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Unsettling moods in rural midwifery practice

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ABSTRACT

Background: Rural midwifery and maternity care is vulnerable due to geographical isolation, staffing recruitment and retention. Highlighting the concerns within rural midwifery is important for safe sustainable service delivery.
Method: Hermeneutic phenomenological study undertaken in New Zealand (NZ). 13 participants were recruited in rural regions through snowball technique and interviewed. Transcribed interview data was interpretively analysed. Findings are discussed through the use of philosophical notions and related published literature.
Findings: Unsettling mood of anxiety was revealed in two themes (a) '*Moments of rural practice*' as panicky moments; an emergency moment; the unexpected moment and (b) '*Feelings of being judged*' as fearing criticism; fear of the unexpected happening to 'me' fear of losing my reputation; fear of feeling blamed; fear of being identified.
Conclusions: Although the reality of rural maternity can be more challenging due to geographic location than urban areas this need not be a reason to further isolate these communities through negative judgement and decontextualized policy. Fear of what was happening now and something possibly happening in the future were part of the midwives' reality. The joy and delight of working rurally can become overshadowed by a tide of unsettling and disempowering fears.
Implications: Positive images of rural midwifery need dissemination. It is essential that rural midwives and their communities are heard at all levels if their vulnerability is to be lessened and sustainable safe rural communities strengthened.

Introduction

To be a midwife within a rural setting is, by its very nature, to be a long way from tertiary services. Families make the choice to birth within the rural area perhaps not quite appreciating how much responsibility this places on the shoulders of the midwife who takes on their care. It is she who must watch for hints of problems, she who must ensure the family knows what to do if 'something' happens, she who must get to the labour in a timely manner (from wherever she may be) and she who must be ready to deal with any emergency that may arise. All this unfolds, family by family, sleep-disturbed night-upon-night, along with unpredictably long journeys to accompany a woman to the urban tertiary hospital. The midwife who carries the load has chosen her [sic] lot. This is also her community, the place she feels 'at home'. Her skills enable her to provide a vital service within this community; she is needed and valued. Within all this, the lack of sleep, the always-being-on-call and the long hours spent driving, it is likely that, after the birth, she remembers afresh why she does this. The joy of the moment of birth gifts in an energy-sustaining way.[1] Yet is this enough? This paper is drawn from a phenomenological study that explored the experience of childbirth in New Zealand's rural regions.

The methodology guiding this study is interpretive hermeneutic phenomenology. Phenomenological data requires lived experience descriptions of the phenomenon of interest in the form of stories.[2,3] Therefore, this study gathered stories of those living in and through the phenomenon of New Zealand rural and remote rural maternity. The stories were interpreted using hermeneutic phenomenological analysis. Other findings from the study are reported elsewhere.[4,5] This paper focuses on the moods that emerged from rural midwives' stories of their experiences. It seemed their burden was heavy yet they relished the opportunity to be listened to and heard. They shared something of the personal cost of practising in relative isolation, a long way from anywhere,

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yet paradoxically in a community where everybody knew them as 'the midwife'.

This paper draws on Heidegger's philosophical notion of attunement or mood.[6,7] Mood, in Heidegger's interpretation, refers to 'being in a mood' and can be also called feelings and affects, yet the meaning goes beyond than these psychological categories.[8] Mood is also more than emotion. Emotions such as sadness are able to be described and even measured in psychometric scoring; mood on the other hand is complex and part of our implicit understanding of "how we find ourselves".[9] Heidegger suggests that we are beings who have moods; mood is what makes us human. In other words, we cannot be without mood; we are always attuned in one way or another to how we find ourselves feeling. Along with the mood of our times, a culture or regional mood, moods are shaped by, and in turn shape, each experience. A fierce winter storm shapes a mood of reluctance to drive an isolated county road; such a mood has one driving with great caution. It is our moods that bring understanding about the events we find ourselves already living through. As the midwife drives through the storm the mood of anxiety heightens her understanding of the predicament she might find herself in should the labouring woman at the end of the road need urgent transfer to a hospital. We can say that rural midwives are always amidst the circumstances of their lives and practice. Driving away from her young daughter's birthday party to attend a woman in labour is likely to invoke a mood of disappointment, yet the midwife knows she will have to disguise such a mood when she reaches the woman. Moods are thus inside and outside, everywhere and nowhere. Mood is not simply a colouring to what is happening or some internal state, it 'is' what is happening around and inside of us. Moods are our pre-cognitive way of sense-knowing the world we live in.[10] Our fundamental humanness is to feel and sense the world we inhabit. Moods therefore, more fully disclose to us 'how we find ourselves' than our cognitive abilities. Thus understanding is always 'moody' and "an existential fundamental connection between befindlichkeit [attunement] and understanding".[7] It is the midwife's attunement to how she finds herself driving through the storm that has her thinking ahead to the predicaments she might find herself facing if there are problems with this woman's labour.

1. The New Zealand context

The maternity system in New Zealand (NZ) is based on a relational model of care in which continuity of carer is central. Outcomes of this model of care, specifically high levels of maternal satisfaction are comparable to other countries.[11] Caseloading self-employed midwives, called Lead Maternity Carers or LMCs, provide continuity of care through the childbirth year and make up approximately 40% of the midwifery workforce; other midwives work as employed hospital staff, called core midwives. Midwives in New Zealand are able to choose how they work in most cases, either as Lead Maternity Carers (LMCs), the focus of this study, or as a hospital based core midwife. While some rural LMCs may also be employed to staff rural maternity units because of excessive travelling times, the majority of rural midwives have no option but to work as self-employed LMCs. They provide continuity of carer for women throughout antenatal, intrapartum and postpartum care. Most LMCs work in community based practices although, in some remote regions, LMCs have to practice alone because other LMCs are too far away geographically. LMCs are funded by the government on a contract for service basis to provide midwifery care throughout pregnancy, labour, birth and up to six weeks postpartum. LMCs can also be GPs and obstetricians but the majority are midwives. Currently there are no GP obstetricians and very few rural GPs acting as rural LMCs. Government funding provides all New Zealand resident women access to free maternity care from an LMC and any secondary services that may be required regardless of where they live and choose to birth (Ministry of Health, 2007). The midwifery LMC service is integrated working closely with other professionals in the maternity care team. This involves LMCs practising across primary and secondary services in partnership with women and their families. To do this they need to provide 24/7 on call arrangements from the time of booking until postnatal discharge and to find cover when away from their practice, which can be challenging for some of the more remote LMCs. There is now national funding for rural and remote midwives to get some paid locum support to help ease this organisational and financial burden.[5] However, remuneration continues to be a concern for many rural LMCs. They often carry smaller caseloads due to population density and less bookings equates to less pay. LMCs in rural regions can also miss intrapartum payments due to referrals (this is challenging because payment from the Government is modular with intrapartum payment continuing to be the largest component).

Rural and remote communities in New Zealand (NZ) are often in mountainous terrain, with roads that are challenging to drive. Climate conditions such as floods and snow are not unusual. While some services are likely to be within one to two hours reach, tertiary services are more likely to be four to five hours drive.[4,12–14] Neighbours are sparse. There are emergency helicopter services but funding constraints, other demands and weather conditions can limit availability.

The reasons for midwives living rurally are many. Some have been born in these regions and, as such, it's a community where they feel most at-home. New comers to a remote or rural region may feel isolated by the unfamiliar situation of living far from city-based infrastructures. For Susan, the principal author, living and practising remotely in NZ was initially challenging due to the social and professional isolation. Yet over time it was local communities and colleagues that enabled her to 'feel' at home with further support from a trusted practice partner. Remoteness can thus be experienced as mood in a positive way. Bollnow writes: "Strangeness stands in contrast with what is his own. Strangeness is the area where man no longer knows his way around and where he therefore feels helpless".[15] Thus rural midwives who know their way around the community are likely to feel comfortable amidst familiar places, people and services. For them, it may be the tertiary hospital that brings a mood of unease.

Evidence is mounting about benefits of continuity of midwifery care.[16] Yet, despite success in sustaining the LMC model, there have been concerns about burnout, maintaining a work-life balance and adequate financial remuneration.[5,17–21] The extent and causation of these concerns in rural and remote regions remains uncertain. Despite an array of recent initiatives, the New Zealand Ministry of Health and the New Zealand College of Midwives are worried about the lack of adequate LMC provision in some rural and remote regions.[19] Although there is emergent research exploring the sustainability of New Zealand midwifery practice,[22,23] how the current model of New Zealand maternity care is experienced in rural communities requires investigation. This is particularly pertinent in regards to the retention and recruitment of health care providers in rural regions which is well-documented and a phenomenon that is shared globally.[13,24–32]

It is perhaps obvious that the experiences of providing and receiving maternity care in rural regions is unlike those in urban areas. For example, an urban midwife is one amidst many. Within an urban setting, the employed hospital midwife will have regular time off and the LMC will be more likely to get cover for post-birth sleep deprivation. Susan found that rural LMC colleagues who accompany a woman into the tertiary hospital can feel invisible in the busyness of place; and just be another LMC with just another

woman on a busy day. The urban midwife is likely to have established relationships with the other health professionals who support her practice; the charge midwife, the consultant on call and the anaesthetist, for example. Regular face-to-face contact with these colleagues brings a knowing and trusting.

The difference between the experience of urban and rural ways of working raises fundamental concerns about how regional maternity health teams understand and appreciate the tired midwife, possibly as a stranger to them and who arrives with a tired woman who has a 'problem'. There are reports of misconceptions leading to divergent understandings about maternity care across settings which manifest in communication failures between rural and tertiary services and between (and within) professional groups and the public.[4,33] There appears to be a mood of despondency when reviewing the literature on rural maternity. Yet rural maternity globally is reported as a dynamic environment that is often innovative.[34] Although many challenges have been identified in the international literature, for example the geographical isolation starkly highlighted in Haraldsdottir et al.'s Icelandic study,[35] rural midwives continue to provide the safest maternity care possible in what can be challenging circumstances.[5,25] Although it is important not to label rural maternity as inherently problematic, the concerns related to sustainable rural maternity care provision in rural and remote communities do need addressing otherwise these communities will become deprived of the high quality, accessible maternity services they need and deserve. Haraldsdottir et al.'s study[35] emphasises the importance of keeping quality skilled care as local as possible in order to improve outcomes for women and babies. How rural maternity is perceived by others who perhaps have little or no understanding may further isolate and disadvantage those working and living rurally. This needs to be addressed.

1.2. Philosophical underpinnings

Interpretive hermeneutic phenomenology guided the approach to data collection informed by the writings of Heidegger and Gadamer.[7,36] The focus of hermeneutic phenomenology is the surfacing of meaning from lived experience descriptions, in this case transcribed interview data. Heidegger's interpretation of 'being' gives the foundation to further interpretation.[7] Gadamer-reveals how language itself can 'speak us' and how text itself interacts with the researcher's understandings through the 'fusion of horizons'.[37] For example, congruent with the methodology, literature is interwoven through the discussion section as fresh horizons of understanding unfold. This reflexive process brings new insights about our shared humanness. In this approach, what matters is not that the researchers give an exact account of what the participant meant (for how can they) but rather that they are attuned to possible meanings within stories. Our interpretations can only ever be drawn from our own historical horizons.[37] Our quest is to draw on the stories as opportunities for us to ponder, think, and offer insights that may be beyond what the story itself said. The aim is to engage readers, not to convince them, but to offer them their own opportunities to think. Thus, there are no firm conclusions drawn from such research. It is instead a shared journey of thinking and coming to new understandings.

3. Ethics and funding

Ethics approval was obtained prior to recruitment and data collection. Ethics approval was gained through AUTEC reference No. 15/18 on 9th February 2015. Approval included a researcher personal safety protocol. The study was made possible by post-doctoral funding from the Kate Edgar Educational Trust.

4. Methods

The method was informed by van Manen.[3,38] Purposeful sampling by word of mouth was used to recruit study participants from the South and North islands of New Zealand. Professional and social networks were used to initiate interest. Participants were recruited by a process of snowballing. A letter of invitation and information sheet was sent once a potential participant had signalled an interest by telephone, email or third person mutual contact. Care was taken to prevent coercion and recruitment was not undertaken in settings in which researchers work or had worked. Non response to the formal invitation was an easy way for people to opt out of the study.

It is acknowledged that not all perspectives have been collected across all settings and we do not make any claim to 'representativeness' with respect to populations in the same broad category. However it is noteworthy that, through the process of snowballing, more participants unknown to the researchers, came forward to be interviewed; these participants provided more experiences which added richness to the overall collected data. Although vastly different perspectives are possible from those who chose not to volunteer to participate, this study was not seeking comparative data but sufficient data to show the phenomenon of rural midwifery. The fluidity of the recruiting process contributed to the trustworthiness and credibility of the findings.

13 in-depth interviews of one to two hours in a range of remote/rural areas in New Zealand were undertaken. Provision of information about the study and the signing of consent happened prior to the interview. All 13 participants were volunteers with experience and an interest in the phenomenon. They lived and worked within different rural regions of New Zealand. Participants were asked to share their experiences of rural maternity care. Interviews were transcribed and stories crafted from verbatim data.[2] As Caelli describes, crafting stories is a process of "deriving narratives from transcripts".[39] This involves identifying stories that have often come in pieces and change in the context of a conversation during the dialogic process of interviewing. On reading and re-reading the transcripts we were able to 'see' story threads that are rarely given in lineal fashion. The crafting of stories from raw data honoured participant's experiences and use of words whilst acknowledging the researchers' pre-understandings of the phenomenon.

Phenomenology does not seek saturation, recognising that there is never an end to understanding, to hearing afresh. The aim in this study was to gather enough data to sufficiently reveal the phenomenon and report plausible and trustworthy findings to provoke further thinking. Although member checking is incongruent with this methodology,[3,40] the crafted stories were returned to participants to ensure they reflected the participant's experiences. This provided the opportunity to change details and maintain anonymity. The process did not alter experiential meaning that surfaced or diminish the emergent themes and sub-themes overall (Fig. 1). Due to the complexity and sensitive nature of data gathered in small population regions, rigorous efforts were made to ensure anonymity. All responses were treated confidentially to protect the privacy of participants. Names, places and institution identifying features were removed from the crafted stories. Each participant was provided an agreed pseudonym. Information on professional counselling was also provided as part of participant information.

4.1. Interpretive analysis

As previously intimated, the purpose of analysis is to provide rich uncovering of the phenomenon in order to provoke further thinking and call to action. Stories were analysed using a phenomenological approach that highlighted areas that spoke to

Fig. 1. Themes and sub-themes revealing how anxiety shows itself in rural midwifery practice.

us as significant. Following an iterative spiralling process of mind mapping, reading, re-reading, writing and re-writing, patterns of meaning emerged and coalesced into themes and sub-themes (Fig. 1).

4.2. Pre-understandings

Hermeneutic phenomenology is a reflexive methodology. All meanings are informed by fore-structures that are culturally, socially and environmentally constructed. It is important to reveal researchers' pre-understandings because these shape the questions brought to the study and interpretation that follows.[41]

Susan was the principal investigator. She had her own lived experience of moods from working as a midwife in remote locations in Europe and Africa. In more recent times she had her own LMC practice in rural New Zealand. Prior to the study she told Liz (co-author) her own stories of long, frightening drives to hospital with emergency situations unfolding as they drove, of then being left exhausted and stranded a long way from home. She loved being a midwife, but the relentlessness of the on-call nature of rural practice and the heavy responsibility prompted her towards a career change. The high level of responsibility in the unpredictable and often uncontrollable work demands was at times too stressful. Liz similarly remembers working in a small Mission hospital in Vanuatu where there was no immediate help available. The mood of relief when all went well was huge. Both authors have a strong commitment to normal birth, yet both are mindful that things can go wrong. They know the feeling of being-responsible. Deb comes to this paper with past experiences of being a mother and a core midwife. More specifically, she brings hermeneutic expertise.

5. Findings

Heidegger says "Understanding always has its mood".[42] Mood is seldom any one thing. When midwives told their stories, the mood shone through. The findings revealed the tensions within mood. These midwives loved being known as 'the midwife' to their community and the joy of rewarding relationships yet they came to fear much that became part of that experience. These fears are revealed in the themes: moments of rural practice and the feeling of being judged and the associated sub-themes (Fig. 1).

5.1. Moments-of-rural practice

5.1.1. Panicky moments

For any midwife there is always a possibility in the back of her mind that 'something unexpected could happen' with a labour. For urban midwives this would mean calling on the wider team, already poised to step in and help. For rural midwives, the sheer mechanics of getting the woman to a tertiary hospital can be huge. Sally tells of a fraught rural transfer.

> *It was really panicky, the husband's anxiety, the mother screaming, rushing around doing what I could on the side of the road as she started pushing. She had had 2 previous caesarean sections and was just 37 weeks. We needed to get to the hospital. The helicopter came out thankfully with the consultant obstetrician. Luckily the obstetrician knows the area well and was able to direct where to land. The women was transferred and had a Ventouse at the hospital. Luckily mother and baby were well. (Sally — LMC midwife)*

The outcome of this situation could have been very different. Fear as mood is always a fear about a particular thing happening.[7] Even if it has never happened to 'me' before, there is the possibility that on any day it could. Midwives are openly engaged with multiple possibilities in any moment whilst at the same time living ahead of themselves in the myriad of actual possibilities that occur.

5.1.2. An emergency moment

Carla shares her practice reality of an emergency situation.

> *I looked down and there was a leg hanging out with the cord wrapped around it. That is really scary. All I had was a volunteer ambulance person. At that stage it was lights and sirens to get there. (Carla — LMC Midwife)*

Midwives need to act and think ahead of themselves. Sally and Carla live the above moments of practice attuned to the future possibilities of what may happen whilst experiencing the lived here and now. Future possibilities provide meaning as to what is unfolding 'here and now'. In other words, what rural midwives do 'now' is made meaningful by being thrown into the 'future possibilities of something going wrong'; the possibility of a baby dying if the helicopter could not land, for example. Sally is already ahead of herself in any given moment attuning to possibilities that have not yet happened. When now and future possibilities conflate into a moment of practice there is a knowing which attunes Sally and Carla to fear of 'luck running out'. The mood of the moment as-fear reveals their aloneness in that moment. Such aloneness may not be experienced in the same way by an urban based colleague.

5.1.3. The unexpected moment

Isolation, rather than keeping one away from the spotlight, paradoxically is experienced as the potential that at any moment the light could shine on 'me'. When one is the only midwife in the place, there is no one else to hide behind or with whom to huddle together. There is only 'me' with all the responsibility and expectations upon 'my' weary shoulders. The moment to enact one's midwifery skills can happen when least expected, as Caroline highlights after returning from a day off:

I wasn't organised and didn't have my stuff in my car I'd been out with the family the day before and we had family stuff in the car and I hadn't put it back in for my routine antenatal visit. I had rung my colleague to come but she came too late. I am a cautious midwife, I do like a second, I don't like doing it on my own even after all these years. (Caroline — LMC midwife)

Midwives in this study continually expressed their feelings of vulnerability especially at the prospect of unexpected events and things going wrong. This moment felt wrong for Caroline in all sorts of ways. She did not have her equipment and she did not have her midwifery partner to support her. Despite being unacceptable, there was no choice but to do the best she could.

5.2. Being judged

5.2.1. Fearing criticism

Sally's fear of censure from those far away as well as those in their community underpins her decision to transfer a woman for IV fluids:

My client was having awful vomiting and diarrhoea at 40 weeks. She urgently needed fluids. The rural medical practice refused to give her the fluids. I had to transfer her to the hospital four hours away at that point otherwise I would have been criticised. Once she had the fluids she was sent back home.

Rural midwives live between what is unfolding in the here and now and the future possibilities that may or may not happen. While it may have been safe to keep this woman within her own community, there was the possibility of things going wrong. When it takes several hours to effect a transfer there is no option to wait and see. Sally makes the decision to transfer not because there is a need 'right now' but because if she waits and things deteriorate she will be criticised for not recognising earlier that such would be the outcome. Heidegger tells us that we are always in our world surrounded by the dictatorial unknown, unseen and impersonal 'They' who commands conformity to follow the rules of living our lives.[7] Likewise Sally feels she is needs to comply with the 'They' otherwise suffer censure.

5.2.2. Fear of the unexpected happening to 'me'

It is not always easy being known and highly visible in rural settings Caroline (midwife) speaks about this as constant pressure:

I am so visible in this small community and that creates a lot of pressure to perform. I guess you get that anywhere but here it is for the profession, for the community, for my family, my friends, everyone. When things do go wrong and there are unexpected outcomes it can be harsh. I haven't had that happen to me; never want it to. I do the best I can every single day. (LMC midwife, Caroline)

Caroline appears fearful of bad outcomes and how they would impact on her, her family, friends and the community. She is also concerned about how the midwifery profession could become scrutinised and held in disrepute leaving rural midwives vulnerable. As Caroline states, "Everyone knows what you are up to!" As a result, she tries, at all times, to be the best that she can in a relentless drive to keep her reputation and that of midwifery safe.

5.2.3. Fear of losing my reputation

Concerns of losing local reputation and the threat to livelihood is very real for rural self-employed NZ midwives because their caseloads and choices of places and ways of working are limited.[5] There is nowhere to hide in small populated areas with only a few 'known' health care professionals. Michelle reveals her concerns about always needing to be 'the midwife' in whom local families trust:

I can't go out and get drunk every night and be a wild thing because everybody knows you around here! If one person doesn't like you and tells the rest of the town you're a crap midwife then it's a bit of a reputation thing! (LMC midwife, Michelle)

Michelle feels that everything is public and her professional reputation is vulnerable. She cannot be seen to be unprofessional in her behaviour. The pressure shows through. She seems to live with a fear of being seen as not-good-enough to be 'their' midwife.

5.2.4. Fear of feeling blamed

It is not just midwives who feel the threat of censure. Jane, a mother in the study, likewise believed she would be criticised locally if things went wrong and she had not made the decision to go to the hospital sooner.

I was unsure of having a homebirth. If something happened the community would be aware. My neighbour had a baby that died here and I hear the community blaming her for not being in the hospital. (Jane — Mother)

As a mother there is also the possibility of feeling judged within a small community where one is known. Being known and visible locally can be a joy and strength of rural living yet may expose one to unwelcomed judgements about decisions such as choosing to birth at home. The mood of this responsibility dwells amidst community.

5.2.5. Fear of being identified

The fear of censure was further revealed during the process of data collection when participants were given an opportunity to review their crafted stories. The fear of being identified and exposed emerged as several participants requested whole stories be removed despite my efforts to remove identifying information and ensure anonymity. One midwife requested I remove more than 50% of the interview data yet was happy to talk to me in confidence. The fear of ending up in a 'high profile case' [clarifier], and of feeling observed and criticised was present, even when this did not eventuate. The fear of being overly scrutinised and exposed locally or nationally ignited a sense of vulnerability; a sense of losing respect in the eyes of their small communities if their stories 'got out'. Susan (author) had experienced being central in a high profile media case in the late 90 s and was sensitive to these concerns:

I was having lunch watching midday news. Suddenly my face was on the television. They were talking about a baby who died after a breech home birth that I was at. I just went cold – the phone started ringing, I felt sick – I'm thinking 'everyone will blame me, I'll probably be struck off the register, the poor parents! It was horrible (Personal diary)

Telling their stories in confidence during one-on-one interview sessions felt profoundly different from the thought of their stories being exposed in various public forms, even though no one would know it was 'them'. In Susan's story, it was the panic of being silenced, unheard and feeling the 'They' will not understand how it all really happened. Dahlen and Caplice[43] also found midwives who were happy to share fears in a safe space yet were reluctant to discuss personal fears with colleagues or the women in their care. The need to remain anonymous and keep certain stories confidential in this current study was honoured and segments of data were removed as requested. Our hope is that in sharing their concerns and hearing that the nature of their story was common to others, the midwives will be helped towards reconciliation.

6. Discussion

The findings revealed significant challenging moments of practice and fears about being judged and thus highlight an unsettling mood pervading rural midwifery practice (Fig. 1). These fears were always of something external. Yet they also point to something pre-cognitive, our anxiety. Anxiety is a mood that assails us and brings us to the core of who we are. Midwives' anxiety is concerned with 'how they find themselves' in any given situation whereas their fears are concerned with the specific demands their worlds (what if the helicopter cannot land?). Fear and anxiety do not exist in isolation from one another; they are part of the flow of rural midwifery experience disclosing understanding in each moment of practice. Previous misunderstandings concerning the contextual realities of rural midwifery by those not there in the moment(s) of such practice can attune rural midwives to anxiety through their subsequent unfair judgements. This anxiety then surfaces as fear about 'something'.

6.1. Mood within moment(s) of rural practice

The mood of the moment is wider than the moment itself. Fig. 2, adapted from the work of Sheehan,[44,45] captures how the thought of what might go wrong, even though it is a mere possibility, comes back to impact on the mood of 'now'. Even in the midst of something already going wrong, such as Jane with a preterm birth on the side of the road or the fear of a helicopter not arriving in time, is right-there, even though the moment of birth has not yet come. Even though a midwife's practice has to-date been safe, the possibility that one day a story portraying her as an unsafe midwife could feature in the national newspaper comes into each birth as a fear. Such possibilities are always inherent in the mood of lived experience.

There is a particular mood that is awakened within the pace and context that makes up rural life. There is a mood-as-fear-of-something impacting on rural midwives. Heidegger[45] interprets fear as a fear of something threatening in the world; in this study the 'something' is the fear of an emergency situation which is beyond their capacity to resolve, followed by the critique and judgement of others. It is fear of losing one's reputation and thereby losing one's livelihood. On a more intrapersonal level, it is the fear that 'my' lack of forethought may result in the death or harm of a mother and/or baby. The spotlight goes on the midwife who was responsible, not the 'help' on the other end of the phone that was slow to respond, the bad weather conditions or the sheer aloneness of trying to cope with so much happening at the same time. Rural midwives work and respond to the here-and-now as well as practising in response to the possibility of something going wrong. However the constant focus on things going wrong is disruptive to morale and can lead to an undermining, ever-present, dread and unsettling mood. Fig. 2 reminds us of the lived reality of rural midwives as they work and live within this tension. Amidst this unsettling mood, as moments of rural practice unfold, is a fear of being judged unfairly by others not there in the context of the moment.

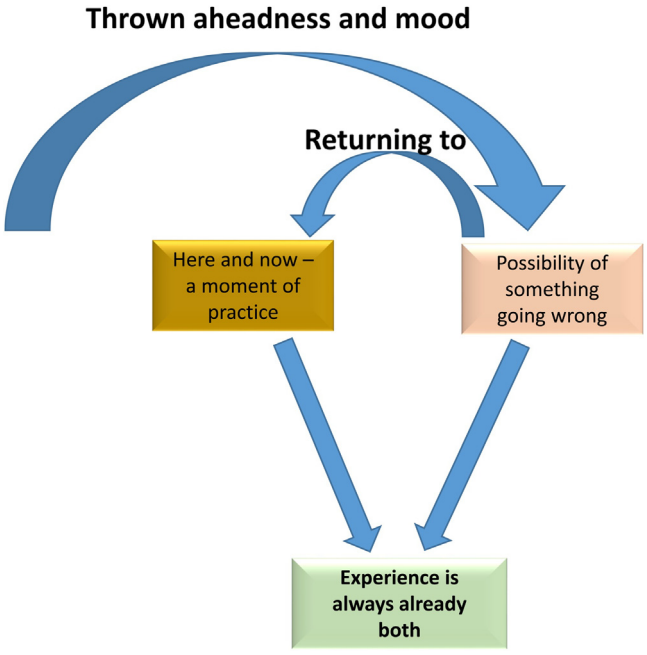

Fig. 2. Thrown aheadness and mood adapted from Sheenan (2015, p. 145).

6.2. Mood of being judged

Whatever a rural midwife does (or does not) do in the moment of practice, she lives with the fear that 'someone' will stand in judgement over anything that goes wrong. Heidegger suggests that the task of judgment is everywhere and is an inescapable part of human life.[42,46] Heidegger asks us to consider what do we do when we judge and what attitude do we adopt toward ourselves and others when we judge? He describes how judgement occurs when there is a conclusion and imagined 'truth' made on interpretations of the facts. Yet these facts and subsequent judgements are not explicitly or deliberately based on a review of the evidence. Judgement, according to Heidegger, predisposes truth about a subject yet such absolute truth can never be fully realised; it is always an on-the-way understanding.[42,46]

This is no less the case for this study's participants who felt that others far from the moment to moment of rural midwifery practice cannot know the unfolding contextual realities being faced. Despite the inability to know fully the actions of another in a given moment a judgement is made and the judging person (e.g. the journalist, tertiary hospital colleague or manager in the case of Susan's personal story) claims authority on the matter at hand. These unknown 'judgers' always feel present even though they are usually far away. Their judgements come from a limited understanding of the complex realities of rural practice. There is a sense of supremacy and anxiety about the judgements of others who are urban based. 'They' are 'the professional body'; they are 'the hospital management'; they are 'the voice of the media'. 'They' assume an authority by whom they represent. Rural midwives, from past experience, expect that the person/organisation who judges from the 'urban' world will not understand the difficulties they face, the lack of support, the tensions involved. 'They' will have no sense of how hard it was to do the best one could, and how helpless it felt to be able to do no more.

Although such authority can be challenged, this is only feasible when there is an avenue to do so. The midwifery workforce has been abused by the media over many years, for example the New Zealand high profile Barlow case that heavily criticised a midwife's actions in causing a baby to die and mother to be placed on life support.[47] Similarly, rural maternity comes under media scrutiny elsewhere, for example, in North East Scotland when a remote maternity services underwent public review following the death of a baby[48] and one of the rural midwives left after publication of the review.[49] This is destructive. It does not help retention and recruitment of rural staff, nor improve outcomes and may be creating additional fear. Dahlen and Caplice[43] were concerned that fear in midwifery directly impacts midwifery practice leading to increased stress and burn out. Would it be possible for a rural midwife to challenge the published verdicts of her practice in a

newspaper already read and 'believed' by the nation? The magnitude of this unsettling mood is reflected in rural regions. Research undertaken by Patterson et al.[12] found that the high profile nature of rural New Zealand midwives in the media is indeed stressful.

Feeling judged and/or potentially judged awakens a fear of censure which shows itself as a mood of anxiety. The unsettling mood revealed in this study highlights a tension between the rural midwife and the systems of professional and urban based health infrastructures that can negatively influence practice and threaten relationships. Relationships are at the heart of safe maternity care and this has been shown to be particularly pertinent in rural regions.[5,50] Yet, to practice with an all pervasive unsettling mood, risks subduing the joy of rural midwifery. Such a mood can shape understanding of rural midwifery making possible solutions seem out of reach and too difficult. As a consequence, recruitment and retention to this these regions is more challenging and difficult to sustain. The consequences may, in turn, be far reaching.

Each rural community functions in its own unique ways despite the challenges they encounter. Each lives with what is 'now' yet is constantly alert and attuned to 'what could happen'. Rural and urban midwives presumably seek the same optimal outcomes yet the journeys to actualising these are different as possibilities are contextually divergent. When options available are restricted and opportunities to be heard are more challenging, the fear of being misunderstood is more likely. We would contend that the real fear is the pervasive urban risk discourse[43,51,52] which awakens anxiety revealing itself as fear of censure in rural midwifery practice. For midwifery practice to be sustainable in all localities, an appreciation of the interconnected relationship of context and practice is necessary.[53]

Tackling the ongoing challenge of sensational reporting to sell media-based news requires a societal based examination of the values concerning childbirth. This requires improvement in communications and understanding between and within professional groups across the primary and secondary health sectors. It is important to appreciate that urban criticisms and judgements about rural maternity can filter into the rural communities in a multitude of ways and awaken the fears described in this paper. This only weakens rural communities leaving those living and working there feeling vulnerable. Rural communities need to be heard and not subordinated and fearful of their urban neighbours. They need to feel safe and 'at home' in their own communities where anonymity is less possible than for those in an urban region. This requires listening and empathy not dichotomising language and further division. Sensitivity to the moods of rural practice provides an opportunity to examine more deeply the concerns of colleagues who are working in isolated regions. Furthermore, empirical research using the phenomenology of moods, as initiated in this paper, would provide significant insights about the realities of midwifery recruitment and retention across all settings.

7. Strengths and limitations

This study has interpreted a range of stories from those living-in and living-through the daily realities of rural maternity and philosophical notions. The authors have also provided their reflexive accounts on previous experiences and on the study itself. The study resonates with others when findings have been shared thus providing reassurance of the study's plausibility. The research is being actualised through acceptance of papers for publication and presentations. However, there are always more voices and further interpretations. For example, hearing the voices of core staff receiving rural mothers and their maternity health care providers on transfer would be valuable. This is a New Zealand study and is focussed on producing transferable findings that are not generalisable. The study provides possibilities for further thinking that will guide rural maternity research and practice.

8. Conclusion

Being known in rural communities is a delightful part of being a rural midwife. Yet it coexists with unsettling moods of fear. Fear is always of something. Fears are concerned with what is happening now while also fearing the possibility of something worse happening in the future. The 'in-the-moment' challenges of rural practice are connected with the fear of being judged by others. Positive images of rural practice need dissemination to support and augment recruitment and retention initiatives. It is crucial that the voices of rural midwives and their communities are heard at all levels. Health services need to attune to the unsettling mood revealed in this paper to ensure a long term, sustainable and safe rural midwifery service. Honouring contextual practice realities and the unique practice moments that make up rural midwifery will help lesson fear and build trust. What matters most in these regions is being treated fairly, being heard, feeling valued, having open non-hierarchical communications, being safe and enjoying a sense of wellbeing. Collective engagement towards solutions is essential to prevent something of worth being lost and to ensure that the joys of rural practice and birth are not undermined.

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References

1. Crowther S, Smythe L, Spence D. Kairos time at the moment of birth. *Midwifery* 2015;**31**:451–7.
2. Crowther S, Ironside P, Spence D, Smythe E. Crafting stories in hermeneutic phenomenology research: a methodological device. *Qual Health Res* 2016;1–10.
3. van Manen M. *Phenomenology of practice: meaning-giving methods in phenomenological research and writing*. Walnut Creek, CA: Left Coast Press; 2014.
4. Crowther S. *All is not as it first may seem: experiences of matenity in rural and remote rural regions in New Zealand from the perspectives of families and health care providers*. Auckland, NZ: AUT University; 2015.
5. Crowther S. Providing rural and remote rural midwifery care: an 'expensive hobby'. *N Z Coll Midwives J* 2016;(52):26–34.
6. Heidegger M. *Introduction to metaphysics*. New Haven and London: Yale University Press; 2000.
7. Heidegger M. Being and time. New York: Harper; 1927/1962.
8. Freeman L. Toward a phenomenology of mood. *South J Philos* 2014;**52**(4):445–76.
9. Gendlin ET. Befindlichkeit:[1] Heidegger and the philosophy of psychology. *Rev Existent Psychol Psychiatry: Heidgger and Psychol* 1978**XVI**(1–3).
10. Smith Q. On Heidegger's theory of moods. *Mod Schoolman* 1981;**58**:211–35.
11. Grigg CP, Tracy SK. New Zealand's unique maternity system. *Women Birth* 2013;**26**(1):e59–64.
12. Patterson J, Skinner J, Foureur M. Midwives decision making about transfers for 'slow' labour in rural New Zealand. *Midwifery* 2015;**31**(6):606–12.
13. Kyle M, Aileone L. Mapping the rural midwifery workforce in New Zealand. In. Edited by Zealand HWN; 2013.
14. Kletchko S, Scott-Jones J. *Rural ranking score: the case for change*. RRS Governance Group, NZRGPN; 2012.
15. Bollnow OF. Lived-space. *Philos Today* 1961;**5**(1/4):31–9.
16. Sandall J, Soltani H, Gates S, Shennan A, Devane D. Midwife-led continuity models versus other models of care for childbearing women. *Cochrane Database Syst Rev* 2015(9).
17. Donald H. The work-life balance of the case-loading midwife: a cooperative inquiry. *Unpublised DHSc*. Auckland: Auckland University of Technology; 2012.
18. Young C, Smythe E, McAra-Couper J. Burnout: lessons from the lived experience of case loading midwives. *Int J Childbirth* 2015;**5**(3):154–64.
19. Adair A, Coster H, Adair V. *Review of international and New Zealand literature relating to rural models of care, workforce requirements and opportunities for the use of new technologies*. Commissioned by The New Zealand Institute of Rural Health; 2012.

20. NZCOM. *The claim August 31st 2015*. New Zealand: New Zealand College of Midwives (NZCOM); 2015.
21. Young C, Smythe L, McAra-Couper J. Burnout: lessons from the lived experience of case loading midwives. *Int J Childbirth* 2015;**5**(3):154–65.
22. Gilkison A, McAra-Couper J, Gunn J, Crowther S, Hunter M, Macgregor D, et al. Midwifery practice arrangements which sustain caseloading Lead Maternity Carer midwives in New Zealand. *NZCOM J* 2015;**51**:11–6.
23. McAra-Couper J, Gilkison A, Crowther S, Hunter M, Hotchin C, Gunn J. Partnership and reciprocity with women sustain lead maternity carer midwives in practice. *N Z Coll Midwives J* 2014;(49):27–31.
24. Grzybowski S, Fahey J, Lai B, Zhang S, Aelicks N, Leung BM, et al. The safety of Canadian rural maternity services: a multi-jurisdictional cohort analysis. *BMC Health Serv Res* 2015;**15**(1):1–7.
25. Stoll K, Kornelsen J. Midwifery care in rural and remote British Columbia: a retrospective cohort study of perinatal outcomes of rural parturient women with a midwife involved in their care, 2003 to 2008. *J Midwifery Womens Health* 2014;**59**(1):60–6.
26. Doescher MP, Andrilla CHA, Skillman SM, Morgan P, Kaplan L. The contribution of physicians, physician assistants, and nurse practitioners toward rural primary care: findings from a 13-state survey. *Med Care* 2014;**52**(6):549–56.
27. Kornelsen J, MacKie C. The role of risk theory in rural maternity services planning. *Rural Remote Health* 2013**13**(1).
28. Hoang H, Le Q. Comprehensive picture of rural women's needs in maternity care in Tasmania, Australia. *Aust J Rural Health* 2013;**21**:197–202.
29. Rayment J, McCourt C, Rance S, Sandall J. Maternity services in rural areas: learning from two trusts serving rural communities. *Perspective – NCT's journal on preparing parents for birth and early parenthood* 2012, June, 19–20.
30. Stewart L, Lock R, Bentley K, Carson V. Meeting the needs of rural and regional families: educating midwives. *Collegian* 2012;**19**:187–8.
31. Hoang H, Le Q, Kilpatrick S. Small rural maternity units without caesarean delivery capabilities: is it safe and sustainable in the eyes of health professionals in Tasmania? *Rural Remote Health* 2012;**12**:1941.
32. Mackinnon K. We cannot staff for 'what ifs': the social organization of rural nurses' safeguarding work. *Nurs Inq* 2012;**19**(3):259–69.
33. Mackie B, Kellett U, Mitchell M, Tonge A. The experiences of rural and remote families involved in an inter-hospital transfer to a tertiary ICU: a hermeneutic study. *Aust Crit Care* 2014;177–82.
34. Bourke L, Humphreys JS, Wakerman J, Taylor J. From 'problem-describing' to 'problem-solving': challenging the 'deficit' view of remote and rural health. *Aust J Rural Health* 2010;**18**:205–9.
35. Haraldsdottir S, Gudmundsson S, Bjarnadottir RI, Lund SH, Valdimarsdottir UA. Maternal geographic residence, local health service supply and birth outcomes. *Acta Obstet Gynecol Scand* 2015;**94**:156–64.
36. Gadamer HG. Truth and method. New York: Seabury; 1960/1975.
37. Gadamer HG. Philosophical hermeneutics. London: University of California Press; 2008/1967.
38. van Manen M. From meaning to method. *Qual Health Res* 1997;**7**(3):345–69.
39. Caelli K. Engaging with phenomenology: is it more of a challenge than it needs to be? *Qual Health Res* 2001;**11**(2):273–81.
40. Morse JM. Critical analysis of strategies for determining rigor in qualitative inquiry. *Qual Health Res* 2015;**25**(9):1212.
41. Smythe E. From beginning to end: how to do hermeneutic interpretive phenomenology. In: Thomson G, Dykes F, Downe S, editors. *Qualitative research in midwifery and childbirth: phenomenological approaches*. London: Routledge; 2011. p. 35–54.
42. Heidegger M. *Being and time*. Oxford: Basil Blackwell; 1995.
43. Dahlen HG, Caplice S. What do midwives fear? *Women Birth* 2014;**27**(4):266–70.
44. Sheehan T. *Making sense of Heidegger*. London: Rowman & Littlefield; 2015.
45. Heidegger M. Discourse on thinking. NY: HarperCollins; 1959/1969.
46. Heidegger M. Bremen and Freiburg lectures: insight into that which is and basic principles of thinking. Bloomington, IN: Indiana University Press; 1994/2012.
47. Johnson M, Akooorie N. *Babies' deaths reignite maternity row*. New Zealand: NZ Herald; 2012.
48. Ross C. *NHS highland: health board cheif defends controversial maternity service changes in Caithness*. Inverness, Scotland: The Press and Journal; 2017.
49. Lironi J. A changing model of rural care. *Pract Midwife* 2017;**20**(5):27–9.
50. Smythe E, Hunter M, Gunn J, Crowther S, Couper JM, Wilson S, et al. Midwifing the notion of a good birth: a philosophical analysis. *Midwifery* 2016;**37**:25–31.
51. Possamai-Inesedy A. Confining risk: choice and responsibility in childbirth in a risk society. *Health Sociol Rev* 2006;**15**(4):406–14.
52. Byrom S, Downe S, editors. *The Roar Behind the Silence*. London: Pinter & Martin; 2015.
53. Crowther S, Hunter B, McAra-Couper J, Warren L, Gilkison A, Hunter M, et al. Sustainability and resilience in midwifery: a discussion paper. *Midwifery* 2016;**40**:40–8.