Catherine describes how she gains understanding of the practice of others through her discussions with women, “You know I hear stories where people are being told things and I think “How on earth and why on earth did they think it was ok to tell you that? It’s

not even true.” Here she questions the accuracy of information with which women are presented.

This was a matter also discussed by Zoe:

...Sometimes when I listen to the explanations, like I booked a woman this week and the explanation that she had been given about her birth last time and the reason for the outcome... and I'm sort of going um... It doesn't make sense to her and it certainly does not make sense to me.

Midwives develop an understanding of the practice of their colleagues through their observations of their practice and through the conversations that they may subsequently hold with women. As midwives work towards being ready they identify the practice parameters that they personally want to have around them and the care that they will provide. Part of their professional positioning includes taking a stand on what they believe to be safe and effective care for women and then strategising to ensure that they meet their obligations and maintain their standards.

Consequence – Managing diversity

As they reflected on the care they provided, the midwife participants, in this study, also reviewed care that had been provided to women from their own perspective. They then consider what the practice of others means for them. By reflecting on their own practice and being mindful of the practice of others they are acknowledging, although not necessarily agreeing with, the diversity that exists within LMC midwifery practice. Once they identified that this diversity within practice exists they then strategise so that they can manage it and either involve themselves within it or ensure that their practice is not representative of it what they consider to be ‘below standard’ practice.

In this instance we see the midwife LMCs develop group practices with midwives that they want to practice with whose standard of work is congruent with their own. As stated by Joy, likeminded practitioners attract those with a similar position. By doing this they know that they will receive the support that they need from their colleagues. The other action that they take is to distance themselves from practices and practitioners that they do not support. By placing these boundaries around their practice and by managing their interactions with practitioners whose practice they do not support they manage the diversity of practice. This enables the midwife to be ready because she knows the practice of her colleagues and she knows they practice with a similar knowledge and skill base to hers.

Summary – working towards being ready for the LMC midwife

Practice contexts differ and LMC midwives choose the spheres of practice and skills that they need as they work towards being ready to provide safe and effective care for women. In order to do this they first identify the parameters that they place around their practice. They identify what skills they need and those skills that they do not need. They identify areas and types of practice that they will work in and adjust their professional position accordingly.

As they do this, these midwives identify the learning needs that they have that supports and sustains them in their practice. This does not get done without its challenges and LMC midwives need to consider the cost and time of education and development opportunities, and how this can be managed within their caseload and by their colleagues. They are also very aware of the needs of the woman and in many instances prioritise the care they provide to her over their own requirements. In doing this, they also reflected in depth and often on a case by case basis on the care that they had provided. Such reflection meant considering their position in light of the practice of others, motivating the midwives to ensure that the strategies they had in place supported the women and their position in practice.

As LMC midwives work towards being ready they know that they are viewed and reviewed by others. What they do and the actions they take, enables them to work towards being ready for whatever that moment may be.

Chapter Seven: Working toward being ready – the midwife working in the rural context

I have this strong drive to do what is right... and to keep up to date with what is happening. I don't want to be behind not knowing that I should be doing something different or [that there is] something that I am not doing. (Samantha)

Introduction

One of the most challenging contextual differences that midwife participants faced was the reality of providing care to women in rural or remote rural areas of New Zealand, as opposed to the midwife whose practice is predominantly urban. Working rurally meant that the midwife identified who she was as a midwife taking into account this geographical context. There were differences in how the midwife planned, organised and prioritised care; used available resources and reviewed and refined her practice. The rural setting brought different dimensions to time and distance and provided the midwife with a different perspective on what it meant to be continually **working towards being ready**. Rural practice was about being ready and being safe. It meant having the skills to manage an emergency with the ever present possibility of being the lone clinician. Rehearsal and awareness were vital in this context and the skill set that these midwives created highlighted the knowledge differentials between themselves and their urban peers.

In this chapter, findings will be presented that explain the way that midwives who may be distanced from advice and education, work towards being ready for the moment. I will present the strategies and solutions that these midwife participants reported they developed in order to ensure the safe provision of care to women. I will also explain the challenges they faced due to geographical isolation that impacted their ability to remain current with practice change. For the midwife whose practice is remote, in both a physical or professional sense, continually **working towards being ready** is about negotiating the multiple complexities that influence practice development which remains grounded in the environmental reality and is reflective of standards for best practice.

Positioning as a midwife working in the rural context

Working in the rural environment is not about debating whether to provide secondary or tertiary care. It is about identifying that as a midwife the practice context must be taken into consideration

as it impacts on the decisions made in the care that is provided to women. For the midwife participants in this study, positioning themselves as a rural midwife eventuated because they, and the women they care for, lived and practised outside the main cities. This was a personal choice. "Being rural" was superimposed on their professional position as either a core or a LMC midwife.

Rural LMC and core midwives working as sole clinicians face issues of solitude as they work towards being ready. For these midwives the significant contextual matter that they worked to address was isolation. For the midwife working in a primary setting, isolation was often from colleagues. This isolation combined with limited backup in the rural context superimposed on the midwife's ability to access and attend education. Further, opportunities to rehearse skills and for reflection with colleagues were limited due to relative isolation in the work place. In this way, midwives worked to develop strategies that kept them involved with practice in order to maintain their competence and ability to practise. Positioning themselves as midwives within the rural practice context meant defining the skills that were required and engaging in processes that promoted wellbeing for women.

Ellen works in a rural primary setting as a core midwife; in her practice she positions herself as a core employed midwife and as a rural practitioner. She is aware of the limitations that are present when she is working in her practice context.

Selecting the skills that you need in the environment that you are working as a midwife. I don't need to know how to do a CTG because we don't have one. Anyone who needs a CTG we transfer...

For instance if a woman comes in and she's got a baby and she thinks the baby is not moving much, we'll listen to the foetal heart, reassure her that it's there, talk to her about movements and if we have the slightest concern, ... 90% of the time we'll ask her to go to the [base hospital] for assessment. And it will mean going to the assessment unit and it will be a CTG and it will be a scan to assess the amount of liquor and it will be a full bio of the baby. Because for us to say "oh we can hear the heartbeat you're alright go home" would be the wrong thing to do and we are very aware of that. (Ellen)

Ellen identifies limits on services that are provided within her work context. This impacts the skills that she must retain and the care that she can provide to women. For Ellen being ready means knowing the boundaries of her practice as well as the services offered within the surrounding districts should transfer be required. From Flo's perspective, as a rural caseload midwife, being competent means being able to perform her everyday duties:

So when I say competent, I see myself as competent because I can perform my day to day duties, I understand the continuity and partnership model and relate

that through my practice. I understand my cultural competencies and can relate cultural needs and apply them to my practice easily. (Flo)

What Flo describes, from her perspective as a rural midwife, is no different to any other midwife. However, Flo works in partnership with women to ensure decisions they make take into consideration the environment in which she works and subsequent impacts on keeping the woman safe. Flo needs to consider the location that she is in and any physical or geographical factors that can impact on the safety of women within her practice. *“Being out on gravel roads with a pager that goes off and you have got no way of ringing that [woman] for another half an hour. Because you are way down near [a remote town] and nowhere near a phone” (Flo).* Because of lack of cellular coverage, some midwives use a tele-pager as a means of communication. However if the pager goes off they need to be able to call the woman when they are contacted. Flo describes the issue when she is out of cellular coverage for some time and her pager goes off. This means that she cannot immediately respond to the phone call. For Flo, **working towards being ready** in a rural area means that she has had to learn to manage these situations, to know when she will have coverage and what she must do if a situation eventuates. She must be aware that there may be times when she does not have the immediate ability to respond.

Flo identifies that being remote there are clinical matters that would not form part of urban practice, yet have become a feature of her practice due to diminished service provision in the area. In these situations midwives can become the proxy, or indeed the only professional, to address matters of poverty and poor health. The rural midwife may potentially require more in-depth education and strategy in particular areas than her urban counterpart. Flo, like Ellen, also sees that there are elements and tasks within her practice that urban midwives refer to other agencies. She describes the conditions she meets in her clients' worlds:

So there are lots of things that we don't get practice with [secondary] aspects of practice], but there are a lot of things in the rural setting that we get a huge lot of practice with, that a lot of other people don't tend too. And that is exposure to ... drugs, deprivation, you know putting babies in cardboard boxes because they don't have bassinets you know, and those sorts of things. (Flo)

Being rural presents challenges to midwives that they negotiate to ensure that they can manage in order to maintain their ongoing competence to practise with the requisite knowledge and skills. The distance from secondary practice means that an in-depth knowledge and understanding of skills required for secondary (hospital level) care, for example syntocinon augmentation for labour dystocia or epidural management of pain relief, may not be retained or required for these

midwives. But increased exposure to challenging lifestyles and economic situations with limited resources to alleviate these situations raises the need for enhanced education around the influences of poverty and addictions on pregnancy and birthing women. These midwives also need to consider safe passage of women when the physical environment impacts on care they can provide:

That last birth that I talked about that happened last week, while I was quite happy and I knew that the baby was happy in second stage, I felt quite nervous that we were actually trapped in a rural situation. (Flo)

Weather conditions meant that if the mother or baby needed assistance during the birth, transfer may not be possible. For Flo, therefore, **working towards being ready** in remote practice means that she needs to have heightened awareness of such eventualities and feel confident she is able to manage care whatever might eventuate. In addition to the physical challenge to provide care midwives working in rural areas face the need to source and access specific targeted education or professional development that meets their needs.

Being located in a rural practice or working in a state of professional remoteness presents challenges to midwives for which they need to identify contextual solutions. Opportunity for skill rehearsal is more challenging. In order to ensure that they were able to retain their practising certificates midwives working in remote rural practice identified the specific needs that they had, and for which they needed to strategise, to meet.

Identifying needs

The midwifery recertification programme does not take practice context into consideration; it is a one size fits all type of programme. Midwives working in rural practice, regardless of their status of employment, are required to meet the same requirements as their urban colleagues.

Identifying other areas of development and capability that need to be enhanced can be problematic under the conditions where systems or process matters influence attendance. Becky explains how she identified the need to attend specific education which would meet her learning needs and assist her to provide appropriate care to women in her community. She demonstrates, in this excerpt, that meeting compulsory requirements of the recertification programme and contextually identified learning needs can be challenging in the rural environment.

Certain parts of the education is compulsory so it's already identified for us. Depending on ...what my needs are for our particular area with the primary unit.

Some of the courses haven't been easy to get into, like the smoking one²⁶ I tried for a couple of years actually to get in and they were just fully booked and there weren't many of them, then I happened to be away [when a space was available].

I felt that was a need because we've got a high number of smokers in our area, young women that smoke so I felt that it was one that I really needed to do and also the domestic violence one as well because we also come across women that are in situations in our area as well ...So really depends on if I feel I need to do the course if it's going to help with my practise with the type of clients that I have there in [the area]. (Becky)

Factors that impact Becky's ability to attend education are travel, frequency of education and her physical ability to attend. When face to face education is provided on a sporadic or once only basis then other factors need to be taken into consideration and managed in order that upskilling can occur.

For midwives in remote areas emergency preparedness was a key factor they identified that enabled midwives to provide appropriate care for women. The midwife participants, regardless of their practice type and setting, all identified the need for regular focused education on this topic. When describing this need, the midwives revealed some of the tensions that they faced when dealing with emergencies. These tensions highlighted the challenge of remote practice and included limited availability of other health providers to assist, which meant the midwife had to make a referral to another service with subsequent additional travel for the woman and midwife:

So I had to transfer this woman I couldn't take her to [a town] because the locum that we had at the time...said to me "Flo I am not doing a Caesar I am on the plane in half an hour, so you will have to take her to [another city]" which was another two and a half hours from where I was. (Flo)

For Flo this issue was not just about her knowing and being prepared for a situation. Safe practice relied on her identifying the need for transfer of the woman and then being able to achieve this goal. As it did not eventuate in this situation, the consequence was a delay in the woman receiving care that Flo believed she needed. Competence often involves the readiness of the team to act, not merely the skill level of the midwife.

Strategising to meet learning needs

Midwives in remote areas used strategies in order to remain competent to practise. For them isolation meant that they had to take additional matters into consideration that often may not be

²⁶ Course in smoking cessation.

considered by their urban counterparts or by their colleagues who practice in settings where there are multiple people able to assist.

Meeting needs

The rural midwife considers and negotiates time, resources, back-up, personal situations, cost, and communication, as she attempts to organise education which enables her to continue to practise. She considers and prioritises mandated activities versus her own personal education needs that are relevant for her current situation.

Time and distance are key in decision making within rural practice. Managing travel is necessary for these midwives when they attend education. In addition, in areas where there are fewer midwives able to provide cover, this can lead to issues pertaining to freeing up midwives to engage in professional development opportunities.

Becky describes the challenges she faces working rostered shifts as a rural core midwife. She advises the difficulty that can be experienced when she needs to attend education, but where there is only a small number of staff and no one is available that can work clinically in order for her to attend. The other frustration that can be experienced is the impact on poor communication practices when midwives travel large distances to attend education and then discover that it has been cancelled. While this is annoying for the participant, the ramifications can be extensive for the midwife, the education provider and potentially the organisation. There are many activities that midwives need to negotiate in order to be able to attend education such as, booking the education, arranging cover to attend, and personal factors like travel and family commitments must all be taken into consideration. To discover that a course is cancelled or that it does not meet all of their needs has implications. It requires rebooking, rescheduling, rearranging a roster, and reorganising back-up; in other words, going through a laborious process all over again. Travelling to attend education can mean that there are additional cost implications for the midwife:

Well most of the courses for us are done in [a city] so it's a travel thing for us getting the time off. Sometimes I've been rostered on, so that no one else, I can't get anyone else to work for me so I can't go to that course. Sometimes with the compulsory ones you have to go and it can be a bit stressful trying to find somebody to work your shifts if you've already been rostered for them.

...Just getting there and sometimes it's happened to me before where a course has been cancelled but nobody let me know and you get all the way up there. That only happened once but that was frustrating.

Generally we have to go out of our area some of the compulsory the CPR has been done down in [our town] but the last session the person who was doing the infant couldn't make it so it was a bit of a waste of time really. Planning your whole day around [education] and you only got the maternal one [resuscitation].
(Becky)

Becky expresses the tensions and frustrations she experiences trying to meet her education needs. If cancellation occurred for a compulsory course then this can mean that the midwife has not met her obligations. The consequence is that her ability to obtain a practising certificate and continue to work may potentially be hindered.

Samantha explains that she got what she calls a “red tick” against her name because she was unable to attend a course due to specific clinical circumstances, *“I ended up having a red tick next to my name until I could get to the next one which was the following year.”* The circumstances, in this instance, were that clinical care was provided by Samantha who was one of very few midwives in her location to provide home birth services. The clinical situation took precedence over the requirement for the midwife to attend her education with the consequence being that from her regulators’ perspective, she was not up to date with mandated requirements. The consequences could have been more dramatic should a situation arise when Samantha’s practice was put into question as the delay in attendance, although due to circumstances out of her control, could potentially reflect badly on her in a situation where her practice is questioned and challenged.

For Samantha, working in a rural setting, the reality was that mandatory courses were held once or twice a year. By prioritising the woman’s need and meeting her practice obligations, her ability to achieve the mandatory professional education obligations was impacted. For the rural midwife the key issue that differs from her urban counterpart is the relative availability of education. As described in chapters five and six, midwives make the judgement call and remain with the birthing woman. In the example provided by Samantha there were further issues that needed to be addressed in that while she was not the only LMC available the day the woman went into labour, she was the only midwife who offered home birth services. In this regard she had a professional and ethical duty to remain in the area and provide care for the woman. This was at the expense of her own engagement in mandatory activities and potentially placed her in a compromising position.

Lack of education in rural areas was a matter that was raised by a number of midwife participants.

I am juggling my life and my business and these factors as well. And also the reality of the practice, I might be in a rural area and there may be only one education course that year. And I have to do that, [but] “oh my woman is having her baby today”, you know there is all those sort of factors. (Catherine)

Although not a rural midwife, Catherine reports that she juggles many factors in order to remain competent to practise. A lack of educational opportunities further impacts strategies that midwives need to develop; a matter that was reiterated by Belinda who also mentors rural practitioners:

If you have to exit your area to commit to going to education or if you really, really need to be unavailable to your clients then as you said there are practice issues, but there might also be professional issues for the midwife, abandoning her clientele, personal issues involved with family.

And I have been involved with mentoring graduate midwives in a [remote area] and that is a really significant issue for them. ...in order to achieve their education in [a city], they really need to leave the area to do it. And it has implications for their practice, quite significant ones. (Belinda)

Belinda explains how, from her perspective as a mentor, there are implications for practitioners who need to leave their area in order to attend education. These implications are both for the midwife, who may have a sense of abandonment towards the women she provides care for, and her peers, who may be required to provide extended periods of cover should she need to relocate to another town in order to attend. There is, therefore, a sense that in order to attend education, midwives develop strategies that are dependent on the goodwill and collective agreement of the practice and the locality; not just the individual's needs and requirements.

Consequence - managing access to avoiding trouble

For the rural midwife participants in this study there were a number of strategies they utilised to ensure they were able to engage in required activities. Regardless of their mode of practice they took the responsibility to ensure these needs were met. However, the problem they faced was, often development opportunities were not provided in a way that took their needs and circumstances into consideration. Infrequent provision, inadequate numbers of providers offering traditional methods of face to face learning, and travelling distances to attend suggest that they experienced issues with access. Poor access means that there is a delay in learning which again impacts midwives' ability to maintain competence to practise.

When the decision is made to provide clinical care over attending education, when the education is offered occasionally, the consequence is that engagement in activities is not at the required frequency. By getting a “red tick”, as Samantha states, a midwife will be brought to the attention of those people who monitor engagement in the recertification programme and who eventually consider applications for practising certificates. Rural midwives develop strategies that allow them to meet these requirements when opportunities for education are limited. Education providers conversely need to consider new and innovative ways to provide learning, as well as plan and develop contingencies to meet the requirements of clinicians.

That's another thing we find sometimes. You do them [courses] and you have to chase along the people who have taken the courses for us, to ensure that they have gone through to the Council²⁷. Maybe that is our responsibility but I did specifically ask at the last course, because I did a full day neonate update because it was only one that I could get into to, it wasn't due but that's okay. And we were told that they did notify the [Midwifery Council] directly but I notice that it [update of record] hasn't been done yet. But that's okay. (Joy)

To ensure that she meets the requirements, when options are limited, Joy has completed education over and above what is required of her. To avoid any “red ticks” she has also undertaken this education in an earlier timeframe than is required. However, she developed another strategy of following up with administrators in order to ensure she remained in good standing.

By **working towards being ready** these midwives are managing the parameters that sit around their rural practice. They are engaging when they can; however there are challenges that they face in a situation where there are multiple needs yet limited access.

Supporting colleagues

When there are few clinicians and few freely available resources midwives sought the advice and the assistance of their colleagues. One of the strategies used by the midwife participants was to access and provide information to colleagues. This could be in direct response to a specific question asked by a colleague; for in these situations the midwives were, appropriately, the resources that other clinicians came to when they had issues with practice:

Midwife comes in [to the primary maternity unit] “my lady's got a thing called so in so and so in so.” “Really! I haven't heard of that one, no I haven't heard of it either. Google!”

²⁷ Course providers are required to send a list of attendees to the Midwifery Council so that individual records can be updated.

We google a lot, we do we google a lot. We try things that are often out of our scene often because of the fact that they are often medical issues... If I don't know then we will google it. (Ellen)

Ellen is describing a hypothetical conversation between two midwives that could occur when one seeks information. In order to support her colleagues, if Ellen does not know the answer to the questions, they use tools and resources that are available to them at the time and from her place of work. Ellen explains that often the questions or scenario arise out of practice issues that are more medically focussed. By supporting her colleague and finding an answer to this need from practice both Ellen and the midwife are **working towards being ready**. Other midwives access information databases as they attempt to be ready: *"I sometimes just look up on "up to date" and then follow up with things that come up"* (Samantha).

Other midwives take the opportunity within their work time to access information resources that are available to them. Becky indicates that she has the time and is able to read and review resources while at work, something that some of her colleagues working in larger units are unable to achieve:

I find that I'm always sort of reading stuff at work or we get a bit of down time quiet time so there's always plenty of things to be reading. There always seems to be stuff coming from everywhere overseas. Sometimes I go on the Australian website, the college over there, and just have a little read of what's happening over there, yeah so it is something I am doing on a fairly regular basis. (Becky)

For Becky, work time is also time for study and she acts in ways to keep herself informed of both national and international change. Ellen also has taken on the role of a resource person for those midwives within her practice area. She advises that:

At the moment the librarian at the [base hospital] sends me some contents pages so that I can pull out articles and I put the articles out for people to read. I have no idea whether they read them or not but I put them out there. I also sometimes say to some "oh look at this it is really interesting." But you can lead horses to water but you cannot make them drink. (Ellen)

Ellen is supporting colleagues by providing them with resources that could be of benefit to their practice. Using traditional hard copy journals, Ellen reviews the journal contents pages and in an attempt to provide her colleagues with information sources articles that, from her perspective, are of value to the practice of other midwives. She provides this support in order to assist midwives to enhance their practice. This is a noble strategy and one that is used by midwives in other areas. However for Ellen, there is no feedback mechanism as she has no idea if these resources are seen or valued by her peers and those that she is trying to assist. It seems that this good will

gesture may potentially benefit midwives but, without structure around it, this can be a wasted exercise. In addition, perhaps unintentionally, Ellen is providing information that she perceives to be relevant, so rather than assist the midwives to learn how to obtain the information themselves she controls content through her selection process.

Regardless of their motives, midwives working in rural areas identified that with limited access to in-service education and information, they were the resources for their colleagues. They developed strategies, therefore, that both assisted themselves to be 'ready for the moment' and supported and informed other midwives with whom they worked.

Structural conditions impacting on working towards being ready

Midwives working in rural or primary units identified that there were structural conditions that impacted on their ability to be ready. These included information systems, input into policy updates, consultation regarding appropriate rural policies, access to update meetings, clarity of policy interpretation, and differences in role boundaries. The presence of these conditions affected the way in which they were advised of, or included in, processes which assisted them to be ready. Many of these challenges related to a need to be informed or advised of change regarding educational opportunities. For the midwives working in these primary or rural environments there was a sense that practice and information was very much centred round a larger hospital and that structures and processes needed to be in place so that they could be informed. Needing to be included was paramount if the midwife was to be able to plan and engage in being ready.

Flo, who when asked how she kept up to date with changes in practice, advised that despite taking the time and making the effort to travel some distance to attend education or meetings she still needed to remind those midwives working in facilities to ensure that clinicians outside the main environment were kept informed.

Probably through my networking ...I do feel that, and even today, I had to remind [the educator] "you guys don't send us things." "Ah well I would if I remembered." "Yes you guys have to up the anti on this, we don't get half the stuff that we are meant too, we don't get informed of the changes in policy and the only reason that we do is that I end up going to monthly perinatal mortality meetings."

I am a member of the maternity safety and quality locality group meetings and I try to get to the LMC meetings. So if I didn't do that and feed back to the rural we wouldn't know half the stuff we know now. And I do think that rural still get forgotten. (Flo)

Flo is recounting the conversation that she has had with an educator in the facility that she accesses and to which she refers women. In this statement she is expressing her dissatisfaction with communication processes that are in place within the facility. Importantly she explains that she is not informed of changes in policy which may imply changes in practice for midwives. She states that she and her colleagues, who are not based within the town or who access the facility where decisions are made or where policy changes are introduced, are dependent on her travelling to the town to attend meetings in order that they can be advised of change.

While within this team of midwives this strategy has been devised it is conditional on midwife availability, ability to travel and ability to cover cost to attend meetings. Should one of these factors not be present then the implication is that this group of midwives can miss out on key changes in policy or information from within their place of practice. For these midwives being ready for the moment requires that they be able to attend and be present at a main birthing unit. Should this not be an option, then there are challenges for communication to occur.

Becky, in comparison, explains that as a core midwife in a rural unit she does have access to policy review and information sharing processes. For her the challenge comes when she must inform others of the changes and requirements that she believes are necessary in order to keep her safe as a practitioner.

Well policies are reviewed, ...and we have input into that they do come out and say well this is a draft everyone look at it and see what you think add or make any comments. ...Most of them [the policies] are probably more for our base hospital rather than our primary unit and they don't always apply they'll take a little section in that includes the primary unit. Some of it does seem a bit over the top. (Becky

Becky advises the process of policy review briefly highlighting that from her perspective a large amount of information within the policy is not relevant to her work and practice. However for Becky, policy review can be used as a tool to inform other midwives of actions that may be required.

I have had situations where I've got the policy out showing the LMC midwife [what it] says in the policy that you need to transfer. Her response, "oh I'm not transferring you know." Then I've got my policy here and well you know you need to consult at least. Her response, "Well I might think about it" ... So you can raise a bit of conflict like that at times, and I just say "well look I'm not happy to continue the care until you've consulted and you've done something of a care plan for me".

You don't want to sort of go down that road but it does happen on occasion where people choose not to follow [policy]. So that can be a bit of a tricky one.
(Becky)

Becky identifies that for her to work safely she needs to be informed of policy. In order to do this she takes the time to engage in the process of development. In her place of work strategies have been put in place to ensure that those employed midwives working in rural areas are part of the process of policy development. While Becky does see that elements of the policy may not be relevant for the women birthing in the primary unit, for her having access to the policy gives her a strategy that she can enact to protect her professional safety. Becky is aware that some of her colleagues may be unaware of the policy. She uses the policy as a tool for her professional protection and takes the opportunity of using policy as a way of informing colleagues of expected standards of practice. In the above situation Becky has brought the policy to the LMC for her information and action. Becky advises that the discussion that follows is focussed on keeping the woman safe, informing the midwife of the policy requirements and keeping Becky safe in her professional role. When asked later what other strategies she enlisted if she believed that there was a lack of informed choice by the woman she advised, *"The only other option, if you are really feeling this is really not safe, I would probably give the woman the policy to read. Her and her partner; because maybe she hasn't been given all the information about what's actually going on."*

Becky and Flo have both described challenges that they face when accessing information. For Joy, another rural midwife working in caseload practice, the challenge is also about the cost of receiving information.

They even charge to park the car in the car park... and we are going there for our professional development. The thing is never ending and we've got the access holders meetings and the other meetings that we are called for. If I work out the hours that I do voluntarily in my own time. When you get a wage and you are paid Monday to Friday, you are going [to meetings] in your paid time. ...Our time is precious... it all starts to add up. (Joy)

Joy knows and understands the importance of being informed and aware of changes within the larger facility and with practice. In order for her to attend meetings at the larger unit, there is a cost. That includes both the physical transport cost and others associated with travel. As a self-employed practitioner attendance at meetings is in her own unpaid time. As Joy states, the unhidden costs of keeping informed is more than the cost of transport and parking.

For Becky the challenge is not so much her ability to be aware of the policy and the change but of ensuring that those with whom she works or provides care for are also informed of the policy. These would be LMC midwives such as Flo and Joy. For Becky the emphasis is on sharing the information so that all can be aware and on an equal footing. However, for the midwife who is not advised, there is a delay in information sharing that can and does impact their ability to be ready for the moment. If there is a delay in information sharing then they are inadvertently dependent on their colleagues being informed and being aware of both skills and emergency procedures and policy and process.

Mia advises that in the unit where she works, a formal feedback system is in place to ensure that after midwives attend education they feedback to their colleagues, "*We have good feedback sessions if people have been to study days or things have changed. We have good ways of communicating with each other*" (Mia). Being away from the main facility has been overcome through this feedback mechanism. Formal feedback systems enable the midwives to continue to work towards being ready for the moment, with the consequence that new knowledge and information is shared. A strategy also used by LMC midwives includes "*sharing you know something that we have read or the latest thing we have heard or read and tying that into an event that is possibly coming up or that we have been through*" (Samantha). There is a sense, therefore, that sharing knowledge is a collective responsibility between midwives in order that all can maintain competence.

Policy change is continuous and can and does impact on practice. For midwives to be aware of change they need to be included and involved in this process. If they are not included or are not able to engage then the consequence in this situation is that they do not keep up with what is required and they may not be ready for the moment, whatever it may be. Processes for information sharing and knowledge translation need to be embedded within practice and with identified communication strategies that include acknowledgement. Without these simple solutions the challenges faced by midwives, as they attempt to be ready, may be insurmountable; with the obvious consequence that instead of engagement with change there is withdrawal. The midwife participants identify that they do have a professional responsibility to maintain their competence and so, regardless of their setting, engage in processes of education and reflection that assist them to ensure that the care they have provided is meeting the needs of their birthing population.

Consequence - creating knowledge differentials

Midwives acknowledge that they need to engage in learning and development. They also acknowledge that they want and need to be advised and informed about changes that occur in both national and local practices. To do this they develop strategies that enable them to be advised or appraised of information. To ensure that they are informed of change there can be a cost for midwives who are not employed. Being informed is also dependent on good information structures and processes being in place. If these are not in operation then it presents barriers to midwives receiving information. Nevertheless, the onus is professionally on the midwife to ensure that her practice is informed by evidence and that she keeps abreast of change. When there are deficiencies in communication pathways this impacts her ability to maintain currency. Further, if attendance at education is not able to be achieved, the consequence is that the midwife may not have the most current advice or practice around an issue. The subsequent consequence is that practice does not develop and change. This results in a knowledge differential between those that have the current knowledge and skills and those that do not; with the ultimate impact that women may not receive best practice advice and care. This is a serious consequence and although the midwife participants in this study had all developed strategies to ensure that they were informed and aware, examples were provided where midwives had to provide direct advice regarding process change to those midwives who appear to have missed changes to practice.

Rehearsing for practice

Being away from the main centres had implications for midwives with regard to the provision of resources and education. Midwives working in rural areas negotiated with other areas for resources so that practice could be rehearsed and refined. Ellen describes how in the unit in which she works the midwives identified the need to practice the skill of cannulation. They were impeded in this ability because they did not have direct access to the correct equipment with which to practice. In order for all midwives to have access they negotiated for an appropriate model to be provided for a sustained period of time which allowed the midwives to rehearse this skill.

We don't cannulate often either so maintaining that is a skill that is quite difficult and the woman that used to come down and go through it with us only had a hand²⁸. Well a hand is useless if you've got someone who is pouring blood, you need an arm²⁹. So we finally managed to get [a private provider] to buy one for [the DHB] so now we bring that down to the primary unit for a month and we

²⁸ A model used to practise the skill of cannulation.

²⁹ Another model used to practise the skill of cannulation – allowing access to other veins that can be used to complete this procedure.

leave it so that everyone can practice on it. So we do that sort of thing to try and keep up those type of skills. (Ellen)

Access to appropriate practical education can be problematic for midwives working in rural areas and they develop strategies that allow them time and the opportunity to refresh and enhance their skills. By doing this they are **working towards being ready** and in one way have refined their emergency preparedness skills. One of the key factors that the midwives identified was the ability to hold appropriate emergency skills education in their own environment. This was often real time education using equipment and resources readily available in the facility; it could be inter-professional so that all who could potentially be involved were prepared. Midwives working in these areas deemed it essential that these skills were rehearsed within the context of their environment to assist them to be ready:

I think some midwives working in base hospitals are very reliant on a multi-disciplinary approach to emergencies but [away from a] base hospital we don't have that luxury and we are it at the end of the day. The response we get from other people on site is very variable we can't rely on that. So the buck stops with us. So I think it is extremely important to keep up with those skills. (Mia)

For Mia rehearsing emergency skills is essential, as she describes the response from other non-midwives that she would receive in an emergency to be variable. For her **working towards being ready** means that she can effectively manage emergencies in her environment, because she acknowledges the variation in skill set that she might receive if she needed to call for assistance. It could be, in Mia's case that those called to provide assistance may not be doctors knowledgeable in obstetrics.

Attendance at emergency education was seen as being vital and, as many of the midwives have described, could be challenging. In order to overcome this, the midwives both negotiated within their practice so that attendance could be achieved and strategised to ensure that what was taught within these sessions was relevant to all:

So we swap and work around our shifts, so that they can get to their education as well. The other thing that we do as well is hold workshops at [our local facility] in our rural centre ...so that we don't have to travel.

Earlier this year we had a neonatal life support and an emergency skills workshop day and [other] midwives came to us. So it takes a fair bit of organising amongst the whole lot of us... my working colleagues and so we really have to plan things so that we can each accommodate our learning needs. (Flo)

For Flo there is sense of responsibility to ensure not only that attendance can occur but that they had the ability to make certain that when relevant education was provided it could be accessed by a number of midwives from different areas.

While the location of the primary unit in which Mia works is not classified as remote rural it is still a considerable distance to physically transfer a woman to a secondary or tertiary facility. Outside business hours, she or any one of her colleagues is the sole midwife present in the facility. In this isolated practice Mia needs to ensure that if there were to be an emergency she and the people who assist her in the facility would be aware of what to do. She explains:

We have got the "Prompt"³⁰ course coming too, so I think that's vital to have emergency-type scenarios in our own workplace... It is all part of teamwork and we have got duty managers³¹ coming to the next 'Prompt' course, which is who we rely on to run and get stuff for us and they need to know where things are in an emergency. And we get a better response attendance-wise if we have them [courses] in our own unit rather than in a base hospital where we are working with people that we don't usually work with. So much better to have our own team, fully confident and working with each other in our workplace. (Mia)

Despite the midwives' needs and desires in working towards maintaining essential skills in the rural or sole primary situation, there can be a mismatch between organisational understanding of the need to be ready and the professional's own understanding. In the previous example, Mia describes how in her unit other health professionals are also enrolled on courses so that they are educated to assist the midwife in emergencies. By including these other professional groups there is a feeling that the midwife who needs help can be assisted by others who have also received knowledge. Not only that, but by holding courses within the actual unit they are focussed on real situations with real personnel as experienced in that context.

This strategy of ensuring appropriate education and then rehearsing enables the midwife to be ready in the knowledge that those she may call to assist also have knowledge and skills. These structural conditions of isolation and organisational versus professional understanding, impact the midwife's ability to be ready for the moment. The organisation must prioritise its needs and service provision which may differ from that of the midwife.

³⁰ Practical Obstetric Multi-Professional Training – a multi-disciplinary obstetric emergencies course provided by different DHBs across New Zealand.

³¹ Nursing managers responsible for the after hours management of the hospital; in an emergency can be first responders.

Those midwives who work as LMCs also identified a need and desire to attend emergency education which they believed to be of benefit and that would allow them to maintain their competence to practise within their environment. However, notwithstanding their understanding of appropriate time and place, the cost of education was often a barrier which limited attendance. While in the first situation the midwife was grateful that other health professionals were skilled so that they could assist, in this example we see, from Joy's perspective, the organisational requirement for payment for the course is a barrier for midwives to actually attend.

You know recently there was a "Prompt" course out at [a primary unit] and I had just done my midwifery review [MSR]. I had been away... I didn't inconvenience my colleagues. I didn't take people [women due to give birth] three weeks either side of that date [time away]. That's no income coming in, I had my midwifery review, I had a whole lot of costs.

I put my name down for the "Prompt" course and when it came up we were going to be charged \$150 for that as well. I am actually going to write a letter to the DHB because I thought we are a rural hospital, when there is an emergency ... we all go to help. It's not about whose woman it isn't.

They [the DHB] were doing the course anyway. We just saw the cost of it and just said honestly at the moment that is just too much. So I would like to see some more cooperation between the DHBs and self-employed midwives who are using primary care units and some sort of way of them acknowledging what we do for them. Going to all their meetings, input and things. I would love to see some sort of way that we can work that out a bit...

That is the whole point of those "Prompt" courses, you are all practising and singing from the same song sheet. That for me would be a wonderful recognition of the fact that we work in a primary care unit... Yes I would just like to see a little more partnership with that with the DHB and us really. (Joy)

As Joy has explained, when faced with an emergency in rural areas there is no delineation of responsibility; it is an "all hands on deck" approach in order to assist with the emergency. Midwives do not refuse to attend and provide care for women in these situations because they have the professional integrity to know that they have an obligation and duty of care to provide assistance to whoever needs it when emergencies occur.

While Joy appreciates the benefit of attendance at the emergency course she questions the course fees. From her perspective, in these situations, she gives her time and energy to assist the midwives in the facility; yet she identifies that there is no reciprocity from the provider of education. Joy explains that working as a LMC, as explained by the midwives in chapter six, she is responsible for funding her own professional education and therefore she makes decisions to ration the education that she attends. Like Flo and Mia, Joy appreciates when education is

provided in her rural setting as the benefits are numerous, beyond those relating to finance and time.

Yet, Ellen reminds us that not all education needs to be formal and by using the example of shoulder dystocia identifies how she reviews this for her own learning needs. Being in a smaller rural primary unit means midwives' exposure to certain events may not occur with the same frequency as colleagues who work in urban secondary centres. While this suggests that risk management strategies have gone some way to mitigate risk, and that appropriate guidance has meant that women with a potential to have a shoulder dystocia do not birth in the primary environment, the reality of shoulder dystocia is that the occurrence can never truly be predicted. Therefore, midwives need to be prepared for the situation should it ever arise.

It's been a couple of years since I have done a shoulder dystocia so because I haven't done one for a while I may just go read the book and have a look at the diagrams and just remind myself of how it works. (Ellen)

Self-responsibility for maintaining competence regardless of context is key for midwives working in rural and primary areas as they are continually **working towards being ready**. Yet is reviewing technical procedures in a book acceptable? For Ellen this review would be over and above her attendance at a practical hands on skills session that would reinforce those skills that she has the ability to rehearse. Yet in this situation she presents her reality that exposure to emergencies is rare, rehearsal of techniques outside of mandatory education is limited and midwives must engage in additional learning activities to refresh these skills.

By strategising and developing innovative solutions these midwives are **working towards being ready**. They engage in this process of learning and development; they develop skills and expertise and, therefore, act in response to the specific needs for their context. The consequence is that they develop skills and expertise that differs from their colleagues who work in the main facilities and for whom help with decision making, advice and skills are easily accessed.

Reviewing practice

I think reflection is a very personal thing. But it is necessary. And you need to look back and look forward and keep moving. (Mia)

As part of **working towards being ready** midwives valued the importance of reviewing practice, self-reflection and peer review from trusted colleagues. Yet strategies for seeking and providing

feedback are essential when day to day one can be at a distance from one's colleagues. For midwives working in rural areas, their feedback mechanisms and the colleagues that they turned to were often the midwives with whom they directly practice. For Flo, reviewing practice is about having informed colleagues whom she trusts and who understand both the context in which she works and the practice of midwifery – be it from a distance.

I think that when you reflect with a midwifery group or with a midwife you learn so much more and you have to have that relationship too though with that midwife 'cos you don't spill the beans to someone that you don't know.

And so for you to have that honest reflection you actually have to have someone that you really do trust and I definitely think that we have built this up amongst our practice. (Flo)

Reflection, as part of group practice, was essential for Flo; to be able to do this the midwives trusted themselves and their colleagues. This was also an essential support mechanism for Joy, "You see my group meet very regularly and we will always debrief after a birth always, and reflect about it and talk about it." For Joy, reflection on practice occurs on a frequent basis, it is a support mechanism that allows her and her colleagues to continue to practise within this rural context and is an integral part of what it means to be a midwife. Joy's practice is as a LMC; for midwives working in rural units as core midwives continuous reflection too occurred in and around the work environment.

I think we reflect all the time every day. You know you've been to work and [something] happened. You think okay could I have done something different there? Or that went well or if I'm a bit worried about a baby I might ring later and see what's going on. It's a constant thing really. (Becky)

For Becky reflection is continuous as she thinks about practice while she is in the clinical environment and looks at the care that she provides in the moment. She considers what aspects of practice, if anything, could have been completed differently. This too was reiterated by Mia who describes how the reflection occurs midwife to midwife between shifts.

I think a lot of reflection happens in conversation in the day-to-day. Have we done this? Woman and her baby - have we done well by them, have we achieved what we wanted to do and she wanted in working together? I think that happens every day, even in handovers between shifts. (Mia)

For Becky and Mia working means being the only midwife on the shift. They must, therefore, be able to make decisions about practice matters. At the end of their shift they walk away from care and hand over responsibility to another clinician. This does not stop the process of reflection. For Becky there is the opportunity to call and ensure that decisions that she made were the right

ones. For Mia reflection occurs at the handover to the next midwife as a process of validation and acceptance.

For rural midwives, working in this clinical context means that there is limited access to other clinicians with whom to discuss and reflect on practice. As demonstrated through the above quotes, in order to engage in reflective process, midwives sought time with their colleagues which could be one on one at handover or as part of regular practice debrief following a birth.

Yet because of the isolation, midwives in rural areas turned to others, away from their practice, for advice and support. *“I seek advice from my colleagues... we talk often, and definitely midwives [from another town]. But I also have always talked to [the unit manager] as a senior midwife, I guess she has been a quiet mentor really”* (Flo). Flo has options available to her to review her practice, those midwives with whom she works on a daily basis, another group of midwives from outside her locality and then finally, when she has needed to, she has sought advice and assistance with review of practice from another midwife some distance away. This person has become an informal mentor for her. While rural based midwives describe engaging a mentor, other urban based midwives in this study identified that they worked as mentors for new graduates, who were working in the context of rural practice, and for rural midwives practising beyond their first year of practice.

I have been a rural mentor for about 18 months. I am very much involved in the mentoring aspect of our profession which has been an amazing experience. I just think it is great. I have learnt so much from the person that I mentored. It definitely helped me in my practice. I think she got benefit from what I shared with her and I very much felt that I was a listening ear. I feel that at this stage in my career I am happy to sit in this chair. I don't have to provide people with solutions and answers I can guide them to learn something. I was mentor for 18 months for a very rural based practitioner and the many complex issues that she faced due to geography and the area that it was in.

I am currently the mentor under the first year of practice programme. So I've been doing that since February. It is a whole new experience. To guide somebody just as they are entering practice it's just a completely different type of mentoring whereas the person I had mentored before had been a midwife as long as I had so it was different. (Mary)

Mary has identified the differences in practice that occur because of the physical limitations placed on rural practitioners. Mary is an urban midwife who sees the benefits that can be brought to the practice of others by listening and guiding midwives. Rural mentors bring a

new perspective to practise that allows for reciprocal teaching and learning to occur and can potentially reduce barriers to knowledge and information sharing.

Regardless of their context midwives working in rural practice engaged in a process of reflection with their peers. Having the opportunity to discuss practice either formally or informally with peers or with either a formal or informal mentor, was one way that midwives worked towards being ready. This gave them access to support and reinforced or challenged them on the practice decisions that they made.

However additional tensions that presented for these midwives referred to situational risk. From the perspective of the rural midwives, because of the delay in knowledge transfer and professional experiences, they identified that some of their colleagues may approach a clinical situation without the same level of understanding of the situation or of the process. For these midwives there was often a heightened awareness of the practice in which they had to engage which was based around their situational context of sole practice.

I don't know if you have ever read Marion Hunters' Masters' thesis³², it was about primary care units. And one of the comments there, some of the experienced midwives at the base hospital said there is no way that they would work out in the primary care unit... you know! Because they've seen so much and they can ring a bell and someone can come answer that bell.

I think the primary unit has managed to train quite a few midwives who have stayed working in the area. What I think, what working out there does, is that it teaches you that you actually can deal with these things. That you have got the skills, that actually you have got the backup and the support and that probably makes you more conscious of maintaining your skills as well. Perhaps because you know that you cannot just press a bell and somebody will come. (Joy)

For Joy the onus lies with the individual midwife to ensure that she is ready for the moment. She sees that because midwives working in rural areas know there are limits on the skills that can assist them, they have developed their skills to reflect this. Becky, a core midwife, develops strategies where she works to mitigate risk regarding the practice of others. When she identifies that another colleague may practice outside of her own set of professional boundaries, she uses the accepted policy to negotiate with the LMC and, at times, sets her own professional boundaries even though it may cause conflict in the work environment. Becky identifies that she needs policy around her to support her practice and to keep her professionally safe.

³²Hunter, M. (2000). *Autonomy, clinical freedom and responsibility: the paradoxes of providing intrapartum midwifery care in a small maternity unit as compared with a large obstetric hospital*. (A thesis presented in partial requirements for the degree of Master of Arts), Massey University, Palmerston North, New Zealand.

Becky and the other rural midwives work alone; they work in isolation. The only discussion they have with colleagues can be at handover in the facility or when a LMC visits the unit. As midwives working in this area they need to feel professionally safe. This could mean that they ensure that they attend education sessions but also that they have the policy and guidance at hand to support them.

Working in midwifery practice requires the ability to negotiate boundaries and to allow for the midwife to engage in a degree of clinical reasoning. The midwife must demonstrate her ability to her employer and the Midwifery Council. In reality, the expectations of both agencies may differ which leaves the midwife negotiating expectations and employment conditions.

But it is a matter of continually reviewing what you are doing. And you are reviewing what you are doing and do I have the knowledge I need to do my job? So you are actually reviewing yourself and that is where the review and reflection comes in. I don't necessarily think it needs to be written reflection.
(Ellen)

Ellen identifies that regardless of the agency involved, in order to maintain their competence, midwives have to be ready for the moment and they have to be ready to perform the skills and the tasks that are specific and relevant to the environment in which they practice. When reviewing and reflecting on practice this can and does occur in a number of different settings and in a number of different ways. It can be thoughts in one's head or written reflection included within the portfolio. It is a continuous process, one that occurs in response to need and is impacted by clinical context. In this way, reflection and subsequent change in practice is different for individual midwives because of the experiences in which they are involved.

Consequence – reinforcing professional differences

Midwives in rural areas reflect on the practice in which they engage and accordingly, like midwives in other areas of practice, seek advice from their close peers to guide care and decisions that both guide practice and take the context of their practice into consideration. LMC midwives in these areas acknowledge that, at times, they seek the informal advice of their peers or indeed receive professional mentoring to assist them with review of practice. By identifying their differences these midwives acknowledge their professional position as being different to other midwives and that their needs, while similar to their urban counterparts, have different priorities placed on them. The nature of rural practice means that these midwives reflect on their roles and the work they do and very much see themselves as the sole practitioner who must be ready to act and prepared to manage any situation within their sphere of practice.

Summary

For the midwife participants in this study there was clearly an appreciation that midwives who practice in the context of a rural situation work in different ways to their urban colleagues. The rural midwives engage in the process of being ready through its component parts; yet they work towards being ready from the position that they are often the sole care provider, knowing that the environment in which they practice will impact on care that they provide and decisions that they make. They work towards being ready in a way that confirms their differences and enhances the strengths and the skills that they both have and need. Working in this way, rural midwives acknowledge and celebrate their professional differences.

Chapter Eight: Working toward being ready – the midwife practising in education, strategic development and research

It is actually about competence at entry level and I'm often saying that to people. This is about maintaining a level of competence. This entry level, we are all on the same page. You can do it, I can do it. Some of us have gone a bit further with things. That's fine but we are all here. This is where we are supposed to be and that's an important message. (Dora)

Setting the scene

This chapter presents the multiple boundaries that are traversed by midwives whose day to day midwifery has moved away from clinical practice. It shows the need for variety and flexibility with practice, and the barriers and challenges that are faced and that must be managed to minimise risk of harm. In this chapter the leadership skills and strategies that are employed to develop and advance individual clinician and midwifery practice as a whole, are demonstrated.

These midwives are engaged in professional positioning, identification of learning needs and review and reflection on practice as continual processes towards being ready. Yet the level at which they function, and the nature of that which they call practise, is not recognised as meeting requirements for a practising certificate. The challenge for this group is to work to grow the midwifery profession and to manage the requirements on their own professional practice.

Introduction

Ten of the midwife participants in this study held multiple midwifery roles at the time of interview. A number had worked in a variety of diverse settings and had, at some stage, worked as core or LMC midwives. Some had moved out of direct daily clinical practice and were, at the time of interview, engaged in education or other professional roles. In keeping with the nature of midwifery regulation, midwives employed as educators are usually required to maintain their practising certificates. Yet the paradox arises as education, research and policy are not recognised as practising across the scope within the Midwifery Council regulatory framework. Therefore the day to day work of these midwives does not meet the regulatory requirement to engage in clinical practice. Education, in this chapter, refers to the entire gamut of education that is provided which includes pre-registration undergraduate lecturers and tutors, post graduate formal professional education at university and polytechnics, and can include those midwives

employed in post –registration professional development education by both in-service education and private education providers.

Each midwife participant was required to ensure that she was fit and able to practise clinically and competently, and able to provide education or advisory services. For this group of midwives there were different challenges and contexts that they managed in order to ensure they met their regulatory obligations. In this chapter I will explain the findings related to what it means to be continually working toward being ready for midwives whose midwifery practice is, by and large, non-clinical, yet who are required to engage sporadically in aspects of clinical practice in order to demonstrate their ongoing competence. Although this chapter relates predominantly to midwife educators and lecturers, there are large and growing numbers of midwives who do not engage in regular clinical practice but who are involved in research, policy and advice, management as well as education. I myself fit into this category.

Professional Positioning

The midwife participants, in this chapter, all identified that they had transitioned away from being a predominantly clinically practising midwife to their non-clinical role. They identified that they were midwives and that clinical practice had and did form a large part of their professional identity, but that with time, they made a decision to work in a non-clinical role. Hazel (i5, 5-6) explains, “*I work as a LMC and have in the past worked as a core midwife and I also work as a lecturer.*” This sentiment is echoed by Lydia:

I was successful in getting a job with [an education provider] as a lecturer which after the first year became full time. So since then I have been continuing on my LMC practice, but doing less and less numbers as my other role has taken over my life. (Lydia)

Dora too explained that throughout her career she has held roles in education and she has maintained a clinical portfolio: “*I went to the University ...to teach undergrad midwifery and then came to [a DHB]... [I am] still there and also working [at the] University with post grad midwifery. In all of that time I have maintained a caseload*” (Dora).

The professional pathway Lydia and Dora followed has framed their professional perspective of the role of the midwife. It guided them in the decisions they made with regard to the standards that they set within their current roles and their expectations of others. Lydia continues:

My role is in education now. That means I am coordinating papers and I am lecturing and also taking groups of students. So I have an obligation to myself and to them to ensure that I do maintain competencies. So that means doing a lot of reading, making sure I still do practice and making sure that I do meet basic requirements, exceed basic requirements really. (Lydia)

Lydia sees her primary role as an educator; yet she clearly articulates her professional standard for practice. She has a moral commitment to engage in her own education and to exceed the minimum standards for herself and for the students with whom she works.

Each of these midwives has the challenge of maintaining competency when hands-on practice is no longer their every-day work. As they work towards being ready, because of the differences within their roles, the range of activities with which they engage differs from their colleagues who work in day to day clinical practice. Midwives, in education, research and strategic development roles, identify that they are midwives, but they position themselves within the sphere of professional education, advisory or research and the actions and strategies that they employ are based around this premise.

Identifying needs

This cohort of midwives reported that they are either required, choose, or believe that they need to hold a practising certificate and consequently engage in the recertification programme for midwives. They therefore have the same obligations with regard to its components as other midwives. However, in addition to this, they have obligations for their leadership role that they identify and incorporate into their professional practice. Their identified needs related to maintaining skills and knowledge of safe practice, congruent educational processes, management, policy development and meeting competency requirements for recertification. In the main, those needs were identified from experiences in clinical and non-clinical roles. But this meant that they also worked to manage the way in which they included the need to practise within the requirements of other roles. Lydia describes the activities that she engaged in, to ensure that she is able to retain her practising certificate.

So first off I am actively involved in the recertification process. So what that means for me is that I like to do a Tech Skills two-day workshop every three years, I do a Standards Review every couple of years, I do the yearly neo-natal and maternal resus updates, I do the breastfeeding update every three years. So that's being fully engaged in the re-certification process. In addition to that, I do undertake a lot of professional and educational activities ...I also read the journals and the newsletters to make sure I know about the consensus statements that the College puts out. (Lydia)

These activities are all focussed on the requirements of the recertification programme and the clinical practice in which Lydia is mandated to engage; yet, as Lydia has previously stated, her role is in education and within that she reads and engages in learning activities. It may also be that in her educational role she teaches some content of the workshops she attends. Further, there is an assumption that by engaging in a workshop she will be equipped to respond competently in a practice situation; however it may be that there is a delay in attendance at education and engagement in actual clinical practice. The ability to practise these skills and contextual familiarisation may make the attendance at these workshops of little actual benefit.

Hermione also described how she works to ensure both her clinical practice and theoretical learning are current and safe:

Sometimes if I have had a birth and I sort of think actually I may need a few more skills with suturing or there may be something identified in the women that I am working with, then I identify that I need some more information. I may attend a meeting or a workshop just to update myself. ...Sometimes when I am an educator I'll think I may be a bit unfamiliar with something and I will try and update myself through a workshop or through further reading or whatever it takes. (Hermione)

Hermione identifies the need to maintain competence in clinical skills as well as to enhance theoretical learning in order to advise others. Her participation in the occasional birth reveals to her the skills that are in need of refreshment.

Once in the clinical environment, the midwife participants reported that at times there were challenges that confronted them. While they experienced some performance anxiety, the challenges faced by this group were often structural and technical changes, rather than midwifery challenges that occurred when working with women. Some midwife participants reported these changes as barriers to clinical reasoning and resulted in rote rather than reasoned midwifery practice. Betty identified that she needed to engage in clinical practice and described her feelings when she returned to the clinical environment

I went back and did some core work. It was really quite interesting because I was very nervous, incredibly nervous. I went back into the tertiary centre. It was a place I used to work at... I was so nervous. So I was worried about my competencies. But what was interesting was really my nervousness ...But actually being in there was okay... Whereas previously when I had worked there, my competencies, I know it sounds terrible, but in a way I never really thought about them, I just did them. (Betty)

Being in the clinical environment sustains the midwife's ability to retain her clinical competence and to meet the requirements in order to retain her practising certificate. When it is identified that there is a need to engage in clinical practice then it is confidence, as well as competence, with systems and process changes that needs to be supported. This is because the everydayness of the activity has been lost and the action is not quite as automatic as it may have once been. Betty's nervousness was perhaps about not having used her technical clinical skills of midwifery practice for some time. Until the moment of need arises one cannot know how ready those skills will be in order to react competently.

For midwives who are working less and less within clinical practice, it is often not the essential clinical care that changes but rather the systems and process. Betty provides an example of a tool that was implemented during her absence from the clinical area. When it was brought to her attention that she had not used this tool, her confidence in her ability to provide clinical care was questioned. She subsequently used the tool and while identifying that it met the requirements of the practice environment, she realised that for her professional capability its use did not support her in her ability to retain her competence. Use of the tool from Betty's perspective removed the need for the midwife to think critically. The challenge arises for midwives who are not working day to day in the clinical environment to be aware of system and process changes. Such changes cannot be rehearsed. So when undertaking the task of reporting the foetal heart trace, a key competency for midwives, Betty was unaware that there was the need to complete the sticker³³ and therefore to incorporate this within her practice:

And what it did do also was then I used the sticker, and I know this sounds really weird, but I used the sticker for the next time I looked at the CTG and actually it stopped me thinking. It stopped me having to think because it was a place where I didn't have to think. I just used the sticker, answered the questions on the sticker, and actually I think that was worse for my own competency and confidence than actually me having to articulate what I was doing and the decision making that sits around that. (Betty)

In a new risk era where safety mechanisms are in place to record and keep a check on deviations from normal, Betty reflects that the use of this tool in fact undermined her own competence. Whereas before she was responsible for making her own judgements of safety, now the pro-forma sticker took away her need to think. Her belief was that this made her less competent. The sticker creates an automatic process that stops her having to think about what she is doing and

³³ Preformatted sticker that lists all the required component of the foetal heart recording

why she is completing this foetal surveillance; it potentially inhibits her documentation and associated thinking processes.

Mary too explains how it is that the peripheral items that assist the midwife to provide care change more so than midwifery care. While she took time out of practice to engage in project work, on her return she identified a need to familiarise herself with machines that aid practice more than actual practice itself.

Some years ago I did take six months away from clinical practice because I was involved in another project ...I didn't feel at the end of that time that I had degenerated or lost any of the skills and competence that I had previously had. Again it was more changes that take place in the environment that I work. It's not the midwifery that changes. It's like they've got different CTG³⁴ machines, we got given different IVAC³⁵ monitors, they bought CPAP³⁶ you know and various things that I... I didn't know about. It's not that I didn't know about them, I did know about them, it's just that I had no personal experience using them and sort of those things and computer systems the lovely Trendcare³⁷. That sort of thing but that to me is not midwifery they are sort of add on adjuncts to the institution where it takes place. (Mary)

Mary highlights that much of updating competence relates to changes in technology and devices that are used in practice. The basic skills of midwifery practice are constant, not easily lost. It is the add-on adjuncts that undermine the midwife's ability to focus on midwifery care. For the midwife who is not involved in clinical practice every day, first she needs orientation, experience and to develop capability with the machinery that assists the midwife delivery midwifery care.

For Dora, being removed from the practice environment has made her consider the increasing complexity of midwifery care. Like Betty, Dora had worked within the tertiary care environment and had been comfortable providing care to women with complex needs. Yet because of time away from practice experiences she identifies that, from her position now, she is best to provide primary core care to women and to allow those midwives who have developed a speciality with complexity to provide care to the women who need that level of skill. For Dora identifying the need for clinical practice comes with the caveat that to provide safe and effective care she works with women in physiological childbirth because that is where her clinical excellence lies. Of

³⁴ Machine that is used to record the foetal heart in labour

³⁵ Intravenous infusion devices

³⁶ Continuous positive airway pressure use of mild air pressure to keep airways open (<http://www.nhlbi.nih.gov/health/health-topics/topics/cpap>)

³⁷ An acuity system that is designed to predict staff numbers and skill mix required to provide clinical inpatient care

particular importance was the recognition of these participants, that when they sit outside the clinical environment of practice they see different levels of clinical competency required for primary care and complex care midwives. They then identify that to meet their mandatory competence they impose boundaries around the complexity care needed for particular women.

You walk into a delivery suite now and you are very likely on any day to see somebody on a mag sulph³⁸ infusion for neuro protection and a diabetic woman on an insulin infusion³⁹ andin another room with a phenytoin⁴⁰ infusion it's becoming very complex and unless you are exposing yourself to that it is very easy to come away. That's expert care, that's excellent care. That's not competent level. So when I go out and work in the delivery suite in the hospital I say to them I want all the primary women. I am going to look after the primary women because that's where my level of competence is at. I am quite happy to say I am not a tertiary care midwife. I will go and look after the normal primary women. (Dora)

Dora implies that there are different levels of competence amongst registered midwives. At the primary care level there is the unchanging skill of being able to care for a woman going through an uncomplicated normal birth. She does not doubt her competence to provide such care. She does, however, identify other levels of care that she knows she would not be competent to offer; for example, when the woman has an underlying complex medical condition. To keep those women safe, she would happily declare herself not to be competent to provide care and handover care to her colleagues whom she believes have the skill and expertise in these situations.

Consequence - creating scope boundaries of practice

The clinical environment changes and with it the systems of care. The midwife who is not engaging in practice regularly needs to know this information and become familiar with new ways and equipment. For these occasional-practising midwives the consequence of their engagement in clinical practice is that they can retain their right to practise; yet, in order to do so, they strategise to incorporate this requirement into their work schedule. They work to overcome matters of confidence and negotiate to ensure that care they provide sits comfortably and safely within their competence spectrum. These midwives have developed skills and excellence in other dimensions of midwifery that may not be directly involved with clinical practice. It does have an impact on the care that is provided to women, either through the education of others or through the research that forms the basis of care or through writing the policy that guides and directs

³⁸ Magnesium sulphate: used in this instance to protect the baby during premature labour

³⁹ Insulin: maintains blood glucose levels during labour and birth

⁴⁰ Phenytoin: drug used in the prevention of seizures

practice. While the number of midwives in these roles are few, these roles are vital to ensure the survival and growth of the profession.

While engagement in 'hands on' clinical practice enhances professional clinical credibility, as the midwives working in education, research or strategic development state, the consequence of engaging for these midwives is a sense of discomfort and at times unease. It also places additional burdens on their professional lives. If midwives are to develop professional capability and maturity then the "other" non-clinical dimensions of midwifery required to sustain the profession need to be valued and supported. When the midwife who works in education or policy engages in clinical work, her colleagues need to appreciate the nervousness she might bring and help her adjust to the changed context of care. Sadly the risk when engagement in clinical practice is required is that it can become a tick box achievement that neither supports professional capability nor effective partnerships with women and, as reported by midwife participants, reduces the need to use clinical reasoning. To reduce the discomfort that these midwives face they create boundaries around the type of clinical practice that they will engage in. They also noted that they have moved away from clinical work and, having identified a sense of responsibility in another area, develop boundaries around their sphere of practice as they work towards being ready.

Strategising towards solutions

Midwives working in non-clinical positions develop strategies that enable them to engage in activities they have identified as necessary to retain their ability to practise. For midwives working in a non-clinical lecturing role, a number of the solutions that they had incorporated within their midwifery practice had been initiated by undertaking some type of formal post-registration education. All of the educators in this study had at least a post-graduate certificate in midwifery. The solutions that these midwives adopted in order to be ready for the moment included maintaining skills in clinical practice and those that enhanced their teaching and research expertise.

For some midwives working in positions with regular hours has allowed them more freedom and flexibility that enables them to engage in required activities without the stresses of negotiating backup or rescheduling clinics, as described by Belinda:

I have to say now in my role, now that I am employed, I find it a whole lot easier to achieve than I did when I was a full-time LMC midwife. I have to say that

because I get professional development leave, it does make a difference. Takes the pressure if something comes up.

[As a LMC] say you are coming up to your compulsory recertification programmes and something happens which throws you out and even though it is only a few days at the most it is a really significant period of time. You might need to reschedule your clinic because you had a birth earlier in the week, but there is nowhere to reschedule it because you have tech skills. ...And so it is a significant period of time that is out of your working life as well. Which is always a challenge. (Belinda)

For Belinda, being an educator allows her the time and flexibility to schedule and engage in learning that she has identified she requires. She sees that through employment she can remove the barrier that means she would be hindered in her ability to engage in education should a woman in her caseload go into labour. Being employed with regular hours facilitates her to schedule time for education which allows her to retain her practising certificate.

Being employed opens up other opportunities when work circumstances allow travel and the opportunity to engage in required activities out of town. This ability to travel is seen as being positive for these midwives; yet this is a direct comparison to the rural and LMC midwives for whom travel was often problematic and costly. For those midwives, as described in chapter seven, there was often a loss of earning, alongside costs associated with travel and a direct loss of income if locums had to be paid. On the other hand, employed educator travel can be incorporated within work requirements and goals.

I guess the role I am doing like with [an education provider] is really busy and the reality is that you have to really plan ahead what study... leave you want for study days, which most of the time is actually quite easy. However there are times that for example I have recently done the Tech Skills workshop and I did that in [a city]...just because it kind of fitted in when I was ... there, and there was nothing similar that I could take the advantage of going to where I was living. (Lydia)

For the midwife working in education there is a need to engage in strategies that enable compulsory activities to occur. Midwives are engaged in finding necessary education, organising attendance and planning study leave; they then attend and in that way ensure that they are acquiring or refining their professional capability. The process of accessing and attending mandatory educations lies in the midwives' ability to discover the available education and work release. As the midwives stated, release from non-clinical work was identified as being relatively simple and straight forward as opposed to their colleagues in clinical practice. The reality in this situation is that midwives who have time granted for clinical practice or compulsory education are

enabled to do so. The consequence in this situation is that goals and objectives can be achieved in a timely and organised manner and the midwife can retain her ability to practise.

For the midwife in education the need to know about an aspect of practice was often in direct response to planned education or professional development that they themselves may provide. Holding the position that they did, at times, was seen as being a significant lever and often worked in ways to allow them to easily access information or the professional services that they needed. Lydia, who for a time worked as both an educator and a LMC, describes the ease with which she can obtain assistance from medical colleagues; something she believes is not easily achieved by other midwives who also access the facility.

I struggle as an LMC midwife working, say my woman has chosen to go to the facility for her birth and I need to consult with the medical people for whatever reason. I grapple if it is a house surgeon because I refuse to consult with them because their knowledge is nowhere near what my knowledge is, and I can kind of go higher because I guess I am known in that unit. However, that is not how it works for all staff and I mean that's great for me because it works for me but I really appreciate that it doesn't work for other people. You see you have got this delay while they have to ring the house surgeon who then has to consult with the registrar or the consultant and there is just this whole delay. (Lydia)

Having a good reputation within the context of practice was important and allowed direct access to senior obstetric colleagues and decisions makers. It meant that women received timely care from appropriate health professionals. For Lydia, therefore, having expertise in practice meant that she could bypass the standard referral pathways and seek advice directly from the most senior obstetric clinicians. This was not an option available to all of her colleagues who followed traditional referral processes.

Strategising solutions: engaging in clinical practice

For the midwives working in professional leadership roles, challenges existed around the need to engage in some form of clinical practice. For many this meant retaining a caseload of women as well as working in their main role, or scheduling time to work in a hospital clinical environment. If the midwife did not retain a caseload then this required her to plan and schedule clinical practice activities. However, most of the midwives retained some form of clinical caseload which meant that they had to juggle the demand of antenatal, intrapartum and postnatal care alongside their role in education, strategic development or research. This required them to plan and arrange backup should they be required to teach or be away with their job.

Hermione strongly believes in the need to keep in touch with practice as this reinforces the clinical teaching that she provides. In order to be ready for the moment, in addition to working as a lecturer, she continues to practise as a LMC:

I prefer to practise as a LMC. I think that as an educator that [being a LMC] keeps me connected to my hands on skills, although weekly with students I am still practising those skills and have access to models and information that can keep me up with my skills. Although I feel that actually the actual hands on practice does keep me more connected. (Hermione)

For Hermione the actual doing of being in practice keeps her connected to the nuances and realities within the practice environment. While she is able to rehearse and revise the skills and tasks that are required of a midwife, actually being in the environment reinforces her knowledge and keeps her connected. Therefore, being involved in practice is one way Hermione works towards being ready for the moment and is a strategy that is used to maintain her competence to practise.

However, there was a time when some midwives working in education, policy or research identified that the physical demands on them were too great and that they needed to withdraw from clinical practice.

I think that you reach a stage in your life where you don't want to get up at five in the morning, or you don't want to be on call 24/7 or getting home at midnight after late shifts and things like this and I think there is a fear in practice which was never there. You know I have been in the health service for years in one capacity or another but there is this fear that has crept into health over the past few years. I know it stems from the neo-liberal reforms and the change in the concept of risk and all that, and yes it is good to be accountable but it is not good that accountability breeds fear and that is exactly what it has done. (Megan)

Megan had been in clinical practice in a number of roles for many years. She engaged in advanced education and developed an interest in a specific area within midwifery that did not require her to engage in clinical practice. For her, in this role, at that time in her life, she identified that she did not need to juggle the demands of academic and clinical work. She chose therefore to cease clinical practice, which meant that she no longer needed to manage the demands that it made on her. What her education gave her was options.

For other midwives working in policy, research and education who are required to maintain their competence to practise their profession, there is a need to strategise ways to ensure that they remain current with practice; thereby retaining their competence, practising certificate and ability to practise their profession. The challenge they face is ensuring they have the time and ability to

complete this activity. These midwives choose the way that works best for them to be able to achieve this goal, which includes deciding on a mode of practice and then arranging and planning to engage in this process.

The reality was, however, that in order to meet this requirement, caseload numbers had to be small enough to ensure that they did not interfere with the midwife's primary role; or time spent in clinical practice had to be arranged around other obligations. There is no mandated time that must be spent engaging in clinical practice and no minimum caseload size. The potential risk to safety and to the midwife occurs when the requirements of the primary role and the regulator start to impact on the midwife and create tension around her ability to practise. While one would expect that these midwives are clear regarding their scope of practice, their experience and their boundaries, none the less, the need to engage in practice over and above their work creates tensions that can potentially impact on either role.

Condition: Evidence impacting on practice

One significant change in the profession of midwifery over the past 20 years has been the introduction of research evidence to inform and guide practice. For midwives working in education, research or policy this formed a large part of the work that they undertook on a day to day basis. These midwives were often highly skilled in obtaining research evidence to support practice, in evaluating research for practice and in engaging in conversations to disseminate findings. They were often the motivator that assisted in the dissemination of research within a community of practice and acted as change agents. These midwives realised that there needed to be a culture of evidence that informed practice, but that there were often challenges faced by their colleagues in order to develop and engage with this culture.

I think acquiring the skills for evidence to inform your practice, you have to be actually quite self-motivated to do it. I think it is very easy for any health professional just to do things because they have always done them. But I think as new evidence comes out then it means that sometimes we are changing our practice to something which has better evidence for it. I suppose that is where it will inform our competencies so we would be using the evidence to make sure that we are meeting the competencies. (Hermione)

Hermione identifies the need for evidence to change practice and understands that there needs to be personal motivation that drives the individual to engage in this activity and further an understanding of the process of research review. She understands that as new evidence is introduced, there is also a need for change in the competencies for practice.

The use of evidence is seen as being pivotal for midwives to argue for their practice from a position of strength. **Working towards being ready** for the moment requires the midwife to develop strategies to engage in learning and to keep abreast of practice changes. This was seen as being necessary for the midwifery profession as well as the individual practitioner,

I have always believed that we, as midwives, as a profession, can only stand our ground and protect and promote and facilitate normal birth if we really understand the evidence that sits around how we practice. And we need to be able to have that knowledge so that we can argue back with our obstetric colleagues who throw evidence at us all the time around why they are doing things. (Dora)

Dora too believes that using evidence to inform practice provides midwives with knowledge to be able to argue around women's care. For Dora, all midwives, regardless of their position, need to be aware of research and incorporate it within their skill set so that they can be assured of the care they provide. "So I think midwives really have to know how to deal with research and evidence so that they are in a more powerful position" (Dora). Midwives wanting to retain their ability to practise, regardless of which sphere they actually practice within, need to be able to access and understand what is new and relevant. Midwives working in education research and strategic development, through their ready access to this information, had strategised solutions which assisted them in their ability to obtain evidence and information. The consequence of this activity was that research findings and changes to practise could be passed on to other midwives. Midwives working in strategic development identified that at times they had access to such information and were in a position of being able to share and disseminate it with their peers.

I mean practice, every day practice, to me for me involves evidence just in a different way. The written word is part of it as well, it clarifies it or sometimes it challenges it too.

So yes it would seem academic in the sense ...but like I say that was the type of thing that put me off initially, being able to read things. But actually I don't know I choose the things I want to read now which is really nice and if I have one that I am really interested in then I will read deeper into that. So it's about me enjoying the reading now whereas before I just read it for the sake of it and never really thought much about it. (Betty)

Evidence review and interpretation is part of Betty's every day practice. She sees that written research is but a part of the evidence that is used to inform practice. Now, in her career, Betty has the ability to be discerning and select the research that she needs to be appraised of. Her colleagues, however, identify that there is or has been a delay in the dissemination of knowledge and understanding of the evidence informed culture of practice.

I think that some midwives are still getting their head around what evidence informed practice means. I think that in some areas we do get tied up in traditional practice in the area, rather than using evidence based practice. And some of the education programmes that are offered post grad now are really good at moving people towards evidence informed practice. (Hazel)

Hazel has an appreciation that not all midwives have an understanding of the evidence informed culture of practice. Yet she also understands that programmes of education have been put in place to assist midwives in this time of transition. These programmes are developed by midwives engaged in education and strategic development as they work towards meeting the needs of midwives in practice. For midwives engaged in these positions, **working towards being ready** means that they develop processes to support themselves in practice but also through their skills and practice develop ways to support and sustain others.

Strategising solutions – sharing knowledge with others

Midwives working in areas of research, education and strategic development work towards being ready, as do their peers; but this cohort of midwife participants identify that at times they have knowledge that their peers may not possess. While there was an expectation that as midwives each individual was responsible for maintaining her own competence, which meant accessing research and understanding its findings, there was also an understanding that things could be shared or ways could be developed that allowed for the dissemination of knowledge and skills. Jane, a manager within a maternity facility, describes how she *shares knowledge* with the staff that she leads. She explains that it is not only her, but the educator with whom she works, who provide clinical staff and LMC midwives with research and practice advice:

If I'm reading something and think 'oh'... I'll often print it off often and leave it lying around for other people too... or the educator will come in and say gosh I've just been reading this and so it is sort of that sharing of knowledge and information at the time. (Jane).

Sharing knowledge is about enabling other practitioners to be ready. In this situation Jane has made an effort to bring the research or the information that she has to the work place for all to see and perhaps share. In her day to day practice Jane may have the time to visit the library or review the online journals. She identifies that her colleagues may lack this opportunity and therefore shares this knowledge with them by printing articles and leaving them in a common place to be reviewed – if the midwives have the opportunity or the motivation. While **working towards being ready** is a personal process there are actions and strategies that are initiated which enable other midwives to obtain information.

However, this also has its challenges as midwives working in research, education and strategic development, at times, perceive that their colleagues do not have access to the same level of support and understanding about the research process that they themselves have. Indeed Becky, a core midwife, believed that while research access and knowledge was important, the process of research critique was not her role. She relied on others more skilled to do this for her because for her the focus in midwifery was not on critiquing research for practice: *"I honestly don't know how I'd go about that [critiquing research]. Sort of not like that ambitious in that sort of study side of things"* (Becky). Becky's role in research is as recipient. She wants to receive information and be informed by those who are knowledgeable. A matter that was reinforced by Hermione, an educator, who sees that being entrenched in research, in her role, allows her to develop these skills,

I think for a lot of midwives who are not used to reading about new evidence and being kind of entrenched in that kind of concept that you would be kept up to date with new evidence you would. I think it is very hard for some midwives to incorporate that into their practice. But I find probably for me being an educator it is kind of something that we are entrenched in all the time...

As a practising LMC it was something that I did engage with personally and I feel like I am probably a bit more easily able to access information where I am at the moment. However most midwives can access most journal articles, there's abstracts online, there's journals that all say the same thing. That depends on ... you know for some midwives, I've heard them, it's not particularly an interest of theirs to go and source that type of information but for me, it's interest for me.
(Hermione)

Hermione reiterates that for some of her colleagues, working predominantly in clinical practice, there is a reluctance to engage in the process of research because for them it is not an interest. She continues, *"I think it is really hard to stay up with current evidence for some midwives, I do think it is quite a challenge because it does require a huge amount of self-motivation"* (Hermione).

From Hermione's perspective, while she is actively involved in the process of research, she identifies that for others engaging in the process of incorporating research into practice requires a degree of personal motivation which, if lacking, can be problematic. If the midwife does not have the motivation that can mean that she does not access evidence to support change in practice.

The challenge that needs to be overcome, in this situation, is to enable midwives to receive this research. Jane advises that she will provide resources for her staff and Hermione has indicated that there needs to be an openness to learning and development.

However the perception from midwives engaged in education, research and strategic development is that some midwives may not have these skills to review research and this led the midwives engaged in education to set strategies to enable this translation. For Jane it was about providing access to research. Lily-Rose perceived that there was a distinct lack of skill in the ability of the staff for which she has responsibility in reviewing and considering research. She enlisted the support of other professionals to provide education and to enhance midwifery professional capability. The consequence was both acquiring knowledge and skills, and a sense of enhanced capability and professional maturity from one midwife who was involved. Lily-Rose, in using this strategy, has shown that the benefits can be extensive and far exceed what is expected.

I mean she did not know that the Cochrane database existed! I mean she has been there how many years? She didn't know it existed. She didn't know that you could go to the library and they would give you lessons... You know the librarian goes in and the librarian teaches you... you know it takes half an hour to take you all through. I have had the librarian come to the ward because ...they've got access to everything there...

I want to tell you that this midwife... it's kind of a light has just gone on with this policy now, she is going to do a teaching session on which I can't believe. She said Lily-Rose I am happy to, I want to do it. I think they are from the era and they think not everyone has the opportunity to learn or [only] certain clever people without actually realising that anybody can do it actually. (Lily-Rose)

Lily-Rose explains that even though some practitioners have been practising clinically for a number of years, they may not have necessarily been exposed to education around research practices. Midwifery capacity and capability is built when this development occurs. Further, there can be a time of realisation when they understand that procuring evidence to support their practice is not as onerous as they believe and, indeed, it can be a motivating factor to develop capability with other colleagues. Dora and Lydia too believe that midwives require these skills and, from their perspective, see that this can be achieved by acquiring formal qualifications that lead to practice change. Dora explains, *"I strongly encourage midwives to get engaged in post-graduate education because it gives them skills and they can go back into their work settings and they have access to libraries. They have access to databases"*. For Dora one way to support and share knowledge is by encouraging midwives to learn for themselves, such as through their engagement in formal education. Lydia's position, however, is that while midwives can access resources and learn, from her perspective the ability to acquire a qualification is a motivating factor that she would encourage midwives to complete:

I think midwives should always have access to all the new information that comes out but I think that education is an ongoing kind of responsibility and I

mean if you are going to avail yourself of all the educational opportunities why wouldn't you go and do higher education, because you may as well and get some formal recognition for what work you are doing. (Lydia)

For the midwives engaged in education and strategic development there is a professional obligation that means they develop strategies that allow them to access and learn from research and development. They then share this ability with their colleagues either by directly providing resources and support or by encouraging participation in formal ways. In this way, these midwives are building professional capacity.

Consequence - effecting change

Midwife participants advised that they have a perception that their colleagues who are not as active in the research and education roles find it difficult to access information. They do not know that resources exist and have a belief, as stated, that the research critique aspect of practices does not belong within their sphere of practice. Midwives engaged in research, education and strategic development identify that this barrier exists and then work in ways to support their colleagues. Lily-Rose has explained that through the strategy of sharing knowledge and skills there is an empowerment of the midwives. Midwives engaged in education, research or strategic development identify that they can be the catalyst to support and promote change by empowering their colleagues in this learning process. By strategising so that knowledge is shared, the ability to effect change occurs.

Midwife participants work continually through this process of needs identification and strategising so that answers can be found and ways to achieve goals can be developed. They do this so that they can retain and expand their knowledge and skills for continued practise. Midwives, however, did not stop this process of being ready once they identified knowledge gaps and strategies to achieve this goal. As with the other groups of midwives, those involved in education, strategic development and research looked at their work and the solutions that they have developed in order that they can be responsive to the requirements of practice.

Reviewing practice

Reviewing practice is a process that all midwives engage in at different levels. They do this to ensure that their work is meeting the needs of the women and, in this case, the needs of their employer or their colleagues. Midwives engaged in education, research and practice considered

the day to day work that they perform; but the focus of reviewing practice was about the standard of clinical practice that they provided:

I think that you can quite easily sign away that you have met the competencies and you know you can work across the scope of practice and all those sort of things, but I think that there are all sorts of things about our practice that it's not just about meeting the bare minimum of meeting the competencies meeting our standards for practice but actually meeting them to a high standard so that we are providing really good care to women, and we do have that professional image to the public. (Hermione)

Reviewing practice and reviewing standards of practice is about demonstrating Hermione's ability to practise at a standard that is higher than the minimum expected. Reviewing practice often occurred with colleagues and was a way of gaining the clinical reassurance to reinforce clinical decision making and reasoning from within practice. This Hermione has linked to her ability to practise and to the public image of the midwifery profession. The need for review of practice was clearly identified; although some participants described frustrations with current processes that were not responsive to the practice needs of the midwife.

I think perhaps that's why there is some negativity on my behalf in relation to the Midwifery Standards Review because it's based on the minimal level to keep yourself a safe practitioner. They don't look at "oh god" here is someone who is sitting here that has done And could be taking the profession here or there... and that is why I think that the audit is enough. (Megan)

For Megan, and for all midwives, review of practice has to be valuable; it has to enable the midwife to review and reflect on her practice. Megan believes that review is not just about ensuring that she has met the minimum requirements which she considers can be achieved through an audit of compliance. For review to be effective, it has to take into consideration the level and type of practice, in whatever form, in which Megan engages. The tensions exist in this situation when the midwife is required to be assessed against the minimal standards in order to retain her ability to hold a practising certificate.

Belinda sees the need to review practice as a part of being a midwife and as part of the growth of the profession. As she reviews practice she understands that the need to be ready for practice is more than just about being able to work in the clinical environment:

But I also think that other stuff that we do above and beyond the required recertification is our survival in the profession. Making sure we are updated, making sure we are current, making sure that we are demonstrating our competence, so that we are seen to be in good standing in the community. Because I think that is important, that outward persona, of being actively

involved. And therefore less likely that we are going to be missing something that is really important, in terms of our profession as a developing one. (Belinda)

For Belinda there is a sense that **working towards being ready** involves reviewing the way that midwives practice and looking at what it means to be a midwife and to be involved in the profession. This in turn is reflected in the way that the profession is considered in society. Yet to provide that public reassurance there was a need for oversight and consideration of practice and consideration of outcomes. The need for this review was discussed by midwives regardless of the place and type of practice. Midwives saw the need for some form of peer review; although formal structures were questioned:

I think that Midwifery Standards Review is a really good process to go through, even though it is every two years. It is a good, really good benchmark that somebody else is looking over your practice. I do seek feedback from colleagues. That if there is any improvements that I could have made. You know in those conversations you have with colleagues about decisions that you make, are they the right decisions you know and actually going to colleagues who will actually say, you know you could have tried this or you know challenge you on some of the things, some of the practice that you do. I find that's a good way of measuring yourself. (Hermione)

Formal review is just one mechanism that Hermione uses to analyse her practice. She also uses peer feedback and direct questioning around her decision making. Hermione identifies that this is a way of measuring her practice that meets the needs of the profession and allows her to continue to practice. Being in practice, and because of the dual natures of roles, brings forth an awareness of the need to ensure that the midwife's practice is safe because of the need to protect herself and the reputation of her employer. For Lydia this eventuates when practice is not occurring as regularly as it had in the past:

I think one of the things that impacts on it [my reputation] is my ongoing LMC practice because I am really, really aware of that reputation and I think the more midwifery I do now the more I am double checking myself far more now than I probably ever have in my career.

Because it is not only my role with my LMC practice but it's my role within [the education provider] that's on the line as well and I can't afford to stuff up in that role and also my credibility with [education provider] and with the students with my midwifery colleagues. I guess now more than any time in my career I really can't stuff up, although I have always felt that right through but now I am more aware of that happening. (Lydia)

Lydia is aware that a good reputation is essential both for clinical practice and because of the role that she has with students as a provider of undergraduate education. For her, work has become more primarily education and clinical practice is secondary. The consequence of this is that when

she is engaging in clinical practise she is double checking the work that she completes; this action is completed primarily to protect woman but secondarily to ensure her reputation remains intact. Being out of clinical practice on a day to day basis means that she might not have the confidence she once possessed. In order to be ready, Lydia must ensure that she is safe and she does this by rechecking what had once come naturally. With rechecking comes challenges and a consideration that practice is observed and critiqued by others.

The scrutiny comes now for me because of other people that I am working with and possibly because I am not seen within the core so much with my LMC practice I feel that I am under major scrutiny with them and that's not just from the medical people, it's from the midwives as well. And it's that thing that you constantly feel you cannot make a mistake at all; any mistake not just a major mistake. But everything has to be done absolutely perfectly. (Lydia)

The role of being an educator creates an additional burden of responsibility to practise at a certain level as one's reputation and one's practice could be under greater scrutiny than at any other time. It was Lydia's perception that her practice was under the scrutiny of her midwifery colleagues and other health professionals. Because of the role that she holds, and the responsibilities that she has, her own clinical practice, which she now delves in sporadically, needs to be at an exemplary level. This oversight is not just from clinicians but also, as expressed by Belinda, by society.

I think unfortunately it is the reality that we are living in, that it is going to become more and more important. Midwives are going to have to, whether they like it or not, take on the role of being hugely visible as respected and respectable members of society. In a way that wasn't perhaps as publicly necessary in the past as it is becoming now. I think the maternity system that we have now has been in place that we need to evolve into something more complex now. (Belinda)

Being a midwife and engaging in midwifery is now more than just providing clinical care. For Belinda, being a midwife and **working towards being ready** is about considering and reviewing the outward position of the professional midwife working in today's society. Midwives working in areas of education, research and strategic development, identify and strategise around the need to review practice, ensure that their practice is at a high standard that they themselves set in order to remain exemplary clinicians, and work towards the future of the profession in which they can and do effect change.

Being mindful of the practice of others

Midwives working in education research and strategic development have gained an awareness of the importance of their reputation as midwives. For them there is a need to practice at a high standard so that their reputation, that of their employer, and the midwifery profession as a whole remains in high standing. They too, as their colleagues have done, developed an awareness of the practice of other midwives and while they developed strategies to share knowledge or advice to support practice, they also developed a sense that from their perspective there may be conditions that impact on the day to day reality of midwives that affects other midwives' ability to work towards being ready.

Mary works as both an educator and a core midwife; she works alongside core colleagues and sees the day to day reality of their practice. From her perspective Mary sees that there can be a reluctance to engage in learning because of work pressures. Such pressures mean midwives spend time at work providing clinical care; yet there is a professional expectation that they engage in **working towards being ready** without any day to day capacity to do so:

I think of the days I go to work and I'm really busy and we may have a ward say of eight postnatal women that have had caesarean sections and I'm helping them breastfeed, the day goes very quickly. There's not a lot of time to sit and research and to read articles. I think for many people that's why they turn to the woman's magazines you know to Women's Weekly rather than midwifery news because that's their life and the world that they sit in. (Mary)

Mary identifies that for the midwife continually working on the ward, when she gets the opportunity to stop her clinical work, rather than consider what she could do to *be ready for the moment*, the time can be spent reviewing lifestyle magazines. This raises questions about the way that work is programmed to occur and of the socialisation of midwives and what they perceive as being acceptable activities to engage in during their quiet times. Mary sees and judges this from the perspective of the educator who works occasionally in clinical practice. She is not part of the day to day reality of the busy working ward. She is framing her opinion on her observations. She does not identify a solution to what she sees as being the reality for these midwives but rather comments on how they spend their time. While Mary may engage in education activities, when she has down time in providing clinical care, she sees that others do not.

Megan too identifies that there are groups within the profession that are resistant to change and to the requirements of practising midwives.

I know that the recertification programme is a form of surveillance but I think it is good. I think the programme itself is really good. I think that there are some practitioners who still believe that they are not accountable despite all this good work that is being done, they still think that they can blame it on management or blame it on each other and I just think I don't know how you get the message through to those people. I think for the average practitioner the requirements are good. (Megan)

Meeting the education requirements that enable Megan to remain in practice is seen as being a necessary minimum standard. This she accepts as being accountable for her practice. Yet within her work context, Megan sees midwives who do not accept this requirement and who attempt to deflect the blame onto others. For Megan the challenge is to work with these midwives to ensure they know and are aware of change. Yet she also identifies that a lot of change that needs to occur comes from within the individual, the context of her life and the priority that she places on practice.

If you want to be a good practitioner and a safe practitioner and adhere to the rules and regulations, which is part of keeping yourself safe, then you will be motivated to do it and you will do your best to overcome the issues that we have just talked about. However, if you go to work just for the sake that you need money and you're not fussed if you are a midwife or not, but you have to because that's all there is that you know and you have done it for the last 30 years; you will moan and groan and you will be quite happy to let the days go past hoping that you get away with it. (Megan)

Hazel, who works as an undergraduate educator, identifies that in the community within which she practices there has been a period of resistance where she has observed the changing nature of the practice of midwives. From her perspective she identifies that the resistance has led to diversification of practice in that those midwives who, for whatever reason, have not engaged in the changing nature of the profession have created a safe place to practice for themselves that may not meet the requirements needed:

There are pockets of resistance as well. Some people are keen, as we know, not to change, to do things as they have always been done and not to be influenced by new evidence... I think the numbers of those people are lessening now so that is going to have an impact. And really it's about having conversations. In our area a lot of those practitioners aren't working across the scope anymore they are probably working in postnatal only.

A lot of it is historically based and there's some really good reasons in these midwives eyes why they haven't maintained their practice across the entire scope. But there's been resistance and they see they have met the requirements in the most basic of forms. Some of them have gone on to challenge themselves and have gone with LMCs to ... birthing for instance but there are others who are just hanging out until they retire to be honest. (Hazel)

Hazel and Megan know and understand what the limits on practice should be; they know where and how midwives need to work in order that they are ready for the moment. Yet they also identify behaviour that distracts from this requirement. Midwives working in areas such as education notice the resistance to change; they are mindful and question the practice of others and their engagement in activities that lead them to be ready for the moment. They form an opinion based on their observation about the appropriateness of what other midwives' practice should be.

This scrutiny of practice occurs in numbers of levels and different fora. Dora describes how policy development and utilisation, which was seen as being a key safety net by the core employed midwives, is, at times, used to control the practice of other clinicians:

I would say, by and large, our primary providers who are largely our LMCs in the community aren't involved in policy development within the hospital. I see that sometimes the policy development in the hospital has often got this overlay of how can we control what the LMCs are doing. You know we want to make sure they are doing it our way. Not necessarily the right way, but our way. So there is kind of a real tension there and like I have always said to midwives you don't have to follow the clinical policies of this institution but if something happens, you have an adverse outcome and your care is scrutinised by an expert somewhere, they will want to know what evidence you do use to inform your practice and what your policy is. If you are not using this one what's your one? Show us your one and where you get your evidence from. (Dora)

Dora sees the practice of midwives from not only the clinical perspective but with an understanding of the need of the clinicians to have policy to inform and guide practice. While she acknowledges that policy can be used as an attempt to control the care that is provided to women; for Dora, being mindful of the practice of others sits at the level of policy development and the evidence that is used in support of this. For Dora, midwives need to be able to use policy to guide and inform their practice.

For the midwives working in areas of education, research and strategic development, there is a sense that they have an understanding of modern practice that needs to be shared with their colleagues. They want to support and reinforce good midwifery practice and they do this in ways that enable their midwife colleagues; for example, through education by sharing research, and support. Yet they also see the barriers that inhibit the uptake of this change. They discuss the resistance to change that comes from the individual and how this has impacted on the work that midwives complete and processes that are engaged in order to be ready. They discuss the use of evidence that restricts practice and, further, they judge engagement in development.

Consequence: Working towards being ready, changing the practice of others

Despite resistance, midwives working in areas of education, research and strategic development, identify change that they see within the practice environment that has occurred through the provision of education. Review of practice is fundamental to all midwives yet within this cohort, who sits outside of the day to day clinical environment, there is acknowledgement of change in the practice of others. Midwives working in areas of policy and education are mindful of the practice of others and seek to develop solutions that assist change. Dora describes how there has been a change within education provided by employers that means midwives have access to the latest information that allows them to reflect on practice and to introduce change:

I think they [midwives] are starting to be exposed to quite good teaching from our educators around latest kind of stuff [research] that is coming out and giving them time to think about how their own practice impacts.

I think they do reflect. I think they are getting information that allows them to think about but they are also getting time out and that is the other important thing. That they get paid time out of their work to have two whole days to sit and absorb this new information and even to be challenged about you know how does this affect you, how does your competency have anything to do with this. So I think that is an encouragement. (Dora)

For Dora, providing others with the opportunity for learning is the way to develop the profession. She identifies that change requires more than attendance at education, but reflection and challenge that can come through participation. For midwives working outside clinical practice, this change comes as a consequence of work that they complete. It shows the integrations of currency in the clinical environment with utilisation of advanced and enhanced knowledge and practice. Hence, while this cohort of midwives may not engage with their colleagues on a daily basis, their work and their practice has a direct impact on that of others.

Hazel too identifies the impact of learning on the practice of other midwives.

We've had several people doing the hypertension⁴¹ paper and just in discussions if we have someone with pre-eclampsia on the ward then there will be some discussion around what is evidence based practice for pre-eclampsia which is influencing what is happening with those women... I think certainly on an individual basis with individual women [education] is influencing what happens with them and particularly if midwives have the confidence to challenge some obstetric practices or provide evidence to some of the obstetricians which in turn may inform their practice. (Hazel)

⁴¹ A postgraduate paper that focuses on hypertensive disorders of pregnancy

Midwives engaged in education strategic development and research see the impact that education and knowledge has on the direct care that is provided to women; and they see the challenges that midwives face in bringing this research into practice. While they acknowledge challenges faced by others they also see the solutions that can be used as midwives work toward being ready. These midwives have time and resources that can, and should, impact on practice. They are the leaders who have access to and knowledge about research. This is how they work towards being ready. They are mindful of the practice of others and of their own professional reputation which is why they engage in activities that support the work of their colleagues.

Summary

Midwives working in areas of education, strategic development and research are often required to maintain their competence to practise. The challenge they face is that their sphere of expertise education or research is not currently identified as clinical practice and does not meet the requirements in which they must engage. For these midwives being ready for the moment requires them to move away from their daily work and to engage in additional activities. There is a cross over when they are required to attend education which may well be their expertise. These midwives clearly articulated that their practice and expertise is outside the realm of clinical practice. Thus, returning to clinical posed challenges which were associated with reorientation, familiarisation with process and system change. However, there was a sense of the level and type of practice that they would engage in, that kept both themselves and women safe. In their roles they experienced scrutiny of practice and articulated concern that they even though they did not work in this way regularly, they had to demonstrate exemplary practice. This created tension and stress; however they endeavoured to retain their ability to hold a practising certificate despite the personal costs and challenges that is imposed on their ability to manage two roles. The concept that practice and review needs to be at the minimum standard was questioned and although they engaged in general processes that kept them aligned with the profession, they sought challenges and experience that enabled them to develop their role outside of mainstream practice.

For these midwives a key change was their ability to hold an overview of practice and, while being mindful of the practice of others, to strategise solutions that enabled both themselves and their professional colleagues to be ready for the moment. Hence, being ready for the moment was about supporting the profession to adapt and to change.

Chapter 9 Discussion

Introduction

In this study I have come to understand how in an ever-changing world, where there is requirement for clinicians to ensure that their practice is current, safe and rehearsed midwives maintained their competence and, therefore, their ability to practise their profession. What this study revealed was that midwives engaged in a continuous process that I have named “**working towards being ready**”. While midwives believed that the process of engaging in competence development was necessary, and they acted in ways to do so, their needs and their actions were focused around their place and role in the world of practice. Learning and development, therefore, was relevant to the midwife’s context and the client group with whom she worked.

In this discussion I will focus on the process of **working towards being ready**, that was enacted by participants, identifying the prevailing conditions that shaped this process. I then consider the consequences of this process for midwives and the subsequent changing nature of the midwifery profession.

Continuously working towards being ready

Midwives in this study were continuously **working towards being ready** as they strove to maintain their competence to practise. This process has four component parts which are: *professional positioning, identifying needs, strategising solutions* and *reviewing practice*. There is a cyclical and continuous nature to this process that is dependent on the context of the midwife’s practice, the boundaries that have been placed around the midwife’s professional role, and the needs of the woman in her care. The conditions that influence the process include, but are not limited to, resourcing, scheduling and fiscal constraints. Midwives were active participants in the problem solving and decision making that framed and impacted on their engagement in this process and, as such, directly impacted on the implied or explicit consequences of maintaining competence. That is, midwives shaped their professional persona.

The component parts of this process are interwoven and dependent on time and necessity. For example, Maree described how she rehearsed and sought learning opportunities when she perceived a need to prepare for a clinical eventuality. In comparison, Becky, as a core midwife, identified her role as providing care in primary units. In this environment she created boundaries around the work in which she engaged. She also ensured that as she was the person likely to provide assistance in emergencies, she had the required knowledge and skills and a heightened

awareness of practice within her facility. This was so that she could be prepared and able to act should the need arise. Through *identifying needs* these midwives were able to consider their educational requirements in order that they could practice safely within their professional context. How they met this learning need was through *strategising solutions*. *Strategising solutions* could require immediate action; for example, when Carol described how she reads about aspects of practice. Alternatively, it could be planned; for example, through attendance at scheduled courses required by the Regulatory Authority, as discussed by midwives when they articulated their need to engage in recertification. How they identified if this matter was resolved or if they needed additional education was through the process of reviewing outcomes. Finally, after this occurred, the midwives went through the process of *reviewing practice*, whereby they reviewed and reflected on care, their practice, and on the practice of others, as they attempted to ensure that they and their colleagues were current and competent as midwives.

Identifying needs

The needs that the midwives had were many and varied and differed from specific knowledge that was related to a direct clinical need, as described by Carol when referring to specific tests required for one woman, through to specific information required to make the working environment safe. For example, Becky and Mia, midwives working in rural or primary practice, identified that they needed to be able to manage emergencies within their own context and so ensured that they were able to attend education that met these needs. For other midwives identifying needs could be to meet some desire that they had to learn about an aspect of practice; for example, Dolly described how she had developed an interest in breastfeeding. Identifying learning needs had the consequence of *refining the midwife's practice* and meant that her practice would adapt to incorporate and advance her subject matter knowledge and expertise.

Strategising solutions

Solutions were influenced by the salient condition of resourcing which included reliance on other clinicians to provide clinical care in the midwife's absence, the availability of learning and development and the opportunity for the midwife to attend education and development activities. Through negotiation, discussion, scheduling and rostering, midwives were able to develop solutions that meant they could engage in the required learning or clinical practice that they had identified. While midwives sought and scheduled development, more and more they could find answers to questions through the changing resources; for example, internet and library resources as described by Jane and Lily Rose. Conditions such as the introduction of evidence based practice and technological resources influenced how the midwife decided on the way in which she

needed to engage in **working towards being ready** and guided the midwife to engage in development or to lead change and education within practice.

For some midwives strategising solutions meant that they enlisted the help of others, they supported or were supported by their direct colleagues and, as a consequence, developed collective knowledge and expertise around the care that they provided to women. In addition, midwives proactively engaged in skill rehearsal to ensure that they could perform certain skills and procedures in times of need. Such strategies had the consequence of reassuring the midwife that she was competent in these procedures and ensured that she was meeting the requirements placed on her by her regulator. For example, the employed midwife who worked in a primary birthing unit ensured that she remained current in management of emergency skills. In order to do this, she had negotiated attendance at such education by firstly booking onto the course and then by scheduling her work requirements to enable attendance. Scheduling was managed through the staff roster and attendance was paid for by her employer. In contrast, the rural LMC who may also attend the same course, negotiated with her colleagues to provide locum cover during her absence, paid for the course from her business and paid for care provided to women on her behalf. Midwives actively managed issues of equity of access to ensure that they received the education that they believed was important for them. Each midwife considered and applied her learnings from education into practice from her particular perspective.

Because of the different contexts and frequency of engagement in clinical practice, the consequences of the action of **working towards being ready**, between the varied cohorts of midwives, was the difference in the nature and type of preparedness in which they engaged. Maree worked infrequently in the clinical environment and ensured that before she engaged in intrapartum care, she refreshed her skills. In contrast, Becky continuously worked in clinical practice and often in support of midwives who provided intrapartum care; therefore, she ensured that her skills are continuously ready so that, if required, she was able to provide advice and take action. Becky practised with a heightened level of repetitive clinical skill and situational awareness. Her counterpart Maree ensured she was able to manage a situation when the need arose, but focussed day to day on the non-clinical knowledge of heightened awareness of process and research. Becky and Maree, because of their different contexts of practice, thus prepared themselves in ways relevant to their own personal needs.

Reviewing practice

The final category of **working towards being ready** was the midwife reviewing the care that she had provided. Through both formal and informal processes of reflection, midwives reinforced their professional position and developed a mindfulness of the practice of others. For example, midwives working in education, strategic development and research, developed strategies that assisted other clinicians to be aware of change in research for practice; while midwives engaged in primary settings ensured that their colleagues were apprised of new policy. When midwives reviewed their own practice, the diversity that existed and the differences that they observed were reinforced.

As a consequence of this activity of review, which is premised around their situational needs, midwives created further boundaries around the knowledge and skills that they perceived necessary for their practice. Midwives placed arbitrary limits on their practice related to what they needed to know and what they needed to do. This led to enhancing expertise and gaining additional knowledge compared to their peers who worked in a different area of practice. It also meant that they discarded skills that they did not see as being relevant to their current practice situation. As a consequence, they created their own *spheres of professional practice*. Such spheres sit under the generic umbrella of midwifery but are impacted by the midwife's practice type and its location. The consequence is that different midwives function at different levels of expertise within different spheres of practice.

Creating boundaries around practice

What was very clear in this research is that midwives act in ways to ensure that they are up to date with their practice. The actions they take are premised around their day to day work. Ellen, for example, does not need to refresh her skills in electronic foetal monitoring because the unit in which she practices does not have a monitor. Similarly Zoe, a LMC midwife, discussed providing elements of secondary care that Judith, another LMC midwife, actively chose not to include in her range of skills. These arbitrary limits create diversity. Audrey discussed the barriers that she faced when she identified that she needed practice in intrapartum care. Barriers imposed on her by her employer meant that she could not work in this area of practice and that her ability to work towards being ready was impaired. The barriers imposed by her employer impacted on Audrey's ability to maintain her skills at the level that she desired and puts into question her ability to meet the mandated activities. Lily Rose spoke of her desire not to lose skills, while Jane described

midwives who hand over elements of secondary care as “glorified doulas⁴²”. Her solution, premised around her professional position, was that midwives work alongside one another and together provide care to the woman.

Midwife participants expressed their opinions regarding engagement in practice across the scope.

Becky discussed what she described as token efforts made by some clinicians to engage in intrapartum care and how this can be “managed” to meet minimum requirements. Lydia discussed the need for midwives to be professional and ensure they worked in all areas but, from her perspective, related this need to her skills as an educator and not necessarily a clinician. The midwife participants were aware that there were different interpretations of requirements.

When boundaries are created by individual midwives, as has been articulated within this thesis, does that impact on the continuous ability of the midwife to traverse the spectrum of practice?

The requirement for this sits within the Midwifery Council’s Recertification programme, the scope of practice and the competencies for entry to the register. These documents describe the work that a person holding the title “midwife” is required to achieve. What is apparent in this study is that because of the boundaries imposed by or on midwives, unless there is continuous development, engagement and exposure to all areas within practice then there is a loss of skills and, as a consequence, midwives retain or develop enhanced capability in some areas but not in others.

For example, if one was asked if a midwife who had worked predominantly in complex postnatal tertiary settings could move directly to LMC practice without some form of reorientation and upskilling within practice, the answer must be no. Yet, within today’s practice environment a midwife can decide to do just that. This study has shown that through the processes of identifying needs, midwives enhance the knowledge that they need in order to be able to practise on a day to day basis. They maintain safe practice within their own context. However, they do not seek to attain on-going competence in a context in which they do not position themselves. Because of the conditions of resourcing and availability of education they are unable to incorporate all new things within their daily practice. Midwifery has limits on its professional interchangeability.

It is argued that to decide the parameters of one’s practise is not to limit one’s professionalism.

Professionalism was based on the “notion of a professional having mastery of a body of knowledge at a time when the corpus of [midwifery] knowledge was relatively small – and upon professional autonomy based on that knowledge” (Professional Standards Authority, 2015, p. 6).

⁴² Unqualified birth assistant.

The body of knowledge required to practise as a midwife today has grown significantly over the past 20 years and it is argued that “no [midwife] could master the entire body of knowledge that has been developed for midwifery practice just as no doctor or dentist could master the entire body required for their practice too” (Professional Standards Authority, 2015, p. 6). The findings of this study showed that midwives adapted their knowledge and engaged in development according to needs of their context.

It may be that the only time in which a midwife could decide to move interchangeably between practice environments is at graduation, where her knowledge and skills are assessed as meeting all competencies and she is current in all areas of practice. However, this means that her capability is at the level of that of a newly qualified practitioner. The need to be reintegrated into areas of practice is supported by international research (McCourt, Rayment, Rance, & Sandall, 2012) which further identified that midwives skills are very much focussed on the context of their practice and that for midwives to move interchangeably between context, required education and reorientation to new practice environments. In addition, Cronie, Rijnders, and Buitendijk (2012) researched the role and responsibilities of midwives employed as clinical midwives in the Netherlands. In their survey, the researchers found differences in the work and scope of practice of midwives employed in clinical practice; their findings supporting the notion of diversity within clinical practice of midwives.

Diversity

Maintaining competence was more than attending a series of required courses; it was a process that was driven by the personal characteristics of the midwife and her desires, goals, attributes and opportunities. The needs of the individual midwife were premised around her own understanding and expression of her role which has been called her professional position. The study has revealed that there exists a diversity within practice: a diversity of levels and diversity of types of practice; all that sit under the umbrella of midwifery and all that are at or above the minimum standard required in order to be able to practise. Such diversity was articulated by Judith who described the care that she provides in comparison to her colleagues who work within a hospital facility. For Judith, the limitations are around the midwife’s role and the ability to provide continuity brings her to this conclusion: “Sometimes I feel there should be separate ones [competencies] for hospital and LMC because it’s different scopes” (Judith). While midwives may be perfectly competent to act in their employed role, they may not meet all the generic midwifery competencies because they have not regularly engaged in all areas of practice. Judith suggested that midwives may not be competent in all areas and expressed the need for different

competence requirements for midwives who work in the different spheres of practice. The findings of this study supports this insight and suggests that while the standards of pre-registration support the midwife to graduate with the required knowledge and skill, contextual factors that impact on practice after graduation, for example nature and type of practice, either support or inhibit the practitioner's ability to retain confidence and develop essential skills. That is not to say that midwives graduate and then cease learning. What was very evident within the study was that midwives engage in learning, skill enhancement and development in order to maintain their competence to practise. By **working towards being ready** midwives change and enhance their own and then, as a consequence, the professional practice base.

Midwives are a diverse professional group with many similarities but also differences in knowledge skills and practice. The findings of this study suggest that the premise that 'a midwife is a midwife', implying that midwives are generic and can work interchangeably with different practice context and type, is flawed. That notion suggests linear uniform development across a profession, which contradicts the findings of this study which shows that midwives learn and engage in activities that are relevant for their particular situation.

For this group of midwife participants, development was aimed at keeping them personally competent to practise their profession and this was achieved, in some way, through meeting mandatory requirements. Yet the learning and development they undertook, that they identified as their personal development, was dependent on their needs and the needs of the women for whom they provided care. It was restricted only by the midwife's position and her understanding of what her role entailed. The personal development of the midwife, when considered as a member of a society of midwives, will lead to evolving development of the profession and, therefore, diversity within the profession. Midwives develop in their career with different expertise. An understanding and appreciation of such diversity must be embraced.

Engagement in development

The concept of engagement in one's profession and engagement in professional matters has been identified as being a key factor that impacts on clinicians providing safe care (Health and Care Professionals Council, 2015; Professional Standards Authority, 2015; West & Dawson, 2012). Engagement, while premised around individual attributes, is conditional on organisational systems and, in some situations, the individual's ability to influence decision making within the clinical environment. Engaged individuals are "more likely to undertake the active elements required of remaining a competent professional, such as reflecting on and keeping up to date with

their competencies” (Health and Care Professionals Council, 2015, p. 42). However, research into work engagement, with a sample of Irish midwives, suggested that engagement was dependent on supervisor and organisational support (Freney & Fellenz, 2013). The sample of midwives that were involved in the current research articulated their engagement in activities that they believed they needed to complete as they were continuously **working towards being ready**. The salient conditions that they managed in order to be ready had the potential to derail their engagement. Indeed, a lack of support for continuous professional development activities has been highlighted as a trigger that could lead to disengagement from professional development activities and ultimately the profession (Health and Care Professionals Council, 2015). That the midwives in this study managed the conditions in the way that they did, using strategies of negotiation, planning, and scheduling, highlights their engagement and commitment to professionalism. Yet, the issues faced by certain clinicians, because of their context, meant that with great effort they juggled matters that they faced in order that they could do what was required.

The need for an engaged workforce has been identified as key in quality and safe health services. West and Dawson (2012) provided a synthesis of literature that describes the concept of engagement and the understanding that organisations and individuals have with regard to the concept (West & Dawson, 2012; West, Eckert, Steward, & Pasmore, 2014). In their research, engagement, while focussed on the individual, is premised around employees being involved and their ability to influence decision making within the work environment. The concept of engagement with the recertification programme, while again focussed on the individual, is about ensuring registrants are motivated to meet the requirements placed on them by their regulator. Midwives engaged in activities that enabled them to continue to practise and that focussed on what the midwives themselves saw as being relevant for their practice. Mandatory requirements were seen as being necessary, but the minimum.

Recent work by Gilkison et al. (2015) described what is required to sustain case loading midwives in New Zealand. In that study the researchers noted that workable practice arrangements and good working relationships sustained midwives to remain in practice. The current study found that midwives, regardless of their place or type of work, were dependent on their colleagues and structural conditions to support them to meet their obligations to maintain their competence to practise. The work of Gilkison et al, also supports that of Warmelink et al. (2015) who surveyed Dutch primary care midwives, who again described their work colleagues as being supportive and

assisted them in their development – findings congruent with the current study. The current study, endorses that midwives are engaged in such activities; yet, what is seen, is the need for the support structures to be in place that will sustain development and ongoing practice. Should these supports be missing, then there is the possibility that new strategies will need to be developed or that barriers will impact on engagement in mandated activities.

Developing midwifery

Not all midwife participants identified that they needed or indeed engaged in regular clinical practice; yet they held themselves as being midwives and identified other roles, for example, strategic development, as their *professional position*. Challenges arose for these midwives when they found themselves returning to a different situational context, one where they had familiarity but not necessarily recent exposure. This was evident when midwives, engaged in education or research, were required to return to clinical practice. Midwives who primarily worked in such areas placed boundaries or restrictions around the type of work in which they would engage. Such limits included deciding on the complexity of care that they would provide or the need to be supported within the practice environment. Working in clinical practice meant that the midwife was working within another sphere of practice; not her norm. In order to *be ready* there needed to be parameters and support, something that was not necessary when they were working in their normal roles effecting change and impacting on the practice of others.

Context was central to drive the midwife to create a professional position through which she shaped an identity for herself and by which she developed boundaries around which she practised. As a consequence midwives developed their own levels and area of expertise and because of this midwifery practice diversifies. Midwives have a core set of knowledge and skills from which they enter practice. As they diversify, they engage in activities that meets the needs of their practice in the here-and-now, they change their skills to meet their contextual needs. However, while clinical practice is currently required, when diversification exists then there is variation in role, expertise in other areas develops. *Effecting change* occurred through the identification of enhanced skills and knowledge that were outside the day to day spectrum of one clinician that supported the knowledge and skills of another. Midwives engaged in strategic development, therefore, were **working towards being ready**, changing the practice of others.

In 1995, Guilliland and Pairman argued that unless a midwife worked as a LMC providing continuity of care⁴³ that they were not practising midwifery and practising as midwives. Indeed they argued

midwives who for whatever reason, choose to provide fragmented care such as labour care only or delegated care, are acting as midwives in that they provide midwifery care to the woman. However they are not independent in their practice and therefore are not practising midwifery because they work in a supportive role to another health discipline who directs their care. (Guilliland & Pairman, 1995, p. 39)

In addition, they added the statement “continuity also means following the woman wherever she chooses to give birth. This means there are no different kinds of midwives – a midwife is a midwife” (Guilliland & Pairman, 1995, p. 40). This is a rather bold statement given that they had just advised the majority of the midwifery working profession that they were not practising midwifery. When Guilliland and Pairman reviewed their partnership model for practice in 2010, they acknowledged the differences in context and how midwives worked together as core and LMC colleagues. There is no mention in the 2010 edition of who is practising midwifery. Indeed, the model describes the relationship between the two midwives as: “Both midwives have a defined role and part to play. Both bring different bodies of knowledge in relation to the woman and the environment” (Guilliland & Pairman, 2010a, p. 68). The findings from this current study reinforce the statement that there is variation within midwifery practice, that midwives have different bodies of knowledge which in turn supports professional diversification.

Practice development

One question that is raised is, are New Zealand midwives reshaping and advancing or changing practice? The work of the midwife and midwifery have been explored in depth by Renfrew et al. (2014). In their paper the authors argued that internationally midwifery practice is limited by barriers placed upon midwives caused by the health system and cultural differences. In New Zealand, midwifery practice has developed in order to support a system that promotes continuity of care for women and that provides essential services to support that service. Midwives work within this system providing their specific expertise. The scope of midwifery services, therefore, covers the scope of practice. Whether the midwife chooses to provide some or most elements of care is a personal choice.

⁴³ Care throughout the antenatal, intrapartum and postnatal period by a midwife and her backup.

In their discussion paper, R. Smith, Leap, and Homer (2010) questioned the status of midwifery and the boundaries or parameters around which it sits. The authors stated that by focussing on the ICM definition of a midwife there is no variation or levels within practice and that the midwife “should be capable of autonomous midwifery practice and that they should be considered a practitioner in their own right” (R. Smith et al., 2010, p. 118). In New Zealand, the LMC model allows midwives to work across their full scope, but sitting alongside, and in support, of that model, are additional services that are required in order to provide necessary care to women and their babies during childbirth, which are again provided by midwives. Midwives who choose to work in either way are practising midwifery because the care they provide sits under the generic scope of practice. What this study has shown is that the scope of practice of the midwife, while seemingly straightforward and time bound, has developed and adapted to meet the necessary changes required through social and technological change. Regardless of philosophical debate regarding the role of the midwife in such care, the participants in this study all identified as midwives and further all identified that the work in which they engaged was midwifery. Yet they are dependent on their colleagues to support them in this process.

Professional expertise enhancing practice

It is clear from this study that as midwives develop their spheres of practice they grow, adapt and change into these roles. Indeed they develop professional expertise within these spheres of practice and, as discussed by other researchers, become a resource for other clinicians. In the report by Dixon et al. (2014) the researchers described how the cohort of midwives in the Midwifery First Year of Practice programme, both LMC midwives and hospital employed, sought advice and assistance from hospital midwives when they were working in that environment. The hospital midwives were a resource for these new clinicians as they were integrated into the world of practice.

This thesis is grounded in the words and experiences of the midwives who participated in the study. It is about midwives acting in ways and exhibiting characteristics of professional practice from their own perspective. The sociological premise of symbolic interactionism sits underneath the method that was used in this research, meaning, in this case, that midwives act out midwifery and identify their needs from their multiple perspectives, all of which impacted on the social environment and context of their practice.

It is, therefore, poignant to consider the concept of public safety and how this is played out. One requirement that is embodied within the midwife’s Code of Conduct is that the public and

profession expect that midwives “conduct themselves personally and professionally in a way that maintains public trust and confidence in the midwifery profession” (Midwifery Council of New Zealand, 2011a, p. 2). I argue that diversity in practice both supports the development of expertise and encourages the development of trust and confidence that enhances public safety. This is not about arguing if one is a better midwife because one has different knowledge but about arguing that they are different midwives each **working towards being ready** in ways that support them in their attempts to work in partnership with women and with one another. It is also about arguing that acknowledging and supporting expertise within a profession matters. The literature around professionalism describes the characteristics of a profession which includes development of expertise. Simpson and Downe (2011) described a model of midwifery intrapartum expertise that explores the characteristics of expertise and aligns them in the continuum of midwifery practice leading to, for example, a technical expert or an expert in physiological birth. Their model would be supported within the context of New Zealand practice where the diversification that is found has led to such expertise. Bodies of knowledge that describe characteristics of expertise “have highlighted the importance of the acquisition and organisation of knowledge as well as the vital role of practice in acquiring the necessary knowledge to build expertise” (Mylopoulos, 2012, p. 98).

What is evident is that practising midwives, through their engagement in the process of **working towards being ready** develop expertise in areas of practice. This is discussed by Mylopoulos (2012, p. 108) who stated, “Expert performance is significantly impacted by the context in which experts find themselves working”; suggesting that even within similar roles there is diversification because of contextual factors. As a consequence of their work environment, and of the practice in which they are engaged, midwives develop an expertise in certain aspects of care and in areas that are outside traditional clinical practice. A significant amount of this thesis was contributed to by those midwives who, for whatever reason, had moved away from clinical practice. Many returned to practise, albeit briefly, often not because of a desire but because it was a requirement. When the midwives were in clinical environments they developed caution around practice and were aware that their practice was being reviewed. The midwives were very clear and placed parameters around care they would provide and to whom they could offer safe care. At no stage in this study was there any indication of midwives practising beyond their chosen limits of competence. Participants kept their practice safe.

Practice is, of course, a relative term. In the current regulatory context midwives engaging in education, strategic development and research are not seen as engaging in practice. Practice is viewed as purely clinical practice. The New Zealand Midwifery Councils stance on this requirement is at odds with other national and international regulators who, as previously mentioned, deem any role in which a person is required to use their professional knowledge and expertise as a form of practice. A number of midwives in this study identified that clinical practice had at one time been an important part of their role but now they had moved into other areas of midwifery. For these participants, the day to day reality was about enhancing and supporting the profession to develop. While there was a certain enjoyment that occurred in returning to hands-on practice, this was tempered with hesitance, reluctance and risk management strategies. For this group of midwives, **working towards being ready** was about advancing the profession. A brief exposure to clinical practice did not appear to adequately refresh competence in specific skills within complex situations. Rather, they avoided situations that would take them out of their depth.

Public Safety

Throughout this study the topic of public safety has been pronounced. Although midwives did not speak about organisations such as the Health Quality and Safety Commission, or the National Maternity Monitoring Group or risk management per se, they did talk about having the required skills to practise, about education, guideline development and implementation and they also identified their actions as they worked towards being ready. Such actions demonstrated that their own and public safety was at the forefront of their mind. Midwives clearly articulated that the woman and her baby's safety was paramount and that it motivated them to remain current in their own practice.

One factor that was articulated under the notion of safety by the midwives was their awareness of the practice of others. Be it through a need to keep themselves "professionally safe" through the avoidance of complaints or through the identified need to support the practice of others. Being mindful of the practice of others" meant that the individual had a raised awareness of clinical practice that required her to be prepared to provide advice and assistance when it was required. Although conditions such as resourcing, and skill mix within units was discussed by some participants, especially core midwives, as influencing their ability to provide safe care, there was clear articulation that midwives saw and experienced different types of midwifery practice. From their perception the standard of some of this care had the potential to compromise their own practice should they have been called into account and also could have put the woman at risk of

harm. In order to mitigate any potential risk they developed the strategies outlined in this study such as keeping apprised of clinical situations so that they were prepared. One of the positive aspects of this practice was that midwives saw themselves as a resource to other clinicians and willingly provided advice and assistance when required. However one anomaly that midwives described related to safe practice across the midwifery scope.

As previously mentioned all midwives in New Zealand who hold a practising certificate are required to practise across the scope. However midwives in the current study described how their colleagues and employers 'managed' the requirements for clinical practice across the scope and were in their eyes able to declare their "competence". The literature indicates that individual self-assessment of competence is problematic (Davis et al., 2006) in that individuals assess their skills, knowledge and competence at inflated levels. A study by Eva and Regehr (2011) identified that physicians were better able to self-monitor their abilities when provided with feedback and learning opportunities; suggesting that the individual may declare that he or she is competent to provide care in a certain area but through his or her own self-monitoring limit or restrict the care that is provided. This finding was very evident in this current study. As previously stated, midwives created boundaries around the care that they would provide and indeed self-monitored their practice. Research that looked at midwives' confidence in intrapartum care (Bedwell, McGowan, & Lavender, 2015) suggested that the influence of colleagues and familiarity with the environment assist the midwife to be confident to provide care. Fahy (2012) suggested that for a midwifery model to be safe the midwife must have recent knowledge that informs practice, appropriate knowledge and skills, and be an integrated part of the workforce providing care to women. Fahy (2012) continued, stating that "no health care practitioner can be isolated from the local and regional health care system for a period of time without suffering loss of skills and experience" (p. 3). Further, Neimeyer, Taylor, Rozensky, and Cox (2014) and Weaver, Newman-Toker, and Rosen (2012) reported that there is a time frame around which knowledge and skills are retained; indicating that unless one is utilising knowledge and associated skills then they are lost from memory or performance declines.

From a perspective of risk and public safety, preventative strategies for risk management would require that midwives have adequate and ongoing training that supports their practice; this includes adequate exposure to areas of practice to ensure that skill and currency of knowledge remains. As has been identified by the midwives in this study there are barriers that impact on engagement in education with the consequent influence on safety. Further some midwives in this

study described barriers that impacted on their ability to practise in all areas of the midwifery scope. While the Council policy requires this practice, it is the reality of implementation that requires review and guidance.

The research studies presented above suggest that lack of familiarity leads to decreased confidence as experienced by midwives within the context of practice. However, the problem, as indicated by the midwives in the current study was that while there is a requirement to demonstrate competence in practice, there is no minimum requirement in the form of guidance that they can use. Midwives suggested the need for minimum hours or days within certain areas of practice be required by the regulatory body. Of course while completion of a minimum requirement does not guarantee competence or indeed safe practice and is suggestive a “tick box” approach, it appeared to give those working within the practice arena the comfort that there was a magic number that all would need to achieve and with which all midwives could be measured against. Understanding the minimum levels of experience required to retain competence is a possible future area of research that could guide future policy development.

However the tension exist that while from her own perspective a midwife may be acting in the interests of public safety by removing herself from the day to day reality of intrapartum care (because she has identified that she lacks confidence, knowledge or skills); unless this is addressed she is not meeting the regulatory policy that requires her to do so. As a consequence of this, there are two situations that can present, the midwife who, as in this study, provides some aspects of care across the scope of practice and the midwife who engages in minimum activities as completion of a requirement. This anomaly needs to be quantified and explored to understand the implications for women, for the midwife and for midwifery.

Perhaps the question arising from this study that needs addressing is not “do midwives meet the expectations of Midwifery Council in maintaining competency across the full scope of practice?” but rather, “do midwives adequately self-monitor their practice to attain safety within their chosen context of practice?” The first question requires some midwives to change the manner in which they maintain competence to include mandated levels of skill and knowledge across the full scope of practice. The second, requires the Midwifery Council to reframe its expectations to recognise that the nature of being a professional is to ensure one is safe to practice in a given context, and in doing so to align with other health professional governing bodies. From the findings of this study, I recommend that it is Midwifery Council who needs to make the change.

Limitations of this study

This study describes the process that a group of midwives working within modern New Zealand society use to maintain their ongoing ability to practise. It does not explore the success or otherwise of their strategies except that from the midwife's perspective the strategies in which she engaged meant that she was able to meet and exceed the requirements of the regulator. It is a study about ways of engaging in a process that is aimed at ensuring ones continued ability to be able to practise with implications that are framed around maintaining public safety.

The study would have been strengthened by including participants whose competence was in question; however there were ethical limitations to include such midwives and given my employed role it is unlikely that they would have enrolled in such a study. There are also questions about my objectivity should this have occurred. Further, it may be that my role within the Midwifery Council tempered what participants in the current study felt safe to talk about as part of the research process. It is unlikely that any of the participants would have willingly exposed practice that they themselves knew would demonstrate a lack of awareness of current practice. Despite these limitations, midwives willingly shared the challenges that they faced and the consequences for them of the process of **working towards being ready**.

Had the research methodology brought an explicit critical lens, issues of power, vested interest, funding and institutional bias are likely to have been exposed in a more telling manner. Further, had the research methodology taken a more quantitative approach, surveying a much wider group of midwives, it may have provided a more thorough understanding of the actual activities in which midwives engage; that is, the courses that they attend or the methods of learning in which they involve themselves. It could also have provided an analysis of the amount and nature of education, as well as clinical practice in which midwives engage in order to meet mandated requirements. While these matters have been raised, the current study does not explore these issues.

Implications for practice

What this study has made explicit is the idea that, across the board, midwives are practising in a number of different ways in a number of different contexts and at a number of different levels. These limits are bounded by the midwife's personal circumstances, environment and professional drive and motivation. There appears to be no "generic midwife", although there is a broad statement regarding the generic practice of midwifery. Midwives, through personal life choices, practise in the way that they want to grow and develop skills in areas related to their expertise.

Is it time now to recognise and make explicit the diversity in practice and to acknowledge the different needs and different requirements for midwifery practice. While this study goes some way towards explaining the diversity there needs to be clear articulation of what midwife practice is in New Zealand in 2015.

Fergusson, Smythe, and McAra-Couper (2010) described in detail the experiences of midwives working in co-ordinator roles in tertiary hospitals, making explicit the decisions and situations that they endure, and highlighting the development needs of this cohort of midwives. Fraser (2015), in an opinion article, described her contrasting working week as a LMC midwife juggling the on call demands of clinical practice and ensuring education needs are met. Further, Donald (2012, p. 199) called for a way to “be found in our professional development programme through ongoing educational programmes to ensure that case-loading midwives can be better prepared for their role”. Donald referred to preparation that would support sustainability within the profession and promote work life balance, this has implications on the everyday work of midwives and the impact that the need for development has on their ability to sustain practice. Strategies used by the midwives within this study were all about managing requirements. What is implicit is that if there is diversity in practice then there needs to be diverse systems employed to meet needs of clinicians and the realities of midwives need to be valued by midwives and midwifery.

Implications for research

This research has raised a number of questions regarding the effectiveness of processes that sit around the midwife and that require her to engage in practice and mandated continuing professional development activities. While it demonstrates how midwives do engage in such development activities it does not answer the question regarding their effectiveness. It has demonstrated the strategies that are used by the midwives as they engage in this educative process and has exposed some of the tensions that exist. It makes explicit the sense for the midwives that, from an educative perspective, what they are required to complete is seen as being the minimum. As internationally other regulators move towards reassurance processes in order to assess ongoing competence (Bolsin et al., 2015; Nursing and Midwifery Council, nd; Spendlove, 2013) the time has come to reconsider the needs of the New Zealand public and the New Zealand midwifery workforce to ascertain if they are meeting their objectives. The first step is to understand if what is currently required is actually effective. Evaluation research needs to be undertaken to ascertain if the component parts of the current programme of recertification are meeting its objectives from the midwife’s, the regulators’ and the public’s perspective.

The study has also made explicit the notion of reflection and how that is incorporated within the remit of the midwife. Reflection, peer support and mentoring were seen as being integral to the midwife as she attempted to make sense of her practice. Reflection is seen as a key component of modern professional practice that leads to change in behaviour; however, it is also seen as being associated with people's over inflation of their own skills and abilities. It is suggested that further research review the robustness and effectiveness of systems and processes that are in place to support midwives with reflection and reflective practice.

This study is about professional development. It is not purely about continuing professional education. However, given that education is a large component of professional development and is a key strategy used in order to maintain competence, it is timely to review education that is provided and required, to expose any the gaps in education and the barriers that impact on midwives engagement in it.

Implications for education

What is apparent in this study is that salient conditions such as availability, rostering, as well as cost factors, impact on midwives' ability to engage in education. Traditional methods of education provision, such as classroom and face to face instruction, are limiting in the number of midwives that can attend such education. This method of education is a slow way to translate knowledge into practice.

A review of the College of Midwives websites provides opportunities for professional education in 11 subject areas; however all workshops are face to face and numbers are limited (New Zealand College of Midwives, 2015c). Currently, the College of Midwives provides no online or webinar based education. A review of other midwifery professional organisations shows opportunities for development in over 50 subject areas and includes the use of online and webinar type programmes (Australian College of Midwives, 2011; Royal College of Midwives, ND). Again, while some of these education programmes have associated costs others are provided free to members of the professional organisation.

Identified within this study were the barriers that are in place that limit access to education, including location, cost and rationing. Such barriers need to be removed and strategies put in place that allows timely access to high quality robust education for midwives that meets their needs. Professional and in-service educators need to ensure that education is robust, effective and meeting the needs of their client group. It is suggested that a high level needs and gap

analysis could be undertaken to ascertain the requirements for midwives and to consider how these can be met.

Midwifery is the workforce that is involved in the provision of maternity care within New Zealand society. It is a publicly funded system and midwives are either employed to provide services or they are contracted to the government. Consideration of the needs of the workforce is required as are strategies to be implemented at a policy level that remove barriers to engagement and that support professional development.

Implications for regulation

The current system of mandated activities is premised around the notion of public safety. Midwives engage in these activities as they are required but questions arise regarding interpretation of these requirements and the way that they are manifested into day to day practice. Indeed, the question must be asked if the programme of requirements, as outlined today, ensures public safety? Further, do the mandatory nature and specific requirements required of midwives ensure development as professionals or have they become day to day practice and, as such, should become business as usual managed by the midwife. The question must be asked if the regulatory focus should move towards assurance of practice rather than audit of attendance. The purpose of the recertification programme is “ensuring health practitioners are competent to practise within their scope of practice” (New Zealand Government, 2003, p. 37). What is evident is that questions remain regarding the appropriateness of the recertification programme and on what assurance measures are put in place. While the midwives in this study identified that they engaged in activities, they also discussed strategies that they put in place to maintain their readiness when they questioned a colleague’s competence; indeed they identified colleagues whose engagement was at bare minimum. They further raised the notion of the validity of self-assessment within practice. In line with recommendations from the Institute of Medicine review of continuing development (Institute of Medicine, 2009), midwives need to be part of a “system built around performance improvement rather than participation: Individuals need to identify the problems within their practice and then work out a system that provides answers” (DeSilets & Dickerson, 2010). Continuing education and development need to be assessed and planned in line with outcomes from practice which is the system that by and large the midwives within this study engaged. Perhaps it is statement of practice outcomes that needs to be used as assurance of competence rather than attendance at education sessions.

In line with the need to attend education, midwives advised how they managed the provision of clinical care to the detriment of continuing education and the potential consequences that they encountered. While the actions taken by the midwife were not a deliberate avoidance of activities, but necessary through circumstances, there were professional consequences for the midwife who, to all intents and purposes, was ensuring the safety of the public. This paradox needs to be explored by the regulator, especially when there are limited education places and travel and locum costs impact on midwives' abilities to engage. Restrictions should not be imposed when there are extenuating circumstances that impact on day to day practice. It is suggested that the regulator review its determinations of engagement and its definition of ongoing competence in line with ensuring effectiveness of processes of recertification.

What was very evident in this study was the concept of practice across the midwifery scope. The midwives in this study demonstrated that by **working towards being ready** they were working within the midwifery scope of practice. There were some similarities and many differences toward how they achieved this goal. However, through the process of **working towards being ready** midwives placed boundaries on the way in which they practised and the care that they provided. Just as case loading midwives placed limits around elements of secondary or complex care that they would provide, hospital employed midwives had or placed their own boundaries placed on their practice through the provision of services for which they were employed. They also made a decision not to provide birthing-at-home services, for example. Conversely rural midwives identified that if a woman needed specific assessments they would refer her to their urban colleagues for care that they themselves could not and did not provide. **Working towards being ready** thus involved midwives placing limits around their practice, which meant that while they practised as midwives, they did not necessarily traverse the full scope of midwifery practice. In simplistic terms this means provision of care from conception to six weeks postnatal and in between, which is the scope of midwifery practice, was not the reality for many of today's midwives. The Council needs to consider its requirements for practice across the scope; it needs to understand the reality of this practice within current context and strengthen the mandatory reporting nature. Alternatively, Council needs to accept that through their own self-monitoring midwives develop arrangements that work for them within their current context which may or may not be in line with expected practice.

In addition, educators and researchers strongly held the view that they were practising midwifery; they saw that their practice was teaching, research or strategic development and not necessarily

as a clinician. Again this cohort of midwives placed boundaries around clinical practice and the care that they would provide as a way of self-preservation. Recognition needs to be given to the skills and knowledge that these clinicians need and develop as they lead change. As highlighted above, their development needs should link with the gaps that they identify. Their type of practice that directly impacts on midwifery and safe care for women needs to be valued as midwifery practice. The Regulator needs to understand the extent to which midwives engage in practice across (or within) the scope and then reconsider the needs of clinicians within the social context where public safety is paramount and risk mitigation is required. The one size fits all approach may not meet the needs of practising midwives today. Indeed it may be timely to review the needs and requirements for these clinicians acknowledging their place in the broad spectrum of midwifery.

It could be that different development needs may be required for different clinicians. Consideration needs to be given by the regulator as to how tightly it needs to define and control practice across 'scope'. In its role to ensure public safety one questions if there needs to be more prescriptive requirements that must be met when clinicians move across different types of practice; especially as they move towards community practice which is largely self-managed, assessed and guided. Yet professionalism requires that the practitioner is cognisant of competence required to make such a move and to take self-responsibility to ensure safety to practice. It is beyond the remit of this study to make this decision; however my opinion is that there is a need to understand the reality of practice and exactly what changing practice context means for any midwife. Further there is a need to reconsider requirements in light of moves within regulation for both self-declaration and third party endorsement of competence to practise.

Conclusion

This research acknowledges and makes real the processes that midwives undertake as they attempt to maintain their ongoing competence to practise their profession. I have written this conclusion at the time where midwives are seeking validation of their professional status and economic worth through a claim to the High Court of New Zealand.

This study shows that for those involved there was a commitment to maintaining high standards of professional practice, of learning, professional growth and development that well exceeded the requirements placed on midwives by their regulator. It highlighted the world in which they practice and the challenges that they faced as they engaged in these activities. It also highlighted the dynamic nature of midwifery and the emerging diversification that exists within practice.

Through the process of **working towards being ready** midwives practice in their different areas to ensure that they are ready for the challenges and situations in which they find themselves. They demonstrated their commitment to providing women with safe care – sometimes at the expense to them personally and in some situations professionally. Midwives actively sought to be current, up to date, competent in their clinical practice and engaged in their profession. They strove to provide care that was safe. The profession, the regulator, educators, employers and funders need to value this development, to consider and implement innovative ways to actively support the commitment of these practitioners.

Regulation needs to focus on assurance processes and not audit processes. Midwives know what they are required to do in order to maintain their competence to practise and they have developed strategies to allow them to achieve context-relevant competence. What needs to occur now is review of current Midwifery Council regulatory policy and processes to ensure assurance of competence that is congruent with the reality of how this study has shown midwives continuously work towards being ready for whatever the moment of practice brings.

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Appendix A : Midwifery Council competencies for entry to the register of midwives

The Competencies for Entry to the Register of Midwives⁴⁴ provide detail of the skills, knowledge, and attitudes expected of a midwife to work within the Midwifery Scope of Practice. Where the Midwifery Scope of Practice provides the broad boundaries of midwifery practice, the competencies provide the detail of how a registered midwife is expected to practise and what she is expected to be capable of doing. By defining the minimum competence standards for registration as a midwife in New Zealand the Midwifery Council has established the minimum standard that all midwives are expected to maintain in their ongoing midwifery practice.

The Competencies for Entry to the Register of Midwives are as follows:

Competency One

“The midwife works in partnership with the woman/wahine throughout the maternity experience.”

Explanation

The word midwife has an inherent meaning of being “with woman”. The midwife acts as a professional companion to promote each woman’s right to empowerment to make informed choices about her pregnancy, birth experience, and early parenthood. The midwifery relationship enhances the health and well-being of the woman/wahine, the baby/tamaiti, and their family/whanau. The onus is on the midwife to create a functional partnership. The balance of ‘power’ within the partnership fluctuates but it is always understood that the woman/wahine has control over her own experience.

Performance Criteria

The midwife:

- 1.1 centres the woman/wahine⁴⁵ as the focus of care;
- 1.2 promotes and provides or supports continuity of midwifery care;
- 1.3 applies the principles of cultural safety⁴⁶ to the midwifery partnership and integrates Turanga Kaupapa within the midwifery partnership and midwifery practice⁴⁷;

⁴⁴ In May 2004 the Midwifery Council consulted on the Nursing Council of New Zealand’s (1996) ‘Competencies for Entry the Register of Midwives’. These four competencies were developed by the Nursing Council in consultation with the midwifery profession and were used to determine the level of competence required for graduates from New Zealand midwifery programmes since 1996. The Midwifery Council made minor modifications to the four competencies and formally adopted these as entry-level standards in July 2004. Further minor amendments were made in September 2007 in order to incorporate Turanga Kaupapa.

⁴⁵ Note: The word “woman” or “wahine” used throughout includes her baby/tamaiti/partner/family/whanau.

- 1.4 recognises Maori as tangata whenua of Aotearoa and honours the principles of partnership, protection, and participation as an affirmation of the Treaty of Waitangi;
- 1.5 recognises and respects the woman's/wahine ethnic, social, and cultural context;
- 1.6 facilitates, clarifies, and encourages the involvement of family/whanau as defined by the woman/wahine;
- 1.7 respects and supports the needs of women/wahine and their families/whanau to be self determining in promoting their own health and well being;
- 1.8 promotes the understanding that childbirth is a physiological process and a significant life event;
- 1.9 communicates effectively with the woman/wahine and her family/whanau as defined by the woman;
- 1.10 provides up to date information and supports the woman/wahine with informed decision making;
- 1.11 negotiates the midwifery partnership, recognising and respecting the shared responsibilities inherent in it;
- 1.12 maintains confidentiality and privacy; and
- 1.13 formulates and documents the care plan in partnership with the woman/wahine.

Competency Two

“The midwife applies comprehensive theoretical and scientific knowledge with the affective and technical skills needed to provide effective and safe midwifery care.”

⁴⁶ Cultural Safety means “the effective midwifery care of women from other cultures by a midwife who has undertaken a process of reflection on her own cultural identity and recognises the impact of her culture on her practice”. Unsafe cultural practice is “any action that diminishes, demeans or dis-empowers the cultural identity and well-being of an individual” (NZCOM, 2005, p.46)

Culture includes age or generation; gender; sexual orientation; occupation and socio-economic status; ethnic origin or migrant experience; religious or spiritual belief; and disability (NCNZ, 2002b, p.7). Cultural Safety provides an instrument that allows a woman and her family to judge whether the health service and delivery of health care is safe for them (Ramsden, 2002).

⁴⁷ Turanga Kaupapa are guidelines for cultural competence developed by Nga Maia o Aotearoa and formally adopted by both the Midwifery Council of New Zealand and the New Zealand College of Midwives.

Explanation

The competent midwife integrates knowledge and understanding, personal, professional and clinical skills within a legal and ethical framework. The actions of the midwife are directed towards a safe and satisfying outcome. The midwife utilises midwifery skills that facilitate the physiological processes of childbirth and balances these with the judicious use of intervention when appropriate.

Performance Criteria

The midwife:

- 2.1 provides and is responsible for midwifery care of the woman/wahine and her family/whanau during pregnancy, labour, birth and the postnatal period;
- 2.2 confirms pregnancy if necessary, orders and interprets relevant investigative and diagnostic tests, carries out necessary screening procedures, and systematically collects comprehensive information concerning the woman's/wahine health and well-being;
- 2.3 assesses the health and well-being of the woman/wahine and her baby/tamaiti throughout pregnancy, recognising any condition which necessitates consultation with or referral to another midwife, medical practitioner or other health professional;
- 2.4 utilises a range of supportive midwifery skills which facilitate the woman's/wahine ability to achieve her natural potential throughout her childbirth experience;
- 2.5 attends, supports, and regularly assesses the woman/wahine and her baby/tamaiti and makes appropriate, timely midwifery interventions throughout labour and birth;
- 2.6 identifies factors in the woman/wahine or her baby/tamaiti during labour and birth which indicate the necessity for consultation with, or referral to, another midwife or a specialist medical practitioner;
- 2.7 provides and is responsible for midwifery care when a woman's/wahine pregnancy, labour, birth or postnatal care necessitates clinical management by a medical practitioner;
- 2.8 recognises and responds to any indication of difficulty and any emergency situation with timely and appropriate intervention, referral, and resources;

- 2.9 assesses the health and well-being of the newborn and takes all initiatives, including resuscitation, which may be necessary to stabilise the baby/tamaiti;
- 2.10 regularly and appropriately assesses the health and well-being of the baby/tamaiti and initiates necessary screening, consultation, and/or referral throughout the postnatal period;
- 2.11 proactively protects, promotes and supports breastfeeding, reflecting the WHO's⁴⁸ "Ten Steps to Successful Breastfeeding";
- 2.12 assesses the health and well-being of the woman/wahine and baby/tamaiti throughout the postnatal period and identifies factors which indicate the necessity for consultation with or referral to another midwife, medical practitioner, or other health practitioner;
- 2.13 demonstrates the ability to prescribe, supply, and administer medicine, vaccines, and immunoglobulins safely and appropriately within the midwife's scope of practice and the relevant legislation;
- 2.14 performs a comprehensive end-point assessment of the woman/wahine and her baby/tamaiti within the six week postnatal period, including contraceptive advice and information about and referral into well woman and well child services, including available breastfeeding support and immunisation advice;
- 2.15 shares decision making with the woman/wahine and documents those decisions;
- 2.16 provides accurate and timely written progress notes and relevant documented evidence of all decisions made and midwifery care offered and provided;
- 2.17 demonstrates an accurate and comprehensive knowledge of legislation affecting midwifery practice and obstetric nursing;
- 2.18 collaborates and co-operates with other health professionals, community groups and agencies when necessary; and
- 2.19 provides the woman/wahine with clear information about accessing community support agencies that are available to her during pregnancy and to her, the baby/tamaiti, and family/whanau when the midwifery partnership is concluded

⁴⁸ World Health Organisation

Competency Three

“The midwife promotes practices that enhance the health of the woman/wahine and her family/whanau and which encourage their participation in her health care.”

Explanation

Midwifery is a primary health service in that it recognises childbirth as significant and normal life event. The midwife is therefore responsible for supporting this process through health promotion, education, and information sharing, across all settings.

Performance Criteria

The midwife:

- 3.1 demonstrates the ability to offer formal and informal learning opportunities to women and their families/whanau to meet their specific needs;
- 3.2 encourages and assists the woman/wahine and her family/whanau to take responsibility for their health and that of the baby by promoting self-health and healthy life-styles;
- 3.3 promotes self-determination for the woman/wahine and her family/whanau;
- 3.4 promotes and encourages exclusive breast feeding as the optimal way of feeding an infant;
- 3.5 demonstrates an understanding of the needs of women/wahine and their families/whanau in relation to infertility, complicated pregnancy, unexpected outcomes, abortion, adoption, loss and grief, and applies this understanding to the care of women and their families/whanau as required;
- 3.6 uses and refers to appropriate community agencies and support networks; and
- 3.7 ensures the woman/wahine has the information about available services to access other health professionals and agencies as appropriate.

Competency Four

“The midwife upholds professional midwifery standards and uses professional judgment as a reflective and critical practitioner when providing midwifery care.”

Explanation

As a member of the midwifery profession the midwife has responsibilities to the profession. The midwife must have the skills to recognise when midwifery practice is safe and satisfactory to the woman/wahine and her family/whanau.

Performance Criteria

The midwife:

- 4.1 accepts personal accountability to the woman/wahine, to the midwifery profession, the community, and the Midwifery Council of New Zealand for midwifery practice;
- 4.2 recognises the midwife's role and responsibility for understanding, supporting, and facilitating the physiological processes of pregnancy and childbirth;
- 4.3 demonstrates the ability to provide midwifery care on her own professional responsibility throughout pregnancy, labour, birth, and the postnatal period;
- 4.4 recognises strengths and limitations in skill, knowledge and experience and shares or seeks counsel, consults with, or refers to, a relevant resource, other midwives, or other health practitioners;
- 4.5 assesses practice in relation to current legislation, the Midwifery Scope of Practice and Competencies for Entry to the Register of Midwives, and the New Zealand College of Midwives' "Handbook for Practice" and "Code of Ethics";
- 4.6 directs, supervises, monitors and evaluates the obstetric nursing care provided by registered obstetric nurses, enrolled nurses, registered general nurses or registered comprehensive nurses;
- 4.7 participates in Midwifery Standards Review using professionally recognised standards and reflects on and integrates feedback from clients and peers into midwifery practice;
- 4.8 recognises own values and beliefs and does not impose them on others;
- 4.9 is aware of the impact of gender, race and social policies and politics on women, midwives and the maternity services;
- 4.10 demonstrates a commitment to participate in ongoing professional development;

4.11 participates in cultural safety education and development;

4.12 assists and supports student midwives in the development of their midwifery knowledge and skills in clinical settings: and

4.13 works collegially and communicates effectively with other midwives and health professionals.

Appendix B Midwifery Council Recertification Programme

Source: Midwifery Council of New Zealand Recertification policy

There are six individual components within the programme:

- 1 A declaration of competence to practise within the Midwifery Scope of Practice
- 2 Practice across the Scope over a three- year period
- 3 Maintenance of a professional portfolio
- 4 Completion of all compulsory education
- 5 Completion of 30 points over a three-year period of elective education and professional activity: a minimum of 15 points in each category over three years
- 6 Participation in a Midwifery Standards Review

Compulsory education is as follows

1. Attendance at an emergency skills day annually
2. Attendance at a midwifery practice day every three years
3. Attendance at the minimum of a four hour breastfeeding workshop every 3 years
4. Completion of one other activity related to breastfeeding every three years

Appendix C: Participant Information Sheet

Participant Information Sheet



Date Information Sheet Produced:

22 March 2012

Project Title

Maintaining competence in midwifery practice

An Invitation

My name is Sue Calvert. I am a midwife and a Doctoral student at AUT. I would like to invite you to participate in my research project. This project is part of my studies and will contribute to my qualification.

Participation in this study is voluntary and participants may withdraw at any time prior to the completion of data collection. In my employed role I work as the Midwifery Advisor to the Midwifery Council and I am involved in the Council's on-going competence processes. My research project is separate from my employment although there is a potential conflict of interest. There are a number of criteria that allow people to be part of this project. However my employer does not have access to any of the information that is presented to me as a researcher. Participation in this study or otherwise will neither advantage nor disadvantage you in terms of Midwifery Council matters.

What is the purpose of this research?

The purpose of this research is to develop a theory of how a group of New Zealand midwives maintain their on-going competence to practice.

This project has been developed and will ultimately lead to the researcher obtaining a Doctor of Health Science degree. The researcher also plans to present the findings at conferences and to write articles for professional journals.

How was I identified and why am I being invited to participate in this research?

This study uses a process known as theoretical sampling to identify participants that can be recruited into the study. In this study midwives with specific characteristics have been approached through professional networks and by the use of an intermediary. Details of the potential participants are forwarded to the researcher after an intermediary has sought your approval to give such details to me.

There are a number of types of midwife who are excluded from this research and they are as follows:

- Any midwife who is or has been under a competence, health or conduct process with the Midwifery Council of New Zealand.

- Any midwife who is selected for Midwifery Council audit during the data collection phase.
- Any midwife who has restrictions on her practising certificate ie a midwife working through an overseas competence programme or who has not practised in New Zealand for a minimum of the previous three years
- Any midwife who does not meet the selection criteria i.e.
 - A New Zealand registered midwife with a current annual practising certificate
 - Located and working in practice in New Zealand
 - Able to converse in English.

What will happen in this research?

Participation in this interview will involve you discussing with me how you maintain your competence to practise midwifery today. This will be the form of a tape-recorded interview. It could be that we complete this interview face to face or with your approval we may undertake the interview using technology such as skype.

After we have completed the interview it will be transcribed by a typist. This person has signed a confidentiality agreement and will not disclose any information that you provide to me to any third parties. The typist is not a midwife.

When I receive your transcript back I will email it to you. The purpose of this is to allow you to read it to ensure that I have captured the nature of our conversation and to allow you to amend any factual inconsistencies.

After this has occurred then I will begin the process of analysing your transcript as is part of the research process. Through the process of analysis further participants with specific characteristics will be identified and their insight will be added to the matrix of analysed data.

In the end a theory will be developed this will be an amalgamation of data from all participants. The data that is analysed also looks at the conditions and consequences i.e. what outside factors impact on your ability to maintain your competence to practise.

What are the discomforts and risks?

You may feel uncomfortable discussing this information with a researcher because of her professional role. Please be reassured that anything that is stated in this research is confidential. My employed role and that of a student are quite separate. While my employer is aware that I am doing this project they have no right to access any of the information that I receive. In addition I will not disclose any information that I receive in my professional capacity.

The potential risk in a small midwifery community is that something you say may make you identifiable to others who know you, however every effort will be made to avoid this situation.

How will these discomforts and risks be alleviated?

You will not be identified in this research. You will be asked to select a pseudonym and any identifying information about you or your place of work will be removed. There will be no identifying information in the thesis that is developed. Quotes that are used in any research outputs will use the pseudonym. If information is provided about participants it will be in collective, for example the report will state that a certain number of midwives participated in

the study including midwife educators, clinical midwifery managers etc... No personal information will be disclosed.

I take the topic of confidentiality extremely seriously and the only people who will know who actually participates in my study are myself and possibly my thesis supervisors. The consent forms will be stored in a locked cabinet in my supervisor's office at AUT, Akoranga Campus. All transcripts will be stored on a CD in my personal file at the Health and Environmental Sciences Postgraduate Office at AUT, Akoranga Campus. The transcripts will remain stored in this file for up to six years as per the University requirements.

If in the process of interview you disclose a story to me that causes you discomfort or distress and you feel that you need to talk through this issue with another person then there is the opportunity for you to have Counselling through AUT counselling services. The counsellors can be contacted on 09 -921 9998 or through e-counselling.

What are the benefits?

Completing this research will allow me as a student to complete my Doctor of Health Science degree. In addition in my professional career journal articles and conference presentations that arise from this study may also benefit me. Finally the Midwifery profession may benefit from the findings of this study if the findings suggest changes in structures and processes that can be implemented that will impact on all practitioners.

How will my privacy be protected?

As stated you will be given a pseudonym and any identifying information about you or where you work or practice will be removed. It may be however that due to the nature of the midwifery profession and the small population size that something you say in your story may be identifiable to another midwife. In order to minimise the chances of you being identified quotes when used will be attributed to your pseudonym and it may be that places and times are amended so as not to identify individuals.

The typist who will transcribe the interviews does not have access to personal information and she will sign a confidentiality statement. All transcripts are stored in secure storage at AUT University for a period of six years after the research has been completed and your consent form is stored in a second location away from the transcript.

What are the costs of participating in this research?

The main cost for you in participating in this study is through your time. That is time to attend the interview and time to read that typed transcript that I will send to you a few days after our interview. It is expected that it will take up to two hours to undertake the interview and another hour to review the transcript.

What opportunity do I have to consider this invitation?

If you would like to participate in this study I would appreciate hearing from you within 10 working days. If I do not hear from you within that timeframe I will assume that you have decided that you do not wish to participate in the study.

How do I agree to participate in this research?

Once you have decided that you wish to participate in the study and have contacted me, then we will agree on a time to undertake the interview. At this time I will ask you to sign a consent form to say that you agree to participate in the study and that you agree to me recording our interview.

Will I receive feedback on the results of this research?

After the research has been completed I will write to the midwives who participated in the study and provide them with a copy of the research abstract and the theory that is developed.

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, Dr Liz Smythe, *liz.smythe@aut.ac.nz* 09 921 9999 ext 7196

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Dr Rosemary Godbold, *rosemary.godbold@aut.ac.nz* ,09 921 9999 ext 6902.

Whom do I contact for further information about this research?

Researcher Contact Details:

Sue Calvert

Mobile: 027 282 4013

Email: Dds8282@aut.ac.nz

Project Supervisor Contact Details:

Dr Liz Smythe

Phone: 09 – 921 9999 ext 7196

Email: Liz.smythe@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 27th April 2012. AUTEK Reference number 12/70.

Appendix D: Consent Form

Consent Form



Project title: **Maintaining competence in Midwifery Practice**

Project Supervisor: **Associate Professor Liz Smythe**

Researcher: **Susan Calvert**

- I have read and understood the information provided about this research project in the Information Sheet dated 22nd March 2012
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that although the researcher will use a pseudonym and that all quotes will be attributed to the pseudonym, it could be that something I say in the interview could identify me to another midwife. I am aware that the researcher will amend names and dates so as to minimise the chance of me being identified.
- 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 information including 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 (please tick one): Yes No

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 27th April 2012

AUTEC Reference number 12/70

Note: The Participant should retain a copy of this form.

Appendix E: Autec approval letter



MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Liz Smythe
From: **Dr Rosemary Godbold** Executive Secretary, AUTEC
Date: 27 April 2012
Subject: Ethics Application Number 12/70 **Maintaining competence in midwifery practice.**

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 (AUTEC) at their meeting on 16 April 2012 and I have approved your ethics application. This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 14 May 2012.

Your ethics application is approved for a period of three years until 27 April 2015.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 27 April 2015;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/research/research-ethics/ethics>. This report is to be submitted either when the approval expires on 27 April 2015 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded

that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEK 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 me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6902. Alternatively you may contact your AUTEK Faculty Representative (a list with contact details may be found in the Ethics Knowledge Base at <http://www.aut.ac.nz/research/research-ethics/ethics>).

On behalf of AUTEK and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Dr Rosemary Godbold

Executive Secretary

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Appendix F: Data Coding

MW
 Being confident
 in my knowledge
~~Let~~ competent
 Refreshing skills
 Being initiative
 Refreshing skills
 Supportive of
 practice

O.K. Things like I have to say I am not ...I am fairly certain that shoulder dystocia, I feel quite comfortable in. Breach I feel I have done few times I feel comfortable because I understand the anatomy and physiology. so I don't feel concerned about that.

Things like suturing um yeah I have done lots. So how do I maintain that, I haven't been back and suturing workshop I did one about three years ago and I did that because I haven't done anything for a while on suturing. so I just did that myself. If I was going back into full time practice I would go and do the cannulation my sense of where I am going and what I am happy to do now is minimal.

How do you keep up with new knowledge that's being introduced into practice?

MW
 Knowledge critique
 Questioning
 Change
 Confidence
 Updating
 Self-directed
 Accessing
 info

Oh well at the moment I have got the most exciting student with me who critiques me in front of my clients, without my clients and she is fantastic she is really bright. I was about to swab a baby I was giving it konakion I think that is what it was and she said do you still swab and I said ah is there something I need to know oh she said we were told not to swab. I said fine I don't mind really um oh well I wont swab then o.k. The grandmother was also a practising nurse who was watching she no we don't do that now she was a public health nurse. That's really interesting so there is that side of it. Then there is how do you keep up in terms of reading the journal, reading and going exploring things that I come across in practice I mean every time something crops up I go into the computer because I find that interesting.

Data	Coding	Concepts	Category
<i>I follow College guidelines about caseloads so that I can provide good care and you see other midwives who you know are interventionist and use medication and are very busy and I don't think they are competent because of my philosophy, but they are not. They haven't been struck off. They haven't - some of their women like them and they don't have adverse outcomes.(Judith)</i>	Practising to my standard Perceiving different practice Questioning philosophies Developing opinions	Being mindful of others Developing awareness of difference	Reviewing practice
<i>I think we have got a huge problem at the moment locally where we don't have good midwifery leadership in the facilities and those midwifery leaders are not engaged in the College, and they are not engaged in ongoing study and I think they are not role-modelling what they want their staff to be doing as well. (Lydia)</i>	Negative role modelling Not engaging Stagnating		
<i>when you see someone else's practice and therefore they are not necessarily at their best. You know the adrenalin rush affects everybody in a different way and so it is hard to judge how good a person actually is under those set of circumstances. You could be quite critical but in actual fact it is not, yeah, certain people use certain techniques should we say or words whatever to cover up certain things that yeah make you feel a little bit concerned at times about their competency.(Claire)</i>	Practice affected by circumstance Covering up Raising awareness of concern		