

**WORKING AS A COORDINATOR MIDWIFE IN A TERTIARY  
HOSPITAL DELIVERY SUITE: A PHENOMENOLOGICAL STUDY**

**Lindsay Fergusson**

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**Primary Supervisor: Dr Elizabeth Smythe**

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### **Attestation of Authorship**

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

Signature.....

Date.....

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## **Abstract**

This phenomenological study has been conducted to reveal midwives' experiences working as coordinator/charge midwives in tertiary hospital delivery suite settings. The methodology is informed by Heidegger's interpretive phenomenological, hermeneutic philosophy (1927/1962). Data analysis is based on van Manen's (1990) research methodology.

Five coordinator/charge midwives who work at three tertiary hospitals were interviewed. These interviews were tape recorded, transcribed and analyzed to uncover commonality of themes which revealed what it felt like 'being' a coordinator/charge midwife. The three themes which emerged and are discussed in the data analysis chapters are: "The performing art of leadership", "Time as lived" and "In the face of the 'known' and the 'unknown'".

The findings of this study reveal coordinators are the 'hub' or the 'pivot' at their workplace with their art and soul of midwifery at the very core of their 'being'. They 'know' the unpredictability of childbirth and are regularly challenged by 'lived time' as they 'leap in' to situations and 'leap ahead'. Their ability to facilitate teamwork and their resilience in the face, at times, of seemingly insurmountable obstacles shines through.

# **CHAPTER ONE**

## **Orientation to the study**

### **Introduction**

This study explores the meaning of the experiences of delivery suite midwives who work in charge of their shifts in three New Zealand tertiary hospital delivery suites. The narratives of five coordinator/charge midwives are interpreted. I have used hermeneutic phenomenology as my methodology to explore what it means to be in charge of a shift in an environment of uncertainty and high emotion. I will reveal something of the nature of the coordinator's work.

### ***Who is this study about?***

This study is focused on the experiences of five coordinator midwives. These women are each central to the decision making processes in their tertiary hospital delivery suite during their shifts. They are senior midwives who take responsibility for the organization and supervision of midwifery staff on duty in the delivery suite. They arrange support for Lead Maternity Carers (LMCs) and work closely with DHB midwives, nurses, medical and ancillary staff.

District Health Boards assign different titles to this role. In one hospital, the title of delivery suite 'coordinator' is assigned to the midwife who is a senior staff member and

is deemed by the midwife manager who plans rosters, to be capable of fulfilling the tasks required. In this work environment, there is no financial incentive or formal job description assigned to the role; the coordinator may coordinate one shift and work as a staff midwife on another shift. In other hospitals, there is an assigned position of ‘charge midwife’. These midwives are accorded status by their title and they are financially remunerated for their senior position. In order to avoid possible identification of hospitals in this study, I have amended transcripts and collectively used the title ‘coordinator’ for the midwives who participated in this study.

## **Setting the Scene**

### ***The New Zealand midwifery system***

The growth of the women’s movement during the 1970’s and 1980’s in New Zealand is described by Banks (2000) as a period of time when women began to challenge “the medical control of birth and the universal hospitalization of women during birth” (p.125). These pioneering women gained independence for midwifery practice and gained autonomy for women in their choices for childbirth in New Zealand. Banks writes “it is vital for the individual woman to reclaim her own personal power in birthing” (p.130), and it was within this framework that the New Zealand College of Midwives (NZCOM, 2005a) which is the national professional body for midwives, was established in 1989.

The NZCOM was founded on the principle of midwifery being a partnership between midwives and consumers. NZCOM ensures women as consumers have their place within its organizational structure and processes as well as midwives. The 'Midwives Handbook for Practice' (NZCOM, 2005a) identifies midwives' philosophy for practice which states: "midwifery care takes place in partnership with women. Continuity of midwifery care enhances and helps protect the normal processes of childbirth" (p.3).

This political partnership culminated in legislative changes and passing of 'The Nurses Amendment Act 1990' which gave New Zealand midwives the right to provide midwifery care independently of medical practitioners. Changes in legislation enabled midwives to work autonomously, to order laboratory tests, ultra sound scans and to prescribe medications. The changes resulted in midwives having a choice of either becoming self-employed practitioners working in home birth, birthing unit or hospital settings or being employed as midwives within a hospital system. Dann (2005) describes these changes as "the paradigm shift in maternity services in New Zealand" with 75% of New Zealand women registered with an LMC by 2004 (p.634).

Prior to 1990, women who were admitted to hospital delivery suites were solely reliant on the care of DHB midwives and doctors. The woman was traditionally 'the patient', and the power lay with 'the professionals' within a hierarchical model of care.

Dallenbach and Thorpe (in Reid, 2007) explain that the vision of the LMC concept was for every woman and her whanau or extended family, to experience midwifery care based on the principles of partnership, information and choice which would facilitate positive

pregnancy and childbirth experiences. As a result of the 1990 legislation, LMCs began accompanying their clients to tertiary delivery suites and chose to provide ongoing midwifery care in both primary and secondary settings. As a consequence, the role of the DHB midwife in secondary and tertiary hospitals changed.

In 1996, the Code of Health and Disability Services Consumers Rights was enacted. This code applies to all health and disability service providers within New Zealand. It aims to improve the quality of provision of health care and disability services by promoting and protecting consumers' legislated rights. Its role also exists to help resolve problems between consumers and providers.

The Maternity Services Notice Section 88 of the NZ Public Health and Disability Act 2000 was introduced in 2002 (Ministry of Health, 2002) and dictates services provision specifications for midwifery care and how LMCs are paid. Legislation brought further changes for midwives with the Health Practitioners Competence Assurance Act (HPCA) 2003. This Act is a regulatory framework which protects the public, by having legislated mechanisms in place to ensure health practitioners from thirteen different health professions including the midwifery profession, are fit to practice. The Midwifery Council of New Zealand was subsequently established in 2004 as a separate entity to the Nursing Council of New Zealand which had previously been the professional regulatory authority for both midwives and nurses.

It is the responsibility of the Midwifery Council of New Zealand to ensure midwives are competent to practice. If concerns are raised about a midwife's competency, Midwifery Council may decide to carry out a formal competence review.

A midwife must have a Midwifery Council generated Annual Practicing Certificate (APC) to be able to practice in New Zealand. To hold an APC, midwives must comply with specific APC requirements which are compulsory attendance at technical skills workshops every three years, evidence of educational and professional development within a points score allocation structure, evidence of annual adult and infant resuscitation certification and breast feeding education hours attendance. There is a robust auditing process of midwives by Midwifery Council to monitor and ensure compliance.

NZCOM (2005a) sets the standards for practice for New Zealand registered midwives. Every midwife is required to attend a Midwifery Standards Review (MSR) every two years where she formally reviews her practice with a consumer representative and a midwife who have each been nominated and approved to be appointed to their positions by their peers. They complete initial MSR training and receive ongoing education from NZCOM to provide a robust review process. Midwives are required to review their delivery of midwifery care across the scope of practice in line with the competencies and standards of practice required of them by their professional body.

The Department of Labour (2006) reports the changes in legislation have put significant demands on the New Zealand midwifery workforce which “sets midwives apart from most other health professionals” (p.1). Childbirth is an emotive subject and involves uncertainties. Stories shared by coordinators for this study will reveal what it feels like managing some of these demands for coordinators in their workplaces.

### *Continuity of midwifery care*

LMCs offer continuity of primary ante natal, intra partum and post natal midwifery care to women in home birth settings, birthing centres, secondary and tertiary hospitals. Some LMC midwives also provide continuity of secondary midwifery care to their clients in hospital settings after a three way discussion between the woman, the specialist obstetrician and themselves regarding responsibility for provision of maternity care (Ministry of Health, 2002).

In contrast, DHB midwives provide primary, secondary and tertiary levels of clinical midwifery care within their workplace for a set period of time during the shift they work. As a result, DHB provision of midwifery care in the delivery suite setting has the potential to be fragmented within a climate of midwifery staffing shortages and the coordinator needing to match the requirements of women in labour with the skill base of the midwives on duty.

There is potential for some DHB midwives to encounter professional challenges working within tertiary hospital delivery suite settings with each other, with LMCs and with

obstetricians. Each of these individuals is a professional in his or her own right. Their paramount focus is upon the wellbeing of the mother and her baby; however they may each hold different philosophies of practice and value systems. For example, doctors are likely to be working from a medical model of care in contrast with midwives who work from a social model of care. Reid (2007) describes the biomechanical ideology of obstetrics where obstetricians believe the level of risk of a pregnancy can only be judged retrospectively. In contrast, the social/midwifery model of care views pregnancy as a normal life event for women where choice for women is an integral part of pregnancy and childbirth. Within the context of the hospital delivery suite interface between midwives and doctors, Reid writes “at their most distant, each appears to be in opposition to the other and reluctant to accept any alternative. But clinical governance requires that best practice should include ‘collective excellence’ in clinical practice and both models have their merits” (p.26). Midwives work in partnership with women, with each other and with their medical colleagues as a collaborative team in the tertiary setting.

It is within this context of tertiary hospital delivery suite settings that LMCs, DHB midwives, registered nurses who are employed because of shortages of midwives in the workforce, obstetric medical staff and staff from associated disciplines find themselves working together with the coordinator in charge of the shift.

### ***The primary / secondary interface and ‘transfer of care’***

Isa, Thwaites, McGregor, Gibson, Earl and McAra-Couper (2002) note “one of the issues that we believe we face as core midwives....is the interface between primary and



secondary midwifery care” (p.11). If complications of pregnancy arise, the three way legislated discussion which takes place between the woman, her LMC and the specialist regarding who takes responsibility for care of the woman (Ministry of Health, 2002 ) makes no mention of the DHB midwife who provides midwifery care ‘at the coalface’ in secondary and tertiary hospitals.

The reason for the invisibility of DHB midwifery service provision to women within Section 88 (Ministry of Health, 2002) is because this Act relates to funding for primary maternity services. In reality, the secondary referral guidelines within Section 88 become an every day challenge for DHB midwives regarding who takes ultimate responsibility for provision of clinical midwifery care of women requiring secondary care; the LMC or the DHB midwife? With the pre existing partnership relationship between the LMC and her client, and a request or requirement for a DHB midwife to provide care for that client, there is potential for challenging dynamics between LMC and DHB midwives at the bedside. The LMC may choose to hand over midwifery care to a DHB midwife and remain with her client in a support role, she may provide secondary midwifery care to her client or she may hand over care for the labour and birth with handover back to LMC care occurring post partum. The dilemma exists as to who holds ultimate accountability.

Isa., et al (2002) write this issue is frequently debated within the midwifery profession and the response is that “it is about relationships and collegial relationships”, however they go on to write “because we are human, we believe there needs to be clarity brought to this interface” (p.16). NZCOM (2008) have published a guideline entitled ‘Transfer

Guidelines', however these guidelines remain open to interpretation with ongoing challenges for DHB midwives, LMCs and women. Ultimately the coordinator can find herself 'on the spot' and faced with managing these grey areas of interpretation.

### ***Birth planning***

Birth planning is an integral part of a woman's preparation for the birth of her baby. Her birth plan is documented in her clinical notes within a framework of informed consent (Ministry of Health, 2002; Code of Health and Disability Services Consumers Rights, 1996). In the event of complications during pregnancy, labour or the puerperium birth plans require amendments and there is not always time to formalize this. It is often the DHB midwife who is at the bedside and needs to effectively communicate with the woman and her family as she explains the need to amend or abandon a prior birth plan. Dann (2005) identifies the challenges which exist and describes the delivery suite environment where "women are accessing the maternity services, expressing their autonomy and making decisions, which may not always be seen as appropriate by all midwives and obstetricians" (p.634). Ethical dilemmas can ensue for all involved when a woman, her family, her whanau or her LMC express conflicting viewpoints to their secondary caregivers. It is often the coordinator who becomes the facilitator and manages these situations.

Tertiary hospital DHB midwives are highly skilled professionals whose skills range from the normal to the complexities of high dependency unit midwifery care. A challenge for

DHB coordinators is how they embrace the NZCOM partnership model within their daily work.

### ***The tertiary delivery suite setting***

The coordinator leads a team where there are numerous complexities which impact on her work. The tertiary delivery suite is an unpredictable environment where midwives are members of a team working closely with allied professionals. This is a learning environment where medical and midwifery students are gaining their clinical experience and increasingly, registered nurses are also employed due to midwifery staffing shortages. In addition to this, registrars are usually on clinical obstetric and gynecology training programmes with differing levels of expertise and there are senior house officers on six month rotational experience.

The coordinator is also at the LMC/DHB midwifery care interface. She becomes the facilitator and the decision maker regarding the feasibility and management of LMC requests. The coordinator is challenged to provide safe care within an environment of staffing shortages and skill mixes. She knows what assistance she should be providing but her reality may require compromise and negotiation.

O'Connor (2006) writes "midwifery is a profession under pressure – from heavy workloads, worsening shortages and an aging workforce; from the constant glare of publicity; and from public statements calling for a review of maternity services" (p.18).

Anecdotally I listen to some midwives who state they find the pace of work in the delivery suite setting within the current climate of staffing shortages and an increasing birth rate too stressful to maintain safe practice and personal emotional wellbeing. I observe senior midwives leaving the profession because they tell me that physically and mentally they feel unable to keep up with the relentless pace of tertiary based midwifery practice. These comments are reflected in the Midwife Occupational Skill Shortage Assessment paper (Department of Labour, 2006) which identifies the primary reasons for midwives leaving the profession as “stress, burn out or not wanting responsibility” with employers reporting “high workloads and long hours puts some people off becoming a midwife” (p.11). This is further supported by Black (2007) cites midwives’ concerns and the risks to patient safety in the workplace, attributing this to “lack of staff, resources, or understanding and support in our roles” (p.20).

### ***The responsibilities of the coordinators role***

Unlike the days prior to Section 88 of the New Zealand Public Health and Disability Act 2000 (Ministry of Health, 2002) when the coordinator was in charge of the unit and working with an employed team of midwives and doctors she knew, the current legislative changes require New Zealand coordinators to also work with LMCs who hold Access Agreements which gives them the legal right to work independently within the hospital maternity facilities. As a consequence, the coordinator is in charge of a unit with LMCs who she may not know.

No national or international research was sourced in relation to the experiences of coordinator midwives. Anecdotally, the coordinator is a senior experienced practitioner who provides decisive leadership during her shift. She is a team builder, a skilled communicator and a teacher. The coordinator is a confident decision maker and has the expertise to contribute life saving midwifery expertise in the management of obstetric emergencies. She works closely with both DHB staff and allied professionals within and outside of delivery suite inclusive of LMCs. LMCs working in this setting request assistance, advice, meal breaks and hand over care of their clients from primary to secondary care. All this occurs in situations of varying staffing acuity which often results in the coordinator also taking on a caseload with responsibility for midwifery care of women during her shift. Doctors can be absent from the unit in other locations whether they be in the operating theatre, on the wards or attending women in the accident and emergency unit; it is the coordinator who is 'ever present' on her shift.

The coordinator is working alongside the unique philosophy of every midwife and doctor on her shift, plus the unique care plans for each woman requiring midwifery care. She needs to keep her finger on the pulse and wants to ensure there is provision of safe care to mothers and babies during her shift.

LMCs and DHB midwives will be focused on the care of their individual clients. The coordinator will be focused on everyone in delivery suite and everything that is happening 'on her watch'. She will be anticipatory in her approach in the knowledge she may need to transfer tertiary midwives from the care of one client to another at a

moment's notice according to their skills. It is the coordinator who has an overview and understanding of the bigger picture.

The LMC model for midwifery practice in New Zealand offers women choices and a voice in their child birth experience, however there appears to be no New Zealand research studies on the experiences of coordinators working in tertiary hospitals. This study will uncover and interpret the lived experiences of five delivery suite coordinator midwives. Although this study cannot be generalised, it is anticipated it will offer new insight into their roles for readers of this study. In particular it is anticipated this study will provide an increased understanding for professionals who are working with coordinator midwives in delivery suite settings.

### **This Research**

My research explores "Midwives' experiences working as coordinators/charge midwives in tertiary hospital delivery suite settings: A phenomenological study". I wanted to listen to the stories coordinators chose to share during their interviews and to uncover meaning from their experiences which would offer them 'a voice' within the New Zealand midwifery profession.

## **Methodology**

### ***Why phenomenology?***

The underpinning philosophy for this study is phenomenology. Heidegger (1927/1962) was a German philosopher [1899-1976] who provided this formal meaning of phenomenology whereby it lets “that which shows itself be seen from itself in the very way in which it shows itself from itself” (p.58). Smythe & Spence (1999) explain this well when they write phenomenology “seeks to uncover meaning from experience” (p.1). Within this study, meaning will be derived from midwives’ stories which will become “manifest and visible” through interpretation and use of the hermeneutic circle (Heidegger, p.51).

I wanted to be able to make sense out of the human experiences of coordinator midwives by investigating their lived experiences. In this way, I hoped to uncover new meaning and would move beyond what I had conceptualized before I commenced this study. I have utilized the work of van Manen (1990) to assist me in my interpretations to uncover themes within this study.

Heidegger’s guiding quest was to explore what it meant “to be” (Cerbone, 2006), therefore, phenomenology and the chosen methodology fit my research question well (p.41).

The stories of coordinator midwives' experiences were so rich and extensive that the decision was made to limit the participants to five, a lesser number than I had originally planned.

The methodology used in this study does not allow for generalization of findings, rather it reveals my interpretations of these five unique women's practice realities. Heidegger's philosophy proposes that it is impossible to be detached from the world as we are always part of our world, so I purposefully looked inwards and addressed my passion for this topic so I could try to be as open as possible to my presuppositions. To achieve this, I initially reflected on my pre-understandings by way of reflective writing, and also in being interviewed by my supervisors, transcribing this interview and interpreting my conversation and viewpoints.

My pre-understandings helped me to identify my starting point to this study by bringing me face to face with my presuppositions, my assumptions and previously unrevealed beliefs about what it could feel like being a coordinator midwife. I needed to look back at myself and consciously put aside what was revealed through interpretation of my pre-understandings interview before moving forward and interpreting the coordinators' stories. This is all part of the hermeneutic circle which Geanellos (1998) describes as "the relationship between the whole and its parts, which has no beginning and no end. Each understanding is taken back to all previous understandings, and moves forward to new understandings. No one understanding stays static or fixed. All are open to growth and



change” (p.157). To this end, I also maintained a reflective private journal whilst pursuing this study.

### ***Phenomenology and seeing into ‘the heart’ of the coordinator’s life world***

Van Manen (2007) describes phenomenology as “the sober reflection on the lived experience of human existence” and goes on to write “the reward phenomenology offers are the moments of seeing-meaning or ‘in-seeing’ into ‘the heart of things’” (p.11). This is how I wanted to come closer to discovering ‘the essence’ of what it feels like being a coordinator midwife in order to see their work through a new lens. I have chosen to call ‘being a coordinator’ a phenomenon within this study.

I hope this study will allow the reader to gain insight in to the complexities of the daily lived experiences of coordinators who work within the unpredictability of tertiary hospital delivery suite settings.

### **The impetus for this study; my personal journey**

I trained as a registered nurse in a teaching hospital in London, England where the medical and hierarchical models of care reigned supreme. I fell in love with midwifery practice as a student nurse. After staff nursing experience I proceeded to train as a midwife. I purposefully chose to train at a hospital where there were no medical students, where the experience was comprehensive and provision of care to women was ‘midwifery led’.

I always had a yearning for travel so decided to travel to New Zealand where I branched out in to community based nursing as a Plunket Nurse, a Public Health Nurse and then as a Home Care Midwife. These were enriching years because I was living and working in an area of poor socio economic conditions, within a community of predominantly Maori and Pacific Island families. As a guest in homes, I was working autonomously, holistically and inclusively with entire families. I learnt about the reality of life, health and wellbeing away from hospitals and doctors' surgeries.

I experienced the New Zealand childbirth model during my pregnancies in the early 1980s in a rural area where we queued outside the doctor's surgery at a quarter to nine in the morning for our 'collective' nine o'clock appointment on a 'first come first served' basis. The surgery door would be unlocked at nine o'clock and ten of us would be herded in like sheep and then processed through the system with a practice nurse 'doing' the urinalysis and blood pressure checks and the general practitioner 'doing' a palpation resulting in us vacating the surgery within a speedy frame. When I questioned the doctor about this process, he told me 'there was no money in obstetrics'.

I enjoyed well active pregnancies and normal births. However I recall my childbirth experiences with an absence of joy, of caring, or any sense of autonomy for me as a woman. The doctor arrived at full dilatation and episiotomies were routine. With my second birth I was regarded as eccentric because I refused to be moved to the theatre to birth and I wore my own clothes, I had music playing during the labour, I insisted on

holding my daughter at birth to breastfeed and I refused to allow her to be put in the nursery or to be parted from me. I recall feeling punished that my request for keeping my daughter with me that first night in my room was granted by the midwife solely on the condition that the main light was left on 'in case my daughter stopped breathing'. As a mother, I experienced the effects of the doctors' and midwives' power and control over my birthing choices and experiences; I did not like it.

I returned to midwifery practice in 1991 because I was inspired by the political changes and the influence of women as consumers and midwives who were changing the face of midwifery practice in New Zealand.

I worked in the community, in the tertiary hospital setting and as a Lead Maternity Carer in sole practice in a rural area prior to my appointment as a midwife/nurse educator at a tertiary hospital in 2005.

My employment as midwife/nurse educator in a tertiary hospital requires my office to be based in the Delivery Suite/Women's Assessment Unit areas of the hospital. With an open door policy, I have the privilege on a daily basis of listening to coordinators, DHB midwives, LMCs, nurses, doctors and hospital aides who choose to share their experiences, tensions, stresses, wisdom and commitment with me. Inevitably, I held pre-understandings based on my conversations with these colleagues, on my observations, on my professional midwifery experiences and my personal birthing experiences which I needed to address to make this research robust.

My job is predominantly a deskbound position; however I maintain nursing and midwifery annual practising certificates and I periodically work ‘on the floor’ in addition to responding to staffing shortages and obstetric emergencies from my office. As a result of these experiences, I was drawn to research this phenomenon, in recognition that midwifery coordinators carry significant clinical, leadership and managerial responsibility within a climate of staffing shortages, a declining midwifery workforce and legislative differentiation between the provision of primary and secondary midwifery care to women in my workplace.

### **My Pre-understandings Interview**

Everything I have written in this chapter reveals my biases, my assumptions, my presuppositions, my beliefs, my understandings and my theories. Van Manen (1990) writes “the problem of phenomenological enquiry is not always that we know too little about the phenomenon we wish to investigate, rather we know too much” (p.46). Crotty (1998) reinforces this and writes “layers of interpretation get placed one upon the other like levels of mineral deposit in the formation of rock” (p.59). I needed to dig beneath my layers of interpretations.

In keeping with my methodology, I was interviewed by my supervisors with the interview tape recorded so I could subsequently interpret my pre-understandings. I needed to discover the influences which have come into play in my life that have influenced who I am, why I chose this study and how I have approached the subject. Van Manen (1990) reminds me that we “come to terms with our assumptions, not in order to forget them again, but rather to hold them deliberately at bay and even turn them into knowledge itself, as it were, thereby concealing its shallow or concealing nature” (p.47).

### ***Standing back and looking in***

I have not worked as a coordinator so this interview helped me understand I have been the outsider looking in at a world I am integrally part of yet in most instances I am on the sidelines, standing back, quietly watching, questioning and wondering what colleagues are really thinking and feeling.

I recall a situation when an LMC came to our office distressed after the collapse of her client in theatre with an amniotic fluid embolism. Whilst this emergency was being managed, delivery suite staff had to continue to provide care for other women in labour in the unit. We supported the LMC who was able to walk away, we nurtured the registrar who had also been able to remove herself due to her distress, but what of the coordinator who had a life threatening emergency to coordinate plus coordinate everything else that was happening in delivery suite at that time, and who needed to 'keep going'? The busyness of coordinators' roles seems to offer no time for them to catch up with themselves and from my perspective, it seemed that on many shifts coordinators are hurtling from one challenge to another whether it be a staffing crisis, a skill mix crisis, provision of safe care, or trying to maintain a midwifery focus within a tertiary medical model of care in the unit.

I hold great respect for coordinators who are highly skilled senior midwives and who carry huge responsibilities. They multitask on a daily basis with no apparent formal training for this leadership position. Coordinator midwives are ultimately charged with trying to keep birth safe in an environment where they have no control regarding the numbers of women who will be admitted to their unit on any particular shift, what sort of problems women or their babies will develop, and limited ability to bring on additional staff to help. As a consequence, sometimes these shifts are a nightmare.

I found I was frequently wondering how different coordinators felt about their role and their experiences. Are there more positives or negatives, what motivates coordinators to

come to work, how do they manage on good and bad days, and what is their definition of a 'good' or a 'bad' day? Are they 'adrenaline junkies'? I asked myself, "Is there a midwifery heart in their daily work; how do they manage their leadership roles; and how do they maintain their resilience?"

A coordinator told me, going to work felt how she imagined it would feel being the commander of troops at the battlefield; never knowing if there will be enough troops, what battles will be fought that day and whether the casualties will receive the treatment they require. She expressed feelings of being unsafe incase there were no backup troops and fearing whether or not someone might die because of the uncertainties of the situation. She explained to me that at the end of a shift she can often hardly string words together as she feels so exhausted from the relentlessness of the demands of coordinating. Wells (2003) voices similar feelings and writes "I wanted to be a good soldier" (p.8). She writes of being "tired of feeling anxious and stressed about my work" and "just waiting for something to go wrong" (p.8). Coordinators who have shared similar feelings with me express a sense of isolation. They are the leaders of the shift and explain they feel like lone voices potentially echoing similar feelings but with an absence of collectiveness.

### *Feeling safe*

I answered an emergency call recently. On entering the room the coordinator advised me the woman in the bed had arrived with no notes, there was no estimated delivery date, she appeared to be at term and in labour, with her obesity precluding accuracy of palpation. The fetal heart rate was audible and unyielding at eighty beats per minute, the maternal

heart rate was one hundred beats per minute with emergency assessment and assistance required immediately. The consultant and registrar were in theatre and unavailable and there were no other midwives or nurses in the unit available to help. This is a not uncommon experience for coordinators to manage when lives are in jeopardy.

I know I find my heart often ‘skips a beat’ when I hear the emergency call system sound, not ‘knowing’, and wondering whether or not extra help will be forthcoming. I can only imagine what it must feel like for coordinators who regularly know they have inadequate staff numbers on duty and hold concerns regarding the skill mix of the staff on duty. I wanted to know what it feels like being the coordinator in these situations and wondered if coordinators would reveal similar experiences.

The philosophies of ‘being safe’ and ‘working in partnership’ stand out for me in my pre-understandings for this research. I recognize as a midwife working in delivery suite that the coordinator midwife sets the tone for the shift by her management style. My sense of feeling ‘safe’ or ‘unsafe’ when I am working on delivery suite relates not only to the staffing situation but also to which coordinator is leading the shift. As a consequence, I found myself asking whether coordinators feel safe with midwives working on ‘their’ shift and what their perspectives are regarding working in partnership with colleagues and clients.

I observe coordinator midwives who respond to an error made by a midwife with quiet, non-threatening direction to maintain the confidence of the client and the dignity of the



midwife, whilst ensuring safe practice resumes. Conversely, I observe midwives under stress being challenged by the coordinator midwife or talked about in the office or public places, with disregard for their vulnerability at that time. I ask myself why this happens and what are the invisible emotional challenges coordinators are experiencing when this occurs?

I can think of coordinators who show immediate strong leadership in emergency situations and delegate well, with whom I feel safe. I can think of others who appear to panic, who take over situations or appear indecisive and with whom I feel less safe. Again, these are my personal interpretations and I wanted to gain insight into the stories about coordinators' individual responses to emergency situations and gain their viewpoints based on their experiences.

When I worked as an LMC I recall one particular coordinator who would always check the documentation of every LMC in secondary care situations despite the LMC having formally accepted autonomous professional responsibility for delivery of midwifery care to her client in the tertiary setting. I would reflect during these times, that it was my response which was critical in our relationship. I decided to view this approach as a double checking process which contributed to client safety rather than an alternative response which could have been one of feeling threatened by that coordinator. It was my sense of confidence and competence in my professional practice which determined whether I perceived she was practising safely or checking up on me because she did not trust me. On occasions, her approach would irritate me; however my choice of reaction

accorded an approach which I believed contributed to ‘safe practice’. I felt comfortable for this colleague to double check, and more so if I felt tired. This contributed to positive inter-collegial relationships, but is it always perceived this way by LMCs? I found myself asking how coordinators relate with LMCs in the delivery suite environment and how do they manage their ‘need to know’ what is happening behind closed doors.

### *My perspectives of partnership in the tertiary setting*

The concept of partnership has been central to New Zealand midwifery practice since the changes in legislation. Pairman (1999) describes ‘woman centredness’ as the philosophy which underpins the midwifery partnership, and identifies the LMC as the professional who establishes a partnership with her clients, based on the continuity of care model.

Partnership is also described by Pairman (1999) as a concept where there is recognition that both partners hold power with the balance of power requiring negotiation and agreement. Pairman cites Foucault (1980) who wrote that power should not be imposed from above. The coordinator works in partnership with a wide range of professionals in the delivery suite setting. Coordinators hold power in their workplace and I was interested how they utilize partnership and power in their daily work.

I recall an LMC caring for her client who was birthing twins in a secondary care situation. The client and her LMC within an informed consent partnership had documented a birth plan which excluded doctors and DHB midwifery staff from the room unless they were invited in. No one knew what was happening in that room. The

‘unknowing’ resulted in tensions, frustrations, anticipation of ‘what ifs’ and a general level of resentment towards the LMC and her client because DHB staff had been excluded from a secondary care situation when they could be called upon for assistance with no warning and no knowledge of what had gone before. This was the woman’s right. It became the coordinator’s role to manage the dynamics of the rest of the team on that shift and maintain cohesion and teamwork ‘just in case’. She set the tone for that shift. The LMC has her partnership established with her client during the course of the pregnancy. If there are complications, there is potential to have to forgo this relationship with its strong bonds based on the principles of continuity of care, when consultation between the specialist, the woman and LMC results in a recommendation for handover of care from the LMC to hospital maternity services in the tertiary setting. I have observed conflict between LMC and DHB midwives based on what I perceived as ‘ownership’ and ‘dependency’ issues between LMC and the client and wondered if indeed this was an issue for coordinators when there is transfer of care, or not. And, what of the LMC who wants to hand over care but staffing shortages in the tertiary setting make this impossible? I was interested in whether this is an issue for coordinators.

### ***My pre-assumptions of stress in the delivery suite workplace***

I perceive the delivery suite unit as an environment where stress exists. Barnes (2006) writes “the process of coping with workplace stress lies with the individual experiencing the stress” (p.19). I anticipated coordinators would reveal experiences which would bring light to how they manage stress in their workplace and whether it is something they find

invigorating and sustainable or limiting and negative. What makes these women want to go to work every day?

I recall colliding with a coordinator on delivery suite who had tears running down her face. She had just left a room where there had been an unexpected stillbirth. She had the ability to find privacy, to cry, to express her distress, her anger and the unfairness of life and then gather herself together and get on with her work. Coordinators tell me the only place for privacy in these situations is the toilet such is the busyness of people within the delivery suite setting and the lack of privacy whereby to find a quiet place.

Davies (2000) asks “Where is the spirit of midwifery in practice?” and describes the “awesome collective power of women” (p.23). Some coordinators I work with appear tired and stressed. To me, they do not reflect their belief in a spirit of midwifery in the tertiary setting, but what do they really feel? Davies also questions why she feels “all too frequently very alone” as a midwife (p.23). I ask myself, do coordinators feel this way too? I hoped I would be able to reveal the spirit of midwifery from interviews with coordinators.

## **Summary**

My pre-understandings reveal my personal and professional experiences, my feelings and emotions which influenced my expectations for the findings in this study prior to commencing interviews. By acknowledging what I knew I wanted to hear, I recognized I needed to be careful not to ‘craft’ the interviews. My challenge was to quietly try to free the interview time so stories flowed and experiences were revealed rather than being prompted by me.

Crotty (1998) describes the ability to see the world “afresh” (p.x) through phenomenological research. By facing my preunderstandings and putting them aside with utilisation of the appropriate methodology, it is my objective to reveal what it feels like being a coordinator for the five participants in this study.

To conclude, I hope this study will offer insight into the role of these five coordinator midwives and it will not only enhance their professional and personal sense of ‘being’ but it will also offer new perspectives for professionals and consumers with whom they come into contact in the tertiary hospital delivery suite setting.

## **Overview of the Thesis**

Chapter Two will provide the contextual basis for this study with the literature review.

This comprises research accessed from journals, textbooks, national project management reports, conference presentations and intranet data base research.

Chapter Three deals with my choice of methodology. My study was informed by the hermeneutic philosophical approach of Heidegger (1927/1962). I utilised van Manen's (1990) work to guide me in my method of interpretation. This chapter describes the ethical approval, protection of participants, analysis, trustworthiness and the general background to this study.

Chapters Four, Five and Six are the data analysis chapters:

Chapter Four is entitled "The 'Performing Art' of Leadership" and is divided into four sub-sections. Coordinators each described similar feelings about their working environment and the roles they play within their workspace. The titles of these four sub-sections are: Being the 'Hub', In the Eye of the Storm, The Role Plays of Leadership, Leaving Work Behind and Moving Forward.

Chapter Five is entitled "Lived Time". Chronologically, time ticks by at a steady rate but within the context of the tertiary delivery suite setting it becomes different things at different times for coordinators. There are five sub-sections in this chapter which are

entitled; The Luxury of Time, 'Thisly' Time, Guarding Time, Time to Support and Time Lost.

Chapter Six is entitled "In the Face of the 'Known' and 'Unknown'". Coordinators' midwifery knowledge is a combination of their clinical knowing and their instinctive knowing, however they are working within a paradigm of institutional hierarchies and a medical technological framework of care where they are charged by their professional body to uphold a partnership model of care and a continuity model of care. Within this chapter there are six sub-sections which are entitled: Knowing People's Practice, Getting the Skill Mix Right, Behind Closed Doors, How Much Longer Shall I Wait?, When There is Nothing Left and Woman Focused, Midwifery Led Care.

Chapter Seven is my discussion chapter where I draw my findings together and attempt to shed light on the experiences coordinators have revealed for this study. I bring the parts together to become a whole and relate the findings of this study to its limitations and its implications for practice, ongoing education and further research. I conclude with discussion of the essence of my findings within this study.

## **CHAPTER TWO**

### **Literature Review**

#### **Introduction**

The literature review will help situate this study within the context of existing national and international writing and research which is relevant to this study. There appears to be minimal research specific to coordinator midwives working in tertiary hospital delivery suite settings. New Zealand research by Earl (2004), Skinner (2005) and McAra-Couper (2007) reveal aspects of experiences of LMC and DHB midwives who work in secondary and tertiary hospitals and their research helps to paint a picture of coordinator midwives' working environment from the perspectives of midwives who are working 'on the floor'.

This literature review chapter focuses on what it is like working in health provider environments where there is unpredictability in the workplace, where there are staffing shortages, staffing skill mix challenges, differences in philosophy of practice and life threatening emergencies to be managed which may occur with no warning.

Aspects of these life worlds will be linked to gain some understanding and try to move beyond what feels like gaping holes and silences about the pivotal role of coordinator midwives.



### **The Realities of the Tertiary Delivery Suite Setting**

New Zealand midwives have been inspired to view themselves as guardians of the normal birthing process (Donley 1986), and the majority of women do birth normally, however with the increasing medical, technological and pharmaceutical advances in reproductive health care, midwifery coordinators working in tertiary delivery suites are increasingly challenged by the associated complexities of care required by women admitted to tertiary hospitals (Sharp, 1998), with a small but increasing minority of women becoming critically ill (Billington & Stevenson, 2007).

There are societal expectations including those of the medical profession who believe women are safer birthing in a hospital setting (Exton, 2008). This belief is shared by obstetricians in the United Kingdom who view the tertiary delivery suite as the safest and most appropriate venue for birth (Lankshear, Ettorre & Mason, 2005). Coordinators are challenged to maintain their midwifery philosophy of practice whilst they simultaneously juggle the complexities of provision of tertiary midwifery care in their workplace, the bed space availability, the 'through put' of mothers and babies in addition to managing staffing shortages and skill mix problems. There is their real desire to provide woman focused care which often conflicts with the reality of the unexpectedness of the tertiary unit and the requirement to meet the needs of the unit by deploying staff and resources, "in order to facilitate the efficient passage of women and babies through the maternity care system" (Hunter, 2005, p.257).

Coordinators work in an environment where their professional judgments may be swayed by the scientific concepts of evidence based practice versus instinct and knowledge. Tupara (2008) states midwives who work in units with higher rates of intervention perceive births as a more risky business than their colleagues who work in low risk, low intervention units. Lankshear et al., (2005) cite Lupton and Tulloch (2002), who write that the birth process is dominated by risk epidemiology which is used to legitimize technological interventions used in childbirth. They argue that the fear of litigation can result in the provision of defensive midwifery and obstetric care. As a consequence, women are exposed to new and different risks which spiral onto organizational and professionally associated risks.

Hunter (2005) revealed in her study that boundary protection occurred between midwives. Her research found midwives manipulated information to keep doctors away and to offer women more time to progress in labour. Hunter also identified in her research that junior qualified midwives were observed to manipulate information in a coercive manner to keep their senior midwifery colleagues happy. Her research is supported by Lavender and Chapple (2004) who revealed similar findings.

Midwives working in the tertiary setting are working within a complex technological medical model of care. Hunter (2004) observed that the challenge for these midwives was “the coexistence of contradictory ideologies of midwifery practice, which created dissonance for midwives” (p.266).

*New Zealand perspectives of secondary and tertiary hospital midwifery dynamics from  
the outside 'looking in'*

The vision of establishing a partnership model of midwifery care for New Zealand women was first written about by Guilliland and Pairman in 1994 and has become central to New Zealand midwife's philosophy of care; however the theory and reality do not appear to necessarily correlate in the workplace. Skinner (2005) writes that the partnership model "believes the complexity of the real lives of women and working midwives". She goes on to observe "although the model has significant uses as an organizational and political tool and as a practice ideal, there is little assistance as to how it might be worked into the everyday messiness of practice" (p.262).

The tertiary hospital DHB midwife works in an environment where legislatively, obstetricians are the decision makers in partnership with the woman and her LMC in relation to the provision of secondary maternity care for the woman (Ministry of Health, 2002). Skinner (2005) makes the point that the New Zealand midwifery profession is unique, with LMCs having access to secondary and tertiary hospitals and able to provide secondary skills to their clients in areas such as epidural management and augmentation of labour. She writes this practice "is now mainstream and 'real world'" (p.152).

The research by Skinner (2005) goes on to identify the place of the LMC at the primary/secondary interface where LMCs felt a diminishing of their power particularly in relation to obstetricians. These midwives found they needed to "work the system" and

revealed their relationships with obstetricians were crucial (p.176). There was constancy of 'knowing' between the obstetrician and the LMC midwife and these midwives reported preferring to work with obstetricians who they found 'like minded'. Challenges were reported if they needed to communicate with registrars who didn't know them or their practice.

Which DHB midwives were on duty also made a significant difference to LMCs' experiences when they cared for their clients in delivery suite with Skinner (2005) reporting feedback from one group interview revealing "support from midwives in the secondary hospital was often lacking and was a source of much distress, heightening the level of medico-legal anxiety" (p.179). Another group she interviewed identified their relationship with their secondary service as "medium to poor" and spoke of being "eaten alive" (p.182).

Thus, for LMCs bringing their clients into the secondary/tertiary hospital delivery suite setting, tensions can be very real. It is the coordinator who is their point of contact at the LMC/DHB midwifery interface and as a result, the relationship between the LMC and coordinator is pivotal for teamwork and a positive professional working relationship.

***New Zealand perspectives of secondary and tertiary hospital midwifery dynamics from the inside 'looking out'***

Isa et al., (2002) presented a paper to the New Zealand College of Midwives Conference which addressed midwifery practice at Middlemore Hospital, an Auckland tertiary

hospital. Their objective was to raise awareness of practice issues for DHB midwives. A follow-up paper was subsequently presented at the 2004 NZCOM Conference by McAra-Couper, Isa, Earl and Berry (2004) which will also be referred to in this study.

The work of the DHB midwife was revealed by Isa et al., (2002) as extensive. In addition to their clinical midwifery responsibilities of working 'with women', are their requirements to teach student midwives, year five medical students, trainee interns and senior house officers. Teamwork, teaching and support of junior midwives and other colleagues on the floor is necessary as well as effective interdisciplinary communication; for example with wards, operating theatres in the general hospital and with other professional colleagues. In addition, knowledge is required of departmental and organizational policies and procedures.

To illustrate challenges in the workplace, Panetierre and Cadman (2002) observed that direct entry midwives are ill-prepared to work in acute care hospital environments with clients who have complex needs and require multidisciplinary care. They write "direct entry midwifery graduates are less likely than registered nurse graduates to feel comfortable with the management of intravenous infusions and interpretation of results of unwell patients and to function effectively within the culture of the hospital" (p.18). Pairman (2002) disputed this paper and commented pre-registration programmes prepare midwives to work autonomously in any setting and "competence should not be confused with confidence" (p.3).

Weston (2009) refers to a questionnaire sent by the New Zealand Nurses Organization to midwifery members for their response to a proposal by the Midwifery Council of New Zealand to investigate the introduction of a 'scope of practice' for a midwifery care assistant to address the current serious midwifery staffing shortage in New Zealand. She notes several responses identified concerns regarding "the preparedness of midwifery graduates and the length of the midwifery programme" (p.20).

There are current national midwifery initiatives in place which specifically address these concerns. The Midwifery First Year of Practice Pilot Programme (Ministry of Health, 2008) was launched in 2006 with a vision "that graduate midwives enthusiastically commence their careers in New Zealand well supported, safe, skilled and confident in their practice" (p.1). Graduate midwives are assigned a mentor for their first year of practice with the executive summary programme evaluation reporting almost all graduates who participated in the programme experienced increased confidence in their practice and all graduates reporting significant gains in their knowledge and skill which they attributed to the mentorship and professional development opportunities available to them through the programme.

In 2009, the Midwifery Council of New Zealand are changing the face of the Bachelor of Midwifery registration education requirements with an increase in minimum learning hours, programmed weeks, midwifery practice hours and theory hours. Professor Gillian White (2005) writes "one rationale for these changes in programme hours is that they will

provide an increased opportunity for students to gain midwifery practice, thereby consolidating competence and improving levels of confidence in new graduates” .(p.1)

Anecdotally, senior DHB midwives remark that due to acute midwifery staffing shortages, graduate midwives do not receive the support they require in the hospital setting. Fraser (2006) affirms this by linking the culture of a working environment where midwives are working under high stress levels with the creation of barriers to learning in their workplace. This in turn impacts on the coordinator’s ability to safely allocate work to midwives during a shift.

There are also the additional unexpected challenges of caring for women who present with no prior antenatal care, prioritizing and adjusting workloads according to demands on the unit at that point in time, working with the unknown of family dynamics, encountering hostility, family violence and managing obstetric emergencies. Within this working environment, Isa et al., (2002) observe “we are very aware that secondary care does not exist in its own right and any reference of secondary care is in relation to specialists or secondary maternity services” (p.11). Three years after this paper was written, the situation had not improved with Skinner (2005) reporting that midwives in her study refer to “the ‘grey area’ between primary and secondary care” (p.178). Anecdotally, in 2009 this ‘grey area’ remains a challenge for DHB and LMC midwives.

Stories of DHB midwives experiences in the tertiary setting by Isa et al., (2002) offer insights which question the legal, ethical and professional responsibilities of the DHB

midwife. Experiences are cited in this paper where the DHB midwife recognizes her professional and ethical responsibilities when an LMC consults with her; however there appears to be no pathway or process for her to follow to action her concerns. Isa et al., write “it so often appears to us what has developed is a culture of core midwives being the support people to LMCs with little or no right of authority in regards to care and practice” (p.16). They go on to observe that communication between professionals becomes paramount with a willingness to respect each others viewpoints in the absence of defensiveness and any sense of being judged.

DHB midwives are working within an institution where the medical model of care is dominant. Isa et al., (2002) make the point that experienced secondary care midwives “are a valuable resource with a wealth of experience and knowledge which they use to keep birth normal” (p.37). Earl is quoted in this paper and states “just because I work in a hospital does not mean that I don’t have a midwifery focus or that I am medicalised. I still believe that we can use a combination of skills that keep us having normal birth outcomes. Maybe not in home delivery terms, but certainly still keeping the woman at the centre of her care and yet working with her towards a satisfactory outcome” (p.41).

McAra - Couper et al (2004) suggest the skill base of midwifery is changing with the expert ‘intrapartum midwife’ across both the normal and complicated, being something of a rarity because midwives are now required to work across their scope of practice. They quote a DHB midwife who recalls in the past when she was called into a room, that the DHB or LMC midwife would tell her what was required of her whatever the situation,



whereas now when she responds to calls to rooms the midwife is often asking for her advice and for a decision to be made. McAra - Couper et al., make the point that within the secondary environment “less and less is seen of birth itself and more and more is seen of the management of birth and this is mistakenly thought to be birth. In such a climate what can result is a version of midwifery that is part medicine and part midwifery – in other words a hybridized version of midwifery – this does little to protect and nurture the knowledge which is midwifery” (p.9).

It is up to the experienced midwives to try and pass their knowledge on within an acute and busy environment. Weil (2008) writes “in one New Zealand urban hospital that provides secondary/tertiary care the total hours of acuity in the birthing suite increased by 21% from 2005 to 2007” (p.4). It is within such working environments that the experiences of senior midwives who are confident in their practice and their beliefs in normal birthing are fundamental in trying to maintain a normal focus and woman focused care (Earl, 2004).

The belief in women’s ability to birth normally, combined with how ‘normal birth’ is defined within the secondary/tertiary setting offers senior midwives opportunities to “push the boundaries of practice and not go completely by the book” (Earl, 2004, p.78). Earl goes on to emphasize the importance of senior midwives willingness to share their beliefs and skills in keeping birth normal not only with women but also with fellow colleagues, inclusive of doctors. The question can be asked is whether this is achievable with the increasing acuity in the tertiary hospital setting.

With the complexities of midwifery and medical care in the tertiary setting, senior midwives hold this challenge of trying to keep birth normal but also recognizing when secondary midwifery care is necessary. Care of women, for example with poorly controlled diabetes, pre eclampsia, complexities of renal, cardiac, neurological, orthopaedic, endocrinological conditions to mention but a few, require specialist midwifery knowledge and clinical care in the tertiary delivery suite setting. When McAra - Couper et al., (2004) wrote their paper, more than half of all New Zealand women were birthing in tertiary hospitals. With such a significant number of women accessing this service, McAra - Couper et al., challenge the philosophy of the current New Zealand midwifery system whereby a midwife's scope of practice is normal, when the reality for midwives in secondary and tertiary hospital settings is that their daily midwifery care and management of childbirth embraces care of women whose care requirements has passed beyond the range of normal. They challenge the midwifery profession not to be divided by titles such as 'LMC midwife' or 'DHB midwife', rather to cherish and pass on the collective body of midwifery knowledge in guardianship of the profession and state "we are in an age of increasing intervention: an age of unprecedented complexity and technological advances. We need to strategize to protect midwifery" (p.25).

It is within this context of complexity of tertiary clinical midwifery care, the presence of self employed LMCs and DHB employed midwives, all working within an institution with a medical hierarchical focus and organizational constraints that the coordinator leads her team.

### **The ‘Emotion Work’ and the ‘Shadow Work’ of Midwifery**

As the person in charge, the coordinator is challenged to “create a relationship, a mood, or a feeling for the wellbeing of staff and clients” in an environment where emotions run high for everyone (Hochschild, 1983, p.440).

The midwife working in a tertiary delivery suite setting is working within an environment of high emotions and intimacy. There is the joy of new life, the despair of unexpected loss; the second trimester terminations which occur within an environment that is traditionally associated with new life; the baby who is born from love and the baby who is conceived unwanted; the emotions are endless. This is the woman’s time, not the midwife’s time and within this framework, Skinner (2005, p.272) highlights the need for midwives to have “the skills to mediate between different worldviews”.

The emotionally charged work of midwives has been researched by Hunter (2001; 2004) who is a senior lecturer in Wales, in the United Kingdom. Hunter (2004) calls this work “emotion work” which she defines as the feelings midwives experience in their work place which they find they need to regulate and suppress when they encounter difficulties (p.253).

Her research shows midwives become adept at masking their emotions in relation to issues of workplace conflict which impacts on staff morale and workforce retention. For example, Hunter (2004) identifies the difficulties for hospital midwives who try to adopt

a “with woman” style of practice within their institutional context of work which becomes an emotional struggle with the institution usually winning (p.254). Midwives find themselves juggling the ideologies of their midwifery focus of wanting to be “with woman” with their employer demands of being “with institution” and the reality of working within an institution with staffing acuity challenges, and often a “clear the board mentality”<sup>1</sup> (p. 257). Hunter found institutions direct midwifery practice according to protocols, policies and guidelines with childbirth likely to be managed within a medical model of care and cites Sandall (1997) and Mackin and Sinclair (1998), who identified stress as being significant with high levels of poor psychosocial health in the midwifery population giving cause for concern.

Just as Hunter identified ‘emotion work’, so John and Parsons (2006) describe “shadow work” in midwifery and the effect this has on the lives of midwives as they mask their emotions for the good of the women in their care but often to the detriment of their own health and wellbeing (p.266). Raphael-Leff (1991, as cited in John and Parson, 2006) suggests masking of emotion is not beneficial to the midwife herself and can potentially lead to increased stress, sickness levels and problems retaining staff in the workplace. This unconscious ‘impression management’ midwives utilize in their daily practice goes

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<sup>1</sup> Delivery suites have a whiteboard or computer screen which is a reference point for staff in the office area and indicates which woman is in which room. Management can be depersonalized with staff focusing on throughput of woman rather than client care by aiming to ‘clear names off the board’ and discharge mothers and babies from delivery suite in a timely manner.

unrecognized and may be conducive to the care of clients, but impacts negatively on them as women and on their collegial working relationships.

The coordinator in her daily life world is not only managing the complexities of the emotions of the staff she works with during her shift, but is also potentially managing her own 'emotion work'. She may want to provide a woman-focused service during her shift but her ideal may be compromised by staffing acuity, bed states, and general institutional demands. Hunter (2005) describes the 'bigger picture' and reality for midwives in her study of "being with institution, ensuring that the needs of the institution were met by deployment of workers and resources, in order to facilitate the efficient passage of women and babies through the maternity care system" (p.257).

***"Is it reasonable to aim for happy healthy midwives?"***

The question "Is it reasonable to aim for happy healthy midwives?" which is posed by Kirkham (2005, p.11) should be answered in the affirmative, however literature abounds with the stress midwives are working under and the detrimental effects this has on them professionally and personally.

Midwifery is a caring profession with associated significant professional and personal demands (Johnston, 2007). Compassion fatigue (Thompson, 2003) often affects those in the caring professions including midwifery, where emotional and physical care is expended and the person reaches a stage of feeling emotionally drained and blunted to their feelings in the workplace. The staffing shortages in secondary and tertiary hospitals

place high stresses on midwives. Both DHB and LMC midwives in the tertiary setting are confronted with unexpected outcomes and emotionally draining critical events.

Thompson (2003) writes of emergency situations when “caregivers spend the majority of their focus on the people directly involved and impacted by the incident and fail to pay attention to their own needs” (p.1). She highlights the reality that those involved usually go home to their own life worlds tired and with work left undone if they haven’t debriefed from their experience. Her research shows significant emotional benefits for professionals if steps are in place in their workplace to provide support to prevent cumulative stress. This process also reinforces professionals practising what they preach in their workplaces and it promotes teamwork.

There is a sense of contradiction in research for this study between the provision of midwifery care midwives aspire to provide and their reality of ‘what is’ (NZCOM, 2005; Kirkham, 2000; Kirkham, 2005; Johnston, 2007). Wells (2003) graphically describes her feelings in her writing as she explains how she tries to provide the best care she is able and leaves her shift “feeling drained, dehydrated, and hoping that something vital hasn’t been forgotten. I know I am not the only midwife who feels this way. I then spend hours at home catching up on my thoughts, imagining the worst-case scenario about the care I’ve been unable to give” (p.7).

Demerouti, Bakker, Nachreiner and Schaufeli (2000) tested a model of burnout and life satisfaction for nurses in Germany with their results confirming the links between job

demands, job resources and their direct impact on nurses' exhaustion and levels of disengagement which were indicators of 'burn out'. Of note was the importance of the other domains of these nurses' lives away from their workplace. For example, family relationships and leisure activities were important factors as to how nurses managed. It was the uniqueness of each nurse which influenced how he or she responded to stress in their workplace.

There are support systems available to midwives. Support has become formalized in New Zealand with the New Zealand College of Midwives (NZCOM) mentorship programme which is available to all new graduate midwives for their first year of practice. Lennox, Skinner and Foureur (2008) differentiate between 'mentorship', 'preceptorship' and 'clinical supervision'. DHB midwives and nurses receive short term preceptorship to support their orientation to their workplace when they are allocated to work with a senior midwife. Clinical supervision is a voluntary relationship with a suitably qualified professional which usually has an associated cost factor. Weil (2008) researched the voluntary engagement of five experienced New Zealand midwives who had accessed professional supervision. She notes clinical supervision and professional supervision are terms which are utilized synonymously in literature searches. Her research found some midwives had a need for professional supervision "in order to remain professionally and personally well" (p.21). In addition to these support systems there is the availability of the Employee Assistance Programme (EAP, 2009) to all DHB staff. EAP offers a self referral system with free counseling appointments and no requirement to disclose

information to the manager regarding their access to this support or the reason why counseling was sought.

There appears to be extensive literature related to the support needs of midwives and the existence of burn out and stress in the midwifery profession, however Deery (2005) writes there is minimal research which addresses how to alleviate the situation. Smythe and Young (2008) encourage midwives to access professional supervision or an alternative process which offers them the opportunities for nurturing, valuing and affirmation in their clinical practice with the advantages of learning strategies which will reveal to midwives their potential for burn out. In her research study, Weil (2008) found there were predominantly positive views aired regarding professional supervision. Midwives levels of understanding about supervision were influenced by their ability to utilize supervision to its potential and thereby judge it accordingly. Weil concluded in her study, “the midwifery profession needs to enter into a discussion about different support processes and its suitability for its members” (p.2).

### **Risk Management and Resilience**

The tertiary hospital delivery suite operates from a culture of risk aversion. Skinner (2005) describes her model of New Zealand midwifery within this context. She describes a three legged birth stool which the midwife not the woman sits upon. The birthing stool seat represents being “with women”, with the three legs of the stool which support the



midwife, representing “working the system”, “being a professional” and “working with complexity” (p. 260). She observes in her study the uniqueness of the New Zealand midwifery system whereby women who have risk factors are not excluded from LMC care. Continuity of care prevails and the LMC usually travels the woman’s journey with her.

Notably, Skinner proposes altering her birth stool to fit New Zealand secondary DHB midwives midwifery practice. Her research suggests midwives working in shift situations in hospital settings “might have ‘the demands of the institution’ as the seat for their birth stools” (p.261). This suggestion reveals the potential dilemma for DHB midwives who aspire to their professional standards of partnership, continuity of care and promoting normal birthing, but in reality, organizational factors hinder them from achieving this. Skinner questions whether midwives who work within the secondary system can be ‘with women’ and identifies this as an area of research which requires addressing.

Organizational factors which impinge on ‘midwifery work’ are highlighted by Walsh (2007). He identifies the pressure of time, institutional constraints, regulations and bureaucratic power differentials both within professional groups and between professionals and women being of relevance, which concurs with Skinner’s research.

In the absence of research relating to coordinator midwives, research on nurses in charge of shifts was accessed. Goldblatt, Granot, Admi and Drach-Zahavy (2008) studied the experiences of nurses being shift leaders in a hospital ward. Coordinator midwives often

carry a case load and offer bedside care whereas this research centered on nurse shift leaders who did not carry a case load and seldom offered bedside nursing as part of their role. Two major themes emerged from the study, which were the burden of responsibility nurses carried and their strong desire to reach the end of their shift safely.

Nurses care for the unwell patient in the ward situation because there is risk. Midwives care for two lives, one of which is unseen; there is the mother and her baby in utero. There may be no apparent risk factors for the mother or her baby in her womb, however there is always the “unknownness of the darkness” (Smythe, 2000, p19) which silently prevails in childbirth. Herein lies the midwifery perspective about which Skinner (2007) observes “in some essence, the midwife is there because there is risk. She provides care both despite it and because of it” (p.161). In the study by Goldblatt et al., (2008) nurses held concerns for themselves, which poses the question whether this study would reveal similar themes for coordinators.

The question is also asked: “How do midwives working in this environment manage?” What makes them want to come to work and how do they manage when they go home? Resilience is defined by Edward (2005) as behaviour which “is a valued quality in today’s stressful and changing health world” (p.147). In her research which addressed resilience of mental health nurses working in crisis care, the implications of her study findings identified resilience as an essential coping strategy which gave carers “confidence in dealing with changes, reframing negative experiences into positive and self enhancing ones and creating positive outcomes” (p.147). This was achieved through

the sense of value nurses attributed to feeling part of a team and where there was the opportunity to debrief with colleagues, thereby separating out work life and home life. Overall findings in Edward's research revealed non work related support systems and professional development enhanced resilience. Self awareness and insight was crucial for resilience in addition to the use of humour in the workplace where creativity and flexibility was achievable. The nurses studied held themselves in high esteem with a strong sense of self worth and clinical expertise. No research on resilience of midwives has been found in literature reviews.

### **Communication and Decision Making**

Coordinators are decision makers who work with risk in the unpredictable high stress delivery suite environment (Health Emergency Management New Zealand Bulletin, 2007; Fraser, 2006; Pitroff, Campbell & Filippi, 2002). With the lack of certainty associated with childbirth, Lankshear et al., (2005) reveal how midwives will pool knowledge with successful risk management occurring in delivery suites when decisions are collectively made particularly regarding management of 'at risk' patients, with this becoming "a socially negotiated activity" (p.374). They go on to observe "any particular decision may be the subject of dispute, negotiation and occasionally pulling of rank" (Lankshear et al., 2005, p.374).

Traditionally, however, within the hierarchical hospital framework, research shows nurses and midwives are not assertive with medical staff (Timmins & McCabe, 2004). Their research entitled 'Nurses and midwives assertive behaviour in the workplace' reinforced previous studies that assertiveness with medical staff and managers was practised less frequently than with their peers. There were fears of retribution and a lack of confidence in confrontation for both nurses and midwives in this study.

The importance of good communication between the coordinator and the registrar in the delivery suite setting is highlighted by Isa et al., (2002) who describe the challenges for coordinators with registrars arriving to work in the delivery suite setting for fixed periods of time and then moving on. There is the need to build relationships with this cycle of registrars leaving and new ones arriving. There can be a variance in skills, for example, there may be a newly promoted senior house officer becoming a registrar for the first time and at the beginning of their learning curve. There can be registrars who bring their overseas cultural mores to the workplace and there can be registrars who have comfortably practised within controlled medicalised models of obstetric care. Isa et al., go on to describe how it takes time and effort working with new registrars, which they refer to as "a breaking in period" (p.22). This entails facilitating a cooperative workplace environment based on respect for colleagues as professionals, and as people in their own right.

There are times when the 'knowing' of the coordinator can positively influence outcomes for mothers and babies, when she 'speaks up'. What it feels like to challenge the decision

of a consultant is described by Isa et al., who explain; “for a midwife to feel comfortable in overstepping a consultant’s instructions, takes one with a strong sense of confidence in her own practice and decision making ability, and to be absolute within boundaries of safety. It would take only one mistake to undo years of gain and we are always very aware of that, consequently we must always be certain of our decision making” (p.26). This observation reinforces the findings of Timmins and McCabe (2004) that a midwife with less experience and confidence would be less likely to voice her opinion.

The coordinator’s communication skills, her approachability and her willingness to work collaboratively will influence teamwork, open communication and learning. This is echoed by Earl (2004) who describes her perspective of the role of the coordinator midwife whereby “she sees her role not as one in a hierarchical system where she is the ruler, but as one of support and adviser” (p.89).

### **The New Zealand Midwifery Workforce and ‘Feeling Safe’**

Midwifery shortages significantly impact on provision of care to women and on safe staffing issues in hospital settings. The ‘Safe Staffing, Healthy Workplaces’ Inquiry was initiated in 2005 (Safe Staffing /Health Workplaces Unit, 2006) as a joint partnership project between District Health Board New Zealand and the New Zealand Nurses Organization (NZNO). Its objectives are to develop best practice guidelines for patient forecasting and management systems in addition to the development of a ‘best practice’

tool kit for management of nursing and midwifery operational systems inclusive of provision of direct clinical support in the workplace. The initiative was set up as a result of the DHBs' national Multi Employer Collective Agreement (MECA) and the concerns of nurses and midwives regarding safe staffing and healthy workplace issues. This project remains a 'work in action' with no improvements for midwives yet apparent at the coalface of tertiary hospital midwifery practice.

In the Kai Tiaki Nursing New Zealand (2008) journal it is stated that the inaugural director of 'Safe Staffing/Healthy Workplaces' resigned from her position in November 2008, with a replacement director anticipated to commence employment in February 2009. This will potentially impact on the time frame for safe staffing initiatives to be implemented in workplaces. In this article it is stated "we must keep a critical eye on all health work-force activity to ensure health and safety of the workforce is always a priority" (p.7).

The midwifery and nursing workforce become inextricably intertwined within such projects. The 'Safe Staffing, Healthy Workplaces Project Brief (2008)', states one of its objectives as "on the day match the right nurse to deliver the right care with the right competencies to the right patients" (p.6). The word 'midwife' is an omission and not included in this critical objective. Undoubtedly midwives are included elsewhere within this document and this is a printing oversight, however this omission illustrates how small and disempowered the midwifery workforce is, in comparison with the nursing profession in New Zealand. Guilliland (2008) notes "DHBs seem unable to work together

in a sustained way and are not interested or courageous enough to stand firm and recognize midwives as different from nurses” (p.8). The New Zealand College of Midwives have identified their recruitment and retention proposals for the midwifery workforce in this article and acknowledge how invisible DHB midwife employees are in some New Zealand DHBs.

Nurses in their general hospital working environments are usually caring for one patient whereas midwives are simultaneously caring for a mother and her baby or babies. Flow charts on paper and the reality of managing staffing shortages in the workplace can be poles apart. The Safe Staffing / Healthy Workplaces project does however highlight awareness and proposed action at government level regarding the gravity of workforce issues for both the nursing and midwifery profession.

The Ministry of Health has published a draft form of the ‘Maternity Action Plan 2008-2012’. Within this report there is acknowledgement of the need for planning “that builds on current national health workforce initiatives to ensure the availability of a skilled maternity workforce” (p.23). This plan reveals there are shortages of midwives and obstetricians in New Zealand with an alarming shortage of professionals in rural and provincial areas. The report also reveals there is an increasing and unsustainable reliance on overseas midwifery and obstetric practitioners. Workforce shortages are attributed to an aging workforce, recruitment difficulties, workforce retention problems and insufficient numbers of midwives being trained in New Zealand. These workforce

shortages result in high workloads and increased stress levels which place the LMC model of care in a vulnerable situation.

The interface of primary and secondary service provision with secondary and tertiary maternity services, strategizing regarding workforce issues, professional relationships and multidisciplinary cooperation are all issues which have been identified in the report and which require attention and action by the Maternity Action Plan advisory group.

Childbirth is an emotive subject and attracts media attention. The headline “Midwife shortage a ‘time bomb’” was released by the New Zealand Herald (Johnston, 2007) revealing twenty percent of the Counties Manukau DHB, one hundred and sixty midwifery positions, are vacant. Within the Manukau DHB region there is also a shortage of LMCs which exacerbates the situation. Lynda Williams, coordinator of the Maternity Services Consumer Council is quoted in this newspaper article as stating “It’s a disaster waiting to happen and it’s going to happen. This would come out if there was a mishap and I feel there is going to be a mishap”.

The current midwifery situation nationally and internationally is of great relevance to all midwives. The shortage of midwives impacts on coordinator midwives who take leadership and management responsibilities in the tertiary setting, where there is an assumption by the public that there will be safe provision of care. Symon and Black (2005) write “dangerous situations are created by heavy workloads, and are aggravated by sub-optimal skill mix, poor communication and individuals making mistakes or not



following accepted procedures” (p.125). It becomes even more concerning to read in the draft Maternity Action Plan (Ministry of Health, 2008) that the national birth rate is rising with 63,250 live births registered in New Zealand in the year to March 2008 which is 9.8% higher than the average number of births in New Zealand over the past ten years.

### **The Heart of Midwifery Leadership**

In her leadership role the coordinator is challenged to be able to lead by example and also stay true to her heart and her philosophy of midwifery practice, which takes strength of spirit within the tertiary environment. Davies (2007) writes “mindful midwifery evolves through the seeds of transformational knowledge that we all carry within us” (p.123). The coordinator is working within a medicalised environment but has a ‘knowing’ based on her experience and her holistic philosophy of care which raises her to another dimension of caring. She has the knowledge and the power, which includes intuition, to maintain a midwifery focus within her work environment as the leader of the shift.

There is an art and soul to midwifery practice which encapsulates both “skilled knowledge” and “emotional intelligence” (Byrom & Downe, 2008, p.4). Thus, the coordinator has the ability to be able to combine her clinical skills with a high level of intuition, and midwifery knowing. The delivery suite is an environment where emotions run high as Davies (2007) poignantly writes “you bear witness not only to the baby’s emergence but to the emergence of the mother, father and family” (p. 45). It is a

momentous time for families and the perception, attitude and sensitivity of the midwife caring for the woman is critical to her experience and her subsequent memories. For this to be achieved, Byrom and Downe describe “the virtuous circle” which invisibly exists whereby the leader of the shift, has the skill to be able to really listen to her staff so they feel strong and focused which in turn strengthens and supports the woman (p.10). This is a cycle of positive reinforcement which enfolds everyone as a team in the unit so they feel safe. Smythe and Norton (2007) reinforce this importance of listening and responding and write “leaders who listen ‘for and to’ the call intuitively know how to respond” (p.87). It is working ‘with’ women and being ‘in tune’ with everything that is happening.

Within the technological environment of the tertiary setting, it is the midwife who is with the woman, who affects the mood of the environment by her manner, who believes in women’s ability to birth and who is charged by her profession to be the guardian of ‘normal birthing’.

LMC midwives, midwives who work in birthing units, DHB midwives and midwives who teach the Bachelor of Midwifery programme collectively attend the Waikato DHB Technical Skills Workshops which is a mandatory requirement by the Midwifery Council of New Zealand for receipt of an Annual Practising Certificate. During the module on ‘keeping birth normal’ which I facilitate, participants are asked to anonymously write their personal definitions of ‘normal birth’ which are displayed on a board for colleagues to read. The fifty definitions contributed so far have each been unique; no two are the

same. This reveals the variance in midwives' philosophies and how they each 'view' normal birth. It is equally important to remember what is 'normal' in a midwife's eyes may be different to the woman who has birthed her baby.

The midwife in the tertiary setting uses technological interventions if they are required as well as, but not instead of, utilizing midwifery knowledge and wisdom. The midwife uses her vision to observe, her eyes will reveal her compassion or at times her fear, and her olfactory senses will give her clues to the sweet smell of liquor or the rotten smell of infection. Her hands will detect fever or shock, a breech or vertex presentation and as she uses her skills, the midwife is communicating, listening, asking, reassuring. She will provide her midwifery care best in an environment where she feels empowered (Smythe & Norton, 2007); it is the midwife who is the first "instrument of care" for women rather than technology (Kennedy, 2002, p.1).

The challenge for coordinator midwives as leaders working within this tertiary hospital system is the expectation that they work within a culture of medically focused care which is dominant with no value placed on alternative ways of 'knowing'. It is the 'knowing' which becomes the basis of clinical practice for midwives (Hunter, 2007). Hunter cites Fullbrook (2004) who describes how midwives utilize their "embodied knowledge to guide their practice in addition to textbook knowledge" (p.3). She passionately extols the importance of midwives holding on to this embodied knowledge within the current health care climate.

Experienced midwives will often ‘know’ when a woman is about to birth, they will recognize the signs of full dilatation and they will often know instinctively when there is something wrong. Midwifery is a predominantly female workforce and intuition is predominantly a woman centred trait. Intuition relates to “our experience of the results of deep cognitive processes that occur without conscious awareness and cannot be logically explained or reproduced” (Davis-Floyd & Davis, 1996, p.4). Nurses’ decision making processes in emergency situations were researched by Cioffi (2000) who identified the use of subjective data by experienced nurses in their decision making processes and the importance of listening to their inner concerns. Edwards (2004) writes about intuition in relation to medical error and views intuition as a subliminal signal to one’s consciousness which shouldn’t be ignored, however he applies this to the ‘going back and checking’ situations rather than utilizing it for clinical decision making in the workplace.

Midwifery ‘knowing’ goes back to being ‘with’ women. The medicalised world is described by Davies (2007) as a world with just two dimensions within the real world which is multidimensional and where midwives espouse “a holistic philosophy, in which we nurture women’s hearts, minds and souls by meeting them with our own” (p.75).

Within this world of complexities of obstetric complications and provision of midwifery care lies the art of leadership for coordinators. Leaders are working most effectively when they are able to challenge processes, empower their colleagues, role model how best to do things, inspire and encourage (Kouzes and Posner, 1995). They write “knowledge gained from direct experience and active searching, once stored in the

subconscious, becomes the basis for leader's intuition, insight and vision" (p.105). This is the essence of how leaders can work to get the best out of their team in the workplace.

### **Summary**

Within the New Zealand maternity system lies the uniqueness of the partnership model of midwifery care and the legislated commitment to continuity of care for women throughout their childbearing experience. The principles and the realities in the tertiary delivery suite setting provide challenges for midwives whether their role is an LMC or DHB midwife but especially for the delivery suite coordinator who takes on her leadership role within a context of uncertainty, unpredictability and potential for communication challenges. This universal reality is well described by Baker (In Davies, 2007) who paints the picture for these midwives of "courage in the face of precipices of clinical risk, unresponsive colleagues and complex clinical risk" (p.132).

Ultimately it is the strength of the coordinator and her level of resilience as the leader of the shift, as a DHB employee and as a midwife, which determines whether or not she has the ability to maintain a midwifery focus within a medicalised, technology based institution which is governed by policies, guidelines and protocols and where there is a risk aversion organizational approach within management systems.

This literature review demonstrates the wealth of research available regarding midwifery practice and its associated complexities but an apparent absence of New Zealand and international research specific to the experiences of coordinators of tertiary hospital delivery suites. With the increasing birth rate and advances in technology associated with childbirth, this lack of research indicates further exploration of this topic especially in relation to sustainability and resilience would be worthwhile.

## **CHAPTER THREE**

### **Research Methodology**

#### **Introduction**

This study is based on Heidegger's interpretive phenomenological, hermeneutic philosophy (1927/1962) and van Manen's (1990) research methodology.

Insights reveal themselves to the researcher in phenomenology through "a journey of 'thinking' in which the researchers are caught up in a cycle of a reading-writing-dialogue which spirals onwards" (Smythe, Ironside, Sims, Swenson & Spence, 2008, p.1389). The simplicity of this explanation however, belies the reality that this methodology is only trustworthy when the researcher is attuned to the text, has an open mind, is able to question and allows interpretations to reveal themselves. Ultimately it is the reader who makes his or her individual judgment regarding the trustworthiness of this study.

I want the reader to be able to identify with what I have written with a sense that it feels "true" to them. Van Manen (1990) describes phenomenology as being that which describes how a person "orientates to lived experience". He continues by explaining "hermeneutics describes how one interprets the 'texts of life'" (p.4). This research is not about proving anything, it is not about transferring what has been revealed to other situations, rather it 'is' my interpretations of the stories of five unique individuals who

gifted me their accounts of personal experiences (Smythe et al., 2008). The commonality between these women is that they each hold the same position of responsibility as a coordinator in the tertiary hospital delivery suite setting. I acknowledge readers of this study may discover their own interpretations from this study and I may never know what thoughts I provoke in them as a result of this study. However, I care deeply about this phenomenon and I want to reflect the 'Dasein' of these coordinators' experiences from my lens which has been as trustworthy as I can achieve in accordance with this methodological framework.

## **Heidegger's Phenomenology**

### ***Phenomenology***

Edmund Husserl launched the school of philosophy in 1900 when he attempted to separate philosophy from science by focusing on how things appear to us rather than addressing theories on how the world functions from prevailing scientific perspectives. Husserl was Heidegger's teacher and is attributed by Harman (2007) as the person who helped Heidegger reach his philosophical beliefs. Whereas Husserl challenged scientific naturalism, Heidegger introduced the notion that these 'things' are 'events' and began to supercede his teacher with his new thoughts.



### ***What is a phenomenon?***

Heidegger (1927/1962) wrote a phenomenon is “that which shows itself from itself” with a caution that what appears to be, may be only a semblance or an appearance of the phenomenon because “what we do see may not represent what we think it may represent, or may only partially represent because the entities may be concealed in the ‘being’ of the phenomenon” (p.58). Harman (2007) explains that Heidegger viewed the world as full of entities, or events which are always partially obscured, “not thoroughly graspable from the outside, and are never entirely exhausted by human thought” (p.175). I will show the phenomenon of being a coordinator midwife in a tertiary hospital delivery suite setting in this study.

### ***Being and Dasein***

The basis to this study is the work of Heidegger. Harman (2007) writes that “every great thinker has one single great thought” and for Heidegger, Harman explains this revelation was ‘Being’ (p.1). Being is our human existence or human presence in our life world, which Heidegger also referred to as “Dasein” (Heidegger, 1927/1962, p.49). Harman writes, “Dasein exists only as an act, event or performance of its reality not as something visible from the outside” (p.33). For Heidegger, ‘being-in-the-world’ can only be experienced by humans rather than animals or inanimate objects and it relates to humans being open to their life world, interacting with it and being affected by it. This study captures the Dasein of five coordinators.

### ***Time and Temporality***

For Heidegger (1927/1962), 'Being' does not correlate with the sense of 'being present', rather, 'being is time' and relates to the temporality of that 'being'. This is a very different concept to time as we know it, which is associated with measurement and the use of a watch, a clock, a calendar or a diary.' The reader is challenged by Harman (2007) to "to forget every scientific theory about how the world works, and to focus instead on a patient, detailed description of how the world appears to us before we invent any theories" (p.4). There is the subsequent challenge that when an entity does become apparent "it may show itself as something which it is not... it may rather 'seem to be'" (Heidegger, p.51). In this study I will search for the hidden, the concealed and the invisible, seeking to articulate the meaning that lies within and behind what is said.

### ***Facticity***

Heidegger used the word 'facticity' which Harman (2007) elucidates is when "human life is not something visible from the outside, but must be seen in the very act, performance, or execution of its own reality, which always exceeds any of the properties we can list about it" (p.25). Coordinator midwives have shared stories with me which are unique to each of them and are set within their own contexts of their individual life worlds. Human life is fluid, it is immersed in the specifics of its situation, there is a context to events, time does not stand still and every person uniquely interacts with his or her surroundings. To this end, in a hermeneutic approach things can never fully be seen, rather they require interpretation which Smythe (in Giddings & Wood, 2001) explains "is uncovering the meaning that's sometimes hidden" (p.22). There is a quest by the researcher to uncover

new meaning and truth. An added dimension is explained by Harman regarding facticity of time, who writes what seems so obvious yet is invisible in “the ambiguous way that time is already at work in our environment before we have noticed it at all” (p.27).

### ***Thrownness and Projection***

Situations occur, and events happen which are not necessarily of a person’s making and which will be revealed in the coordinators’ stories. Harman (2007) explains that human ‘Dasein’ is thrown into a world in the absence of choices. It is how coordinators respond to these situations, and how they project themselves, with the choices they make within their unique lifeworlds which will be revealed within the methodology of Heidegger’s (1927/1962) philosophy of phenomenology and van Manen’s (1990) interpretation of researching lived experience.

### ***Incorporation of van Manen into the methodological structure***

Van Manen (1990) was attracted by research of “every day lived experience” which was influenced by European and North American movements (p.ix). To remain true to the research question and to the methodology, van Manen challenges the researcher to address six research activities which are discussed herewith, however he points out “there is no definitive set of research procedures offered here that one can follow blindly” (p.34).

Van Manen (1990) charges the researcher to choose a study which requires both commitment and interest. I was attracted to the phenomenon of the experiences of tertiary

hospital midwives working in delivery suite settings because I care passionately about coordinators who appear to have no voice within New Zealand midwifery circles and this topic had not been previously addressed in New Zealand midwifery research studies.

Coordinator midwives are women with expert clinical skills who I conceptualized work under significantly challenging circumstances with provision of safe care of women in the tertiary delivery suite at the core of their 'being'. I knew I would remain focused on this study; such was my interest and commitment to the phenomenon. Van Manen (1990) makes it clear there is always potential for another research study to discover "richer and deeper meaning", so this study will be my interpretation and just "*one* interpretation" (p.31).

The researcher is challenged to research the experience of the phenomenon as it is lived rather than how it is conceptualized (van Manen, 1990). I recognize I had unconsciously conceptualized coordinators' experiences prior to commencing this study. By addressing my pre-understandings through taped interviews, transcribing and interpretation, I was able to peel back, face and work through my beliefs which are documented in Chapter One. Only then could I open my mind to listen to the lived experiences of the women I interviewed and what they chose to share with me, rather than crafting what I wanted to hear.

I was challenged to allow themes in this study to reveal themselves to me rather than me finding them. Van Manen (1990) describes experiences within dimensions of "time,

space, things, the body and others” which constitute the nature of lived experience (p.32). Discovery of appearances and the “essence” of experiences took time and required intimacy with the content of the material. I needed to listen to the tapes, the nuances, the tones of voice, the humour and the frustrations. Repeatedly, I was listening, reading and writing. I became inseparably part of the process as I worked towards reliability of my interpretation. What was said and how I interpreted transcripts was not ‘Dasein’ unless I followed van Manen’s methodology and discovered what was revealed. This revelation took a longer period of time than I had anticipated with a number of themes eventually identified and consistent between stories. I learnt that I could not rush this process and rather like Heidegger’s notion of time, clocks, watches, calendars and diaries needed to be discarded before I recognized I felt free enough to really explore the concealed content of the ‘Dasein’ of the phenomenon I was peeling back.

Interviews were initially transcribed, crafted into stories (Caelli, 2001) and then participants approved the content which became the canvas from which to work. By listening to and reading transcripts word by word, sentence by sentence, meaning revealed itself and writing flowed. Over the course of the interpretive time, thoughtful reflection required that I wrote and rewrote. It took many months to discover the elusiveness of the phenomenon. Van Manen (1990) refers to “the art of writing and rewriting” as an essential component of “*bringing to speech*”, the phenomenon being revealed (p.32).

I found myself regularly challenged to stay focused on the phenomenon I had chosen to study. Van Manen (1990) writes “unless the researcher remains strong in his or her orientation to the fundamental question or notion, there will be many temptations to get side-tracked” (p.33). I needed to journal, reflect and refocus regularly as there was the constant tendency to detract and pursue beliefs based on my pre-understandings and my ongoing communications and experiences during the course of this study. My feelings and belief systems initially invaded the texts and as my supervisor gently advised me, my interpretations initially read ‘like a madeira cake rather than a sponge’. As a consequence, I would regularly need to reflect, omit personal crusades from the text and refocus on the content and the coordinators’ telling of their stories.

By revisiting transcripts and the tapes I eventually discovered fluidity, resonance and recurrent themes in stories. Many of the stories had interweaving themes. Themes of the coordinators were found to align in part with van Manen’s ‘life world’ themes.

## **Study Design**

### ***Ethical Approval***

Approval was gained from the Auckland University of Technology Ethics Committee in February 2008 with my obligation to protect participants in this study complied with throughout the process (See Appendix A and attached Participant Information Sheet).

### ***Participant Recruitment***

My workplace is a venue where some of the participants work and I also enjoy networks with colleagues in other regions, so confidentiality was paramount regarding processes for recruitment of participants. With differences between the hospitals of the title for the role of coordinator and charge midwife, I chose to refer to all participants as ‘coordinators’ in this study.

All coordinators were recruited with purposive sampling. I discussed my intention to commence this study on an individual basis in privacy with coordinator colleagues at my workplace. Interest was expressed by each coordinator so with their consent I posted a Participant Information Sheet (Appendix A) to their home addresses.

Contact was made only when I received a response from participants to confirm formal notification of each prospective participant’s interest. I was aware of the potential for me to skew findings with my choice of participants so purposely approached coordinators who I perceived had significantly different personalities and professional backgrounds. Although they were not required to do so, I asked participants to consider maintaining confidentiality regarding their participation in this study because I believed absolute anonymity would further prevent any possibility of connectedness between stories and interpretations. There was verbal agreement by coordinators to comply with this request.

One supervisor distributed participant information sheets in another region and as a result, I responded to e-mail contact from a coordinator who expressed an interest to be

involved. Another coordinator at a different hospital was approached by an intermediary colleague and advised me by phone that she would be willing to participate. I e-mailed the relevant information to her and arranged an interview time after receiving her response via e-mail that she was happy to proceed.

There was an initial intention to interview eight coordinators for this study, however only five coordinators were interviewed because the volume of experiences transcribed from these interviews was extensive and I was advised by my supervisors there was plentiful data to work from. Rather than accumulating large amounts of data, phenomenology requires detailed descriptive experiences from a relatively small number of participants. The methodology for this study does not seek to generalize meanings; rather it reveals the life experiences of participants interviewed.

### ***Consent***

After receiving contact from participants I arranged a suitable date, time and venue to meet. In each case, we met at a place of the coordinator's choosing. At that meeting, I began each interview by explaining the rationale for the study and answered outstanding questions, after which the participant was invited to sign the consent form (Appendix B). Participants were advised they had the right to withdraw from the study at any point and could delete or amend any part of the transcript before I would start to work with the data. One participant deleted portions of the transcript with the amended transcript subsequently returned to her for confirmation of my compliance with her request.



### *Anonymity and Confidentiality*

For maintenance of anonymity and confidentiality, interview tapes and transcripts were numbered two to six with my pre-understandings interview at number one. The consent forms are kept separate from the transcripts with neither supervisor knowing the identity of the midwives. This data will be kept for six years until it is destroyed in accordance with the organizational requirements of the Auckland University of Technology. A typist was employed to transcribe the tapes and a non disclosure consent form was signed by this person (Appendix C). I employed a typist with a background of medical typing who did not live in this area, who was unfamiliar with the tertiary hospital delivery suite setting and who had no work contacts with participants or myself for assurance of absolute confidentiality.

I accorded pseudonyms for each participant which have been used consistently in the study. Names of hospitals have not been identified and names of clients were not used by participants. One participant did name colleagues in her interview, however these names were deleted so no name appeared on any transcript to protect privacy and maintain confidentiality.

I have segregated all communication for this study by not using the internal hospital mail system or the hospital e-mail system.

### ***Protection of Participants***

Each participant was given information in the Participant Information Sheet regarding availability of counseling via the Auckland University of Technology's Student Health Centre, however there was no indication at interview or thereafter that this was required by any of the participants.

The midwives fulfilled the requirements to be part of this study in their positions as midwives with extensive midwifery experience who were working in coordinator and charge midwife positions. They were each experienced practitioners with pseudonym names assigned by me as Sally, Alice, Amiria, Jane and Irene.

### ***Interviews***

As the interviewer, I was tasked with listening to personal life experiences within a framework of conversation where I needed to be disciplined and focused on the demands of a hermeneutic phenomenological study. Van Manen (1990) identifies two purposes of this interview which are exploring experiential material which becomes the resource with which to develop "a richer and deeper understanding of a human phenomenon" and utilizing the interview as a means of establishing a conversational relationship with the interviewee in order to gain meaning from an experience (p.66). So, I needed to encourage the telling of stories and experiences which came to light for interviewees, and at the same time, in the background, there was a constant challenge of trying to maintain a relaxed atmosphere, asking the right questions, allowing for silences and trying to explore experiences to gain greater depth and understanding.

### ***Interview venue***

Participants chose the venue they felt most comfortable with for their interview. One participant chose to be interviewed at my home. Within minutes she asked me to stop the tape recorder and told me she found it difficult speaking with the tape recorder running. She explained that despite knowing what she wanted to say, she found the tape recorder distracting and it inhibited her ability to continue. With her consent, I stopped the interview. After an amicable discussion, I wiped the tape clear of our recording and destroyed all documentation to ensure confidentiality. We then sat down and had a coffee together which was a relaxed environment in which to talk and for each of us to debrief on the experience. I asked her if the venue had any influence on her experience and she advised me it did not. This participant was not included in the research.

One venue was at a neutral meeting room away from the participant's workplace, with all other interviews occurring in participants' homes. I would take baking or a small gift as a token of my appreciation and the interviews were usually preceded with coffee and food. There was a tendency for a social interlude and time to relax, so I utilized this time to set up the tape recorder and switch it on at a point where we felt we had established a relaxed mood and we could move on to the interview talking freely with the tape recorder on, and feeling that it was less obtrusive and off-putting.

### ***Interview format***

I gave participants the consent form to read at the beginning of our meeting. Time was made for each participant to read it and to ask questions before it was signed.

My goal for each interview was to gain the participants' unique perspectives of their experiences which they owned (Koch, 1996) with the aim that each participant would be able to control the flow of conversation. I commenced the interviews reminding participants of the research question and then asked a leading question such as "*What is it like being a coordinator?*" I found some participants would offer qualities 'required to be' a coordinator rather than their experiences of 'being' one, so I would then use open questions such as "*Can you think of a story that comes to mind to illustrate what you are describing?*" Throughout the interviews I tried to let the participant take the lead but was conscious of staying focused on the research question, so I would use open questions to delve more deeply such as "*What did that experience feel like?*" to try and get the most out of each participant's lived recollections. Open questions such as "*Can you think of a good day?*" and the antithesis, "*Can you think of a bad day?*" would reveal the unique individual responses from women holding the same job positions at their workplaces. I took a list of questions to interviews which I could use as 'prompts' if the interview became difficult and I needed assistance to get the interview back on track, however this was not required.

Interviews lasted between one hour and one and a half hour duration with total time spent with participants averaging two hours including social conversation interaction. My greatest challenge was to allow for silences which was something I learnt reflectively 'on the job'. Koch (1996) writes that styling interviews takes practice and with only five interviews to complete, my learning curve was too short which was frustrating.

Two coordinators knew what they wanted to share from the commencement of their interviews and needed little prompting. Another had documented the things she wanted to share during the interview, talked freely and used her notes as a check list at the end of the interview to make sure she had spoken about everything that was important to her. Two participants revealed a relaxed style and quietly reflected with a level of humour in their interviews. One other participant had prepared for what she wanted to share and requested I put the tape back on after I thought the interview was complete as there was more she wanted to talk about.

Despite the initial time before the interview that was spent creating the right ambiance and achieving a relaxed feeling, it was interesting that after the interviews had been completed, participants tended to continue to talk about their experiences and I found myself wishing the tape was still on. But I left the option to each participant to request this be done, which only happened on one occasion. This revealed my 'beginners level' of skill in relation to phenomenological research interview techniques.

Interviewing participants was a privilege as I listened to stories and participants recalled experiences which were important to them. I marveled at the similarity in themes which emerged and the diversity and the complexity of coordinators' roles. Stories appeared to be told with energy and passion and time flew by.

### *Transcribing*

One interview per participant was conducted with all interviews taped and transcribed by a medical typist. I am not a skilled typist. With the associated time involved in word processing skills to transcribe well, I decided I would learn best by utilizing my time listening to the tapes repeatedly during the course of this study and reading the typed transcriptions, rather than transcribing.

I worked methodically with one transcript at a time. Caelli (2001) requires the researcher to immerse herself in each transcript in order to ‘unpack’ stories from each narrative which is what I did. I then returned the full transcript and a copy of the stories which captured aspects of the phenomenon with duplicates to the participant. Participants kept a copy of the unedited transcripts and the stories. The duplicates were returned to me in a stamped addressed envelope that I supplied.

I felt supported by participants who returned the data promptly. The process of interviewing, having the tape recorded interview transcribed, listening to the tape again, crafting stories identified within the transcript, then posting the data back to the participant before embarking on the next interview took an initial intensive three months. Participants were invited to alter or delete material. One participant chose to delete stories which she felt could identify her at her workplace. Predominantly, it was grammatical amendment that participants made to the transcripts.

I made tentative notes about themes I thought revealed themselves in stories but in hindsight recognized I was rushing the process, and I learnt to take time for thoughts and a deeper understanding to emerge. This reflects the process of the hermeneutic circle (Crotty, 1998).

### *Analysis*

The phenomenological research I had read prior to commencing this study had inspired me. Caelli (2001) writes that phenomenological methodology offers a framework within which to explore lived experiences which would have been previously inaccessible through traditional scientifically based methods. I found I had experienced a ‘showing’ and new clarity about midwifery practice as I read phenomenological interpretation of the lived experiences of midwives (Smythe, 1996; Smythe, 2000).

I spent an initial week at a writing retreat where I repeatedly read participants’ transcripts and stories and listened to their audio-taped recordings. During this time I wrote and re-wrote as I tried to understand and interpret the experiences participants had revealed in their stories. I found it helpful to initially highlight themes I had discovered within the stories. I then grouped stories together to find commonalities. I was gently empowered by one supervisor to put aside stories I personally favoured but which had no place in the study. I discovered I held an initial reluctant ‘letting go’ of what I had anticipated would be revealed in stories, what I hoped would be ‘there’ and what was ‘really’ there. This was helped by maintaining a journal and doing a lot of walking and reflective thinking

which distanced me from ‘my world’ and brought me to see coordinators’ experiences in a new light.

I was challenged to achieve “phenomenological reduction” (Caelli, 2001, p. 277) as I delved deeply into the stories which revealed themselves over the following months of writing and rewriting (p.277). I was encouraged ‘to trust the process’ by my supervisors and realized I was traveling an unknown but exciting road. Retrospectively, I strongly identify with Caelli who remarks “Because little is written about the constructive endeavour of deriving narrative from transcripts, the path through this challenge was a particularly lonely one as well as one that may be open to discussion and dispute” (p.278). The themes were there within the participants’ stories but it took time as I became increasingly immersed in the hermeneutic circle which Koch (1996, p.176) describes as “the experience of moving dialectically between the part and the whole” with the guidance of my supervisors (p.176).

Throughout phenomenological research, van Manen (1990) requires the researcher to maintain “a strong and orientated relation” (p.135) between the research, the writing and the pedagogy, which I always tried to do. I brought the themes in the coordinators’ stories together within a phenomenological framework, with the objective for “a free act of seeing” (van Manen, p.70) for readers of this study. The findings were then linked to known research identified in the literature search chapter of this study and conclusions reached.



## **Literature research**

I delved into a wealth of journal articles and texts during the course of this study.

Midwives research which shaped my learning around being safe in midwifery practice and the emotion work involved included Smythe (2000); Hunter (2001, 2004, 2005) and Kirkham (2000, 2005). Theses written by New Zealand midwives Skinner (2005); Earl (2004) ; Vague (2003) and McAra-Couper (2007) were each a source of inspiration and assisted me apply my research to the context of New Zealand midwifery practice.

Harman (2007) was my beginner's companion to understanding Heidegger (1927/1962) alongside Crotty (1998) and Cerbone (2006).

Crotty (1998) links Heidegger (1927/1962) with the use of poetry as a means to source the Dasein of a phenomenon. Davies (2007) has published an emotive text book entitled "The art and soul of midwifery" and explains poetry is "a direct way of empathizing with and learning about the infinite variety of women's childbirth experiences" (p.79). This reiterates for me the focus of care midwives offer to women but begs the question, 'what of the poetic expression of the coordinator midwife which reveals her experiences?', which is something I was unsuccessful in sourcing.

### **Trustworthiness and my Prejudices Brought to the Data**

Koch (1996) explains over the past two decades there has been “a shift from a conventional empirical paradigm to alternative paradigms” (p.178) in relation to the rigour and trustworthiness of qualitative research. Koch believes it is up to the writer to show the reader how trustworthiness is achieved within a qualitative study and it is up to the reader to decide whether or not that study is believable. Within this context, I will attempt to show the trustworthiness of my study.

Researchers may choose to utilize Husserl’s methodology in phenomenological research to “bracket out” their own pre-understandings (Crotty, 1998, p.219). Bracketing is described by Crotty, as “the act of suspending one’s various beliefs in the reality of the natural world in order to study the essential structures of the world” (p.175). I chose not to use such methodology; instead I followed Heidegger’s philosophy by addressing my pre understandings of the lived experiences of coordinator midwives because I acknowledge I am part of this world and I believe I cannot detach myself from it. Smythe et al (2008) write “what matters is not accuracy in the sense of reliability, or how the researcher came to make certain statements; what matters is what has held the thinking of the researcher and in turn holds the thinking of the reader” (p.1397).

My initial pre-understandings interview assisted me ‘look from the outside in’

Geanellos (1998) offers alternative adjectives to describe pre-understandings as “prejudices, preconceptions, presuppositions and forestructures” (p.41). These are revealed in chapter one where I describe the impetus for my choice of research topic and I interpret my pre-understandings.

I believe it has been to my advantage that I have never worked as a coordinator in the delivery suite setting as I have no life experiences of ‘being’ a coordinator through which to make judgments. However, during the course of this study, I have been regularly challenged to address the emotional perspectives of what I think, what I observe, and what coordinators share with me especially when I am at work.

During the course of this study, I kept a journal which was my steady companion and which I would return to read and write in at any time. Heidegger’s version of the ‘hermeneutic circle’ (Crotty, 1998) asks the researcher in his or her quest for understanding ‘Dasein’ to discover initial understandings and to then “leap into the ‘circle’, primordially and wholly” (p.98). In this way, Crotty explains “understanding turns out to be a development of what is already understood, with the more developed understanding returning to illuminate and enlarge one’s starting point” (p.98). Thus my engagement with the hermeneutic circle was complete as I engaged with the transcripts and emerging themes, I looked back and I addressed my pre-understandings, I reflected through thought processes and reflective writing and I wrote and re wrote as I delved deeper into the text to find the themes hidden beneath the surface.

During the course of this study my supervisors would read and provide written and verbal comments on my interpretations. Dignam in her interview with Giddings regarding grounded theory (in Giddings & Wood, 2000) comments that when phenomenological research is presented, there is “resonance” and “everybody says ‘yes, we knew that’” which Giddings acknowledges is the “phenomenological nod” (p.9). Two midwifery colleagues who did not participate in this study asked to read chapters four, five and six. One coordinator remarked the stories so ‘rang true’, that she experienced increasing difficulty reading the stories. She realized she identified with the coordinators’ experiences in this study to such an extent that it had made her wonder why she came to work. The other coordinator remarked how affirming she found the stories. This coordinator remarked for the first time she recognized and understood her “helicopter view” in her workplace (Draycott, Winter, Croft & Barnfield, 2006, p.95). In turn she expressed feelings of empowerment from participants’ stories which she explained mirrored her own experiences and highlighted how pivotal she is in her role as a coordinator.

I believe I will have achieved trustworthiness for this study if the reader responds in similar ways and if this study brings the reader to new levels of understanding about this phenomenon. Ironside sums this up well; “...if it grabs you, hooks on, then you’ve ‘got it’” (In Smythe et al., 2008, p.1396).

## Summary

In this chapter, I have identified my philosophical stance in relation to the research question and how the philosophical approaches of Heidegger and van Manen form the basis of my study.

I have described the study design, how ethical approval was gained, participant recruitment was achieved and anonymity and protection of participants was ensured. I have detailed the interview process, how I analyzed data and how trustworthiness has been achieved in this study. I have utilized the key philosophical constructs in this study, which Koch (1996) identifies are discovered through application of “the hermeneutic circle, dialogue and the fusion of horizons as metaphors for understanding in interpretive work” (p.62).

I leapt into the hermeneutic circle with great enthusiasm. My pre-understandings had been revealed and I held a readiness to uncover new meaning and themes with which to reveal understanding of the experiences of coordinator midwives in the delivery suite setting. The experiences coordinators shared often felt adrenaline charged, exhilarating and exhausting. There were stories which felt on the edge of safety, which read more like fiction than reality and which placed these women in undeniably difficult professional situations. I had not anticipated how difficult it would be to bring these stories together and to bring meaning to the Dasein of the phenomenon.

## **CHAPTER FOUR**

### **The ‘Performing Art’ of Leadership**

To commence interpretation of the themes which have revealed themselves for these chapters, I have chosen to initially give voice to the coordinators’ descriptions of what their job feels like in their leadership role. Coordinators’ descriptions reveal similarities with their analogies of spatial dimensions. A sense is conveyed of coordinators being in the midst of a swirling circle of unfolding events equidistant from everything that happens in their workplace which is revolving around them. This chapter reveals their reality.

#### **Being ‘the Hub’**

Smythe and Norton (2007) write “the centre of interest is not in an isolated office but amidst the hearts of the people who share the quest” (p.76). Within the ever changing environment of the unit with the busyness, routines and emergencies, coordinators reveal themselves as central to the activity of the unit, wherever they may be from a physical perspective. Their “lived space” is something that is experiential and not a physical entity (van Manen, 1990, p.102).

Irene explains:

*Being the coordinator feels as though I am the hub and I am in the centre of a circle with the multidisciplinary team who surround me each doing their jobs.*

*By coordinating I am giving directions and receiving directions. Directions travel in and out of the circle. I am at the interface when directions come into the circle and as a coordinator I send directions out. It is a constant in out interplay of communication with colleagues about a variety of topics ranging from clear instructions to practice directives to positive reinforcement. The coordinator is constantly in the middle of everything that is going on.*

As the coordinator, Irene is pivotal to the smooth and safe running of the delivery suite during her shift. There is a sense of fluidity in her work and of weaving threads together to make things whole. Effective communication skills are the basis of her management style and her ability to listen and respond appropriately shines through in her descriptions of working with colleagues. She gives and she receives with no sense of power play conveyed in her interview.

### ***‘Being the pivot’***

Alice speaks about ‘being the pivot’:

*You try to make the system work and I think you are a very pivotal person in that respect. I was saying the other day “what do I really like about my job?” because I do nothing but moan about it. I like being a pivotal person that things happen around, I get a buzz out of that I suppose.*

There is almost a sense of love/hate feelings for her job such are the swings of emotions for Alice. She identifies her work as ‘people management’ in what is often a stressful environment. At the same time, she is the professional who is central to everything happening in the delivery suite, which is exhilarating and stimulating for her.

### ***‘Feeling the peck, peck, peck’***

Alice continues:

*There’s the phone, and then people at you the entire time, peck, peck, peck; its part of being the pivot. Some days it’s fine but when you’re busy it becomes hard to deal with and gets frustrating especially when it’s not necessary.*

How Alice reacts to people and situations is critical to the smooth running of the shift and ultimately reflects on safe care for mothers and babies. Her description of being ‘pecked’ is effective and conjures up an unpleasant sense of being worn down by the persistency of people, each with their own agenda. However there is also a sense that this is an integral part of her role and something she has to manage. It is how Alice reacts to this persistent pecking and sustains herself that reveals her leadership skills as a coordinator.

### ***‘Solving the puzzle’***

Sally uses a different analogy for describing her work:

*I like coordinating because I enjoy being in control and seeing all the mess come together. I enjoy having a great big puzzle that I can fix and bringing everything together at the end of a shift, then knowing it all came together really well. Where*



*I work, the difficulty is the staffing shortages and when the puzzle just doesn't fit together.*

Sally enjoys being in charge, being “in control” and being a decision maker. This is not ‘just’ a puzzle; rather it is “a great big puzzle” for Sally which highlights just how challenging her puzzles can be. Fixing a puzzle takes resoluteness, patience, determination and persistency. It is only at the end of her shift that she is able to reflect and feel the satisfaction of fixing the puzzle, in the knowledge her achievements directly relate to safe practice for staff and safe delivery of care for clients. These puzzles are not easy, she does not complain, rather she reflects on the ‘difficulty’ she faces when the puzzle does not fit. Something that is difficult to fix is not necessarily impossible and that is the enjoyment factor for Sally.

### ***Experiencing ‘the plop, plop, plop of a good day’***

Within the phenomenon of lived space for coordinators, Alice describes how it feels on a good day:

*A good day is when you've come away feeling good. When there have been lots of deliveries, they've all been normal, there's been lots of midwife led deliveries around the place and it's all just been straight forward, plop, plop, plop and the midwives are all happy because they've had nice midwifery care. It's not been too busy so everyone's had a chance to sit in the coffee room and have a laugh and a cup of tea which is important. When things have flowed, there have been lots of*

*normal deliveries and nothing bad has happened or if it has, if there has been an emergency, its been dealt with well; that's a good day.*

Everybody needs good days. In tertiary delivery suites every day is unpredictable. Irene spoke about the need to look at the positives and here, Alice describes the positives that help to make her feel good. Her description of good days is when there is normal birthing and she evokes a sense that babies have just 'fallen out' with ease in her workplace where women often require intervention and assistance for birthing. Her good days are when births are midwifery led in the absence of obstetric intervention, midwives and colleagues have time for each other, there is nurturing, caring, teamwork and fluidity in the day and an absence of undue tension.

Coordinators can rejoice in the good days and need these days as their balance; however the stories in this study will reveal mostly the tensions and challenges of the job and the skills these coordinators bring to their roles as leaders.

### **In the Eye of the Storm**

Coordinators know they are working in a high risk environment with the unexpected often revealing itself with no warning within their complex working environment. The analogy of being in the centre of a storm may conjure a variety of images to the reader. Storms are unavoidable parts of life experiences to which we each react differently. Some

weather storms better than others just as some midwives enjoy coordinating and others prefer not to. Irene remarks:

*It makes me think about a movie I once saw about a storm. Part of me always remains in the centre of the storm even though there may be times when I am weaving in and out of the storm with everybody around me moving too.*

Irene's analogy fits well as she describes partly being centred in 'the storm' but in reality, never static as she multitasks and moves in time to the rhythm of the happenings of the unit and the colleagues she works with. Smythe and Norton (2007) write "thinking leaders live a back-and-forthing, drawn to lead and pulled back to follow, to being with and then to being alone, prompted to act and cautioned to wait" (p.76). Weaving in and out with these encounters is something which has to be done and for Irene there is a sense she will dance in the rain of the storms she experiences. She has no control over what 'is' or what 'may be', rather she is a player in life's events as they unfold in her workplace.

Amiria describes being in charge of a shift when she is multitasking:

*It was very busy. Everyone was caring for one or two labouring women, when a lady came in. It was so busy, I had to look after the woman plus deal with everything else going on, and in the midst of this I realised there was a staffing crisis and I had to solve that as well as support the woman in labour. It was hard because I was telling my manager I needed help, as the baby was being born and was told that they've catered for the shortfall with experienced staff nurses. That was not what we needed, we needed midwives. Ultimately, I am responsible for the nurses in the birthing unit setting and it is hard. You can't leave your*

*colleagues with three on at night with a birthing unit our size and with the acuity we had. On that particular day I wondered why I was a coordinator because I couldn't see a way out of it.*

There is a sense that Amiria has to be everything to everybody in her story. John and Parsons (2006) researched the “shadow work in midwifery” (p.266). In their study, they identified the dichotomy of emotions midwives experience in their workplace and the masking of the unseen emotional work which exists and is hidden behind the apparent professional conduct of the midwife.

In Amiria's story, she is the leader of her shift; she is in charge with a staffing shortage which manifests itself at a critical point when the woman she is caring for is about to birth her baby. Amiria manages her emotions as she simultaneously tries to provide optimum care to the mother, holds concern for what is happening with the busyness of the unit outside the room where she is confined and working, and then finds herself having to negotiate with her manager by phone regarding a staffing crisis with an unfavourable response given to her. Goldblatt et al (2008) describe “the burden of responsibility” (p.1) which Amiria reveals in her story whereby she continues in her role as coordinator as she thinks ahead and tries to find solutions to the staffing problem. In theory it is her manager who is providing her with a solution but in reality, Amiria reveals her inner sense of hopelessness that the solution provided by the manager is unhelpful because it impacts further on what already appear to be onerous responsibilities

for her as coordinator. This story illustrates the unpredictability and diversity of challenges for Amiria which compounded for her within a short time frame.

Kouzes and Posner (1995) write “knowledge gained from direct experience and active searching, once stored in the subconscious, becomes the basis for leaders’ intuition, insight and vision” (p.105). Amiria reveals she had this inner knowledge and recognised she had been thrown into a situation where there was no safe answer for her as the leader. She reflects a sense of helplessness and hopelessness but in the meantime, she still needed to lead her team effectively until the end of her shift. Smythe and Norton (2007) describe how leaders manage the challenges they encounter when they write “our research suggests that effective leaders have a sense of which way to go, guided by their internal compass” (p.74). Amiria reflects these research findings both with her leadership style and her level of understanding.

Alice reiterates what this multitasking feels like:

*You carry a caseload as a coordinator if you have to. It's like that. It's ghastly because nothing gets done properly. You are in the room trying to get a handle on what's happening with a woman or even trying to deliver a baby and your phone rings. You have to try and think yay I'm looking after someone because that's nice, I love doing it but it can be frustrating. It's hopeless trying to be in a room looking after a woman, the phone rings then someone wants the keys.*

Alice is in charge of the shift and reveals her lack of choice regarding having to take on a caseload at times. Malloch and Porter-O'Grady (2005) write "the role of the leader is to create a safe environment where people can adjust their patterns of work behaviours to fit an ever changing context" (p.148). Alice's story illustrates how challenging her role is. As with Amiria's story, Alice is multitasking and having to change her patterns of work as well as those of the staff she is leading. She also masks her emotions as she 'tries' to think positively about the privilege of caring for a labouring woman who should be her focus of care but at the same time, as the leader, she is at the beck and call of colleagues. This is the way it is. Alice is the coordinator and leads the shift because she has the expertise. Like Amiria she uses the word 'hopeless'; there is no choice. All Alice can do is her best and in this way she role models to her colleagues how best to work under duress to try and achieve safe practice in the unit.

Jane recalls a story:

*Last Sunday night shift I had the Women's Assessment Unit (WAU) triage phone. The registrar went to theatre so I was given the pager and obstetric acute phone, then the house surgeon gave me his pager. So, I end up with all these phones and pagers in my pocket, trying to provide patient care because I have my own workload, I am coordinating, then the office phone rings! And because I'm the only one free I usually have to run from the far end of delivery suite to the office to answer it and they hang up just as I get there!*

An anonymous quote is cited by Malloch and Porter O'Grady (2005) who write "Life is a grindstone. Whether it grinds you down or polishes you depends on what you are made of" (p.171). Again, in this story, Jane as coordinator has to take a caseload and also lead her shift. As the leader, it is up to her as to how she manages the multitasking that is required of her. Her colleagues, patients and family members in the unit will be consciously and subconsciously observing the way she manages these challenges. Dunne (1993) writes "we benefit more from what comes into play in our experience without our having the power to summon it than by what results from our deliberate calculation and choice" (p.14). Jane works 'in the moment', managing 'what is' as she knows from experience that she has no power to control what may be thrown at her at any future point in the shift.

### **The 'Role Plays' of Leadership**

In their leadership positions, these coordinator midwives reveal they are consciously and unconsciously 'playing' multiple roles which are revealed in the stories they share. The roles they play meet the needs of the colleagues they are working with and effect the safest care they can achieve at any point in time. What coordinators are really feeling however, in comparison with the roles they play, can be very different.

Jane remarks:

*I've learnt to switch off. Coming off nights and going home is alright because you know that there is a bit of fat in the system during the day. If the worst comes to the worst which is often, the midwifery director, the educator, the operations manager, the delivery suite clinical midwife manager can all do clinical, so there are four extra people you have at the drop of a hat. At night we haven't got that and at times it's really scary because short of actually physically having the time to ring one of the day staff at say 3am in the morning and say "You have to come in now" there is nothing. The main hospital can't help you. They may be able to send an RN<sup>2</sup> to do a recovery but often when our troubles hit they are midwifery troubles.*

Jane reveals the fear she experiences when she knows there are no midwives accessible to help in an emergency on a night shift. What Jane feels and how she appears to colleagues and clients may be very different. She states she has learnt to switch off but her reality of helplessness lurks beneath her mask of coping. Raynor, Marshall and O'Sullivan (2005) explain that women need to be and to feel safe with the midwife caring for them. They extend this requirement in relation to the midwifery leader who needs to "help subordinates to feel that they are in 'safe' hands emotionally" (p.10). Jane is role modeling her leadership style. It is how she reacts to staffing shortages on night duty

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<sup>2</sup> RN is a registered nurse who is employed to work in the delivery suite hospital setting within her professional scope of practice.



which reflects on the colleagues she is leading and in turn reflects on the atmosphere of the delivery suite during the shift.

For Amiria, no matter how she is feeling inside, her outward focus is on safe care and trying to keep everyone happy:

*On a bad day it's trying to juggle and keep everyone happy. The worst days are when you feel unsafe and your practice is compromised by what's happening around you and knowing that you've just got to keep going and hope that nobody is harmed in any way and that is really hard because sometimes at the end of a shift you think 'nobody died today, it's pretty good'. That's not a nice feeling at all. I think you get used to it.*

Raynor., et al (2005) write “human beings cannot juggle too much information at once” (p.79). The question can be asked ‘how much is too much?’ for Amiria. There appears to be no choice for Amiria or her colleagues who share their stories for this study about their experiences of coordinating. Malloch and Porter- O’Grady (2005) write about “complexity science” and describe “while the leader looks for order and symmetry in the workplace, just beneath the surface lies the chaos and complexity that are the foundations upon which the next order and symmetry will unfold (p.15). It is this continuous dance between order and chaos, symmetry and complexity and leadership and systems that guides the unfolding of the future role of the leader. To read the stark reality for Amiria that nobody died during a shift is shocking. Like Jane, Amiria has learnt coping mechanisms which sustain her emotionally.

Sally reflects similar sentiments:

*We always seem to just manage it by the skin of our teeth. I just think what if one day we don't.*

She recalls the end of a shift:

*..... one of the LMCs came to me and said "Do you sometimes feel that somebody's watching over this place?" I said "Nine shifts out of ten. We always seem to just make it. It's not through any good judgment or skill, it's really through luck". It really is. One day we're not going to. One day somebody's going to die, or a baby's going to die because there isn't anybody else to pull to put in there.*

It must take courage for Sally to go to work with her spoken reality that a mother or baby could die in the absence of adequate staffing numbers. Malloch and Porter-O'Grady (2005) identify characteristics of courageous leaders who do not withhold negative information, speak out when there is controversy, are unafraid of sharing their views and who engage directly with people. In her leadership role, to be effective, Sally needs to utilise her midwifery knowledge, her courage and strength to positively lead her team. Sally reveals her true feelings to an LMC which may otherwise be masked with clients and colleagues in her work setting. There is a sense that she potentially plays different roles with different people.

Alice explains what it feels like for her when she arrives at work and the emotions she masks:

*You are in a position where people who are looking at you are quite critical. I come to work, take a couple of deep breaths. If I'm feeling anxious I try and get rid of it and I try to be calm. I think about what I did and didn't like about coordinators I worked with and I try to use that as a bit of role modeling. I role model myself on a coordinator who was very good when she came into the room because she didn't interact with the woman, she interacted with the midwife. She said 'hi' to the woman but she wasn't interfering. It's how you present yourself when you walk into a room. There are lots of little things to be working on and I suppose it will all add up but I may never get to the sum total.*

Alice's story is another example of the masking of emotions with her role. What she is feeling when she arrives on duty and how she portrays herself as the leader of the shift are different. She conceals her apprehension and positively works on her emotions because she recognizes her responsibilities being in charge of the shift; she is the leader.

Van Manen (1990) writes "the space in which we find ourselves affects the way we feel" (p.102). Although the delivery suite unit is Alice's working 'lived space' where she is familiar and holds a position of power, she has learnt from a senior colleague she trusts and by her role modeling, how to gain information effectively. Alice has learnt the importance of upholding respect for the midwife and her client as she enters a room where dynamics already exist and where she chooses to play the role of a guest in that

lived space rather than the coordinator in charge of the unit. By acknowledging the importance of the woman as the focus for care and the partnership between the midwife and the woman, Alice gains the information she requires by role modeling respect and understanding.

She shares another story:

*The place is going to work well if you have good interpersonal relationships with people, you are interested in them and you show yourself as being reliable, authentic and honest. I think that's a good place to be. If I can just try and be that, other things are going to come out of that. We work very closely with the registrars and it's important to have a good working relationship; you've got to have mutual respect.*

*We've got junior registrars you have to be watching. You have to be aware of everybody really. It's things like how they talk to women; like rushing in and shoving their hands in, barely saying a word to the woman. If you've got a nice friendly relationship with a young registrar you can say "Look, don't forget to talk to the woman while you're doing this." Say it nicely and help them improve with their bedside manner because often they're very skilled with repairing of the perineum but it's what they say while they're doing it – or what they don't say. They're concentrating on what they're doing and forget to talk to the woman. If you have relationships with people its easier to say things in a nice way. There are always going to be people that challenge you and that's not going to go away. You're not going to be able to change everybody.*

Alice reveals she has to subconsciously think how best to act in situations to achieve the objectives she sets as situations are thrown at her. Her story illustrates the importance of her leadership which is enmeshed within the complexities of doctors learning process in the delivery suite setting. Malloch and Porter-O'Grady (2005) cite Ann McKay Thompson who writes "If you face a delicate situation, don't go into it wearing your spurs or you'll rip it apart. Instead, dress for the occasion. Cloak yourself in diplomacy. Vest yourself with wisdom, and wear a smile" (p.64). This is exactly what Alice did in her story. A vaginal examination is an intimate but often necessary intrusion of personal privacy for a woman in the tertiary delivery suite setting. Alice is realistic and acknowledges that her approach may not always work, however she recognizes the best way to play her part for the provision of appropriate safe care for women during her shift. She knows this course does not always run smoothly and that effecting change is not always successful but it does not stop her trying her best to summon up the skills to manage situations as they arise.

Irene offers her story:

*I came on duty and took over charge of the delivery suite. They had quite a number of women waiting for caesarean sections and hadn't prioritised who was going first, although there was still some elective surgery needed to be done. One of the women waiting had ruptured her membranes with a breech presentation. Instead of being proactive the midwife caring for her had just called the house surgeon and wanted them to do a speculum examination to actually see how much those contractions had been doing.*

*When I came on I used the role of being in charge as a challenge and educating too and I asked them why they had not done the job themselves. “Why didn’t you go in, why didn’t you use your skill, why didn’t you do the speculum exam yourselves?” It could have been an assessment finished already and they could have prioritized and actually moved on another step.*

Irene reveals in her story the two faces of her role. As the coordinator she recognizes the ebb and flow of the delivery suite setting and her need to know the results of the vaginal examination to prioritise the order of women requiring caesarean sections on that shift. Irene also expected the midwives on duty to have used their initiative to have completed this examination for the wellbeing of the woman and her baby as an integral part of their professional practice, which they did not do.

Husserl’s concept of time is described by Cerbone (2006) as; “one’s conscious experience is always “flowing”; time is always “running off”” (p.28). For as much as time is forever moving forward for Irene as she leads this shift, she knows she can utilise her role to impart her expectations and empower her midwifery colleagues to improve delivery of midwifery care when she is in charge. Malloch and Porter-O’Grady (2005) describe the leader as a person who is guiding the system “on the fly” (p. 13), which is epitomized in Irene’s story. As events unfold within the delivery suite environment, Irene tries to work in step with situations that present themselves as she balances organisational demands, midwifery purpose and the work involved to achieve safe outcomes.

Irene reveals there are different roles to be played in different situations:

*We had a breech birth this week. It was the woman's 12<sup>th</sup> baby. My thought was that the baby was going to fall out, however the midwife was in her first year of practice and had never seen a breech birth before. She was mortified. It was my role to reassure her, to get her communicating with the registrar, to ensure the communication was well done, to make sure she didn't get lost in the whole system and that she gained experience.*

Perception is revealed by Irene as she recognises what her role must be to achieve the best outcome for the mother and baby who are being cared for by a midwife whom she describes as 'mortified'. Irene took on the role to show a vulnerable new graduate midwife how to effect the best outcome possible. Dunne (1993) writes "One cannot determine in advance the efficacy of one's words and deeds. Efficacy turns out to be a form of influence; it lays not so much in one's own operation as in cooperation of others. The nature and extent of this cooperation cannot be counted on beforehand, and even afterwards one cannot be sure just what it has been" (p.359). Irene used her role modeling to achieve a positive outcome however as Dunne observed, there was no guarantee the outcome would be as she predicted. All she could do was influence the midwife to utilise appropriate communication skills especially with the registrar, to aim for an uneventful vaginal breech birth. Irene's reality that she could role model and play the part with no guarantee of a happy ending reflects Dasein in which Harman (2007) writes any outcome "in its very depths is *fate*" (p.76).

## Leaving Work Behind and Moving Forward

The characteristics of an executive leader which are described by The Boston Consultancy Group (2006) are equally applicable to the delivery suite coordinator. They suggest leaders will need to “strive to achieve a balance between their working and family life” whilst living their leadership skills (p.24). So, to conclude the interpretation of experiences coordinators have shared for this chapter, the question is asked, how do these women manage when they leave their workplace? Do they achieve a work/life balance?

Alice explains:

*I often wake up in the middle of the night thinking about things, or on my walks with the dog I think about things. You have to. You don't want to be obsessed by it but you still have to process things to make sense out of them and you don't have time at work to do that necessarily because it's bang, bang, bang.....*

Leaders are described by Malloch and Porter-O'Grady (2005) as individuals who are “simply playing a role they do not need to live every moment of their lives” (p.31). At the end of her shift Alice leaves her ‘lived space’ of delivery suite and she returns home to her “lived other” life world (van Manen, 1990), where her role is very different (p.76). However, her work experiences catch up with her and reveal themselves to her at home where she often finds herself processing her thoughts as a matter of necessity. Her sleep is often interrupted with thoughts about work and there is a sense she has no control



regarding this overspill or emotional ‘run off’ of her coordinator experiences into her home life. Alice regards this as something that she has to work through, in order to understand and rationalise her experiences.

Kouzes and Posner (1995) write that “knowledge gained from direct experience and active searching, once stored in the subconscious, becomes the basis for leader’s intuition, insight and vision” (p.105). Alice processes her past experiences which help her manage future ways of managing situations. She does not comment that her experiences are stressors to her, rather this is the way it is, and she reveals she has developed the life skills she needs to cope as a coordinator.

The question can be asked whether interrupted nights’ sleep are sustainable for Alice’s long term health and wellbeing, and will her responses change over time?

Jane reveals she has learnt to cope over time:

*My coping is a learned thing as time goes by. I remember in the beginning when I was a new practitioner being hugely upset about stuff but you have to learn to put up a wall otherwise you can’t survive. You can’t come home to your family and bring all of that crap home with you; you’d never survive. I think if I let it all get to me I would have gone under years ago.*

Time and experience have taught Jane how to survive. Hunter (2001) writes “the context of midwifery work, particularly when it involves childbirth, could be described as an

emotional minefield (p.441). Her wall has been mentally constructed over time to keep her work and home roles clearly divided for the sustainability of her professional and personal lives. Jane reveals her strength of character and level of resilience which she has learnt as her way of 'surviving'. Resilience is described by Barnes (2006) as "a positive personality characteristic enhancing individual adaptation" which includes having a perspective on life which is balanced, with self direction, a sense of purpose in life, self belief and belief in one's capabilities (p.23). Jane fulfils these criteria with her personal strength revealed in her comments which sustain her taxing work demands. As with Alice, the question can be asked; 'is this sustainable long term?'

For Amiria, she simply reflects:

*"I'm lucky because my husband has a good listening ear. We talk with our colleagues and with other coordinators".*

Amiria seeks out what she needs to sustain her from her husband and her work colleagues. She is the only coordinator in this study who identified her midwifery colleagues as a source of support as well as a family member. The question is asked, 'is this adequate?'

Smythe and Young (2008) refer to a New Zealand publication by Wepa (2007) regarding professional supervision of health professionals and note "the midwifery perspective is not surprisingly absent, for anecdotally it seems few midwives routinely have

professional supervision” (p.13). What if Amiria was ‘unlucky’ and had no husband with a ‘good listening ear’ when she works shifts and arrives home at unpredictable times?

Irene shares her coping strategies:

*When I go home after a difficult experience, I journal some stories because I have to get the sequence of events and the emotions off my chest, but not often. I think about things. Sometimes I dream about situations because I am angry and maybe that is one of the reasons why I cycle because when I cycle I just push the energy into something else, actually transfer feelings into physical energy. I talk about things in a general sense with my partner without going into detail. I talk about my own struggles or what was I struggling with at that time.*

In their reflections on professional supervision, Smythe and Young (2008) cite Merton who wrote “the individual person is responsible for his own life and for ‘finding himself’” (p.27). Irene has shared how she achieves this. She has found her own answers to addressing the emotional toll she describes when she leaves work. Her “relationality” (van Manen) with her partner away from her workplace is part of her emotional wellbeing (p.104). She has developed coping strategies which she will utilise depending on circumstances, however like Alice, her sleep is also disturbed at times. Irene travels back in time to reflect, to analyse and to make sense as her means of moving forward in her midwifery journey.

Sally explains her coping strategy:

*When I go off duty, I forget about work. I have reached a point that things wind me up too much and I won't fight other people's battles. It's survival, it really is. I feel I am fighting everybody's battles just to coordinate a shift.*

There is a sense that like Jane, Sally has created a wall to divide her work and her non work lives so she can walk away from her workplace 'battlefield' and mentally take herself to a different place when she leaves delivery suite. She needs to be able to mentally move from the 'lived space' of delivery suite which she finds so demanding to her 'lived space' away from that workplace; she needs to leave her coordinator role at the door and become the woman who she 'is' as she walks away.

Is working in a battlefield sustainable? Smythe & Young (2008) write about the responsibilities of independent midwives whereby "the role and life of an independent midwife oozes with the possibilities of stress" (p.13). What of DHB midwives? Sally reveals her stress levels as a coordinator midwife are also significant. How does she 'wind down' when she leaves delivery suite? She has not shared this information so we do not know.

## Summary

This chapter reveals how coordinators feel, the multitasking they achieve, the roles they play and their resilience which sustains them.

Coordinators use analogies to describe their experiences such as being the ‘pivot’, or ‘hub’, or ‘central figure’ in their workplace. They are central to the seen and unseen happenings in the unit and their analogies reveal the Dasein or ‘being’ of their roles. Coordinators are physically ‘on the move’ as they play their roles. This is not a ‘desk job’, nor is it a job where staff necessarily know where to find the coordinator because she is weaving through encounters, trying to lead a safe, well functioning unit from wherever she happens to be within the unit. She is at the centre of the ‘happenings’ rather than physically in a central physical location.

The analogy of puzzle solving was used by Sally. The delivery suite puzzle is not a jigsaw puzzle left on a table to complete at leisure. It is a real life puzzle in a unique world of complexities which involve tertiary obstetric and midwifery evidence based care and social interactions between colleagues, clients, families and friends. Everyone has their own agendas and unique perspectives regarding safe care whether it be for mothers, babies, whanau and/or staff in the unit. It is a puzzle which often has to be solved with urgency with no guarantee all the pieces exist. With or without the pieces the coordinator’s ‘puzzle’ always has to be solved, which in theory is impossible but in practice requires compromise which will be revealed in Chapter Five.

As leaders, the coordinators play multiple roles during their shift which Kouzes and Posner (1995) describe as “a performing art” (p.30). They are consciously and unconsciously role modeling their leadership and midwifery skills. Their experiences are revealed in a manner that Harman (2007) describes as “a shadowy event not a lucid spectacle” (p.32). It is these coordinators’ thinking as well as their ‘doing’, their spoken and unspoken responses, their reactive and reflective practice which come together revealing their roles through the stories they have each chosen to share.

At the end of the shift coordinators leave their ‘lived space’ of the delivery suite setting and return to their life worlds away from work where they reveal the influence of their work experiences on their personal lives. Their associated levels of resilience are revealed. Edward (2005) identifies resilience as “the ability of an individual to bounce back from adversity, persevere through difficult times, and return to a state of internal equilibrium or a state of healthy being” (p.142). In her research, Edward identified resilience as a “valued quality in today’s stressful and changing health-care world” (p.147). Coordinators explain within this study how they cope, but for whatever reason, they do not reveal much about the impact of their workplace experiences on their personal wellbeing or their perceptions about levels of resilience. Chapter Five will examine the urgency experienced with this job and how far coordinators are stretched with their coping abilities.

## **CHAPTER FIVE**

### **Time as lived**

The clocks secured on the walls of delivery suite are a constant physical, visible reminder of chronological time for everyone within the unit. Time is a universal phenomenon and wherever a person may be, the seconds, the minutes and the hours will pass by predictably and consistently worldwide, which is what Harman (2007) terms “clock time” (p.28).

Harman (2007) reminds us however, that “time is already at work before we have noticed it at all” (p.28). Coordinators work for a set number of hours for their shift, with no knowledge of what will need to be fitted into the hours that lie ahead of them. There are occasions when they feel constrained by time, when time feels on their side and other times when they are seriously challenged by critical situations and a sense of urgency regarding time frames.

Coordinator’s stories reveal their feelings and actions in their stories which bring to life the impact of time in their work lives.

### **The Luxury of Time**

Jane is the only coordinator who shares stories of what it feels like when there ‘*is*’ time:

*Friday night, now that it's over I can say the Q word – it was reasonably what I would call quiet which was great for me having come off 6 weeks of annual leave because the last thing you want when your brain is trying to get back into gear is a hell night. We had a few babies, we had a few LMCs through, everybody got their meal breaks, you got time to go to the toilet. I had time to undo all my mail that had accumulated in 6 weeks and action certain things for that... yeah and Saturday night was fairly similar, enough people to do the work, time to sit down and talk about things with the registrar and anaesthetist and feel like you are being collegial with supporting the wards. Just feeling like you belong to a team rather than just what is happening in delivery suite. Supporting a house surgeon who was upset about a second trimester SRM and having the time to just support and talk with her.*

With the uncertainty and unpredictability of delivery suite work, it was not until the shift was over that Jane could retrospectively look back and reflect on what felt like a quiet shift for her. A sense of superstition is revealed, that if she verbalises '*the Q word*' it may rebound on her. This 'quiet' shift feels like a precious gift; a luxury in comparison with the usual busyness of her workplace. Having time for a meal break and going to the toilet are accepted rights in most work places but for Jane as coordinator, for staff to get their breaks and for her to achieve all she needed to do during her shift is the exception rather than the rule. Her sense of 'team' and her appreciation of having time to talk, to listen and to feel satisfied with what she achieved during her shift shines in this story. Jane also



reveals her interpretation of what it felt like to 'be' quiet which she related to the unhurriedness of time which enabled her to 'be' and to 'do'.

Cerbone (2006) writes "the various moments of time are throughout 'synthesized' as standing in an unchangeable order that is irreversible and unstoppable: one's conscious experience is always 'flowing': time is always 'running off'" (p.28). Despite time 'running off' the shift still felt good for Jane as she was able to keep up with the quiet pace that night and felt satisfied with what she had achieved.

Jane shares another positive experience:

*It was good because we had time. I told the registrar and anaesthetist what I thought and it was good because we had a three way discussion about how it was going to be safest for this woman. It was nice to have the time to know that the three of us, each with a different focus could sit down and talk about what could be the best outcome. They ended up agreeing with my thoughts that if we had time we would get her to main theatre because there was more anaesthetic and nursing backup if it proceeded to a hysterectomy. There are times when it's not as easy as that with the luxury of time to discuss things.*

Within this short story, Jane uses the word 'time' five times which highlights how critical 'time' is as a component of care for her, in her delivery suite leadership role. This is an immeasurable, subjective lived time (van Manen, 1990) which Jane reveals is not always available to her as coordinator. Time met her needs in this high risk situation to be able to

talk with her colleagues, share opinions and reach decisions regarding optimum care for a woman. Having time to utilise their working partnership enabled them to make contingency plans and offered the best possible decision making for the woman's wellbeing. Harman (2007) writes about time and temporality whereby "life has a structure of past present and future" (p.28). Jane and her colleagues were able to simultaneously utilise the temporality of the woman, her colleagues and herself to reflect on past events, on the current situation and plan for future eventualities with mutual agreement achieved. Each of their roles and temporality were inextricably woven together. Jane explains that the availability of lived time to achieve this outcome was a luxury and not something that is the norm for her as a coordinator.

### **'Thisly' Time**

In contrast with Jane's stories of 'having time', Sally describes a story which reveals the level of conscious thought that flows as she has to multi task 'on the run' with time feeling as though it is 'running away' from her, and '*this*' is how it was. She is alert, with a level of readiness, not knowing what lies ahead amidst the absolute busyness where it feels that subjective time and chronological time seem to clash and each contribute to the stress of the experience. Harman (2007) describes life as "thisly" which evokes a sense of the present as something that is felt, but just a fleeting moment which is enmeshed in all its possibilities as we live it, with time forever flowing onwards (p.28):

*We had a woman needing to go for a caesarean section, another woman was having decelerations, and another woman was admitted with decelerations. We had to leave the first woman, with the last woman bumped up to first place for a caesarean section and the second woman sent to main theatre for a caesarean section. We needed a staff member to go to main theatre, we needed two staff members in our theatre and we had the woman who was already supposed to be going to caesar with no one to look after her. There were three members of staff on delivery suite and we needed at least 5 members of staff, with the challenge of where do you get them from?*

*The problem is that colleagues don't always understand the urgency when I ring them and say "I need you now". I rang the wards and had a midwife respond she would come and help in twenty minutes. I told her "I need you now" and her response was "but I haven't done my paperwork". Even when I told her we needed her immediately and this couldn't wait, she still responded that she hadn't done her paperwork.*

*I was so mad I told her "please can you just do it". You end up with everyone thinking you are really bossy but I needed help there and then.*

*With those two caesars we had a bradycardia of 60 and the other was a horrendous trace. There were two doctors in our theatre, we had called a consultant from home to go to main theatre, main theatre were ringing me asking*

*where the consultant was, and the consultant was being shitty with me because I questioned how long it had taken her to get to theatre.*

*Meanwhile staff were sitting on a bradycardia of 60 on the ward for 6 minutes. It eventually all worked out but it's really difficult if there are no staff and we need staff quickly with some staff just not recognising the urgency.*

Clock time exists for Sally but is of no help to her in this situation. This story is an example of what Cerbone (2006) describes as “temporality” (p.56). Sally knows how rapidly a baby can be compromised in childbirth but is thrown into a situation of urgency where she is simultaneously managing both the known and the unknown as she fights to be heard. Sally is managing ‘what is’ at any point in time with the situation constantly changing and moving forward as she tries to keep up and respond to new challenges being thrown at her.

Sally recognises timing is critical for these four mothers and babies to ensure the babies are born in the best possible condition. Harman (2007) writes “our current life is there before us as the hand we are forced to play. The most we can do is to try to work with the situation as we find it – every moment however dull or horrible has its possibilities”, and this is Sally’s reality (p.28).

Staff members in her unit each have their own agenda. The tasks each of them needed to do with their jobs took time. Sally is the catalyst for effecting urgent action and she finds

herself desperately trying to engage staff in an environment where temporality not only exists for her but also for each staff member within their own unique life worlds. The midwife regarded completing her paperwork as her priority and the consultant had her reasons for the time it took her to get to theatre. Sally is the person who has the ‘big picture’ and there is a sense that she is conducting an orchestra, trying to keep everyone in time and harmony for the common good, rather than everyone trying to play their own tunes with discord, uncertainty and lack of cohesion which puts mothers and babies at risk. It was the urgency of time which demanded her prioritisation

Within this context, Sally achieves her goals and explains that ‘eventually it all worked out well’, however it required her clear assessment of the current situation, assertive dialogue with her colleagues and actively responding to each urgent demand.

### **Guarding Time**

Irene speaks about her communication style with staff in an emergency situation where every second counts:

*In the moment, I can be very clear, even non negotiable, because I see tasks that need to be done and there is no time to negotiate. I expect people to work as a team. I expect that they can look beyond their emotions because there is time later for that. They need to act in the moment where the action is needed rather than getting carried away. And if I do see that happening, I would say to the midwives*

*the same as I said to the consultant, that 'now is not the time'. And if they are distraught and non functioning then you have to tell the person to step out and get somebody else in if it is possible. If that is not possible you can end up being quite hard on somebody and I will say "I am sorry I understand where you are coming from but I have to ask you to continue".*

Irene reveals what Polkinghorne (2004) writes is the “practical perception to identify with clarity and discernment the features of a complex situation that are significant for determining the most appropriate action” (p.117). In her story, Irene describes how she effectively communicates with staff when time is critical to achieve the safest outcome possible. Time will not guarantee a safe outcome but may precipitate one.

Irene is clear how she speaks with staff in emergency situations. There are times when she can relieve a distraught midwife and there are times when there is no one else available and she is explicit in her expectation for midwives to fulfill their professional duties, however difficult it may be if there is no other choice. Her philosophy for practice reflects Cerbone (2006) who writes “my futurity thus conditions both my past (my understanding of where I have been) and my present and so neither my past nor my present can be properly understood apart from my futurity” (p.56). Irene knows what she has to do to effect safe care for what she anticipates ‘may’ or ‘will’ happen in her workplace.

Sally offers a story with a different perspective to Irene but with the same theme of awareness of what ‘could be’ and the importance of wise use of time ‘just in case’ the unforeseen occurs. Childbirth is a momentous experience in a woman’s life and ‘time’ can be a precious gift with which to support women achieve a normal birth. Time is equally precious during the first hours post partum when the mother and baby are adapting to new experiences, touching, feeling, sensing and bonding with each other.

In this story, Sally explains the reality of birthing in a tertiary delivery suite and the readiness that is required for midwives to vacate a room for an unexpected emergency which can happen with no warning:

*Some midwives have no sense of the importance of time in delivery suite, especially if they have never coordinated. Some midwives think if it is quiet, they have hours to tend to a woman, so I will explain “look, no matter even if we’re quiet, this woman needs to be ready to be transferred out because we don’t know what’s going to happen next”. I try to make it clear and say “do everything that needs doing and then if you’ve got time do the niceties and sit down and have a chat that’s fine, but make sure you can get the mother and baby upstairs in five minutes if you have to”.*

*There is always the unexpected, with a helicopter landing from somewhere or we may have to go out on a helicopter retrieval. You are not going to be able to leave if you have been with a woman for three hours and she’s still not ready to ward.*

*A new midwife on her first rotation to delivery suite was terrible with this. It was really quiet one day and she did exactly that. I explained what could happen if something else comes through the door and she saw my point. Then, we had three admissions, each a nightmare and it was really good. She said “I get what you were saying”.*

Heidegger identifies the two faces of ‘Being’ as being in “the shadow” or “the light” and the “veiling” and the “unveiling” (Harman, 2007, p.3). Time is already ‘at work’ in the new midwife’s environment before she becomes aware of it. The ‘light’ or the ‘unveiling’ may occur with an emergency which the new midwife finds she is unable to manage as she is not prepared.

However ‘woman focused’ Sally wants to be and wants her staff to be, the reality is the potential for the unexpected to occur in a tertiary delivery suite setting. By giving ‘too much time’ to one mother and baby the new midwife may inadvertently compromise the safety of another woman and her baby. Sally in her position of coordinator knows this so she teaches the new midwife about realistic use of chronological time to safeguard subjective time. Sally teaches this midwife to understand the importance of ‘time management’ so every member of the team knows she is as ready as she can be for any eventuality. Sally teaches her to complete necessary tasks within a realistic time frame and to then offer the ‘niceties’ if there is time when other tasks have been completed. Sally is protecting the mother and /or her baby *in utero* who are as yet in the ‘shadow’ and ‘veiled’. The new midwife learnt by Sally’s teaching and experientially by the



subsequent three ‘nightmare’ admissions they managed on that shift, when ‘unveiling’ occurred.

Alice offers her perspective and highlights the challenge for coordinators of the ‘flow’ of women passing through delivery suite versus ‘woman focused’ midwifery care:

*If people want more time, or if the midwife wants more time, give them more time. We have our own set of recommendations and it's not the end of the world if you don't want to take them. Keeping the women central is quite hard because it's like a factory and because I'm dealing with flow. I've got more waiting and I've got to get some out. It's quite hard when you're not dealing with women directly. You have to keep telling yourself that women are central and keep reminding yourself. You don't want to lose sight of that but all this institutional stuff takes over.*

There is a sense that Alice is torn between upholding women’s rights to be central to delivery suite and the requirements of the institution. In the absence of working directly with women, there can be a level of detachment for her so she has to consciously remind herself at times why she is there; a delivery suite exists for safe midwifery and obstetric care for women. The care women or midwives or Alice want to be provided, especially in relation to time frames and progress in labour may collide with institutional guidelines and protocols within the busyness of the delivery suite unit. Symon (2006) cites Murphy – Lawless regarding the “imposition of obstetric time over a woman’s time” (p.42). As the coordinator, Alice recognises, she is the key person to be able to advocate for the woman to be given more time, when she recognises it is appropriate.

Irene shares a story which supports Alice's comments. Irene reveals her sense of responsibility to challenge obstetric colleagues regarding the rigid timelines which can be enforced upon women within which they are expected to progress in labour at a prescribed rate, in the absence of consideration of individual circumstances:

*A primigravida woman was being induced who was almost classified as morbidly obese. In this situation the registrar was focused on a timeline for her progress and the timeline for when to commence augmentation of the labour. We know syntocinon<sup>3</sup> can lead on to an epidural which for these overweight women can make things really complicated. So, I challenged the registrar by asking him whether he was aware that current research shows heavy women labour differently because they are slower and their body functions are not the same as a woman with a normal BMI<sup>4</sup>. This communication resulted in the woman being left alone long enough to progress to a vaginal birth with no assistance. This was a good outcome for the woman rather than being categorised 'this is what you are; this is how I treat you'.*

Harman (2007) writes "time cannot be understood when it is measured by clocks, or stop watches or calendars since all of these instruments distort time in the same way that science distorts its objects, by viewing them from the outside" (p.26). There is a sense this was 'a body in a bed in labour' not progressing at an acceptable rate with a clinical

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<sup>3</sup> Syntocinon is a pharmaceutical medication which contains a synthetic version of the naturally occurring hormone oxytocin. It is used to induce labour or stimulate strong contractions to facilitate progress in labour.

<sup>4</sup> The body mass index (BMI) is a statistical measurement which estimates a healthy body weight

decision to augment the labour based on hospital protocols and probably the Friedman curve time line which is incorporated into partograms (Fraser & Cooper, 2003), whereas Irene saw a morbidly obese woman in labour who needed flexibility of time and empowerment to labour in harmony with the physiology of her body.

Irene knows women do not fit into rigid uncompromising time lines for how they progress in labour and birth. Reid (2007) writes the medical and social models of care for women in labour are viewed as being at opposite ends of the spectrum “yet midwives and obstetricians are at the coal face in tertiary hospitals” (p.20). Considering the different lenses doctors and midwives view obstetrics and maternity care from, Irene chooses to combine her midwifery ‘knowing’ with evidence based information to back up her advocacy for this woman. Symon (2006) writes “applying clock times emerges as a strong feature of obstetric thinking” (p.42).

Here we see the registrar looking narrowly at a time line as the basis for intervention and Irene advocating for the woman and her baby in the knowledge that time lines for labouring women differ for a plethora of reasons.

Walsh (2007) highlights the reality of time pressures which exist in hospital settings and are part of institutional constraints and regulations. Irene could have been ‘short sighted’ with immediate concern for the impact of this extra time allowance on the staffing situation in delivery suite and the implications for the ‘flow’ of women passing through delivery suite at that point in time. However, in her ‘midwifery heart’, she knew that time

would free the woman to birth normally within a time frame that was unique for that woman. By intervening and gaining time for the woman, Irene made the difference between a vaginal birth and a potentially traumatic birth experience with the avoidance of the spiral of interventions which can result from immobilising a morbidly obese woman labouring with her first baby such as continuous foetal monitoring, epidural pain relief and a possible instrumental birth. Irene was proven right with the woman birthing normally.

### **Time to Support**

For Jane, her sense of responsibility to her fellow DHB midwives to offer support and teaching, conflicts with time constraints which poses a difficult challenge for her:

*If there was time to teach it would be fantastic. There is nothing worse than throwing a DHB midwife in the deep end with something that is probably beyond their scope of practice but I don't have a choice. It means I am going to have to stretch myself so thinly to teach and support that particular midwife to make sure she stays safe and feels supported and taught as well as trying to deal with all the other stuff that's going on plus my own patient workload.*

Jane recognizes what she should be doing, however she is challenged by what she believes in which conflicts with the reality of her situation. She is stretching herself and stretching time at her own expense. The reality of the busyness of delivery suite

environment is well described by Campbell (cited by Isa et al., 2002) as “walking on a tightrope” (p.6). Jane and her colleagues are trying to balance on that tightrope with potential for disaster with the amount that has to be achieved with the staffing and time constraints in the delivery suite arena. She goes on to explain:

*Other times it's an appalling board and you think "I'm hardly going to get through the night, let alone have time to teach a more junior midwife how to be the coordinator. You just don't have time, so learning opportunities go out the window. Other midwives are not going to learn and grow because it's too busy and too short staffed.*

Jane is multi tasking as the coordinator, as she constantly juggles with ‘what is’ and looks forward to ‘what might be’. She is anticipating how to fit real and potential scenarios which constantly reveal themselves into the achievable time frames according to staffing availability. Time passes on its continuum, never still, with Jane responding accordingly. She is ‘leaping in’, she is ‘leaping ahead’ and in the midst of this is her knowing that she needs to ‘make time’ to teach. The concepts of ‘leaping in’ and ‘leaping ahead’ are terms Heidegger (1927-1962) uses to describe the way a person shows concern for another. Jane knows the advantages of teaching and the difficulties for colleagues who are put in positions where they are unprepared, however time will not allow her to teach because she is constantly encountering new situations she has to manage whilst simultaneously planning in anticipation of what may lie ahead.

Similarly, Amiria feels she is letting her colleagues down in the absence of time to support them:

*You want to grow a good solid midwife and sometimes you think you're lacking, because you can't give them as much support and talk through. For example the doctor's made a decision and you weren't happy with it, or there's an emergency and you don't get enough time to talk about it. Sometimes I feel I've let them down and haven't been able to help them out.*

Isa., et al (2002) highlight one of the responsibilities of DHB midwives – that is, as a teacher who “in a day will teach students, nurture new practitioners, encourage people that need upskilling” (p.6). Time passes with opportunities for learning lost because of time constraints in the delivery suite setting. Learning incorporates kinesthetic ‘hands on’ learning, combined with what is already known, what is observed, what is said, what is heard and what is taught. A positive learning environment is vital for effective learning where midwives can learn ‘in their own time’ and gain confidence in the workplace. Time is not their own in delivery suite, and Amiria reveals her awareness that the hurriedness and busyness of the unit is detrimental to learning opportunities for midwives. Time flies by and opportunities are missed.

Sally shares her story:

*We were quite busy that night and the new grad LMC said to me “I’m going to need help with this lady.” I asked “Who have you got as backup to support you?” Their exam results come out in December and I recall this was the*

*beginning of January so she was brand new. She replied “Well, I don’t really have one”. I remember saying to her “Well you must have some kind of back up in place”. I ended up ringing the midwife whose name she gave me and said “Look your extremely new colleague is in here and needs the support that we cannot provide. She basically said to me “Well, I’m at the beach and I’m not coming back so you lot have to deal with it.”*

*I thought that was really unfair. First of all it was hugely unfair for that poor new grad LMC, and awfully unfair for the woman who probably hadn’t got a clue. I remember that particular incident because we didn’t have time, so you just pray that it is going to go okay because you don’t have any staff to put into that room.*

Sally as a coordinator reveals her professional allegiance to the new graduate LMC midwife and her frustration managing the busyness of the unit in a situation where her lack of staff means a lack of time to support this midwife. She knows these consequences may impact on the safety of the mother and baby being cared for. Sally can rationalise the midwife is an autonomous practitioner but recognises that she has been asked for support. Sally can rationalise she holds no legislative responsibility to provide support but recognises how vulnerable this midwife will be feeling. She can tell herself the midwife should have arranged LMC support but the reality is this was not done.

This leaves Sally knowing on that particular shift, because it was busy, she could not support the midwife and all she could do was ‘pray’. Van Manen (1990) discusses “lived

time” in relation to memories of the past that leave traces on who we are and how this influences our present (p.104). By ‘praying’ Sally reveals whatever she has experienced in the past raised real concerns for her at that point in time for the LMC midwife, the woman, the baby and the dynamics of the whole situation. Sally was helpless within the context of time and her feelings are internalised; they are invisible.

### **Time Lost**

Symon (2006) writes “one of the real challenges is to develop methods of communicating risk (and choices) to women who are faced with rapid decision making in an acute setting” (p.129). Sally shares such an experience:

*I had a situation where an LMC came from a remote rural area with a woman who was admitted with decelerations. I couldn't find the foetal heart abdominally so I explained we needed to do an ARM<sup>5</sup> and put on an FSE<sup>6</sup> to exclude foetal distress. The father responded “no that's not in our care plan”, the mother said “no”, and the midwife supported them saying “that's not in our care plan”.*

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<sup>5</sup> Artificial rupture of the membranes (ARM) is performed by a midwife or doctor when there is an obstetric indication to drain the liquor which surrounds the fetus in utero.

<sup>6</sup> A fetal scalp electrode (FSE) is attached to the presenting part of the fetus during a vaginal examination to electronically monitor the fetal heart rate.



*I didn't even have the midwife's back up with my recommendations, so eventually I asked "well may I ask you why you came?" They got really mad and said "well because the baby is at risk!" So I said "well if the baby is at risk and you've come here for help then you need to let me do these things and if you don't let me, then you're going for a caesar because I have no idea if your baby is alright. I know this will be the consultant's decision as soon as I ring her. If we can't find a foetal heart you'll be down for a caesar. If you let me do this little thing, chances are you'll have a normal birth." It just took ages and ages.*

*In the end it was fine and the woman had a normal birth because we managed to do the ARM and put the FSE on.*

This couple was asked to make choices by Sally whilst they were simultaneously coping with unexpected events and the physical and emotional demands of labour. Hibbard and Peters (2003) offer insight into the perspective of health care choices when they explain the consumer who is decision maker is "in an arena where choice is important but the information is unfamiliar, and the amount of information may exceed human information processing skills" (p.415).

Tupara (2008) writes "the way information is framed and packaged will determine to a large degree what information is used in the final choice" (p.7). Sally had no means of reassurance available regarding the baby's wellbeing. Sally 'lost time' communicating the urgency of the situation to the couple and the midwife. She knew what needed to be

done but found herself losing time negotiating with the couple and the LMC. To her, the 'small' intervention of rupturing the membranes prevented a momentous intervention of a caesarian section but to the couple and the LMC an artificial rupture of the membranes and fetal scalp electrode were apparently interventions to be negated. In the busyness and urgency of a critical situation, Sally took an approach she believed would work. She recalls '*it took ages and ages*', but "this was the hand she was forced to play" (Harman, 2007, p.28). The outcome was positive but the experience memorable for Sally with 'time lost' with what could have been a compromised baby as a result of the delay in decision making.

In this situation and Irene's story below which addresses a different temporality, the coordinators were not only faced with urgency but also with their midwifery colleagues verbalising their opposition to siting of a foetal scalp electrode. There is a sense of 'them and us' in these stories, with the LMCs aligning 'allegiance' to their clients rather than professionally addressing what Sally and Irene regarded as safe practice.

Irene enters a room as coordinator to discover the second twin's heart beat is not audible:

*I spoke with the couple and explained that I couldn't understand why we were unable to find the heartbeat as it was there earlier on when the labour was less advanced. I couldn't find an obvious reason for this and asked the LMC whether there had been prior discussion of consideration of using the foetal scalp electrode. The LMC responded that the woman had been adamant in her birth plan that she didn't want one. I tried to listen unsuccessfully again for another*

*minute, then got up and said to the husband “what I see here is a situation where I can’t pick up one baby’s heartbeat and I can’t tell you if the baby is well or not. Your baby could be sitting there as happy as can be or it could be screaming for help. We do not know.” I explained to him that I did not believe this was a safe situation and I suggested he re-discuss with his wife that we put a clip on baby’s head to pick up the heartbeat. He asked me a few questions, we talked about it and he responded that they were happy to go ahead and do it.*

In this situation, prior knowledge of the situation revealed to Irene there is no indication for the baby to be distressed however at that point in time, the heart rate could not be found and it was imperative the baby’s wellbeing was ascertained. Irene was coordinating the unit, she had entered the room with consent and she recognised her need to convey her concerns to the couple and the LMC simply and clearly so they understood the potential consequences of the decisions they were making. She wanted to be assured the baby was safe and to be able to then withdraw, leaving care with the DHB midwife and the LMC once more.

Irene had choices and approached this situation by talking with the husband. Her description of the baby *in utero* ‘silently screaming for help’ is not only potentially accurate and timely, it is also graphic and emotive. She achieved what she had set out to do and was able to withdraw from the situation in the knowledge the baby was safe in a timely manner.

## **Summary**

Polkinghorne (2004) writes “the practices of care require a kind of decision making appropriate to the human realm in which they operate” (p.176). The stories in this chapter reveal a realm where time is critical for everybody within the unit from every perspective, whether it is a mother, a baby or a staff member and it is the coordinators who truly understand this as they utilise their skills to try and ensure safe practice occurs.

For Jane, there was a busyness on the unit when she returned from leave but for her, that busyness was a ‘quiet shift’ in comparison with many, because it allowed her the time to achieve the ‘catch up’ tasks she needed to complete on her first shift back at work. Byrne and Maziarz (1969) write that man “is not merely ‘in time’ he ‘uses time’, he ‘takes time’ to do this or that, or if he fails in his responsibility, he ‘wastes time’” (p24). Time is viewed as a precious commodity and there never seems to be enough. When any situation arises, there is no escape for coordinators from decision making and management of situations with time needing to be used appropriately. Coordinators try to safeguard time for the benefit of mothers and babies but often find they are left with no time remaining to teach their colleagues.

Malloch and Porter-O’Grady (2005) write “good leaders recognize that time is a gift, not a weapon ...leaders recognize that how time is used is a universal issue and the proper use of time is the greatest vehicle for creativity, innovation and the full experience of

life” (p.192). The coordinators have revealed the truth of these words in their stories within this chapter.

In the absence of research on coordinator midwives, research was accessed on the experiences of being a nurse shift leader in a hospital ward (Goldblatt et al., 2008). One of the main themes in this study was the “temporal dimension of wanting to reach the end of the shift safely” (p.45). Chapter Six will reveal the ‘knowing’ which exists for these coordinators and their universal relief that at the end of a shift nobody had died whilst they were in charge.

## **CHAPTER SIX**

### **In the Face of the 'Known' and the 'Unknown'**

When the coordinator arrives on duty the only certainty that awaits her is the physical, inanimate geographical layout of the delivery suite unit; everything else is unpredictable.

The work of the coordinator is centred on the provision of safe care for mothers and babies in the unit which involves knowing what is happening within an environment of busyness and uncertainty.

Coordinators arrive at work with pre existing unseen, unspoken midwifery knowledge and wisdom. They hold unspoken 'knowing' and 'unknowing' about the staff and LMCs they will be working with. When they arrive on duty, coordinators reveal they have different needs to 'know' about what is happening behind closed doors in the birthing rooms to prepare themselves as far as they feel they need to be, for what may lie ahead during the shift.

Coordinators will be managing the unpredictability of admissions into the unit, discharges of women from the unit to birthing centres or home, emergency transfers in and retrieval of call outs to emergencies within a large geographic region. This is all part of their day's work in addition to the busyness of everything happening for women in the unit.

“*Techne*” and “*phronesis*” are discussed by Smythe, MacCulloch and Charmley (2009) and are relevant to the role of the coordinator midwife (p.1). *Techne* relates to a person’s knowledge which enhances understanding and *phronesis* refers to a person’s wisdom which is incorporated into their daily living. This chapter reveals the complexities of how coordinators’ *techne* and *phronesis* guide their practice. It also reveals the reality that *techne* offers no guarantee that coordinator midwives can provide safe care during their shift; rather they utilise their knowledge and wisdom to offer the best they can, often under challenging circumstances.

### **Knowing People’s Practice**

Amiria explains:

*You want to know the practitioner. Women come into our hospital to be safe so I think, as a representative of the hospital and the system, it’s our responsibility to know the standard of people’s practice. It’s not being finicky about things. People practice differently. It’s knowing they are competent.*

An LMC may have a caseload of forty or sixty clients per annum and she knows her clients. The partnership between LMCs and their clients is the cornerstone of New Zealand midwifery care. The specialty of LMC midwifery practice is normal birthing. Continuity of care within the tertiary hospital delivery suite is often unachievable. DHB midwives working on delivery suites care for a larger number of woman per annum

varying from uneventful normal birth experiences to highly complex care situations. By comparison, coordinators experience a vast overview of childbirth situations every day. A coordinator will be potentially involved with more clients in a week than the LMC will care for in a year.

It does not appear to be the intention for Amiria to use her knowing about colleagues' practice to undermine them; rather she is revealing her 'need to know' in relation to her desire to feel assured of safe practice for mothers and babies whilst she is in charge of her shift. Her 'techne' is the knowing of 'what is'; the 'phronesis' of these situations is having the wisdom to manage the situations so there is a safe outcome for everyone – the mother, the baby, the midwife, the coordinator and the organization.

Jane explains it is not just the clinical skill base of midwives that has to be taken into account; it is also how midwives manage under stress which in turn impacts on her in her coordinator's role:

*As a coordinator, the skill mix I have to work with can be a huge stress on how the shift goes because I know that this person can't do that or that one's gonna crack under that sort of pressure, or I know that there's three middle-ish midwives, but they're all really good and they think and they're not afraid to ask and they will get on with it.*

Stress is an unavoidable, integral part of the delivery suite setting. The response of a practitioner to stress in delivery suite will be unique to that person. Jane has no choice



regarding who is assigned to the shifts she coordinates. Her only tools to manage situations are the combination of her knowledge base and the knowledge she develops regarding the skill base of her colleagues and how they respond to stressful situations. She needs to know how these colleagues may react in emergencies. Holden (1992) writes “Some of us choose to rise to a challenge, others choose to avoid it. Some choose to thrive in chaos, others choose to collapse in chaos. Some choose to enjoy confrontation, others may avoid or evade it” (p.13). She has to manage with the staff on duty for the smooth running of the shift and this knowledge is the basis for her decision making regarding how she allocates work.

Amiria echoes Jane’s need to know:

*It’s knowing what your staff are like and how to work with them to get the best out of them on a particular shift because with some of them you just have to leave them to themselves because they’re okay, others just need a little bit of coaxing to do things and some just do their own things and have their own mindset and that’s just what they do; they get their job done, maybe not in the way you’d like sometimes and that’s a bit of an issue but when you’re pushed with staff numbers sometimes its the only way you can get through.*

Leadership is described by Kouzes and Posner (1995) as “the ability to mobilize others to want to do” (p.31). Amiria reveals her desire to ‘get the best’ out of the colleagues she works with. She knows that looking for the positives in her colleagues and accepting the differences in their personalities is the mark of the uniqueness of every individual. She

knows, provided there is provision of safe practice, there can be different routes to the same destination. This is the real world where her colleagues are professional, autonomous practitioners each with their own set of tools with which to deliver midwifery safe care. She cannot change who her colleagues are; they each have their own Dasein. A colleague coined the phrase for me within the context of leadership that leaders need to 'treasure and measure'. This is revealed by Amiria in her approach to the colleagues she works with.

Within the delivery suite setting, there will always be the unexpected emergencies when staff have to 'leap in' and manage an emergency within a critical time frame. The unpredictability of childbirth keeps midwives humble.

### **Getting the Skill Mix Right**

Sally describes an emergency situation at the end of her shift when she would have been tired and ready to go home, however she had the background knowledge and a complete picture of the staffing situation for the unit and the wards. There is a sense in her story that she switches on to 'automatic pilot' regardless of her fatigue and becomes the leader and decision maker based on her 'knowing' when she responded to her colleagues call for help:

*Just as I was heading out of delivery suite they yelled from the end of the corridor "don't leave!" We didn't have enough staff to cover yet – it was brilliant. Staff*

*who hadn't even been orientated to delivery suite just arrived, no questions asked. I was trying to make sure the staff who had never worked on delivery suite before were supported so I could deploy experienced staff to the complicated cases. You take an experienced midwife out of a room that might be low risk but at least you can replace her with a junior midwife, so the continuity goes out the window, but everybody gets care. Sometimes I find I end up apologizing because I have swapped staff to three different rooms in ten minutes because I have had to rethink my decisions. It doesn't worry me because at the end of the day I know I get the right mix. I get the right people in the right rooms and everything comes together okay. It's about getting the right midwife with the right woman really. Unfortunately sometimes a woman gets left with no midwife and they are hopefully the lowest risk. I just go in and explain to them why this is happening and how to use the call system. That's just the way it is.*

Sally knew what to do. It was her knowledge about the staff on duty she could deploy from the wards and what was happening with women requiring DHB midwifery care in the unit at that point which became the basis for her decision making. In addition, Sally had the confidence to change her mind regarding deployment of staff as she tried different pieces of the puzzle until it felt the right fit for that situation.

Even with the busyness of deploying staff, Sally was aware of the principles and importance of continuity of care for women versus the reality of providing safe care in the tertiary setting. She recognized she had to compromise on provision of continuity of

care and used her knowledge to place the right midwife with the right woman according to that midwife's skill base for provision of safe care.

Sally reveals that sometimes there will be situations where she knows a particular woman may be at the lowest level of risk in the unit, still has a risk level but there are no midwives left to care for her. She can only work with the number of staff who are on duty at that time and the finality of her words '*that's just the way it is*' offers her reality and acceptance that she does her best and this is as good as it gets.

It was unseen events or what Heidegger (1927/1963) describes as the 'hidden darkness' which were suddenly revealed and completely changed the dynamics of delivery suite in an instant in this story. Smythe (2000) alludes to this when she writes "so much of the knowing that could inform practice lies in the darkness" (p.18). It was only at the point when the emergency revealed itself with inadequate staffing numbers that Sally could truly know whether or not all mothers and their babies in the unit could be kept safe. It was how she responded to the emergency which was critical to everything that was happening in the unit at that time.

Heidegger (1927/1962) use of the analogy to 'leap in' as a form of concern when a person takes over and manages a situation is exactly what Sally did. She instinctively 'leapt in' with no forewarning and managed the situation because she knew what to do. Her knowledge was within her, ready to be utilized; she knew the staff she was working with, she knew their skill mix, she was familiar with the delivery suite systems, she knew

the staff would respond to her directions and she knew she had no problem in changing her mind with her decision making.

### **Behind Closed Doors**

The dilemma of coordinating but not necessarily knowing what is happening ‘behind closed doors’ in a delivery suite can be stressful. The coordinator holds responsibility as an employee of an organization which is risk averse; she has a responsibility to herself, to the midwifery profession and above all, to the mothers and babies in the unit.

Coordinators share their concerns in this study for women who are receiving primary care from their LMC in the delivery suite when they are in charge and the strategies they use to ensure safe midwifery practice is occurring. They could do nothing with the premise that it is ‘not their problem’, however stories reveal in reality they choose ways of addressing their concerns and their ‘need to know’ what is happening behind closed doors. They could use their position of status and power to demand entry to a room but reveal they choose to negotiate the situation collegially from the perspective of midwife to midwife; colleague to colleague. Communication is a two edged sword with the coordinator reliant on her communication skills to effect a positive working relationship with the midwife or LMC for safe provision of woman focused midwifery care. Inevitably, there may be past experiences for the coordinator or the midwife which may impinge on their working relationship.

As much as coordinators want to protect the mother and baby, childbirth is unpredictable. Polkinghorne (2004) describes techne as “the knowledge and skills needed to protect oneself from the suffering that nature can inflict” (p.10). This techne is especially relevant to midwifery practice. Within the tertiary delivery suite setting, it is the coordinators’ knowledge, skills and partnership with their DHB midwives, their medical colleagues, the mother and her LMC which offer the best path to safe care.

Coordinators reveal in these stories their need to ‘know’ what is happening in the unit. This knowledge becomes their unique ‘form’ of techne. Once the coordinator has the information she recognizes she needs to know, this becomes her assuredness of the best foundation possible from which to launch into her shift. This ‘solid foundation’ becomes the platform from which she can ‘leap into’ and ‘leap ahead’ of situations in the unit. She also consciously and unconsciously uses her phronesis in her decision making which Smythe et al., (2009) describe as the ability to trust in her instinctive wisdom which is something that “can seldom be adequately explained” (p.17).

Jane is very clear regarding her need to have baseline knowledge at the beginning of her shift:

*I want to know what’s going on in every room. With the DHB midwives it’s fine because I have every right to know what’s going on in there and it’s just a case of being collegially friendly and saying “How’s your lady going? I believe she’s due an assessment at such and such time”, or “look the day handover says there’s been some issues with the fetal heart in there, how’s everything now?” It’s not a*

*case of going in and demanding to know what's going on, there are ways and means around that.*

*With the LMCs, it's a little more difficult because some of them are in delivery suite under primary care. If they are providing completely absolutely primary care I don't really care what they are doing because all they are in delivery suite to use the four walls and the roof. But again that's practitioner dependent because some of the LMCs I trust implicitly and I know when they say "I'm stuck here I need some help", I know they really are stuck and really do need help so I damn well listen to them.*

*Whereas other LMCs, some of the new ones, I will very much keep an ear on what's coming in and out of the door because I don't know their level of practice, so I don't know if they are okay. If they're not okay, do they need support? Do they know how to ask for support? Is everything really okay in there? I don't know. So, for the newer LMCs I'll be more alert just to make sure they are okay, because for some of them, the delivery suite is a really scary place.*

*Then there are times with some midwives when aspects of their practice creates concern and you think "Hmm I hope it's going okay in there". You're just waiting for something to happen.*

Jane is ensuring she is as prepared as she can be by trying to gain the knowledge she deems necessary to manage whatever may eventuate during her shift. There is always 'unknowing' in the 'hidden darkness' of childbirth (Smythe, 2000). Jane knows childbirth is unpredictable and all she can do is be prepared; this is as good as it gets. She has the knowledge and wisdom to manage situations but will never really know when or how situations will reveal themselves. In this conversation, Jane reveals she has developed skills to try and successfully access information about women she holds responsibility for, on the basis of her past experiences.

Although Jane says she doesn't 'really care' about what is happening in primary care situations, her words reveal she cares very much. Her caring centres on the wellbeing of mothers and babies and her 'unknowing' of situations behind closed doors versus her 'knowing' of the LMCs who are caring for their clients.

Jane recognizes the delivery suite is a 'scary place' for new LMCs and reveals empathy for her colleagues. There is a sense of Jane being 'on edge', with a heightened awareness and a readiness to 'leap in' to unknown situations. Her reality is that she tries her best in the midst of different personalities, different philosophies of practice, the principles of informed consent, the partnership model of care and individualized birth planning between the LMC and her client.

It is also acknowledged, this is not a one way process. Just as Jane expresses negative perspectives about LMC's, Skinner (2005) reveals in her study that LMC's found



“support from midwives in the secondary hospital was often lacking and was a source of great distress” (p.179). It seems there are times when trust is weak between colleagues who perhaps have different beliefs on what constitutes safe care, or perhaps have false impressions of the nature of the practice of ‘other’.

### **How Much Longer Shall I Wait?**

Irene speaks about her feelings and parallels these stories to reveal how past experiences influence current feelings and decision making:

*It is hard to feel confident expecting things to happen based on prior experience and at the same time hoping I am right. I find myself thinking, ‘how much longer shall I wait’, ‘shall I go in the room now’ or I find ways of entering a room which I wouldn’t have used before. I may offer somebody a 15 minute tea break, although they may have had one an hour ago because that is the best way to get in there and see what is going on without sticking your nose in and going through notes and giving the impression to the midwife and to the woman, that I am not trusting what is happening in the room. To infer distrust creates an unhealthy atmosphere.*

There are occasions when Irene feels concern for a situation and recognizes her need to know what is happening behind closed doors. She reveals despite her experience and knowledge, uncertainty exists as to how and when she accesses the knowledge she needs.

Past experience has taught her the reality that even if she is invited into a room and gains the knowledge she wants, events and outcomes remain unpredictable, however some knowledge is better than none.

She reveals her veiled dilemmas in these situations of wanting to know what is happening, wanting to be sure of safe practice but also wanting to uphold the partnership and trust which exists between the midwife and her client. Irene sounds as though she is teetering on the edge of a precipice knowing she needs to have more information to be assured of safe practice, not knowing how long to wait, what is safe, what tactic to utilize to gain the information she needs and knowing even then, armed with the knowledge she wants, she may encounter an outcome which is unexpected and over which she has no control. She is dependent on her communication skills to acquire the information she needs to be prepared for the next step of the woman's journey. Her journey, the woman's, and the midwife's journeys may become inextricably intertwined if Irene discovers a situation where her support is required. All she can do subsequently is coordinate whatever situation unfolds. She goes on to explain:

*Most stories would be along the same lines where I am invited into a room where I have had very little prior involvement and find a situation where I see practice which is not good. It is often situations like women being made to push when they shouldn't be, especially when epidurals are on board so then unnecessary intervention occurs.*

When Irene is invited into a room she often recognizes she needs to share her midwifery knowledge. When she approaches this the right way, she becomes pivotal in supporting the midwife and her client towards a potentially more positive birth outcome. There is no mention of power or ownership in her story, rather there is her focus on woman centred care and her striving for a positive outcome in the absence of unnecessary intervention.

It is Irene's wisdom or phronesis which differentiates the two approaches she could take. She could be authoritarian and use her position of power to make the decision to physically enter a room but she chooses to acknowledge the place of the woman in delivery suite. The woman is the primary focus for care. By negotiating an invitation into a room Irene leaves the power with the woman and her midwife which is a sound base from which to be able to communicate openly, honestly and effectively thereafter.

### **When there is Nothing Left**

Jane describes a shift when she uses all her 'knowing' to ensure the provision of safe care during her shift:

*On Sunday it was a twelve hour night shift, staff sickness on the antenatal floor, post natal was busy, and delivery suite staff had sickness. There were two off sick, so it's the situation of how many inpatients have they got in the ward and who I can pinch to cover. I closed the assessment unit so I gained that midwife plus one from the ante natal ward which gave us four midwives plus a registered nurse on*

*delivery suite which was a luxury. But, we ended up with all admissions being previous caesars from out of town with their midwives not accompanying them.*

*I ended up coordinating, three midwives 'specialing' women in labour, one on synto, one with an epidural and one with synto and an epidural, and I cared for a twenty nine weeker with placenta praevia.*

*So I had a patient load as well coordinating and ensuring safe staffing for the night for the block. Once it was sorted out you start thinking 'I hope nothing comes in overnight because I don't have anybody else to give'. Then of course an LMC wanted to hand over at around 4am for an epidural for her client. Well I'm sorry I don't have anyone. She got all narky and said "can't you bring someone down from the wards" "No I've already done that, so you are going to have to explore other choices for your client because an epidural is not a choice".*

*So, all night you're making sure that the midwife left on the antenatal floor with 6 women is safe and phoning her to see if she needs anything. The RN couldn't help us, so she went to help on the postnatal floor for about 5 hours until I needed her.*

*Then my client started to bleed, with the complete praevia at 29 weeks. Is she going to come unstuck, bleed and then deliver? Where is the best place for her to be delivered? So I am working through these scenarios with the registrar and*

*anaesthetist as to what is safe for the woman, because if they get stuck doing a 29 week praevia caesar on delivery suite in the middle of the night and she bleeds and they need help, there isn't any.*

*By 6am just when we thought we had got through the night quite well one woman had to go for a caesar which was okay because she already had a DHB midwife and our RN would scrub. But at the same time, the woman who couldn't have the epidural started pushing and continued for quite some time. We had an LMC ring in who wanted, well I don't know what she wanted because she was quite rude and barely spoke to me. Then another LMC rang to say she had a lady coming in who was going quite fast. The woman was fully dilated and pushing on the doorstep when she arrived, so I cared for her because the LMC hadn't arrived.*

*Amongst this I was worried about my placenta praevia client who was bleeding. I hadn't checked on her or the baby's well being because I was busy with the lady who was trying to push her baby out. None of the other three midwives had had a break all night because I had my own patient load and I couldn't relieve them. They were entitled to breaks but didn't get them.*

*By 6.30am everything fell apart. The registrar had completed the caesar, the LMCs client who had been pushing needed assistance and I agreed so the registrar went in there and ventoused that baby. Unfortunately there was no paediatric support for an instrumental delivery so that was me again. Fortunately*

*I had asked the anaesthetist to stay around. Just as well because the baby came out rather flat and took a couple of minutes to pick up, so we got the newborn unit down to assist. Just as I had the nurse practitioner from the newborn unit and the anaesthetist helping me with that baby, the LMC had arrived for her client who was fully dilated and pushing by that stage. She double belled from her room so I left the anaesthetist and NNP<sup>7</sup> with the baby, and jumped into that room. The woman had quite a major tear, so she was rushed straight down to theatre. Then the day staff arrived and said “We’re ready for a handover, do you think you could come?” “Yeah, sure I’ll find time”.*

*When I have enough staff to cope with everything I enjoy coordinating. The times I don’t enjoy it is when you know there is absolutely nothing, nothing, nothing left and if one more thing comes through the door it would tip you over the edge. I just hate those times because I’m really frightened that someone’s going to die because there is no one, absolutely no one to care for the woman.*

Jane’s story reveals the busyness and complexities of coordinating on delivery suite.

Jane’s decision making and her prioritization was based on her knowledge base. Her first task when she starts her shift is to know the staffing situation of the entire unit and the

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<sup>7</sup> The Newborn Unit Nurse Practitioner (NNP) is a highly trained registered nurse practitioner whose job includes responding to emergency calls for assistance with resuscitation of newborn babies in hospital and community settings

skill mix. Her knowledge regarding unsafe staffing for that night gave her the confidence to close Women's Assessment Unit. Despite the busyness of the unit she has the added challenge of having to provide midwifery care for a woman in a high risk situation.

Jane reveals in her decision making that she knows there is uncertainty with women in labour and she needs to be prepared to manage the unexpected at any point in time. She is a part of this environment which is not of her making and bases her preparedness on the knowledge she has within her. Harman (2007) explains in his interpretation of Heidegger that "direct presence of the world is never possible" and concealment belongs to the very nature of the phenomena of 'being' (p.33). She knows what might happen, she will never know everything that could happen, but with this premise Jane reveals how she is thinking ahead all the time in her story.

The LMC has the right to hand over care just as her client has the right to an epidural but neither are realities on this shift. Jane knows this and has to manage this reality the best way she can in trying circumstances. Jane is reliant on the LMC to use her midwifery skills to get her client through her pain barrier.

Jane knows the midwife caring for six ante natal woman on the ward feels unsafe so she maintains contact with her for both their reassurance. She knows the consequences of torrential haemorrhage with a placenta praevia and reveals her team approach to forward planning the 'what if's' for that woman needing to go to theatre for safe care. She knows she has no option but to care for the woman who has arrived on delivery suite in the

second stage of labour and who is actively pushing. She knows she should be checking on her own client but staffing shortages make this impossible. She knows no one had had breaks all night which impacts on safe practice but there is nothing she can do about this. The pace remains frenetic and it is her knowledge base, based on her experience as a coordinator which helps her anticipate potential problems. She is ready to resuscitate the baby who was birthed by ventouse<sup>8</sup>, she recognizes the need for assistance from the newborn unit and she responds to the post partum haemorrhage situation by transferring the woman to theatre at speed.

Jane is working in the midst of great complexity. She knows her limitations and reveals her fears of the ‘what ifs’ of her job. She has no control over the unexpected, all she can do is respond and utilize her knowledge to make the situation as safe as possible under the circumstances. Heidegger (1927/1962) explains how a phenomenon, rather than announcing itself which would equate with Jane telling her colleagues she knows what to do, is announced *through* something. In this situation, Jane’s knowledge was announced through her effective management as a coordinator of multiple challenging emergency situations.

In this next story, Sally reveals her thoughts and the journey she travels as a result of an emergency situation in delivery suite. She sets the scene:

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<sup>8</sup> Ventouse is a vacuum extractor which is a cup device. This allows traction to be exerted to pull the fetal head along the birth canal to facilitate the birth (James, D.K., Steer, P.J., Weiner, C.P., & Gonik, G, 1994).



*'I'm already overseeing three women with junior midwives, I am caring for a woman, our staff are all deployed and we are running a caesar',*

at which point, she has to manage an unexpected emergency admission to delivery suite with no midwife to care for the woman. All she can do is use her knowledge to prioritize care:

*I had to go in and say to the dad "right this is the story, we have no staff, we actually don't have anybody to look after you, I'm really sorry for that, there's no excuse but I'm being up front and honest with you." He said "fine, that's okay". I ran into Annie who was in a room with a woman to see how far off she was and she'd just delivered the baby, so I grabbed Jan who is a registered nurse and put her in the room with the couple. Then I put Jan in with Annie's woman when the placenta was out and I told Annie she was needed in the other room. I gave Annie a quick run down, she went in to the couple and I went back into the office. Annie must have only been in that room for four minutes when she rang a double bell. The woman had a prolonged bradycardia, we rushed her down to theatre and luckily she delivered on the table. It was all okay, and they're like "thank you, thank you". And I thought "you have no idea how you just scraped by, by the skin of your teeth".*

Harman (2007) writes "our current life is there before us as the hand we are forced to play. The most we can do is try to work with the situation as we find it and every moment however dull or horrible has its possibilities" (p.28). Sally knew there were no more staff available to assist at that point and she recognized she was skating on thin ice but she had

no choice. Sally did not dwell on this reality, rather she responded in the best way she could based on her knowledge of her staff on duty by 'leaping in' to the situation. She used her knowledge to deploy staff with critically effective timing as well as continuing to care for her own client and oversee the entire unit.

Dasein incorporates "a structure of care" (Harman, 2007) which means rather than being observers within this world, we care what happens (p.29). Sally illustrates her caring and the emotions she veiled when she reflects:

*We always seem to just manage it by the skin of our teeth. I just think what if one day we don't. That baby could have died. What if I hadn't put Annie in there, what if that dad hadn't noticed something was wrong? Who knows, what would have happened if Annie's woman hadn't delivered and I hadn't been able to run her across. Annie was in the room for less than 5 minutes and it all turned to custard. That was a nightmare shift. But it was good. Everything was all done very calmly. I thought "I can't find any staff, there's nothing else I can do, I am doing the best that I can do with the staff that I've got". And you know everything worked out alright.*

*It's not the hard work that bothers me, I can run for 12 hours and it really doesn't bother me, its knowing what you're leaving in the wake of that that bothers me.*

In reality those 'what ifs' did not happen, but they are a real part of Sally's sense of 'being' in her story. Her questions are a very real consequence of her reflection on her

experiences which contribute to her knowledge and how she may respond in the future to emergency situations. Harman (2007) describes our ability to “glimpse possibilities” (p.29) and the level of unrest which can exist between the poles of reality that are made up from our past and the possibilities of our future which is what Sally was doing.

Although Sally is generalizing in her comments, the sense of danger is felt in her story. The large cruise ship leaves a wake in the ocean and those on board may be oblivious to the consequences of that wake. There may be fishermen in a small unprotected boat in that wake who experience the consequences as they are precariously tossed and turned. Such repercussions from the wake are invisible to the captain of the ship, his crew and passengers as they obliviously travel forward in time. And here we turn full circle back to the unseen darkness, what unexpectedly reveals itself; what control or lack of control the coordinator may have in any situation and what unknown repercussions may eventuate. Sally is reliant on what she knows to carry her through her experiences as she leads her team. Her knowledge grows with her coordinator experiences.

### **Woman Focused, Midwifery Led Care**

The influence the coordinator can have in the delivery suite during her shift is immense. Alice reveals how important it is to her that value is attributed to midwifery knowledge within the medicalised tertiary delivery suite setting. She is the key person who sets the scene and she is pivotal in upholding a midwifery focused environment. She is assigned

the coordinator position because of her expert midwifery knowledge base and she regards it as her role to model woman focused, midwifery led care during her shift for the benefit of mothers and babies. She has the techne and the phronesis to be a decision maker as an autonomous practitioner.

***‘You want midwives to be midwives and use their capabilities to the full’***

Alice shares her philosophy of practice as a coordinator:

*The midwife is worried about a trace and you go into the room and there’s nothing wrong with the trace; its just a few variables or something like that. That’s so often the case and it’s irritating because you want midwifery solutions. You want midwives to be midwives and to use our capabilities to the full and to develop ourselves as highly capable secondary level carers. If I catch someone on the phone ringing a registrar I say “what are you doing?” “Oh well I’m worried about .....” and I say “Well you need to come and speak to me first because there might be a midwifery solution”. Coordinators need to know.*

Alice is absolutely clear in her expectation that midwives will primarily work with her to find midwifery solutions for women rather than what can be the hierarchical tendency for midwives to refer to medical staff as their first point of contact. Day (2000) writes effective leadership requires “an intelligent head and an intelligent heart” (p.123). Alice holds the position of coordinator because she is an expert practitioner. An integral part of her job is to take on responsibility for decision making. She utilizes her clinical midwifery knowledge and her Dasein as her basis for decision making. This is her role;

this is her opportunity every day when she is on duty not only to positively influence colleagues she works with but also to ensure woman focused care prevails. She knows when it is appropriate to leap ahead with a midwife by perhaps changing a woman's position in relation to variable decelerations thereby teaching the midwife that one small action may be all that is required. Equally so, she knows when it is appropriate to call in obstetric colleagues. Smythe and Norton (2007) write about the combination of techne and phronesis in leadership situations when there is an understanding that at times, the wrong decision can be made. This is the price a coordinator pays in her leadership role, however there needs to be the ability to make a decision based on what is known and the wisdom of her inner self.

***'I am a midwife and that is my expertise'***

Irene reveals her philosophy for practice:

*The language matters. I am not 'just' a midwife, I am a midwife and that is my expertise. I have seen a lot, I have made my own mistakes, I learn from my mistakes and I still make mistakes which is why I have become more assertive, My midwifery is inside me and if I don't bring it out it will be invisible; I practice by example.*

Irene reveals a sense that she stands tall in her professional role. Smythe et al., (2008) explain how phronesis stems from a person's life experiences. Irene's basis for her strong coordinator midwifery skills stems from what she has learnt during her career which is inclusive of the mistakes she has made along the way; this is what makes her who she is.

Within the context of time, Irene's coordinator experiences accumulate. This makes her increasingly knowledgeable and able to stand up for what she believes in. She reveals her techne and her phronesis in her midwifery actions and decision making in the powerful stories she shares:

*A woman in labour with her third baby was transferred to delivery suite from a planned home birth situation because the midwife had difficulty determining the cervical dilatation. The midwife asked for registrar review. People in delivery suite were making negative comments about home births and without any communication with the homebirth midwife or her client, the registrar asked a DHB midwife to take the ultrasound machine into the room to check the position of the baby. There had been no question about the position of the baby, so I went up to the registrar and said to her "do you mind me pointing out that it might not be the most sensible action to push a scanner in to the room before you have even talked to the woman?"*

*The registrar came out of the room and remarked to us that the woman wasn't "that unpleasant". I responded that I had never intimated the woman was unpleasant. All I had requested was consideration by the registrar that she would try to understand the woman's perspective so she could get her cooperation.*

It is so easy for doctors and midwives in the tertiary setting to become reliant on technology rather than using it appropriately to complement a midwifery or obstetric examination. In the knowledge this woman planned for a home birth, Irene recognizes the importance of first encounters between hospital staff, the woman and her LMC. Downe

(2004) writes “the place of birth has the potential to shape the woman’s experience, determining who is in control, and what interventions are available” (p.88). Irene reveals her ‘knowing’ that a first encounter with a machine rather than a health practitioner who has the skills to complete an initial assessment is inappropriate and unacceptable. As a coordinator Irene is in the unique situation of being able to role model and teach her midwifery knowledge to doctors as well as midwives. The philosophy of New Zealand midwifery is the partnership model of care (New Zealand College of Midwives, 2005) not a hierarchical power focused model which hospital systems can be identified with.

Irene’s focus in this story is the wellbeing of the woman and her baby. As a coordinator, Irene understands the chasm of philosophy differences between a home birth and a tertiary hospital birthing experience. Her decision to ‘leap in’ to this situation was to safeguard the birth experience for the woman as best as she could and to support the LMC until they discovered what the next vaginal examination revealed from the ‘hidden darkness’ of the progress of labour.

### ***When two worlds meet***

This penultimate story reveals the profound influence knowledge and wisdom has on Irene’s decision making when there is an emergency situation steeped in multiple layers of complexity yet Irene still keeps the mother and her baby central to everything that happens:

*I was thinking about a story today when I came here, about two worlds meeting each other and the coordinator in the middle. Two LMC midwives transferred a*

*woman in labour who had planned a home birth. The woman had been very reluctant to transfer despite the midwives recommendation.*

*On one side we were engaging with LMC midwives who in some regards followed quite a staunch homebirth philosophy and that was wonderful. On the other side a junior registrar was on duty and an experienced consultant who was there as back up, with an emotionally charged situation because the woman's care had not been managed according to hospital protocols and guidelines. This was the consultant's first kind of 'boiling point'.*

*The pot boiled over completely at the birth when complications arose in the room with the two LMC's present and the consultant outside the door. The consultant was called in to the room and I went in as well.*

*He examined the woman, there was fetal distress and we knew we had to caesar which resulted in a more or less panic mode. It was all one big unknown. The woman was very distressed.*

*As coordinator, one of my jobs was to immediately organize the caesarean section, and the associated staffing requirements. But, at the same time I ended up being right in the middle of a situation because the minute we walked out of the room the consultant completely lost it. He was so angry, and vocal that his emotions stopped him functioning. He was unable to walk down the corridor, get*



*shoes and a gown on and be ready for surgery, because he was wasting all his energy expressing his anger which was not helpful.*

*In that situation of being stuck in the middle between the consultant and the midwives, my first role then became that of a scout leader or something. I had to say to the consultant “this is not the right time to spend any energy on your anger and frustration”. Although I had my own thoughts about the situation I said to him “I can understand you” because my primary issue was how I was going to calm him down fast enough to get him to theatre to do his job.*

*In that position I had to get on his side and say: “Look, I understand you, but now is the wrong time to get angry. Get moving, get down there, we will bring the woman down, we will be quick, don’t worry”. I had to be a peacemaker and a negotiator to try to bring him back to earth. I went into theatre, the baby came out flat and I knew that the consultant was still really angry and holding back so much.*

*Both midwives had come into theatre as well. The baby had to be resuscitated and the neonatal team was looking after the baby. In the meantime the consultant was suturing. One of the midwives who was coming from a spiritual perspective started making this kind of encouraging, almost chanting communication to the baby, encouraging the baby to start breathing and empowering the mother to encourage the baby to breath. I reflected on the midwives chanting and thought “I*

*don't know how much longer you can do this before the consultant loses his cool again!"*

*My perception was that the consultant felt the midwives didn't care about the physical implications of the birth and were all up in the air spiritually. I stood there thinking, "Please, please, let him hold it together". I felt unable to go to the midwife and ask her to "just be quiet for five minutes". For me that was the wrong thing to do, because I could understand where they were coming from.*

As a midwife, Irene understood the philosophy of informed consent and the partnership model of legislated New Zealand maternity care. Irene does not pass judgment on the woman's birth choices and makes it clear that the woman was reluctant to transfer to the tertiary hospital for whatever reason. This is part of Irene's 'knowing' and reflects the way she approaches the situation. We do not know why the woman chose to birth at home nor why she declined to have the obstetrician in the room at the birth. This is also the way it was.

Irene is caught between supporting the woman's birth plan choice which was to exclude the doctors and herself from the room, and supporting the doctors who are awaiting the unknown, oblivious to what is happening in the room. Irene knows all she can do is be ready to 'leap in' to a situation if an emergency reveals itself.

Irene was skilled and able to view the whole situation with clarity which Draycott, Winter, Croft and Barnfield (2006) explain occurs when leaders achieve a “helicopter view” (p.95) in an emergency situation. Irene knew how to respond however she also needed to calm the doctor who was immobilized by anger. She recognized the importance of being clear headed and did not enter into the emotions of the situation, instead she prioritized her actions.

It took courage for the LMC to commence chanting to encourage the baby to breathe, within the medicalised caesarian section operating theatre environment. Downe (2004) explains how some home birth midwives will “call the baby” with the belief that at the point of birth “the spirit of the baby has to decide to stay or go” (p.x). Irene reveals this midwifery ‘knowing’ yet also holds the tension of how such chanting might impact on the obstetrician. She realizes that he was the one who ‘at the end’ saved this baby’s life.

The woman had reluctantly transferred from choosing to birth her baby at home, where she had empowerment and control, to being transported to an emergency life saving surgical environment. Irene gave the woman and her LMCs the opportunity to play the complementary roles they believed important to address the spirituality of the situation. As the coordinator she found herself at the inter-section of different world views, where all had the safety of the mother and baby at heart. There was tension in holding possibilities open for the woman to still have aspects of her desired birth experience amidst this emergency situation. This midwife reflects:

*At the end of the labour there is the woman and she is the one who has to carry the canvas of her experiences.*

The coordinator holds the tension for the sake of the woman.

This leads on to Jane's story:

*We had a first year registrar who had been employed at our unit for three weeks and he was on nights. I thought "Great I'm in for a good night here!" considering I didn't know who he was, where he'd come from or what his practice was like. It was some ungodly hour of the morning about 3am, a 16 year old was labouring. She was doing alright but her baby had other ideas with quite dramatic foetal heart decelerations. The registrar, to give him his due, had been ringing the consultant every hour. The consultant came in. I was busy because I had my own patient load as well as being the coordinator. Next minute I know, she is heading off down to theatre for a caesarian section. I disagreed with this and believed it was the wrong decision. The registrar was too junior to know what was going on. I challenged the consultant. I was very blunt with her and said "I think you're making the wrong decision, we need to talk about this".*

*The girl was on the caesar table about to have a spinal put in, so I told the anaesthetist he had to stop. I said "I think you're making a mistake. I think in this instance you need to site epidural and not a spinal, to get her comfortable. This was a few years ago before we were doing pH's as a more standard procedure. I*

*suggested they did a pH<sup>9</sup> on the caesar table and, if it was good, allow her to go back and labour and if it's appalling then section her. It was fine. She went back to her room and gave birth normally a few hours later. I was happy with my decision because I'd based it on sound midwifery knowledge.*

Harman (2007) writes about the authenticity of Dasein and “if you are still looking for someone or something else to tell you what to do, you have not yet reached the point of resoluteness” (p.65). Jane was busy and had her own caseload but despite all these circumstances, she recognized a situation was unfolding which instinctively felt wrong to her. She did not know the registrar's practice and she knew the consultant was likely to be overtired from the hourly phone calls made to her by the registrar. Jane was resolute enough to use her midwifery knowledge and leap in to this situation to challenge the consultant and anaesthetist.

She used communication which personalized her feelings and was forthright. Jane reveals her focus:

*In this instance I'm advocating for this young girl who could have ended up with a scar on her uterus unnecessarily which had implications for future pregnancies. She would have ended up staying at the hospital for three to four days and her*

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<sup>9</sup> pH is a fetal blood test. This is a transvaginal procedure performed by an obstetrician when the woman is in active labour to determine the fetal acid – base balance. An abnormal result suggests the fetus is poorly oxygenated and contributes to determining whether labour proceeds or urgent delivery is indicated.

*family couldn't have stayed with her. She was a young Maori girl, who needs her whanau with her.*

Within the busyness of her shift and at a debilitating time of night, Jane clearly understood what the consequences would be both of her inaction and her action as this situation unfolded. She had not been caring for the woman but used her position as coordinator to 'leap in'. Cerbone (2006) explains Dasein projects itself in terms of its possibilities and is always 'ahead of itself' (p.53). This is demonstrated by Jane's actions as she was 'thrown' into a situation not of her making but was able to bring together her personal experiences or '*Befindlichkeit*' which is the historical nature of 'Dasein' (Cerbone, 2006). Her '*Befindlichkeit*' reveals the uniqueness of her personal experiences which influenced her decisions and thereby changed the outcome for the woman. Jane's techne and phronesis is revealed by this young woman birthing normally and going home to her whanau.

### **Summary**

Within this chapter, coordinators stories reveal their clinical midwifery knowledge, their inner sense of knowing, their intuition and their wisdom with the judgment calls they make. This is their techne and phronesis. They reveal clear examples of their situational awareness which is described by Draycott, Winter, Croft & Barnfield (2006) as "how we notice, understand and think ahead in such a fast paced, constantly changing situation. It is what makes you expert, gaining that 'sixth sense' and 'gut instinct'" (p.94).

The responsibility coordinators undertake is huge with their decision making often made during times of emotional duress for the woman, her family/whanau and staff. The coordinator manages the additional challenges of midwifery staffing shortages, simultaneous demands on their time and the resources of the unit with no guarantee they will always be right with their decision making (Malloch & Porter-O'Grady, 2005). The stories reveal an exhausting, adrenaline packed pace of work full of complexities and unexpected twists and turns. The reader is charged to remember these are real life experiences with no opportunity for coordinators to stop, take a break or walk away from situations. This is their Dasein.

Tensions are revealed within this chapter regarding what happens 'behind closed doors' and the unease which exists for coordinators when they have 'knowing' based on prior experiences or intuition regarding the skill base of their midwifery colleagues. What shines through however in this chapter is the commitment by coordinators to women and their reality of trying their best with the mother and baby – the focus of their care. Davies (2007) writes "midwifery espouses a holistic philosophy in which we nurture women's hearts, minds and souls by meeting them with our own" (p.75). Irene, Sally, Alice, Amiria and Jane reveal their midwifery hearts and souls as they advocate for women. Irene sums up her midwifery focus and her 'knowing' that the woman is in the delivery suite for only a short period of time but *'she is the one who has to carry the canvas of her experiences'*.

Gould (2000) writes “medical knowledge is thoroughly interwoven into the midwifery profession” (p.425). Coordinators know there are midwifery solutions and they want to be able to teach and share their knowledge. They use their *techne* and their *phronesis*, however within the busyness of the delivery suite unit where staffing acuity is a constant challenge, they do the best they can and this is the way it is.



## **CHAPTER SEVEN**

### **Discussion**

#### **Summary of the Key Themes**

This study reveals the coordinator is an expert midwife in addition to being the leader, the broker, the mediator and the peacemaker; she can see the bigger picture and wisely takes action whenever required. The stories in the preceding three chapters reveal the complexities of what it feels like to be in this position of responsibility and the multiple skills coordinators possess to be effective in their role including complex clinical midwifery knowledge, wisdom, instinctive ‘knowing’ and a woman focused philosophy of care.

The tertiary hospital environment is the focal point where the skills of obstetricians, anaesthetists, sonographers, medical and surgical specialists, LMC midwives, DHB midwives, nurses and ancillary staff merge. These skilled people cannot work in isolation. They are part of a team with the united objective of offering the highest possible standard of care to mothers and babies who require assessment, treatment and care within this setting. Each of these professionals holds their own personal lens, with different cultural mores and philosophies in relation to the situations they manage. It is the coordinator midwife in the delivery suite setting who is the ‘pivot’ or ‘hub’ for everyone and of everything that happens in the unit. In her pivotal position, she has the

leadership skills to be able to positively influence the atmosphere for the smooth and safe running of the tertiary hospital delivery suite unit.

### ***Being the 'pivot' or the 'hub'***

It is the coordinator who is always 'on the floor' and accessible to everyone, She keeps 'a finger on the pulse' of the unit wherever she may be, whether coordinating from the office or in a room caring for a woman in labour, she remains central to everything happening during her shift.

Being the pivot means there are times when the coordinator feels at the '*centre of a storm*'. Coordinators reveal they are thrown into emergency situations where they display an outward appearance of assertiveness and confidence. Whatever coordinators may be feeling inwardly, they model a role of strong leadership to their colleagues and clients. It is this which determines whether everyone achieves their common goal, or not.

This 'centrality' means the coordinator is not only accessible to staff but she is continually consciously and subconsciously monitoring what is happening in the geographical 'lived space' of the delivery suite unit and beyond to the wards. She 'needs to know' what is happening and it is her effective 'relationality' with her colleagues which is the means to her 'knowing'. Her 'doing' is reliant on her 'knowing' and it is this 'knowing' which gives the coordinator her ability to lead her team effectively.

### ***‘Needing to know’***

Coordinators work with different practitioners in the delivery suite setting who each work within their professional scope of practice. There is an expectation by society that there is both provision of safe care and immediate readiness to act in the event of an emergency in the tertiary hospital setting.

Coordinators know the reality and unpredictability of childbirth in this setting where there can be ‘lulls’ and ‘storms’. When it is busy there are times when doctors and midwives will not be immediately available. It is up to the coordinator to manage as safely as she is able until help arrives, so there is always the need for contingency planning.

It is her ‘knowing’ which helps the coordinator hold the big picture of what is happening on the unit at any point in time and what resources she has access to. This gives her the opportunity to think about the ‘what ifs’ during her shift and to plan ahead.

Part of the coordinator knowing what to do and when to do it is ‘knowing’ who she is working with. This study reveals the judgment calls coordinators make about their colleagues which appears an integral part of their ‘mind set’. Judgments may be made by coordinators based on their previous experiences or knowledge, which may instill emotions within them ranging from confidence, to acceptance of ‘what is’, to dread and trepidation.

Their 'need to know' extends to what is happening 'behind closed doors' with coordinators revealing the ways they are proactive in capturing information to support their knowing but at the same time consciously trying to maintain a focus of respect for the midwife, the woman and her partner in the room.

The way coordinators manage to do this reveals their acknowledgement of the importance of safeguarding the working partnership between the woman and her midwife in a room, the principles of informed consent but primarily this study reveals the intent of coordinators to safeguard the wellbeing of the mother and her baby within the context of the busyness of the delivery suite environment.

By making herself accessible, the coordinator is role modeling the potential to explore midwifery solutions for the care of women in labour. If the coordinator discovers midwifery practice which concerns her, she utilizes her midwifery expertise, leadership skills and interpersonal communication skills to be able to share her knowledge and contribute her perspective appropriately.

With the knowledge gained from her encounters, the coordinator can 'leap in' to situations or 'leap ahead' of what she discovers. She can be anticipatory within the context of everything else she knows is happening in the unit and on the wards with her sense of readiness. Yet always, she knows that within this dynamic context there are unknown dangers which reveal themselves at a moment's notice, sometimes too late to keep the situation safe.

### ***Facing the 'known' and the 'unknown'.***

In midwifery and obstetrics, practitioners are caring for two lives, one of which is unseen and whose wellbeing can never be totally guaranteed. The 'unknowing' of what is happening in utero to the unseen baby and the implications for the woman who has been referred with secondary complications makes for complexity with a need for multidisciplinary care planning.

Coordinators reveal the teamwork and respect which exists with their medical colleagues in their united desire for a 'healthy mother and a healthy baby'. However, they also reveal their 'knowing' of how easy it is for their midwifery and medical colleagues to veer towards interventionist solutions.

It is the coordinator's midwifery 'knowing', intuition, wisdom and expert tertiary level clinical midwifery skills which lie at the heart of her practice. This is her foundation on which she bases her desire for midwifery solutions when she knows it is appropriate.

There is 'knowing' that one small intervention such as siting a fetal scalp electrode will ensure close monitoring of a fetal heart rate and the best potential for a vaginal birth.

There is 'knowing' that a woman in advanced labour with an undiagnosed breech baby and previous uncomplicated normal births can birth her breech baby vaginally. These are women, with a holistic perspective within a medicalised world of tertiary obstetrics who are accorded respect from medical, midwifery and nursing staff alike. They know how life saving obstetric intervention is and how appropriate it is in the tertiary setting. They also know when to utilize midwifery solutions to best advantage.

### *Lived time*

In the face of the ‘unknown’, coordinators are regularly thrown into situations where they have to multi task and bring together a team of doctors, midwives, nurses, neonatal practitioners, anaesthetists and anaesthetic technicians with no forewarning. Such situations are often emergencies where every second counts. The reality is that time lost could compromise the quality of life for a mother and/or her baby forever.

Within the tertiary setting, the coordinator is working with colleagues who each have their own agenda and their own focus. With no warning, these colleagues are required to work together as a team at speed, with all the tensions accompanying such situations when time is critical. The coordinator leads her team by weaving in and out of their life worlds to bring everything together calmly, yet with urgency.

Members of the team may panic, or feel they are beyond their ability to cope. Whatever the coordinator may be feeling, she is the only person with a ‘helicopter view’ of the situation. She knows the numbers of staff on duty; she knows what else is happening within the unit and what could happen in addition to the current emergency. She knows the skill mix of the staff she is working with and what needs to be done in a safe, timely manner.

There is always the ‘unknowing’ of the outside call regarding an admission to the unit, a regional retrieval request or an emergency transfer from a ward to delivery suite. It is up to the coordinator to lead, to direct and to use time to best advantage for all concerned

which may involve empathizing, reassuring or alternatively being direct and non negotiable for what she requires of team members at any point in time. In situations when she knows it is impossible to relieve a staff member from their situation of non coping it becomes her onus to empower that colleague to keep going in spite of all that obstructs her ability and belief she can do so.

Experiences can be breathtakingly dramatic with time seemingly speeding by in single or multiple emergency situations however there are other situations where time is also of significance to coordinators. There are situations where women need to be ‘given’ more time to labour, rather than progress being plotted on a graph with a philosophy of ‘*this is what you are, this is how I treat you*’. There is the frustration of having inadequate time to teach and support midwives. On the good days they enjoy the luxury of time to be able to have time to go to the toilet, to enjoy a meal break and be able to discuss client care without the urgency which often prevails.

### ***Beneath the ‘doing’***

The coordinator is seen to be ‘doing’, ‘directing’, and ‘facilitating’ to get things done, always with the safety of the mother and baby paramount. There are occasions when she is pushed to her limit and may speak out, however the majority of her emotional work is veiled and invisible.

In Chapter One I described a coordinator colleague who had been part of my impetus to choose exploration of this phenomenon. She explained that it felt for her that she was

‘going into battle’ when she went on duty and how helpless and unsafe she felt in her role at times. The word ‘battle’ is used within this study by both Sally and Jane to describe their feelings.

This study has revealed coordinators’ daily work is about experiences of high stress where they sometimes find themselves thrown into situations which feel unsafe. They encounter situations where they want to ‘speed up’ time and other situations when they feel frustration with time lost. There are the challenges of asking colleagues for help and being declined; managing poor skill mixes of staff on duty; having inadequate staffing numbers on a shift; wanting to teach and having no time to do so; having their recommendation of a small intervention which will prevent a greater one declined; feeling unsupported and at times reaching the point of wondering how to move forward with so many barriers to overcome. Yet, in spite of this there is a sense of resilience in their capacity to manage risk.

Coordinators reveal their fortitude to manage ‘what is’, whatever their emotions may be and however they feel at any point in time. They return to work each shift with the ‘unknowing’ always present. There is a sense of breathtaking speed of action and urgency in some stories, whilst other stories reveal a sense of sheer helplessness. Yet throughout these stories, there exists an underlying level of excitement, adrenaline rush, ‘buzz’ and sense of achievement in how they manage on a regular basis.



Coordinators take their emotional work home with them; however they do not perceive this as a burden, rather it is something that happens which they put into context. Sleep is interrupted for some coordinators as they work their way through and *'make sense of'* their experiences. They reveal having found their personal ways of debriefing and destressing, which may be through physical exercise, journaling experiences or talking to someone they trust.

Yet, there is also a sense of helplessness revealed in their experiences and it is hard to accept that the relentlessness of the demands of their job has no ill effects for coordinators. They are all regularly placed in unenviable situations which are not of their making and over which they have no control. They have to take on caseloads as well as coordinating shifts with all that this role entails. There is a concerning theme of *'nobody died today'*.

It is their lived reality in this study that even when they contact a manager, ultimately it is often up to them to find an immediate solution to situations they find themselves in, whether it is leaving a woman alone who is bleeding with placenta praevia, asking a husband to watch the fetal monitoring in the absence of a midwife or leaving a new LMC to manage alone because there is no one else to call on for help. The feeling that *'if one more thing comes through the door it would tip you over the edge'* is the coordinator's reality and the questions are asked: do their experiences affect them more than they currently acknowledge or realize and what happens to a coordinator if or when that does occur?

### **Relationships between this and other studies**

Within this section of writing I will attempt to show how this study relates to other studies.

In the absence of research on midwife coordinators, the findings of Goldblatt et al.,(2008) who researched the experiences of hospital ward nurse shift leaders was the only comparable study. Their study revealed themes which identified nurse shift leader's concerns for their personal emotional wellbeing as a result of their work experiences. Coordinators in this study reveal their focus is on the provision of the best possible delivery of care for mothers and babies, with a strong concern revealed for their professional colleagues and an equally strong objective for provision of midwifery focused care during their shifts. The question of their personal emotional wellbeing was left unsaid.

Smythe's (2000) research on 'being safe in childbirth' is reflected in this study with coordinators revealing their understanding and management of the 'unknownness' and unpredictability of midwifery work. The research by Earl (2004) and McAra - Couper (2007) combined with conference presentations by Isa, et al. (2002) and McAra – Couper et al. (2004) offer practical, honest observations and experiences of New Zealand midwives who work in secondary care delivery suite workplaces. These hospital midwives are working 'under' the influences of institutional constraints in their hospital settings whilst maintaining their strong desire to offer midwifery focused care and

solutions – which offers resonance within my study. This is especially so in relation to the coordinators in my study who reveal their desire to provide midwifery focused solutions for women in the tertiary setting. Just as Irene remarks '*I am not 'just' a midwife, I am a midwife and that is my expertise*', so Earl, who has a background working as an 'acting charge midwife', remarks "just because I work in a hospital does not mean that I don't have a midwifery focus or that I am medicalised" (Isa et al, 2002, p. 41).

Skinner (2005) writes that the hospital midwife "might sit" on the seat of a birth stool which represents "the demands of the institution" (p.261). The challenges for midwives finding they were working 'with institution' rather than 'with women' has also been researched by Hunter (2005). Within my study, the demands of the institution were very real for the coordinator midwives; however they remained focused on the mother and baby's journey and their wellbeing. Perhaps they also recognised the challenge for an institution to plan ahead for the unknown busyness of any particular shift.

Research is available regarding supporting the emotional wellbeing of midwives (Weil, 2008; Lennox, Skinner & Foureur, 2008; Smythe & Young, 2008). Coordinators do not explicitly refer to their needs for professional support in my study. Nevertheless, it would seem that there is a call within this study for strategies to support coordinators.

The coordinators' concealment of their true feelings revealed in my study reflects the research by John and Parsons (2006) and Hunter (2001; 2004; 2005). Coordinators spent

minimal time during their interviews addressing what it feels like when they hide their emotions, and how they manage when they leave their workplaces. Instead, each coordinator chose to look ‘outwards’ with her focus on the wellbeing of women rather than ‘inwards’ on herself. The long term repercussions for coordinators who conceal their emotions are unknown.

The coordinators’ passion for midwifery focused care is very real in my study, reflecting Davies’ (2007) text with its focus on midwives passion for providing woman centered, midwifery focused care in their workplaces. The constraints described by Walsh (2007) are evident in the stories of coordinators in my study and reveal their constant ‘juggling acts’ as they try to maintain safe care and midwifery focused care within their medicalised institutionalized workplaces.

The work of Smythe et al., (2009) and also Edwards (2004) on intuition and ‘knowing’ bears great relevance to my study. Coordinators reveal their preparedness and courage to utilize all their midwifery ‘knowing’ to achieve the outcomes they believe in within the stories they share.

The leadership skills of coordinators in my study reflected the findings in texts by Malloch and Porter - O’Grady (2005), Kouzes and Posner (1995) and Smythe and Norton (2007). Coordinators revealed they were unafraid to speak out, to advocate for women, to challenge decisions, to empower colleagues, to play their roles of leadership as they concealed their true feelings and to draw the strands of situations together for

cohesiveness and teamwork. Alice sums this up well when she comments '*it's how you present yourself when you walk into a room*'.

It is not known, whether the combination of coordinators' leadership skills and confidence in their midwifery knowledge is perhaps the basis of their levels of resilience, or is it their work life balance or perhaps their particular personality types? Literature is available regarding the stress levels midwives experience at work in the hospital setting (Wells, 2003), but nothing was sourced in relation to their resilience in the current worldwide climate of shortages of midwives and how they 'keep going'. The question is asked: is there a breaking point and what is the potential future cost to that coordinator who has a life beyond her workplace?

Above all, the partnership model of midwifery care in New Zealand (Guilliland & Pairman, 1994) is reflected in the spoken and unspoken actions of coordinators in this study which poses the question whether it is this partnership concept of care with women which provides coordinators with their strength and mandate to role model sound midwifery practice within their medicalised, institutionalized work settings?

### **Recommendations to the profession for practice, education and research**

The experiences of the coordinator midwives participating in this study clearly reveal they are senior practitioners with an expert level of clinical tertiary hospital midwifery skills. They hold an understanding about normal birth, a commitment to woman focused

care and insight into aspects of provision of LMC midwifery care within the tertiary hospital setting. In addition they understand and apply their knowledge to the associated legislative requirements; they also show they possess strong leadership skills, expert communication skills, wise decision making and apparently strong levels of resilience.

Especially with the current national midwifery staffing shortage, the position of coordinator midwife should hold kudos. It needs to be a sought after position interested midwives can strive to be appointed to for their career advancement and which accords appropriate financial remuneration.

Two of the three tertiary hospitals where these coordinators are employed have specific job descriptions attached to the coordinator's role with managerial level salaries.

Questions are unasked and unanswered in this study regarding midwives working at the tertiary hospital where midwives are allocated the role of coordinator with no formal job description or appointment to this position. How do these midwives feel? What preparation do they receive when they are allocated this level of responsibility and how do they manage the added responsibilities when they are thrown into situations of coordinating which may not be of their choosing, where their responsibilities are significant and where their pay is that of a staff midwife? New Zealand is a small country where consistency between District Health Boards with regard to midwifery appointments requires consideration. This requires further research.

There is a career pathway for DHB midwives – the Quality Leadership Programme (QLP), with its highest level of attainment entitled ‘Leadership Midwife’. The leadership role of the coordinator midwife is shown in this study to be multi-faceted and complex. It is unknown whether midwifery managers link the QLP professional development programme as a pathway to midwives becoming coordinators and whether this pathway prepares midwives for the diversity and complexity of skills required to become a coordinator midwife. Anecdotally coordinators have told me theirs is a role ‘you learn on the job’.

Coordinators clearly highlight their lack of time to teach colleagues and express their concerns regarding skill mixes during shifts. Midwives are required to complete comprehensive education in line with Midwifery Council of New Zealand Annual Practising Certificate requirements, however the complexity of tertiary hospital midwifery care, the lack of time and the current limited funding to specifically address education in the provision of complex tertiary midwifery care requires acknowledgement at DHB, NZCOM, Midwifery Council of New Zealand, New Zealand Nurses Organization (NZNO), Midwifery Employer Representation and Advisory Service (MERAS), and government levels.

Auckland University of Technology (AUT) offers a ‘complex care’ paper in partnership with National Women’s Hospital (Complex Care Course, 2008). This is an exciting and significant step forward in recognition of the knowledge and clinical skills tertiary

hospital midwives require to complement their provision of safe, high standard midwifery care in their workplaces.

The allocation of Central Training Agency (CTA) funding for midwives who are accepted for this course will make this a more realistic and attractive career pathway for tertiary hospital midwives. CTA funding will be available to the DHB employer when tutorials or clinical placements for participating midwives preclude them working their rostered shifts. This funding also provides financial support to the midwives including costs of fees, travel and accommodation. The question is asked however, with the current midwifery staffing acuity challenges in the tertiary sector, whether or not there are enough midwives to cover rosters whilst senior midwives undertake this course. ‘Short term pain for long term gain’ will be a necessary consideration by District Health Board managers who decide to support midwives who want to enroll for this course and do not live in Auckland.

Close monitoring of the advantages of this course for participants, for mothers and babies in the tertiary setting and for DHBs who will have staff appropriately trained to work in complex midwifery care situations will provide a strong baseline from which to further develop robust tertiary specific complex midwifery education for New Zealand midwives in the future.

In the long term, it is hoped this ‘complex care’ postgraduate paper will attract midwives working in the tertiary sector who want to extend their knowledge and skill base. This



will enhance tertiary level clinical midwifery practice and has the potential to support coordinators in their leadership role.

Midwives who complete this course may choose to remain as highly skilled midwives who specialize in complex midwifery care working 'on the floor'. Alternatively, it will provide a career pathway for midwives to become coordinators with inclusion of team leadership training as a component of the course and compulsory attendance at a 'Practical Obstetric Multi- Professional Training' course (Draycott, Winter, Croft & Barnfield, 2006). It is asked however, why should a midwife work towards becoming a coordinator if there is no financial recognition or status accorded to this highly demanding position?

The Safe Staffing / Healthy Workplaces Unit (2006), and Maternity Action Plan members (Ministry of Health, 2008) need to urgently address why midwives leave their employment in the tertiary sector. Robert Hipkiss, Information Analyst for the Ministry of Health (e mail communication, 20 February, 2009), advises "unfortunately there is no exit survey that would capture this data" in relation to my request for statistical information regarding reasons why midwives leave the tertiary sector. As recently as February 2009, Kate Weston, professional nursing adviser to the NZNO refers to the experiences of DHB midwives working in situations "at best frustrating and at worst affecting the quality of care and creating burnout among staff" (Kai Tiaki, 2009, p.20). Tertiary hospital managers need to consider automatic exit interviews with a guarantee of anonymity for participating midwives.

To understand why midwives leave the tertiary sector will support managerial employment strategies aimed at retention of staff. In turn, such an initiative will support coordinators who are currently faced with inadequate numbers of midwives to call upon during their shifts. This will potentially alleviate the feelings of desperation revealed in this study. If DHBs purposefully monitor why midwives leave their employment, there is potential to identify trends and effect change. It is possible that the consequences of midwives leaving tertiary hospital employment becomes the invisible price coordinators pay for the demands they reveal they experience in their workplaces; this requires further research.

The experiences shared in this study indicate more in-depth research on the resilience of coordinator midwives in tertiary hospital delivery suite settings is warranted. The coordinators in this study all revealed their personal levels of resilience but is their resilience sustainable given the pressures they are working under and over which they have no control? A longitudinal research study would offer insight into this question.

Recent articles and research (Smythe & Young, 2008; Weil, 2008) suggest consideration of professional supervision for midwives warrants consideration by DHBs. The experiences revealed in this study indicate further research will also be relevant to this subject.

The stories shared by coordinators in this study reveal ‘grey areas’ within their experiences which pose more questions than answers. For example, do tertiary hospital coordinator midwives’ experiences within this study reflect the repercussions of worldwide midwifery workforce issues? Will consensus between District Health Board midwifery managers and LMC’s regarding the New Zealand College of Midwives transfer guidelines from primary to secondary care for women (New Zealand College of Midwives, 2008) reduce tensions revealed in this study? Further research is required to address these questions. It is important to remember this study interprets the experiences of just five coordinator midwives and findings cannot be generalized. Harman (2007) writes that ‘time’ will reveal an answer with its “unveiling and motility” (p.29).

One of my objectives when I commenced this study was to ‘give a voice’ to coordinator midwives. From an education perspective, it would be helpful for LMC midwives, DHB managers, midwives, tertiary hospital medical staff, ancillary staff and midwifery students to be aware of the contents of this study to increase their understanding of the daily realities coordinator midwives may encounter.

This study has revealed openings for further research which have been identified and it is my hope my study will lead to an increased awareness and understanding of coordinators circumstances which will foster investment in staff development, appropriate remuneration and attention to personal wellbeing.

### **Limitations to this study**

This appears to be the first study completed on the experiences of coordinator midwives in the tertiary hospital delivery suite setting. It became evident at an early stage in this study that the stories these five coordinators shared were so rich, that from the phenomenological perspective no further participants were required. As a consequence, this study is limited by its small number of participants and the findings which are non transferable.

Phenomenological methodology was my attempt to provide a baseline from which researchers may choose to explore different aspects of coordinators' experiences in the future. It is one of many methodologies which could have been used but it was the most appropriate for me as I was interested in using an interpretive approach which would assist me in my understanding of coordinators' experiences.

Other methodologies offer different scopes for research of this topic. For example, grounded theory could be used to encompass a larger sample of coordinators to develop a theory regarding coordinators' experiences. Aspects of research from the feminist perspective could potentially reveal gender issues for coordinators in their workplace and inequity in working conditions; alternatively participatory research could be utilized to empower coordinators to improve their working conditions.

This research offers no insight into the experiences of coordinator midwives in relation to their ethnicity. I was reliant on the voluntary response of coordinator midwives to contact me if they were interested in participating in this research. They did not reveal aspects of their ethnicity or their cultural mores during their interviews and I did not ask for this information. Maori perspectives were not revealed by participants in this study and experiences of Maori coordinator midwives are unknown.

Participants were from the upper North Island of New Zealand. It is acknowledged this study is therefore limited by its geographical location.

My personal limitation with this study was how deep to search for meaning and when to stop in accordance with requirements for a master's thesis, because the questions this study raises are compelling for me. Everything revealed in this study has arisen from these five midwives. Despite the findings being non transferable, there is a sense that the stories may also reflect the experience of others.

Given the worldwide shortage of midwives (Maternity Action Plan, 2008), the “genuine skill shortage” of midwives in New Zealand (Department of Labour, 2006, p.2), the increase in technology in childbirth (Symon, 2006) and the increasing national birth rate (Ministry of Health, 2008), despite the limitations of this study, I hope it may contribute to positive changes for tertiary hospital coordinator midwives.

## **Conclusion**

Heidegger (1927/1962) and van Manen (1990) have been my constant companions and guides along this journey. This study reveals that the everyday appearance of the coordinator midwives, as they go about their daily work, is not necessarily what really 'is'. How these women may appear to others and what is really at the core of their being may be very different. These amazing women are each enmeshed within their unique lifeworlds with a commonality that 'being' a midwife is the 'essence' of who they are.

Van Manen (1990) explains it is our sense of purpose in life which sustains us. Being a midwife is the springboard from which these women leap. Coordinator midwives choose to work in the tertiary setting where many 'grey areas' have been identified yet their passion abides to maintain a strong, safe midwifery focus for the mothers and babies who are central to their care.

The focus of this study is their experiences as coordinator midwives in the tertiary delivery suite setting, however, it must be remembered these women also have a life apart which makes up their 'sum total' and contributes to who they are, how they respond to situations and perhaps, why they are so resilient.

Their relationality shines through in this study. They reveal their ability to work alongside people, to work ahead of time and to project themselves into worlds of unknown possibilities over which they may have little or no control, yet they return to

work shift after shift and reveal no indication of wanting to walk away from a job which poses immeasurable challenges.

New Zealand is a small country with its total population equating to less than one major city in other parts of the world. The midwifery workforce of New Zealand is small enough to work together to 'get it right' for tertiary hospital coordinator midwives. Midwifery research opportunities need to be encouraged, to find out how we can do things better before more midwives leave this profession.

Change can only happen with courageous leadership supported by a united midwifery workforce. The 2008 Health Workforce Annual Survey (Ministry of Health, 2008) shows 31% of midwives are currently over the age of fifty years. What will happen when these senior experienced tertiary hospital midwives retire from their profession within the current climate of midwifery staffing shortages in tertiary hospitals and high stress levels? Midwives called on to replace them may be ill prepared, due to the current lack of time for senior colleagues to pass on their expertise.

This study took place within the New Zealand context of a rising birth rate and tertiary hospital delivery suite units which are increasingly busy providing care for women who require complex care. Who will want to take on the role of a coordinator midwife in a tertiary hospital in years to come unless this situation is addressed?

To conclude, a profoundly rich ‘heart and soul’ of midwifery and a true intent to offer the best and safest of care to mothers and babies shone throughout this study. It has been a privilege to share and interpret the experiences of these five strong women whose passion is abiding despite the storms they navigate.



## GLOSSARY

**Coordinator/Charge midwife:** The coordinator/charge midwife is in charge of her shift. Midwives interviewed for this study work hold differing job titles of ‘charge midwife’ and ‘coordinator’ at their places of work.

**Lead Maternity Carer (LMC):** This is the nominated midwife, general practitioner, obstetrician specialist or hospital team who has been chosen by the woman to provide her maternity care. The time frame for LMC care is from the point of formal registration with her LMC to the point of formal discharge which is usually post partum. The LMC is legally required to refer women with identified complications during the ante natal, intra partum or post partum period in accordance with Ministry of Health legislation (2002). The LMC may subsequently continue to provide care for the woman in partnership with secondary care services or be required to hand over the care to secondary care obstetric and midwifery care when she may thereafter choose to remain with the woman in a ‘support’ capacity. Within the stories in my study, LMCs are registered midwives.

**District Health Board (DHB):** There are 21 DHBs in New Zealand. District Health Boards hold statutory obligations which include improving, promoting and protecting the health of their communities, promoting the integration of health services, in particular primary and secondary health services and promoting disability support and personal care services (Ministry of Health, 2008).

**DHB Midwife/Core midwife:** The DHB (District Health Board) midwife/core midwife is employed by a District Health Board to provide midwifery care within a DHB hospital facility or the community setting. In the delivery suite setting the DHB midwife provides midwifery care in accordance with legislated requirements to women who have an LMC, which

may be an LMC obstetrician, an LMC midwife or an LMC General Practitioner. Women who have not registered with an LMC and who have received little or no antenatal care receive DHB midwife/core midwifery care when they present at a DHB hospital. DHBs employ midwives who specifically offer LMC hospital team midwifery care to women. DHB midwives/core midwives also provide midwifery care to women whose conditions require handover of care to secondary services in accordance with Section 88 referral guidelines (Ministry of Health, 2002, p. 31-36).

**Tertiary Hospital:** There are six tertiary hospital facilities in New Zealand with three in the upper North Island where this study is focused. These facilities provide intensive care facilities for women and babies in addition to the provision of secondary care and are referred to as Level 3 units.

**Secondary Hospital Care:** There are 18 secondary care hospitals in New Zealand which provide limited specialist maternity and neonatal care and are referred to as Level 2 units.

**Primary Hospital Care:** There are both DHB and privately owned primary care birthing facilities in New Zealand where woman who are identified as 'low risk' may choose to birth with the anticipation of the normal birth of a well neonate. These are referred to as Level 1 units.

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## APPENDIX A

### Participant information sheet

Date Information Sheet Produced:

10 November 2007

<p><b>Participant Information sheet</b></p>	 <p><b>AUT</b> UNIVERSITY TE WĀNANGA ARONUI O TAMAKI MAKAU RAU</p>
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#### Project Title

Midwives experiences working as coordinators/charge midwives in tertiary hospital delivery suite settings: A phenomenological study.

#### An Invitation

My name is Lindsay Fergusson. I am employed as a Midwife/Nurse Educator and work from an office based on the delivery suite of a tertiary hospital. Thank you for responding to this invitation which invites you to participate in this research study which will contribute to my thesis for a Master of Health Science at Auckland University of Technology. Please read this information sheet and if you think you would like to take part in this study, I can be contacted by E Mail: [wade.lindsay @ slingshot.co.nz](mailto:wade.lindsay@slingshot.co.nz). Your participation would be voluntary and you would be free to withdraw from the study at any point with no repercussions. If you would like to participate, please contact me within two weeks of receipt of this letter. Thank you.

#### What is the purpose of this research?

The aim of this study is to offer midwives who choose to participate in this research 'a voice'. By sharing experiences encountered whilst working as coordinators/charge midwives in tertiary hospital delivery suite settings, this pivotal midwifery role will become visible to the New Zealand midwifery profession, prospective midwifery coordinators/charge midwives will gain insight into this role, District Health Board managers will gain new understandings of the lived experiences of coordinators and I anticipate,

midwifery coordinator/charge midwife participants in this research will feel empowered by their sharing.

How was I chosen for this invitation?

You have been chosen to participate in this research because you work as a coordinator / charge midwife in a tertiary hospital delivery suite in Hamilton or Auckland and have indicated a willingness to be interviewed. After reading this information sheet, if you remain willing to share your experiences I would welcome you in to this study.

What will happen in this research?

I will make contact with you and arrange to meet you at a venue of your choice. I will interview you for approximately one hour and for no longer than ninety minutes. With your consent I will tape record the interview which will then be transcribed word for word. I will send you two copies of the transcription. One will be for you to keep and the other returned to me in a pre paid courier envelope with any changes you wish to make. You may decide you wish to delete, amend or add information. I anticipate interviewing between four and eight midwives. I will be analysing the transcripts, looking for themes and interpreting information with the support of Auckland University of Technology supervisors. On the completion of this work, the thesis will consist of interpretation of themes which have emerged from the interviews and how they are understood within the contexts of human science and behaviour. Within the thesis will be theoretical information and processes relating to why I chose to study in the way I plan.

How will these discomforts and risks be alleviated?

It is possible you may find recalling difficult experiences reveal unanticipated emotions. You may feel inspired, excited, angry or distressed. You may decide retrospectively that you have shared information you later regret. You can choose what you do or do not tell me, you can have information withdrawn from the transcript, and you can withdraw from the study at any point with no repercussions. If recollection of experiences does cause you distress, I will arrange access to a free counselling session for you to discuss issues which may have resulted from the interview.

What are the benefits?

This study will enable you to share your unique experiences and perspectives. Participants often report this is an empowering opportunity. As a result of this thesis, through my interpretations of midwifery

coordinator/charge midwife experiences, your world will become visible to midwifery colleagues, managers, doctors and associated professionals who are working with

How will my privacy be protected?

Your privacy will be protected by you choosing the time and venue for the interview. A pseudonym will be assigned to your transcript. Tapes, transcripts, computer memory stick and all other information will be kept in a locked file in a locked room. On completion of the thesis my supervisor is required to keep all information in a secure place for six years after which it will be destroyed. If you choose to withdraw from the study, all information will be destroyed.

Your confidentiality is assured by my responsibility to you as a researcher, requirements of the Health and Disability Commission and Auckland University of Technology (AUT) Ethics Committees. I will employ a person to transcribe your interview and he/she will be required to sign an AUT confidentiality agreement.

What are the costs of participating in this research?

The costs are your time and your energy commitments.

What opportunity do I have to consider this invitation?

After reading this invitation, I would be delighted for you to contact me within two weeks of receipt of this invitation if you would like to participate.

How do I agree to participate in this research?

We will arrange a time and venue to meet at your convenience to conduct the interview. I will ask you to read and sign an Auckland University of Technology form entitled 'Consent to Participation in Research' prior to commencing the interview which will offer you the opportunity to clarify any issues at that point.

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, whose details are documented below.

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTECH, Madeline Banda, [madeline.banda@aut.ac.nz](mailto:madeline.banda@aut.ac.nz) , 921 9999 ext 8044.

Whom do I contact for further information about this research?

Researcher Contact Details:

Lindsay Fergusson

E Mail: [wade.lindsay@slingshot.co.nz](mailto:wade.lindsay@slingshot.co.nz)

Project Supervisor Contact Details:

Associate Professor Liz Smythe, Faculty of Health and Environmental Sciences, Auckland University of Technology.

E Mail: [Liz.smythe@aut.ac.nz](mailto:Liz.smythe@aut.ac.nz)

Phone: 09 921 9999 ext 7196

Approved by the Auckland University of Technology Ethics Committee on 28 February, 2008.

## APPENDIX B

### Consent form

<h1>Consent Form</h1> <p>For use when interviews are involved.</p>	 <p><b>AUT</b> UNIVERSITY TE WĀNANGA ARONUI O TAMAKI MAKAU RAU</p>
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*Project title:* Midwives experiences working as coordinators/charge midwives in tertiary hospital delivery suite settings: A phenomenological study.

*Project Supervisor:* Associate Professor Liz Smythe

*Researcher:* Lindsay Fergusson

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated dd mmmm yyyy.
- ☐ 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 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:

## APPENDIX C

### Confidentiality agreement

<h1>Confidentiality Agreement</h1>	 <b>AUT</b> UNIVERSITY <small>TE WĀNANGA ARONUI O TAMAKI MAKAU RAU</small>
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*For someone typing data, e.g. notes of interviews.*

*Project title:* Midwives experiences working as coordinators/charge midwives in tertiary hospital delivery suite settings: A phenomenological study.

*Project Supervisor:* Associate Professor Liz Smythe

*Researcher:* Lindsay Fergusson

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- ☐ I understand that all the material I will be asked to type is confidential.
- ☐ I understand that the contents of the notes or recordings can only be discussed with the researchers.
- ☐ I will not keep any copies of the transcripts nor allow third parties access to them while.

Typist's signature:

.....

Typist's name:

.....

Typist's Contact Details (if appropriate):

.....  
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.....  
.....

Date:

Project Supervisor's Contact Details (if appropriate):

.....  
.....