MIDWIVES WORKING IN STANDARD MATERNITY SETTINGS: AN EXPLORATION OF THEIR VIEWS ON MATERNITY REFORM

Submitted by

Bridget Roache, RN, RM, Graduate Diploma (Child Birth Education), IBCLC

A thesis submitted in fulfillment of the requirements of the degree of

Master of Science Research (Applied)

School of Nursing & Midwifery
Faculty of Health, Engineering and Sciences
University of Southern Queensland
Toowoomba, Queensland
Australia

Date of submission: 2016

ABSTRACT

Over the past two decades, Australian maternity services have been the subject of a number of state and federal inquiries, reviews and reports. As a result, midwifery practice throughout Australia has acknowledged that maternity care must change to meet the needs of women and families (Commonwealth of Australia, 1996; 1998; 1999; 2008; Hirst, 2005). As such, the Australian Health Ministers in November 2010 endorsed the National Maternity Services Plan (NMSP), which specifies four key priorities for Australian midwives (CoA, 2011). The objective of the NMSP is to provide a framework within the Australian health care system to guide the delivery of high quality, woman centred maternity care within a five-year period of 2010 to 2015.

Implementation of the key priorities in the National Maternity Services Plan are critical to contemporary midwifery practice and for strengthening and expanding women centred care. Therefore, research into exploring the views of midwives during a period of reform was viewed as essential. Consequently, case study methodology was employed to discover the level of knowledge midwives had regarding the NMSP priorities and, the perceived impact of the reforms on the way midwives provide care. Additionally, midwives included in this study were asked to explain how they perceived they would transition into providing more autonomous care to pregnant and birthing women.

Semi structured interviews were utilised to collect rich data for analysis. The results highlighted significant differences and deficiencies in participants' knowledge of the NMSP and its implications on midwifery practice. In particular, the participants who were employed in a private maternity facility had significantly less awareness of the NMSP than midwives employed in public hospitals. However, a limitation of this qualitative study was that the findings from seven midwives cannot be generalised for the national population of midwives. Findings revealed that the reforms were

perceived as an obstacle whereby the midwives claimed they would be burdened with additional responsibilities to enhance their practice. Therefore, this study concluded that registered midwives need significant, well-planned professional development to enable the transition process to autonomous, woman centred, contemporary practice.

CERTIFICATION PAGE

CERTIFICATION OF THESIS

I certify that the ideas, experimental work, results, analyses, software and conclusions reported in this Thesis are entirely my own effort, except where otherwise acknowledged. I also certify that the work is original and has not been previously submitted for any other award, except where otherwise acknowledged.

Signature of Candidate

Date 27/01/2016

ENDORSEMENT

Signature of Principal Supervisor

Date: 27/01/2016

ACKNOWLEDGEMENTS

Like every student who undertakes writing a thesis for the first time (and perhaps last time!), the learning curve is steep, challenges enormous and rewards immeasurable. Many have shared this journey with me and it is now time to acknowledge their contributions.

I acknowledge with sincere gratitude my supervisors, Associate Professors Jennifer Kelly and Jillian Brammer. To Jenny, thank you for your invaluable academic and educational support in shaping my translation skills and for being a source of motivation. To Jillian, thank you for your wisdom and superb editing skills. To the participants of this study, I am sincerely grateful for your honesty and for allowing me to share your views.

I would like to take this opportunity to thank my husband Gerard for providing a solid foundation throughout my career. Without your indulgence of my pursuits I would not have travelled this road and would not be at this point. Thank you seems inadequate.

To my children, Declan and Mairaed, I hope this thesis provides you with encouragement and motivation that it's never too late to learn and that learning is a gift not to be taken for granted.

Finally, I place on record, my gratitude to one and all who directly or indirectly lent their support in various forms in this venture.

Dedicated to my beloved parents.

The capacity to learn is a gift; the ability to learn is a skill; the willingness to learn is a choice.

Brian Herbert

TABLE OF CONTENTS

APPENDICES

TABLES

Title

TABLE OF FIGURES

Title

ABBREVIATIONS

AHMAC	Australian Health Ministers' Advisory Council
AIHW	Australian Institute of Health and Welfare
AUD	Australian dollar
BMid	Bachelor of Midwifery
BNur	Bachelor of Nursing
CoA	Commonwealth of Australia
GP	General Practitioner
Grad Dip Mid	Graduate Diploma of Midwifery
Grad Dip Psych	Graduate Diploma of Psychology
IBCLC	International Board Certified Lactation Consultant
ICM	International Confederation of Midwives
MGP	Midwifery Group Practice
NMBA	Nursing and Midwifery Board of Australia
NMOQ	Nursing and Midwifery Office Queensland
NMSP	National Maternity Services Plan
NSW	New South Wales

Post Grad Adv Mid	Post Graduate Advanced Midwifery
QLD	Queensland
UNFPA	United Nations Population Fund
VIC	Victoria
WA	Western Australia
WHO	World Health Organization

GLOSSARY OF TERMS

Autonomous	Self-governing, self-regulating: taking responsibility for one's decisions and actions (ICM, 2011).
Case study methodology	Case study is an approach to research that facilitates exploration of a phenomenon within its context using a variety of data sources (Jack & Baxter, 2008).
Caseload	A term that describes a midwife who has an agreed number of women (caseload) per year for whom she is the primary midwifery caregiver (McLachlan et al., 2012).
Contemporary midwifery practice	Care provided by a qualified and skilled midwife with the woman the central focus of care, respecting the woman's rights to make informed choices, control and culture (NMBA, 2010).
Continuity of care	The practice of ensuring that a woman knows her maternity care provider(s) and receives care from the same provider, or small group of providers, throughout pregnancy, labour, birth and the postpartum period (Commonwealth of Australia, 2011, p121).
Continuity of carer	Denotes continuity of carer as relational continuity or "one-to-one care" provided by the same named caregiver being involved throughout the period of care even when others are required (Australian Institute of Health and Welfare, 2015).

Maternity care	Care and treatment provided in relation to pregnancy and delivery of a baby. It is influenced by the physical and psychosocial needs of the woman, the woman's entire family, and the baby. Maternity care is provided by a range of healthcare professionals (National Institute for Health and Care Excellence, 2015, p38).
Midwife	A person who has successfully completed a midwifery education program that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title "midwife"; and who demonstrates competency in the practice of midwifery (ICM, 2011).
Midwifery group practice (MGP)	A number of midwives working in caseload practice who organise themselves into a group or an agreed working arrangement. There is no ideal number of midwives in a group practice. Midwives may organise themselves in partnerships or small groups within a larger MGP, or a service may have a number of small MGPs (Ministry of Health, 2012).
Midwifery-led care	Maternity care provided in a range of settings by a team of professionals that is led by a midwife or a team of midwives. (CoA, 2011, p122).

Model of care	Multifaceted concept, which broadly defines the way health services are delivered (Queensland Health, 2000).
NVivo 10	Computerised software program used in qualitative research that assists in the management of data.
Primary care midwives	Midwives providing care as the first point of contact through pregnancy, labour, birth and in the postpartum period. The midwife works in partnership with the woman and oversees investigations and refers in appropriate circumstances (Ministry of Health, 2012).
Standard maternity setting	Standard care with rostered midwives in discrete wards or clinics (Tracy et al., 2013).
Skype	An application for communication with other people over the internet using video or voice calls (Cambridge Dictionaries Online, 2016).
Woman centred care	Care focusing on the woman's individual needs, expectations across antenatal, intrapartum and birth and postnatal periods. Care that respects the woman's right to self-determination, right to make choices about her own care and carer, incorporating social, emotional, physical, psychological, spiritual and cultural needs (Ministry of Health, 2012).

CHAPTER ONE
INTRODUCTION

Introduction to the Research

Birthing is a significant life event for many women. Ideally, paralleled to a woman birthing is a birth attendant who places the woman at the centre of the experience. The role of the birth attendant includes being woman centred whereby the woman is supported physically, emotionally and spiritually according to the woman's belief system. Pivotal to woman centred care is the provision of an environment in which the woman's ideology is respected and the practitioner is competent and appropriately qualified to support women and their families. This thesis will explore the views of a small group of Australian midwives surrounding the changes to maternity services recommended and outlined by the National Maternity Services Plan (Commonwealth of Australia [CoA], 2011). The role and practice of midwives are critical to the successful implementation of the National Maternity Services Plan (NMSP). As such, the views and insights of current, practicing midwives regarding the proposed changes and anticipated organisational support required during the transition process is, at present, unknown. Further, the views of midwives in relation to maternity reforms are significant as findings may reveal the preparedness of midwives to provide woman centred care.

Women have the right to access appropriately skilled, high quality care by midwives during the life changing yet normal event of childbirth (Australian Commission on Safety and Quality in Health Care, 2010; International Confederation of Midwives [ICM], 2011; ICM, 2013; Nursing and Midwifery Board of Australia [NMBA], 2010; United Nations Population Fund [UNFPA], 2014). Currently in Australia, pregnancy is not always considered within a wellness

framework. Pregnant women can be offered care by a number of health professionals across the pregnancy, labour and birth and postnatal spectrum resulting in mixed physical and emotional outcomes (Hirst, 2005). Introduction of midwifery continuity of care models provide women with choices regarding carers and the parameters of care reflective of the rights of women to self-determination (CoA, 2011). Evidence supports that the qualities of midwifery continuity of care models are reliant on midwives identifying strategies that facilitate autonomous practice (Hartz, White et al., 2012; Homer et al., 2009; Wright, Cloonan, Leonhardy, & Wright, 2005).

Australian midwives and maternity services are slowly reviewing the National Maternity Services Plan (NMSP) priorities endorsed by the Australian Health Ministers (CoA, 2011) in November 2010. The objective of the NMSP is to provide a framework within the Australian health care system to guide the delivery of high quality, woman-focused maternity care within a five-year period of 2010 to 2015. The four key priority areas identified in the NMSP include: (i) greater access to maternity services for Australian women including families in rural and remote areas; (ii) provision of information about and delivery of a range of models of care by various providers including midwives, General Practitioners (GPs) and obstetricians; (iii) delivering high quality service in particular to Aboriginal and Torres Strait Islander people and vulnerable populations; and (iv) development of an infrastructure of quality and safety to support this new maternity care service ensuring a sustainable quality-driven, multidisciplinary workforce. One aspect of the NMSP recommends that the provision of midwifery services be transitioned from standard, hospital-based maternity care to a more autonomous, holistic, woman centred relationship with pregnant women and their families. The priorities of the

NMSP advocate and reflect the need for change in line with consumer demand, equitable service provision and workforce efficiency.

The focus of this study is to explore the views of midwives working in standard maternity settings during a period of reform aligned with the priorities highlighted in the NMSP. Identification of the views of midwives currently employed in maternity settings provides an opportunity to identify anomalies in organisations and education structures and programs that require alignment with the NMSP priorities. Hospital and governmental systems will require significant changes and adjustments to accommodate the delivery of maternity services recommended by the NMSP. These adjustments will necessitate significant changes to current maternity care delivery, midwifery culture and practice. Midwifery practice will move to a more autonomous, inclusive and respectful paradigm whereby pregnant women are equal and central to the midwife-woman relationship. Transitioning from standard maternity care to a more contemporary service will mean changes and challenges to the culture of midwifery practice. For instance, professional relationships and demands between midwives, medical officers and women may be challenged by the introduction of midwifery models of care.

Today, midwifery continuity of care models vary in terms of configurations and structures, also continuity models of care are used in a limited number of settings in Australia. The number of eligible midwives and midwives with prescribing schedules in Australian states and territories is highest in Queensland. In 2013 there were 6,610 midwives practicing in Queensland, seventy one of these midwives were Medicare eligible and seven held prescribing schedules (Nursing and Midwifery Office Queensland [NMOQ], 2013), indicating a significant deficit in numbers of midwives who hold a skill set that contributes to full scope of midwifery practice. At

the time of retrieving the above data from NMOQ, the number of midwives in Queensland with Medicare credentialing accreditation equaled the combined total of midwives in other states and territories with Medicare eligibility. Although it is important to acknowledge that some midwives are embracing the transition to midwifery continuity models of care, there exists a significant number of midwives who are disengaged and even resistant to practicing autonomously, in accordance to the full scope of midwifery practice (Brown & Dietsch, 2013; Hartz, White et al., 2012; Sullivan, Lock & Homer, 2011).

The hesitancy of midwives to move from standard maternity care to autonomous practice may be attributed to the historical emergence of midwifery in Australia. Historically, midwifery practice was based on a nursing care model that is reflective of the majority of maternity services being delivered through hospital-based systems. As a result, in the past and today, women are exposed to a number of health professionals across the pregnancy, labour and birth and postnatal journey. Exposure to multiple systems and people often results in a fragmented and uncoordinated experience (CoA, 2011). This fragmented care has evolved over time based on an infrastructure within hospitals, supported by state and national health policies that reflect a medical ideology rather than a woman centred, multiprofessional philosophy (CoA, 2011). Consequently, women have experienced high intervention rates such as caesarean section rates resulting in financial stress on the national health care system in addition to maternal morbidity for women (CoA, 2009).

The proposed new approach to maternity service as identified in the NMSP is a significant contrast to current standard hospital maternity service provision (Australian Health Ministers' Advisory Council [AHMAC], 2008). Revision of

current maternity services favours midwife-woman partnerships focusing on continuity of care models, in particular caseload midwifery models (CoA, 2011). Caseload midwifery can be defined as a "one-to-one or continuity of care model whereby each midwife has a *caseload* of women for whom she is the first point of reference, through pregnancy, labour and birth and the postnatal period" (AHMAC, 2008, p 17). The NMSP recommends changes to midwifery practice surrounding the infrastructure within private and public hospitals including the opportunity for midwives to work autonomously in a hospital-based midwifery model of care and / or in a private practice midwifery model of care. Overall, midwives are more inclined to achieve greater autonomy and satisfaction in continuity models of care (Walsh & Devane, 2012). This view supports the aim and purpose of this study, which is to explore the views of midwives during a period of reform through a case study method.

Purpose of the Research

The purpose of this research is to explore the views, knowledge and preparedness of midwives in relation to the priorities of the NMSP. Findings from this research could provide evidence for institutions and governmental leaders to guide and effectively manage change within organisations and the profession. The findings of this study could also inform education providers and influence the design of postgraduate programs and continue to provide essential and contemporary content for undergraduate programs. For instance, programs could expand the focus on the significance of the supportive role of midwives and the importance of autonomous midwifery practice according to the NMSP priorities. Furthermore, this

research could assist in promoting a universal midwifery culture to enhance and consolidate the professional status of midwives.

Significance of the Study

The key significance of this study is to explore and identify midwives' views, knowledge and preparedness to transition to contemporary midwifery practice. Further, this research is significant as findings and insights can be shared with education providers to enhance midwifery education programs. Findings could be incorporated into education programs in health care settings to further develop and capacity-build currently practicing midwives. This study is also significant because of the scope it provides to build and promote a contemporary midwifery culture that consolidates the professional status and reputation of midwives to benefit childbearing women.

Finally, the significance of this study is to gather evidence surrounding the experiences of a group of midwives working in standard maternity settings during a period of national reform. This study aims to contribute to the existing body of midwifery research and to identify preparedness of midwives for reforms, by identifying strengths and gaps in midwifery practice to enhance the transition process for midwives to autonomous, holistic midwifery practice. Finally, this study is significant because it has the potential to contribute to and promote further research in this area.

Outline of the Thesis

This thesis consists of five chapters. Chapter 1 provides an Introduction and brief account of the current status of midwifery in Australia and discusses the aims

and purpose for exploring the views of midwives surrounding the NMSP reforms. Chapter 2, the Review of Literature, provides an examination of the literature surrounding the historical background of midwifery in Australia and outlines factors that have and continue to influence and impact midwifery and the midwifery profession in Australia.

Chapter 3, the Design of the Study, details the methodological approach to be employed to explore midwives' views of the impending reforms. This research will use case study methods including semi-structured questions during an interview to explore the views of midwives working in standard maternity settings during a period of reform. Chapter 4 presents the Data and Analysis of Findings. This chapter will outline and describe the categories and subcategories that emerge following descriptive analysis. The final chapter, Chapter 5, titled Discussion and Conclusion will discuss key findings and present recommendations for future practice, research and limitations of this study. From the outset of considering the scope of this study, it was apparent that there is little to no evidence that specifically addresses midwives' views of impending NMSP reforms in Australia.

CHAPTER 2
REVIEW OF LITERATURE

Introduction

This chapter explores the literature surrounding midwifery in Australia and factors directly related to introducing priorities identified in the National Maternity Services Plan (NMSP). Literature presented in this chapter includes outcomes and findings from systematic reviews, randomized controlled trials, grounded theory and phenomenology studies. The search strategies utilised electronic databases including but not restricted to CINAHL, PubMED, Cochrane Library, ScienceDirect, Scopus, Web of Science and Wiley Online Library. Some search terms used were midwifery, models of care, continuity of care, maternity reform and midwife. Articles were predominately dated from 2010 to 2015 and originated from Australia, New Zealand, Britain, China, Sweden, Ireland and the Netherlands.

Exploration of the literature provides a deeper understanding of the current state of maternity services and the roles midwives play as service providers. Furthermore, exploration of the current state of practice and culture within the midwifery profession as influenced by historical events and subsequent midwifery culture will be presented in this literature review. The literature presented will discuss the implications associated with the provision of midwifery continuity of care in relation to contemporary midwifery practice and professional identity. Finally, complexities such as relationships between users and service providers of maternity services will be examined. Exploration of relationships is critical in order to identify factors that could impact on change necessary for successful implementation the NMSP.

Historical Perspective

Exploring the historical perspective of midwifery in Australia will facilitate an understanding of current midwifery practice and the development of the NMSP. The level of anticipated change for midwives that align with the NMSP involves the provision of new maternity care services that differ greatly from the historical approach of service users and providers (CoA, 2011). The historical perspective of midwifery provides clarity as to why the introduction of the proposed reforms will require strategic planning and future changes.

Historically, and until the early twenty first century, midwifery practice reflected a nursing model of care that included processes and governance structures and limited the evolution of a full scope for midwifery (Monk, Tracy, Foureur, & Barclay, 2013). The nursing profession in Australia developed an alliance with the medical profession to discount midwifery as a discrete profession by incorporating midwifery within nursing and expanding nursing's occupational domain (Fahy, 2007). Autonomy of midwives and their ability to independently care for women in a wellness model was disregarded or not well understood in the early 1900's (Davis, 2003). Incorporation of lay midwives in hospitals and in nursing roles was legislated in Queensland in 1911and supported at a national level which created powerlessness throughout the midwifery profession (Davis, 2003).

Over a decade ago, limitations imposed on midwives and midwifery practices were explored through a neoliberal lens by Reiger (2006). Reiger claimed that limitations were also imposed on midwifery practice due to the influence of obstetricians surrounding childbirth and funding. For instance, health care rebates were limited to obstetric services for childbirth. Consequently, politically sanctioned financial control reinforced the presence of obstetricians at births in preference to

midwives. Additionally, medical dominance led to high intervention rates associated with pregnancy and birth and subsequent high financial costs to the health system and women (Reiger, 2006). The medicalisation of maternity services resulted in a fragmented relationship between midwives, doctors and women due to the constraints placed on professional midwifery practice (Grigg & Tracy, 2013; McIntyre, Frances, & Chapman, 2012).

The medicalisation of childbirth was strengthened by the centralisation of maternity services and the closure of small rural primary maternity units and the transfer of maternity services to larger, more specialised, high-risk units reinforced medical dominance (Monk et al., 2013). Over a number of years the closure of rural maternity units resulted in women birthing away from their families, home and support networks. This dislocation is both financially and emotionally detrimental to women and families. Monk et al. also found the resultant cessation of rural birthing services removed an equitable range of choices for rural and remote women and increased medical interventions where previously there was minimal intervention, further hindering the priorities of the NMSP.

The medicalisation of childbirth does not equate to normalisation of pregnancy, but rather leads to women experiencing a complex web of surveillance and monitoring (Carolan & Hodnett, 2007). Constant monitoring and medical surveillance were viewed as 'risk management' and resulted in over-treatment and in some instances, practices of extreme risk (Carolan & Hodnett, 2007; Downe, Finlayson, & Fleming, 2010). Moreover, the concept of risk management became inherent in childbirth and the need to have medical supervision at normal births was reinforced and further consolidated biomedical dominance over women and midwives. Finally, government incentives for consumers to join private health

insurance companies enabled obstetricians to further dominate and monopolise maternity care due to the rebates for services (Reiger, 2006). Therefore, childbirth adopted a biomedical discourse resulting in the scope of midwifery services having boundaries and limited models of care being available or introduced (Davis & Walker, 2010; Reiger & Lane, 2009).

Scope of Reform for Midwifery in Australia

Following a number of state and federally funded reviews of maternity services in Australia, four priority areas were identified in the NMSP to facilitate provision of more effective and woman centred maternity services (CoA, 2008; 2011). The key priority areas of the NMSP include, greater access to services for Australian women (including rural and remote families), provision of information and, providing a range of maternity models of care. The second priority is ensuring high quality service delivery in particular, to Aboriginal and Torres Strait Islander people and vulnerable populations. The third priority is to establish a workforce that is appropriately skilled and qualified to provide maternity services, including an Indigenous workforce. Finally, the fourth priority is to ensure a sustainable quality-driven, multidisciplinary workforce to meet the diverse needs of all communities and an infrastructure of quality and safety to support this new maternity care service (CoA, 2011 p 23). Therefore, midwifery continuity models of care are highlighted in the NMSP as an integral part to providing future maternity services (Australian Institute of Health and Welfare [AIHW], 2014a; CoA, 1998; 1999; 2009).

Midwifery continuity of care is a relatively new concept in the Australian maternity services environment compared to other Western countries. Midwifery continuity of care has existed for many decades most notably, in the United

Kingdom, the Netherlands and New Zealand (De Vries, Nieuwenhuijze, & Buitendijk, 2013; Grigg & Tracy, 2013; Sandal, Devane, Soltani, Hatem, & Gates, 2010). For Australian midwives, this relatively new approach to maternity service is in contrast to standard hospital maternity services that are based on a nursing practices and models whereby the care women receive is reflective of traditional infrastructures that exist in maternity hospitals (CoA, 2011; Hirst, 2005). Furthermore, there have been inadequacies at governmental levels to enable midwives to practice as autonomous practitioners including the inability to secure Medicare provider numbers and establish agreements with hospitals (CoA, 2009; 2011; Homer et al., 2009).

The underlying principles of the maternity reforms in Australia are to support a sustainable future workforce in addition to providing genuine financially viable options for pregnant women utilising maternity care services (CoA, 2011). The NMSP aims to address the high costs of interventions and associated expensive medicalisation of obstetric care (AIHW, 2014b; CoA, 2008). Presently in Australia 30.3% of women have caesarean section births with rates for women birthing in private maternity facilities as high as 40.3%. This is in excess of the recommended 15% rate for developed countries (CoA, 2008; World Health Organization [WHO], 2010; United Nations Population Fund [UNFPA], 2011; 2014). Due to the high morbidity and mortality associated with caesarean section births, the high rates in Australia places a burden on the health system and adds a financial cost to hospital resources.

However, maternity care delivered across the pregnancy continuum by a "known" midwife in midwifery continuity of care models has been shown to significantly decrease intervention rates and quantify a significant reduction in

financial costs of birthing in Australia (Tracy et al., 2013). Because of the safety and efficacy of midwifery models of care, the NMSP aims to decrease financial costs through increasing access and availability to autonomously practicing midwives throughout the pregnancy continuum and in partnership with women (CoA, 2009; Hirst, 2005; McAra-Couper et al., 2015; Newton, McLachlan, Willis, & Forster, 2014; Tracy et al., 2013).

Taxonomy of Models of Care

There are many terms or phrases and subsequent understanding of terms used to describe midwifery continuity of care (CoA, 2011; Donnolley, Butler-Henderson, Chapman & Sullivan, 2015). The range of terminology for midwifery models of care leads to confusion for midwives and women. For example, commonly used terminology includes: midwifery-led care, known midwife, one-to-one care, woman centred care, midwifery-led continuity models of care, midwifery group practice, caseload, continuity of care, continuity of carer and primary care midwives (AIHW, 2014a; Beasley, Ford, Tracy & Welsh, 2012; Beckmann, Kildea, & Gibbons, 2012; Browne & Taylor, 2014; Hartz, Foureur, & Tracy, 2012; Rawnson, 2011; Schmeid et al., 2012; Tracy, et al., 2014; 2010; Warmelink et al., 2015). As a result of having numerous terms and phrases associated with midwifery continuity of care (for women and their families), terms are often used synonymously, however they have different applications resulting in categorical challenges when defining and establishing standardised datasets for state and national reporting (AIHW, 2014a; Donnolley, Butler-Henderson, Chapman & Sullivan, 2015).

The NMSP has identified the need to increase access to a range of models of care for women across the childbearing spectrum in particular, midwifery continuity

of care models (CoA, 2011). Continuity of care has been described and defined by many authors with a variation in definitions and understanding and ultimately, service delivery (AIHW, 2014Aa; Beasley et al., 2012; Beckmann et al., 2012; Browne & Taylor, 2014; Hartz, Foureur et al., 2012; Huber & Sandall, 2009; Rawnson, 2011; Schmeid et al., 2012; Tracy, et al., 2014; 2010; Warmelink et al., 2015). The lack of consistency in terminology and understanding of roles is not restricted to Australia. A study of Chinese midwives' views of a proposed midwifery-led birth unit, identified a lack of conceptual analysis by the midwives of their roles in relation to collaboration and conflict with other professions, misuse of problem solving in clinically complex situations, differences with approaches to continuity of care and a discord in responsibilities (Cheung, Mander, Wang, Fu, & Zu, 2009).

Caseload is a term frequently used synonymously with the provision of continuity of care (Dawson, Newton, Forster, & McLachlan, 2015; Donald, Smythe, & McAra-Couper, 2015; Edmondson & Walker, 2014; Rawnson, 2011; Tracy et al., 2013). However, in contrast, there are studies that refer to caseload as the number of women a midwife cares for rather than identifying the philosophical ideology underpinning the provision of midwifery care (Beasley et al., 2012; Gilkison et al., 2015; Warmelink et al., 2015; Williams, Lago, Lainchbury, & Eager, 2010). Similarly, midwifery group practice (MGP) is used to describe a method of providing continuity of care as opposed to the number of midwives practicing within a group arrangement (Beasley et al., 2012; Beckmann et al., 2012; Williams et al., 2010). Further, there is confusion and inconsistency in terminology throughout the literature whereby some studies cite caseload and MGP interchangeably. Today, many researchers recognise and acknowledge the inconsistency associated with

definitions of models of care and the relative confusion (CoA, 2011; Hartz, Foureur et al., 2012; Schmeid et al., 2012; Williams, et al., 2010).

In an attempt to clarify continuity of care terminology, studies have been undertaken to identify features that constitute 'continuity' (Donnolley et al., 2015; Hartz, Foureur et al., 2012; Huber & Sandall, 2009; Jenkins et al., 2014; Schmeid et al., 2012). Key aspects aligned with the term continuity of care include informational continuity, longitudinal continuity, relational continuity and management continuity (Huber & Sandall, 2009; Jenkins et al., 2014; Schmeid et al., 2012). Informational continuity is loosely described as medical or social information about the women that can be shared between care providers (Jenkins et al., 2014; Schmeid et al., 2012). Longitudinal continuity refers to care by service providers in a given location (Schmeid et al., 2012), whereas management continuity refers to services provided by several providers, such as the case management of complex care (Jenkins et al., 2014). Finally, relational continuity describes the relationship between woman and the care provider characterized by interpersonal trust and responsibility (Aune, Dahlberg, & Ingebrigtsen, 2012; Huber & Sandall, 2009; Jenkins et al., 2014; Schmeid et al., 2012).

Despite attempts to clarify and standardise terminology used in providing midwifery continuity of care for women, there remains ambiguity and consistency not only in terminology but also in models of care that purport to deliver the same style of care (Beasley et al., 2012; Hartz, Foureur et al., 2012; Warmelink et al., 2015; Williams, et al., 2010). In an attempt to develop a classification system for continuity of care models AIHW is conducting a national project to classify and standardise models of care (AIHW, 2014). The aim of the project is to standardise terminology to enhance the quality of indicators for data collection, analysis and

reporting of continuity of care models at a local, state, territory and national level. This standardisation of terminology will facilitate consistency in data collection and reporting, consistency in practice and provide guidelines for outcomes of future midwifery continuity of care models (AIHW, 2014). Additionally, the work being conducted by AIHW will continue to inform consistent terminology during this period of reform.

Critical Success Factors for Change

Measuring outcomes for models of care is a key indicator in evaluating the quality of care received by women who use maternity services (Collins & Draycott, 2015; Patel & Rajasingam, 2013). Additionally, there are complex determinants that impact on midwifery continuity of care models such as relationships and ideologies between midwives and other service providers, including doctors and hospital administrators (Colvin et al., 2013; Davis & Walker, 2010; Homer et al., 2009; Hunter, 2004; Reiger, 2006; Reiger & Lane, 2009; Smith, Dixon, & Page, 2009). Overall, there is significant evidence to support the need for consumers and providers of models of midwifery care, to identify and reinforce satisfactory outcomes to benefit future service provision and professional relationships (Browne & Taylor, 2014; Sandall, Soltani, Gates, Shennan, & Devane, 2013; Sutcliffe et al., 2012).

Complex professional relationships in maternity services have resulted in contested boundaries and relational disparities. For instance, practices and relationships have been plagued by conflict and mistrust between obstetricians, midwives, birthing women and hospital administrators (McIntyre, Francis, & Chapman, 2012; Sandall, 2012; Reiger & Lane, 2009). A critical discourse analysis

by McIntyre et al. (2012) identified a shift from the medical dominance of maternity care driven by consumers and midwives. However, the findings also identified a differing perception as to how collaboration on maternity services will emerge in the future. Furthermore, Reiger and Lane (2009) revealed that the lack of mutual respect between midwives and obstetricians, and the lack of trust and "professional courtesy" places a strain on workplace relations. These strained relationships signified the impact of the obstetric dominance over midwives and subsequent mistrust of obstetricians by many midwives. Additionally, there was a high level of disharmony over professional boundaries and power relations. These conflicts inhibit birthing women from having a greater access to a wide range of care models in partnership with midwives within a collaborative framework (Noseworthy, Phibbs, & Benn, 2013; Sandall et al., 2010; Walsh & Devane, 2012). As such, midwives and birthing women have been conditioned to trust the biomedical model, which has added to the complexity of relationships and inhibited change and growth (Noseworthy et al., 2013). Likewise, factors that challenged quality relationships such as miscommunication, tensions and even antagonism between obstetricians and midwives have occurred when professional boundaries have been opposed (Downe, Finlayson, & Fleming, 2010; Rieger, 2006). In Downe et al.'s (2010) research, a number of factors were identified that influenced interprofessional behaviour between doctors and midwives and created tension. For example, tense relationships became the normal pattern of behaviour between doctors and midwives and continued when the doctor became a senior staff member. Despite both disciplines striving to achieve similar positive health outcomes for women and their babies, this opposing and conflicting behaviour resulted in a number of negative outcomes

reflective of the philosophical, clinical and professional differences between midwifery and obstetrics (Lane, 2006; Skinner, & Foureur, 2010).

Positive outcomes such as a reduction in interventions during labour increased satisfaction with care by women accessing midwifery-led care rather than physician care were identified in a British study by Sutcliffe et al. (2012). A reduction in the need for interventions is considered indicative of a positive outcome for women. It was also noted in Sutcliffe's study that there were no adverse outcomes with midwifery-led care and no evidence that this care differed from physician-led care in terms of safety. This study corresponded with a systematic review by Sandall et al. (2013), which concluded that there were no identified adverse outcomes in midwifery-led models of care and found significant benefits evidenced by a reduction of epidurals with fewer episiotomies or instrumental births. Sandall et al. also found there was a greater chance of women having a spontaneous vaginal birth when being cared for by a midwife they knew. Another key point identified by Sandall et al. was that women who experienced a midwifery-led model of care were less likely to experience preterm labour or loss of a baby prior to 24 weeks gestation. However, their findings did not detect any difference in caesarean birth rates.

There was a significant difference in elective caesarean section rates before onset of labour between women in caseload care versus standard midwifery of 8% caseload compared to 11% standard care (Tracy et al., 2013). The most significant finding was the overall median cost of birth per woman was significantly lower compared to the cost of obstetric care (in favour of continuity care). There were few differences in instrumental births and epidural analgesia but less pharmacological analgesia used in the caseload care group. Generally, women who experienced

continuity of care had shorter lengths of hospital stay, fewer occasions of service in the antenatal period and fewer birth-related blood loss and higher on-discharge breastfeeding rates. In 2004-5 an estimated AUD$1,672 million was expended on maternity services during which time 30% of Australian women experienced a caesarean section (CoA, 2009). Caseload midwifery care has demonstrated a decrease in the cost of maternity care as well as providing safe and quality health outcomes (Tracy et al., 2014). Further, in Tracy et al's. 2014 cross- sectional study the cost of caseload midwifery care was AUD$1,375.45 which is less than private obstetric care (AUD$1,590.91).

Despite evidence demonstrating the quality of clinical outcomes and cost effectiveness of midwifery continuity models, there remain a significant number of midwives who are disengaged and even resistant to joining a caseload model of care (Hartz, White et al., 2012). Key reasons cited for this resistance include, fear of burnout, tension with obstetricians, lack of experience in practicing to the full scope of clinical skill and professional practice and for some midwives an imbalance between their personal and work lives (Collins, Fereday, Pincombe, Oster, & Turnbull, 2010; Gu & Zhang, 2011; Hartz, White et al., 2012; Munro, Kornelson, & Grzybowski, 2013; Reiger & Lane, 2009; Walsh & Devane, 2012; Young, 2011). Burnout impacts on staff retention and was identified across the age spectrum of midwives regardless of years of working experience and is considered an indicator for workplace dysfunction (Pugh, Twigg, Martin, & Rai, 2013; Sandall et al., 2010; Young, 2011).

Midwives' often-expressed fear of a work-life imbalance associated with midwifery continuity of care is identified as unfounded as caseload midwives manage work issues and social life (Donald, Smythe, & McAra-Couper, 2014;

Fereday & Oster, 2010; McAra-Couper et al., 2014). Fereday and Oster's (2010) quantitative study used the Maslach Burnout Inventory (MBI) and although the study was small (n=17), gave insight into innovative strategies that midwives actively engaged to facilitate work-life balance. These strategies included setting boundaries to prevent an unhealthy woman-midwife dependency. Therefore, promoting realistic expectations with women and time management skills around family life and working within service agreements were pivotal to achieving a healthy work-life balance. Achieving and managing an effective work life balance was time consuming to accomplish but worthwhile in achieving. These findings concurred with those of McAra-Couper et al. (2014) and found midwives' joy and passion for caring for women were supported further by practical measures that defined clear boundaries of reciprocity between woman and midwife.

Midwives strive to deliver high quality care to women and as such organisational support, regardless of standard care midwifery or midwifery continuity models, offers a degree of protection against burnout (Mollart, Skinner, Newing, & Foureur, 2013; Yoshida & Sandall, 2013). Furthermore, Sullivan, Lock and Homer (2011) linked staff retention with job satisfaction levels, citing midwifery relationships (with women, their families and their workplace colleagues), professional identity (pride in being with women) and the practice of midwifery (elements of the job) as incentives to remain within midwifery. Overall, midwives are more inclined to achieve great agency (autonomy) when working in continuity models of care (Walsh & Devane, 2012).

Numerous challenges are encountered by midwives during their day-to-day work life adding to the risk of burnout such as increased workloads, interpersonal relations, supporting midwifery students and new graduates, and potential for the risk

of litigation due to critical events (Colvin et al., 2013; James, 2013; McAra-Couper et al., 2014; Larsson, Aldegarmann, & Aarts, 2009; McCool, Guidera, Reale, Smith, & Koucoi, 2013; McInnes & McIntosh, 2012; Pugh et al., 2013; Van kelst, Spitz, Sermeus, & Thomson, 2013). Midwives and policy makers have identified the need to increase the skill of the midwifery workforce in order to achieve high quality midwifery continuity of care models (De Vries, Niewenhuijze, & Buitendijk, 2013; Pugh, Twigg, & Martin, 2013; Van kelst et al., 2013). The impact of the changing role of the midwife to adjust and function in new situations such as midwifery continuity of care models requires a reorganisation of midwifery responsibilities (Colvin et al., 2013; Sidebotham, Fenwick, Rath & Gamble, 2015). Colvin et al's systematic review on task-shifting in midwifery services, concluded that although focusing midwifery skills and resources is a powerful means to optimising health outcomes, the complexities and impact of change on the workforce can undermine confidence and increase stress levels for midwives. Conversely, when an organisational framework exists that promotes job satisfaction there is a more positive culture for professional development (Ouyang, Sang, & Peng, 2015; Sidebotham, et al, 2015).

Professional Identity

Of the many challenges preceding the introduction of maternity reform, two major elements that are needed to equip midwives for practicing to their full scope of practice in midwifery continuity models are, education and midwifery clinical skill development (Begley, Oboyle, Carroll, & Devane, 2007; CoA 2011; Halldorsdottir & Karlsdottir, 2011; Sullivan, Lock, & Homer, 2011; Reiger & Lane, 2009). Similarly, evidence suggests that education and skill development are the attributes

and characteristics of what constitutes the qualities of a good midwife (Dawson, Brodie, Copeland, Rumsey, & Homer, 2014; Kim, Lee, Eudey, & Dea, 2014; Renfrew et al., 2014). As illustrated in the table below, Qualities of a Good Midwife (Table 1), include fundamental elements and attributes such as education, communication skills across the organisation and between professionals and with women are essential to ensuring transparency. Further, these and other qualities are pivotal to the progression of the profession and professional development.

Table 1:
Qualities of a good midwife

Article	Research Aim	Methodology	Characteristics of a 'good' midwife
Borelli, S. (2014). What is a good midwife? Insights from the literature. *Midwifery 30*, 3 – 10.	Review literature around what is considered to be a good midwife.	Literature review	Theoretical knowledge Professional competencies Personal qualities Communication skills Moral/ethical values
Byrom, S., & Downe, S. (2010). 'She sort of shines': Midwives' accounts of 'good' midwifery and 'good' leadership. *Midwifery 26*, 126 -137	Explore midwives' accounts of the characteristics of 'good' leadership and 'good' midwifery.	Phenomenological interview study – thematic analysis	Emotional intelligence Skilled competence
Carolan, M. (2013). 'A good midwife stands out': 3rd year students' views. *Midwifery 27*, 503 – 508	Explore 3rd year students' view of a good midwife	Qualitative thematic analysis	Skilled practitioner Caring and compassionate individual Beyond the call of duty: passion and enthusiasm for midwifery
Halldorsdottir, S. & Karlsdottir, S. (2011). The primacy of the good midwife in midwifery services: an evolving theory of professionalism in midwifery. *Scandinavian Journal of Caring Sciences, 25*, 806 – 817	Explore factors that make a midwife a "good" midwife	Qualitative phenomenology, theory synthesis	Professional caring, Professional competence Professional wisdom Interpersonal competence Professional development
Nicholls, l., Skirton, H., & Webb, C. (2011). Establishing perceptions of a good midwife: A Delphi study. *British Journal of Midwifery, 19(4), 230 – 236*	To determine the qualities of a good midwife that are most valued by midwifery professionals and by potential or current service users	Delphi study (n=226)	Good midwives continue to learn throughout their careers Good midwives tailor care to women as individuals Good midwives have good communication skills

There are also generic qualities associated with midwives working in any midwifery model of care such as attitudes, knowledge development and skills of the practitioner, and integration of the practitioner into the organisation (Fahy, 2012). The qualities of midwives are essential to providing an environment of safety for women, as well as the organisational and political cooperation that is required to support and maintain the midwife-woman partnership (Lungren, 2007). Equally important to the success of implementing midwifery continuity models of care, are the professional preparation and competency of clinicians (Begley et al., 2007; Lane, 2006; Smith et al., 2010). Skill development is vital to prepare midwives for the changes and challenges of midwifery continuity of care models (Colvin et al., 2013; Van kelst et al., 2013; Walsh & Devane, 2012). Meanwhile, developing entrepreneurialism is identified as needed to manage the impact of change to complex professional and managerial aspects of providing continuity care within a business framework (Drennan et al., 2007). Finally, development of a strong sense of identity during a period of change or reform requires resilience and optimism (Colvin et al., 2013; Hunter & Seagrott, 2014; Hunter & Warren, 2014; Rigg, Schmeid, Peters, & Dahlen, 2015; Wood & Bhatnagar, 2015).

Chartering for Change

The NMSP advocates that maternity services need to reflect a more significant presence of midwifery continuity of care models (CoA, 2011). Introduction of midwifery continuity models of care will be a new approach for the users of maternity care, the providers of care, and the system that supports maternity care (Homer, 2006). There exists the need to identify attitudes, understanding and motivation when evaluating the impact of change on those who are influenced by

that change (McMurray, Chaboyer, Wallis, & Fetherston, 2010). Further, McMurray et al. argue that attitudes, understanding and impetus enable a respectful change management implementation process. Implementation, evaluation and sustainability of midwifery continuity of care models require careful monitoring of quality and safety because of the impact of widespread change to midwifery practices (Forster, Newton, McLaughlin, & Willis, 2011; McKellar, Charlick, Warland, & Birbeck, 2014). A framework that enables midwives to deliver care using new care models, with measureable outcomes, will be invaluable for future planning. Forster et al. (2011) explored four constructs of implementing caseload midwifery models. This framework included one construct that included interactional workability (shared understanding of caseload midwifery), while other constructs included relational integration (understanding of "how" caseload works), skill set workability (division of workload), and contextual integration ("fit" into the organization). Additionally, mentoring or supervising midwives into roles of responsibility within new working environments has been beneficial in New Zealand and the UK (Cox & Smythe, 2011; Gilkison et al., 2015; Henshaw, Clarke, & Long, 2013).

The relationship that the birthing environment and the ways midwives practice through continuity models of care creates neurobiological responses (release of oxytocin) in midwives that influenced the interaction and action by midwives in providing quality care for women (Hammond, Foureur, Homer, & Davis, 2013). Quality of care in this instance incorporates heightened trust, calmness and a reduction in anxiety facilitated by the release of oxytocin (Hammond et al.,). Furthermore, the hormonal response of a positive work environment can influence the midwife to develop positive relationships and provide quality care for women. In an environment of change and uncertainty, the coping mechanisms of health

professionals can have impacts resulting in a vulnerability or resilience in coping mechanisms (Wood & Bhatnagar, 2015). Resilience of midwives in coping with adversity in the workplace was explored in a qualitative descriptive study resulting in four themes that contributed to resilience such as challenges to resilience, managing and coping, self-awareness and building resilience (Hunter & Warren, 2014). The various subthemes revealed how the midwives recognised the impact such as professional practice and autonomy, in addition to workloads, risk-centred policies and relationships with colleagues compromised the quality of care they provided. Similarly, the midwives incorporated management and coping strategies that included separating their personal and professional lives. Hunter and Warren also argued that a strong sense of vocational commitment to midwifery and the powerful connection to being an autonomous individual and professional is essential to contemporary practice. Finally, building resilience through strong collegial relationships, effective role modelling of midwifery practice and mutuality and reciprocity between midwives, and midwives and women contributes to resilient behaviour (Hunter & Warren, 2014).

Conclusion

The literature presented has provided a summary of the historical influences to midwifery practice in Australia to support the need to introduce a new infrastructure through implementing the NMSP. Understanding the historical journey of Australian midwifery practice is instrumental to comprehending the need for strategic planning to enhance the implementation of reforms. Moreover, findings from related studies indicate that exploration of the period of transitioning from a familiar midwifery mode of practice such as the current standard maternity care to a

less familiar practice of an autonomous and contemporary midwifery model of care is warranted and necessary.

The challenges surrounding implementation of contemporary midwifery models of care will impact on how midwives engage, practice and interact with other users, consumers of maternity care, each other and other health professionals. Despite a high-level of evidence to support midwifery continuity models of care with respect to safety, cost effectiveness and satisfaction of staff and women, reluctance or resistance to connect with NMSP reforms may emerge within the midwifery workforce. Furthermore, the literature presented outlined that professional relationships and challenges between the key providers of maternity services, the obstetricians and midwives will be relevant to the successful emergence of autonomous midwifery practice within the hospital setting and the community.

The Commonwealth government has identified key priority areas to address the discourse and complexities involved in providing midwifery care according to the recommended reforms. However, there is a need for strategies that address the impact of change in the workplace and subsequent resilience and emotional effect of change for midwives. Australian women and families stand to achieve greater access to quality and safe maternity care through a greater range of options for care through the NMSP reforms. In summary, midwives are ideally placed to provide greater options for women when working to the full scope of midwifery professional practice. Therefore, it is important to explore the views of midwives to determine how best to enable and enhance the transition to autonomous, contemporary practice in a variety of settings as recommended by the reforms.

This chapter has highlighted the impact of complex historical events in relation to the current way that midwifery is practiced in Australia. The NMSP has

identified four priority areas that are targeted at current maternity services and subsequent midwifery practice to negate the dislocated and fragmented provision of care for pregnant women and their families. This literature review supports the need for further exploration of the impact that the NMSP priorities will have on midwives and their professional practice. The following chapter presents the research methodology and methods used to explore the views of midwives working in standard maternity settings during a period of reform. Data collection, data analysis and processes to ensure ethical management of participants and rigour are addressed in detail in Chapter Three.

CHAPTER THREE
DESIGN OF THE STUDY

This chapter describes the research methodology and methods used to explore the views of a group of midwives during a period of reform. A qualitative approach using an exploratory case study methodology was chosen to gain an understanding of the views of midwives during a period of reform. This chapter justifies the appropriateness of the method chosen for this research, the population and sampling techniques, the process for data collection and data analysis, and highlights methodological issues and limitations associated with case study research. The first section of this chapter outlines the emergence and significance of qualitative research in particular, the value of rich understanding of a phenomenon that can be gained through case study. Explanations of processes of the research will be presented.

Qualitative Research

There are two broad approaches to conducting research: qualitative and quantitative methodology. Much qualitative research is grounded in philosophy and seeks to understand phenomena from a deeper perspective, and to understand human behaviour and reasons that govern behaviour (Gray, 2009). Gray contends that quantitative research views phenomena from a larger population using survey methods to generate statistical data to answer an inquiry. Additionally, differences can be found in the overall framework, focus and emphasis of the research. For instance, quantitative research seeks to confirm hypotheses and qualitative research aims to explore phenomena through in-depth description and understanding, and may or may not generate hypotheses to be explored (Yin, 2014).

Qualitative research is the development of explanations and understanding of social phenomena through inquiry and exploration. Liamputtong (2013) asserts that qualitative research is a valid tool to use for researching the subjective experiences of people to enable the understanding people have within their own environment. Qualitative research takes place in natural settings of life and acknowledges multiple realities to present holistic accounts of the participants (Creswell, 2013). In doing so, qualitative research uses the participant's words to develop a meaningful and culturally significant understanding of phenomena from the participant's perspective. These rich explanations using the participant's own words allow the research to be directed by the emergent information rather than following a rigid process of questioning technique. This information can also provide a conceptual understanding and evidence that would not be revealed in a structured format of quantitative research using a pre-determined survey. In particular, the epistemological framework of qualitative research demonstrates a competence and integrity that is congruent with qualitative research as a valuable contributor to knowledge, primarily due to the ethics and rigour of the research (de Wit & Ploeg, 2006; Liamputtong, 2013).

In recent years, qualitative approaches have increased in popularity due to the growing discontent of quantitative research being unable to explain social science paradigms in a contextual framework (Langdridge, 2007). Qualitative research typically employs the use of words, quotes and descriptions to explore meaning, rather than use statistics (Kitto, Chesters, & Grbich, 2008). Furthermore, qualitative research is primarily concerned with data collection that enables description and interpretation of textual data. As such, data collection is generated from conversation, observation or documentation. Kitto et al. also identified that the primary goal of qualitative research is to explore the experiences, behaviour values,

processes of interaction and meaning of purposefully sampled individuals and groups in their natural setting. Therefore, qualitative research focuses on description and interpretation of phenomena in their natural settings and to make sense of the people's belief system and what this meaning brings to these settings, and it is ideal in providing insights to phenomena where little is known (Gray, 2009). A qualitative methodology provides an opportunity to understand complex and complicated issues and to uncover meanings that have significance to individuals and the wider population, which fits with understanding midwives views of the complexities of national reform (Reeves, Kuper, & Hodges, 2008).

Qualitative Research Methodologies

The underlying rationale and framework of ideas and theories associated with qualitative research determine the approach, methods and strategies to be adopted for research. For instance, qualitative researchers use a variety of approaches and procedures to gather data and achieve their aims (Creswell, 2013; Gray, 2009; Langdridge, 2007; Yin, 2009). Examples of some methodologies include ethnography, grounded theory, discourse analysis and phenomenology, among others.

Ethnography is a qualitative approach that describes and interprets an entire culture or social group (or an individual or individuals in a group) who share the same behaviours, beliefs and language based primarily on observations (Gray, 2009). Ethnographic research is conducted over a prolonged period whereby the researcher spends time in the field listening, observing and recording with the intent of learning from the group (Liamputtong, 2013). Ethnography has not been selected for this research, as the participants will be from a variety of settings to provide a snapshot of

midwives views at a given time rather than having participants from one setting and observing them over a prolonged period.

An influential and popular qualitative method is grounded theory whereby the researcher uses symbolic interactions, systematically collects and analyses data surrounding a phenomenon that explains some action, interaction or process (Gray, 2009). Analysis is continual and follows a process to enable the researcher to continually develop, explore the field and categorise themes. Through observation, making multiple visits to the field, constant comparison, identifying and grouping concepts to form categories and relationships between identified categories, a theory (or theories) begin to form. The final outcome of grounded theory is to develop a context-specific theory that is frequently explained through a diagram and hypothesis. Grounded theory was not considered suitable for this research because analysis of data at the conclusion of each interview is not considered appropriate, developing a theory is not required and it is not necessary for participants to actively make sense of the phenomena.

Discourse analysis has emerged as a preferred qualitative research methodology (Denzin & Lincoln, 2003). Denzin and Lincoln found that discourse analysis is favoured for social science inquiry because it covers a wide variety of sociolinguistic approaches. For example, this methodology encompasses language beyond the level of a sentence that seeks to find an underlying rule found in language that has a communicative function. Discourse analysis seeks to understand language as it is linked to social practices and language as a system of thought and how messages construct a social reality or view of the world for individuals (Reeves et al., 2008). Discourse analysis was not considered for this research, as a sociological perspective is not reflective of the objective of this study as the focus is to explore

specific views surrounding maternity care reforms.

Phenomenology has consistently remained a preferred method employed by qualitative researchers for decades (Liamputtong, 2013). Phenomenology is both a philosophy and a qualitative research tradition that aims to identify the meaning of lived experiences by those who live the experience (Cammarata, 2013). At this point in time, practicing midwives have not yet experienced the lived experiences of changing midwifery practices that are recommended in the NMSP. Therefore, the essence of the phenomena as experienced by a midwife cannot be explored, therefore eliminating phenomenology as an appropriate methodology of inquiry. However, this methodology would be an excellent approach after the recommended changes of the NMSP have been implemented.

Qualitative methodologies, such as case study, have specific nuances that determine the suitability and applicability of the approach for the intended research. For instance, case study approach has a strong emphasis toward social science. Moreover, case study research gained popularity due to the emphasis on sociological inquiry (Liamputtong, 2013). Case study exploration and analysis is considered a form of social science research that can lead to a rich understanding of phenomena (Yin, 2014), which led to this methodology being employed for this study.

Understanding Case Study Methodology

The philosophical underpinnings of case study research are based on a constructivist paradigm where the participant's creation of meaning equates to their reality (Baxter & Jack, 2008). Case study can be used as an education tool as well as a means to conduct qualitative research (Stake, 1995; Creswell, 2012; Liamputtong, 2013; Yin, 2014). The purpose and use of case study is often confused in relation to

the conduct of research (Liamputtong, 2013). Meaning, case study is an empirical inquiry process that poses questions and explores the "how" and 'why" of a contemporary phenomenon and is capable of generating and testing hypotheses (Baxter & Jack, 2008; Gray, 2009; Yin 2009). The focus of case study research is to gain an in-depth understanding of a particular phenomenon at a specific time through a variety of data collection approaches, to obtain a "snapshot" view from a multidimensional perspective (Baxter & Jack, 2008).

The versatility of case study methods enables the exploration of real life contexts of a phenomenon within a bounded system or "case". Additionally, case study can be utilised to conduct research into a broad and variable range of topics or units of analysis (Gray, 2009; Liamputtong, 2013; Yin, 2014). The ability to explain a range of topics is why case study is commonly used in the social sciences and practicing disciplines such as psychology, nursing, midwifery, social work, economics and anthropology (Yin, 2014). Case study methodology can provide insight into understanding and expansion of knowledge about a unit of analysis (Gray, 2009). Additionally, case study is beneficial when exploring issues where there is ambiguity and uncertainty (Gray). Overall, case studies are particularly useful to discover new behaviours or new understanding of an event where there is little knowledge or understanding (Liamputtong, 2013).

Two Case Study Schools

There are two key advocates of case study methodology who have consistently provided direction with case study research (Baxter & Jack, 2008). Stake (1995) and Yin (2009) both seek to ensure the essences of the phenomena are well explored through case study. Although Stake and Yin have similarities in their

approaches to case study research, their methods differ considerably. According to Stake (1995) the three approaches of case study depend on the purpose of inquiry. The three approaches identified by Stake include an 'instrumental case study' which provides insight to an issue, an 'intrinsic case study' which looks to a deeper understanding of phenomena and the 'collective case study' designed for multiple cases to explore given phenomena. Yin's perspective also categorises three types of case study as explanatory, exploratory and descriptive. Similarly, both advocates of case study maintain the use of a variety of guides to ensure critical examination of data is rigorous and credible (Zucker, 2009).

The planning and design of a case study are important steps that contribute to the choice of case study method (Yin, 2014). Further, Yin deems the need to follow a rigorous methodological pathway and adherence to formal and explicit procedures providing a sound foundation to explore complex issues. As such, there are four types of design, two aspects that address a holistic or embedded and another two aspects that include a single unit of analysis or multiple units of analysis (Gray, 2009; Yin, 2014).

The 'case' or unit of analysis is a key and sometimes-difficult issue to define in case study research (Creswell, 2013; Gray, 2009; Yin, 2014). The case or unit of analysis and the bounded system or systems need to be clearly defined to ensure credibility (Baxter & Jack, 2008; Yin, 2014). The unit of analysis is what the case is and what it is not (Creswell, 2013; Merriam, 2009). The unit of analysis can be a circumscribed individual or individuals (Baxter & Jack 2008; Stake 1995; Yin, 2014). A bounded system is what can be studied with respect to the unit of analysis within contextual parameters (Merriam, 2009). There may be single or multiple units of analysis that can be holistic or embedded in nature (Gray, 2009; Yin, 2014). Yin

explains that a single case is one where a single case is identified and examined. A multiple case is where multiple units of analysis are investigated. Case study methodology offers a way to examine complex social units, inextricably woven in real-life or naturalistic situations and involving a combination of many variables of importance in coming to a rich understanding of a phenomenon (Creswell, 2013; Gray, 2009; Yin, 2014).

This case study research employs a single unit of analysis approach, meaning the group of midwives form a bounded system explored as a single unit (Yin, 2014). To ensure rigour, a variety of procedures will be employed to guide data collection. In-depth interviews and a reflective journal noting participants' gestures and nuances will enable the exploration of midwives in their natural setting during a period of reform. Evidence of an audit trail or chain of evidence is provided by the ethical recruitment of participants, data collection processes, data analysis and rigour. Importantly, the views of the midwives are held by the participants and the researcher had no control over the views of midwives (Yin).

Case Study and Midwifery

Case study is highly relevant to midwifery research whereby the level of knowledge and understanding of national reforms by midwives, who are currently required to move from one model of care into a more contemporary model of care, is being explored (Gray, 2009; Hartz, White, et al., 2012). Maternity care in general and midwifery practice are undergoing complex changes in the provision of service (Hartz, White et al., 2012). Case study methodology of inquiry is relevant to explore and add clarity to a topic that is highly relevant and significant to current midwifery practice (Anthony & Jack, 2009). This research aims to contextualise the views of

midwives working within the bounded system of a standard midwifery setting during a period of maternity reform (Creswell, 2013; Gray, 2009; Liamputtong, 2013; Yin, 2014).

Some literature exists that discusses midwives' experiences of working with women in hospital systems and an increasing amount of literature illustrates midwives' experiences of working in models of care managed within a continuity of care framework (Hartz, Foureur & Tracey, 2012). Importantly, Hartz et al. (2012) found there is little investigation of views and experiences of midwives currently working in a standard midwifery care setting in relation to national reforms. This case study explores the views of midwives working in standard care settings during a period of maternity reform that is a bounded system in a natural setting. Therefore, the design and methods employed to conduct this case study are significant.

Design

When undertaking case study research diligent attention to design methods is crucial and processes must promote authenticity and remain robust throughout the course of the research (Baxter & Jack, 2008; Liamputtong, 2013; Schneider & Whitehead, 2013; Yin, 2014). Attention to the design and participant selection ensures that multiple aspects of the phenomenon have been identified and therefore, better understood (Liamputtong, 2013). For this reason, sampling, participants, ethical considerations, data collection, data analysis, credibility and rigour require explicit detail to provide a rich, multidimensional picture of the phenomenon of midwives in their natural setting (Liamputtong, 2013; Yin, 2014). The following section of this chapter outlines ethical considerations, sampling and recruitment, participant criteria and rigour to support the use of research methods consistent with

case study methodology (Yin, 2014).

Ethical Considerations

Ethical approval decrees that the intent of the research is outlined with a detailed description of the methodology and methods (Creswell, 2013; Gray, 2009; Liamputtong, 2013). Permission to recruit participants was successfully obtained from the University of Southern Queensland (USQ) Human Research Ethics Committee (HREC) (Appendix 1). Ethics approval from the private maternity facility was also obtained and confirmation forwarded to USQ's Ethics Office prior to commencement of recruitment and interviewing. Obtaining ethical approval reinforces research credibility as the process employed by HREC to gain ethics approval is meticulous and all documentation associated with the study is scrutinised.

Key ethical considerations related to this research included obtaining informed consent and maintaining participant confidentiality (Creswell, 2013; Gray, 2009; Yin, 2014). All participants were provided with an information sheet (Appendix 2) outlining the purpose and process of the research. Participants made initial contact with the researcher and following an initial discussion whereby the purpose of the research was outlined to participants and information sheets were distributed. Any queries from the participants were answered at the initial contact discussion and at other times as questions arose. Written consent (Appendix 3) was obtained from each participant prior to interviews and data collection commencing (Creswell, 2013; Gray, 2009; Liamputtong, 2013; Yin, 2014).

The consent form reinforced that midwives would volunteer to participate in the research and outlined that there was provision to exit the study at any point without repercussion. Additionally, the consent form outlined the intended use of the

data collected and, explained that their participation was confidential and identities would be protected (Creswell, 2013; Gray, 2009; Liamputtong, 2013; Yin, 2014). Finally, the consent forms are stored in a location separate to the data to ensure participant identity is not connected to data.

Participant confidentiality was a priority as disclosure of information related to this research may be viewed as sensitive as it related to the participants' knowledge and awareness of current professional issues (Creswell, 2013; Gray, 2009; Liamputtong, 2013; Yin, 2014). Participants were de-identified by the researcher and provided with a pseudonym. Only the researcher knew the true identity of the participants. No personal information was used and participants did not know the identity of other participants. Audio recordings were transcribed by the researcher and all transcripts were de-identified and coded by the researcher. In accordance with research requirements, the audio recordings and transcripts will be stored in locked cupboards for a period of 5 years and electronic information stored on a password-protected computer (Creswell, 2013; Liamputtong, 2013). The adherence to ethical considerations will be evident in the following sections whereby sampling, data collection and analysis, and research credibility are outlined.

Sampling

Purposeful sampling was deemed relevant for this case study because it involves the recruitment of small numbers of participants who are reflective of the criteria for inclusion and exclusion of this research (Liamputtong, 2013). As such, purposive sampling was an appropriate sampling method as the characteristics such as range in ages, cultures and background of the participants were present but they had not worked in continuity of care model (Liamputtong, 2013). Purposive

sampling enables crucial information to be elicited and rich data to be gathered to inform the research (Creswell, 2013; Gray, 2009; Liamputtong, 2013; Yin 2014). Purposive sampling is highly relevant because it allows for the deliberate selection of specific individuals who can supply critical and relevant information (Liamputtong, 2013). Furthermore, homogeneous sampling ensures the participants are appropriate or applicable to the research (Langdridge, 2009). The purpose of this study is to explore the views of midwives working in standard maternity settings during a period of reform. Therefore, purposive sampling was utilised to ensure participants reflected the perspective and intent of this study. Inclusion and exclusion criteria are identified in Table 2.

Table 2:
Inclusion & Exclusion Criteria

Inclusion criteria	*Exclusion criteria*
Participation in this research was open to midwives working in a standard care maternity facility. Midwife participation was dependent on working in clinical areas such as antenatal clinic, birth suite, or postnatal units.	Midwives who had worked in midwifery group practice or a 'team midwifery' model.

Recruitment of participants from public maternity facilities and a private maternity facility was deemed essential to this case study. Participants from the public sector were recruited through two advertisements in the Australian College of Midwives (ACM) e-Bulletin (Appendix 4) in July and August 2014. Additionally, a poster was used to recruit the midwives from a private maternity facility (Appendix 4). The poster was displayed in the tearoom of the maternity unit from July – August 2014. This poster provided a brief description of the research project, the aim and objectives of the research, contact details of the researcher and participants' level of

commitment. As insufficient numbers of participants were recruited from the poster invitation, the researcher attended three unit handovers to further discuss the study and promote interest to join the study.

Participants

The outcome of the recruitment process resulted in seven midwives agreeing to participate in this study. The participants had a variety of experience, qualifications, age and years of practice. Three midwives, Louise, Susan and Melissa were employed in the same private maternity facility in Brisbane, Queensland. Recruitment of participants from the public sector was reliant on the advertisement through ACM e-Bulletin. Therefore, the four midwives employed in public maternity facilities (Jane, Beth, Katrina and Kylie) were from four different states in Australia. Table 3 displays the demographic information of the midwives who agreed to participate in this study.

Table 3
Participant Demographics

Pseudonym of the Participants	**Age**	**Years practicing as a midwife**	**Midwifery Qualification**	**Nursing Qualification**	**Other**	**Additional Tertiary Qualification**
Jane Public Hospital NSW	40 – 49	3	BMid	N/A		Industrial engineer
Louise Private Hospital QLD	50 – 59	29	Hospital certificate	Hospital certificate		
Susan Private Hospital QLD	50 – 59	>20	Hospital certificate	BNur; Hospital certificate		Diploma: Community Health; Post Grad Adv Mid
Beth Public Hospital QLD	30 – 39	7	BMid	BNur	IBCLC	
Katrina Public Hospital VIC	50 – 59	30	Hospital certificate	Diploma - Nursing		
Melissa Private Hospital QLD	50 – 59	>30	Hospital certificate	Hospital certificate	IBCLC (lapsed)	Infection control; Immunisation
Kylie Public Hospital WA	50 – 59	30	Grad Dip Mid	BNur		Grad Dip Psych

In summary, of the seven participants, three midwives worked in birth suite but one of these three midwives was infrequently deployed to other areas of the maternity unit. The other two midwives were frequently deployed from birth suite to assist in other areas of maternity when birth suite was not busy. Another three midwives worked in postnatal areas. Two of the three midwives who worked in postnatal areas are employed in a public maternity facility whereby they must also work for periods of time in antenatal clinic, birth suite, and special care nursery. The remaining three midwives worked in the private maternity facility and could be deployed to special care nursery. The seventh midwife worked in an antenatal clinic. The diversity of this sample demonstrates that the sample group was working in fragmented models of care. The midwives who consented to join this study will be referred to as participants for the remainder of this thesis.

Data Collection

Participants in this research attended one face-to-face interview either in person or via Skype™. The duration of each interview was approximately 30 - 40 minutes. Following the transcribing of audio recording by the researcher, the participants were requested to read the transcript to confirm what they stated was correct. Participants were requested to read and amend their responses as necessary. Four participants responded to the researcher in relation to the return of their transcripts with no additional inclusions or exclusions to the data.

Data collection used semi-structured, open-ended, trigger questions (see Appendix 5) during the in-depth interviews with informal observation of the participants during the interview process (Yin, 2014). The objective of asking open-ended questions was to develop a rapport with the participant, promote conversation

and provide a greater depth and richness of data (Liamputtong, 2013). Additionally, semi-structured questions assisted the participant to respond freely without the formality of following rigid questions. All participants were supplied with a flowchart to outline the priorities of the NMSP prior to the interviews to establish a basic foundation of knowledge (see Appendix 6). This flowchart was then explained in more detail during the interview once existing knowledge was explored. The content of the flowchart was discussed with all participants regardless of knowledge. The content of the flowchart was discussed to provide a baseline of information and ensure consistency of information for all participants in order for them to form views where they may have been absent due to lack of information.

Interviews were conducted at a location and time of the participant's choice. Three participants were interviewed in a café and four participants were interviewed via Skype™. All interviews were digitally voice recorded to ensure capture of the entire interview allowing the researcher to transcribe the recordings verbatim. Freedom to explore particular responses or issues in more detail during the interview by the researcher or participant was enabled by recording the interview. The purpose of recording the interview was for data collection and analysis and to maintain the essence and accuracy of the information provided (Creswell, 2013; Liamputtong, 2013). Recordings of the interviews were transcribed by the researcher verbatim and themes identified by the researcher using thematic analysis to interpret, describe and understand the findings of the data (Creswell, 2013; Gray, 2009; Liamputtong, 2013; Yin, 2014).

An additional means of data collection that assists with reporting of findings involves the researcher maintaining a reflective journal (Liamputtong, 2013; Yin, 2014). Maintaining a reflective journal provided a means for the researcher to record

notes during recruitment and after the interview and reflect on the experiences and processes (Creswell, 2013). Reflective journals also provided the researcher with a place to record subtle differences surrounding the participants such as physical nuances when they raised their voice or how they reacted to questions by the researcher (Liamputtong, 2013). A reflective journal was maintained by the researcher to capture the responses by midwives during the recruitment sessions in the private facility and following each participant interview. All data was managed using NVivo 10™ and data analysis involved a number of techniques.

Data Analysis

Data analysis is the process of making sense or meaning from data that is collected and analysis of qualitative data is often scrutinised by quantitative researchers (Creswell, 2012; Gray, 2009). Quantitative researchers are known to challenge the credibility and rigour of qualitative data collection and analysis (Ajjawi & Higgs, 2007; Creswell, 2013; de Wit & Ploeg, 2005; Earle, 2010: Gray, 2009). Therefore, it is important that the data analysis process has attention to formal and explicit procedures (Baxter & Jack, 2009; Stake, 1995; Yin, 2014).

Data analysis for this research included the development of a descriptive framework whereby concepts were categorised on the basis of describing general characteristics and connections of the phenomena being investigated (Gray, 2009). Descriptive data analysis incorporated pattern matching and building explanations surrounding concepts from the case. Pattern matching is an analytical technique used to compare patterns and develop categories from the data to determine if the patterns/categories match or do not match (Mills, Eurepos, & Wiebe, 2010). Pattern matching is used in case study to predict corroboration from a combination of

sources to address the most significant complexities of the case and identify any major rival interpretations of the data (Creswell, 2013; Mills et al., 2010; Yin, 2009). The steps for data analysis are illustrated below in Table 4.

Table 4

Stages of data analysis (adapted from Ajjawi & Higgs, 2007, pp621-622)

Stage	**Tasks completed**
1. Immersion	□ Organising the data-set into texts □ Iterative reading of texts □ Preliminary interpretation of texts to facilitate coding
2. Understanding	□ Identifying first order (participant) categories □ Coding of data
3. Abstraction	□ Identifying second order (researcher) subcategories according to Case Study □ Grouping second order patterns into sub-categories
4. Synthesis and themes development	□ Grouping sub-categories into categories □ Further elaboration of patterns as per Case Study □ Comparing patterns across participants
5. Illumination and illustration of phenomena	□ Linking literature to the categories identified above □ Reconstructing interpretations into stories
6. Integration and critique	□ Critiques of categories by the researcher □ Report final interpretation of the research findings

The data analysis process involved the researcher becoming immersed in the data to gain an in-depth insight into the understanding of the participants' words and statements (Gray, 2009; Liamputtong, 2013; Yin, 2014). The data were transcribed verbatim from the digital voice recorded conversations by the researcher using

Dragon™ software, a speech to text computer program. This also allowed the researcher to re-visit the recordings as often as required to understand and identify the participant patterns or categories (Liamputtong, 2013; Yin, 2014). The researcher identified second order subcategories and compared the relationship with other subcategories and participants. This process of re-visiting the original data, categorising data and identifying patterns as they develop, ensures the findings are truthful, accurate reflections (Baxter & Jack, 2009; Liamputtong, 2013; Yin, 2014).

In exploring the views of midwives during a period of maternity reform, research procedures were used to construct a framework to support exploration of this study. For example, all participants were provided with a summary of their audio taped interview and the participants were given the opportunity to confirm that the data are correct, accurate and the essence of their story is true (Creswell, 2013; Liamputtong, 2013; Yin, 2014). Verbatim quotes from the participants were used throughout the analysis of data (Liamputtong, 2013).

Credibility and Rigour

Credibility and rigour are essential criteria to qualitative research. Credibility and rigour are fundamental and significant because activities associated with credibility increases the probability that credible findings will be produced (Liamputtong; 2013, Yin, 2014). Member checking is one strategy to increase credibility. Member checking for this research included returning the full-transcribed transcripts to the participants to check for accuracy. Four of the participants responded stating that all content was true and accurate and no amendments to content were recommended however, three participants did not respond.

Rigour guarantees an in-depth insight into phenomena (Creswell, 2013; Liamputtong, 2013; Yin, 2014). Rigour is enhanced in qualitative research through strict adherence to protocol and prudent development, management and maintenance of data (Creswell, 2013; Liamputtong, 2013; Yin, 2014). Procedures to ensure rigour and robustness in this study included participant audio recordings being transcribed verbatim by the researcher, casual observations, maintaining a reflective journal, an audit trail and rich descriptions. These procedures ensure legitimacy and rigour to validate the use of case study methodology for this exploration (Creswell, 2013; Liamputtong, 2013; Yin, 2014).

Research credibility and rigour can be established by ensuring that researcher bias is eliminated (Creswell, 2013; Liamputtong, 2013; Yin, 2014). Researcher bias means that the research process has been compromised and that preconceived ideas and opinions did affect aspects of the research (Yin, 2014). Bias can influence the data collection process due to the direct contact between the participant and researcher and data analysis (Miyazaki & Taylor, 2008). Removal and avoidance of research bias is particularly relevant when the aim and significance of the study is to explore the views or participants. Therefore, open ended questions were used to encourage participant responses and generate discussion. Purposive sampling, inclusion and exclusion criteria and data analysis strategies were employed to eliminate researcher bias.

Conclusion

This chapter has provided a background to the methodology and methods used to conduct this research. Case study methodology enables an in-depth understanding of a phenomenon whereby participants form a single unit of analysis

and their views are explored within a natural context. This research employed case study methodology to discover the views of midwives employed in standard maternity care settings during a period of reform. As outlined, insights from midwives were obtained through the use of methods such as purposive sampling, ethical processes that protect the participants, data collection and analysis procedures that adhere to a coherent research design that promotes credibility and rigour. This case study research is rigorous and credible due to implementing strategies to ensure findings make a worthwhile contribution to the profession of midwifery. The following chapter discusses the findings that emerged from data collection and analysis and outlines the relevance of these findings in relation to midwifery practice and national reforms.

CHAPTER FOUR
PRESENTATION OF DATA AND ANALYSIS OF FINDINGS

Introduction

This research explored the views of midwives working in standard care maternity settings to identify possible effects of impending maternity reforms based on the National Maternity Services Plan (NMSP). Data analysis and findings from the case study exploration are presented in this chapter. Seven midwives working in private or public maternity facilities were the participants for this study. The selection criteria for this research necessitated that the participants had worked in antenatal clinic, birth suite and or postnatal area. However, participants could not have worked in midwifery group practice or team midwifery.

Case study exploration was chosen as it offered the opportunity to utilise a systematic, critical enquiry, into understanding of the National Maternity Services Plan (the phenomenon) from the point of view of the participants. Semi-structured questions guided the face-to-face interviews and data were analysed and findings are presented as *categories* and *sub-categories.* The findings presented are representative of the participants' views during a period of national reform in maternity care, specifically midwifery practice.

Four categories were identified from the data and these categories set the framework for analysis. The categories included *Personal Responses, Sense of Purpose, Atmosphere of Rigidity,* and *Optimism for the Future*. Each of the four categories has three subcategories. The categories and subcategories are outlined in the Figure 1 below:

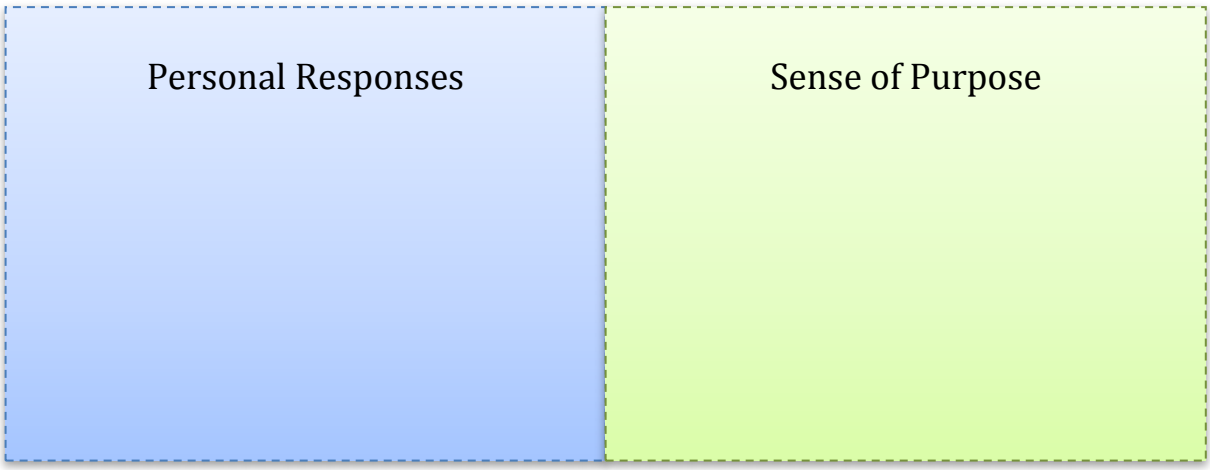
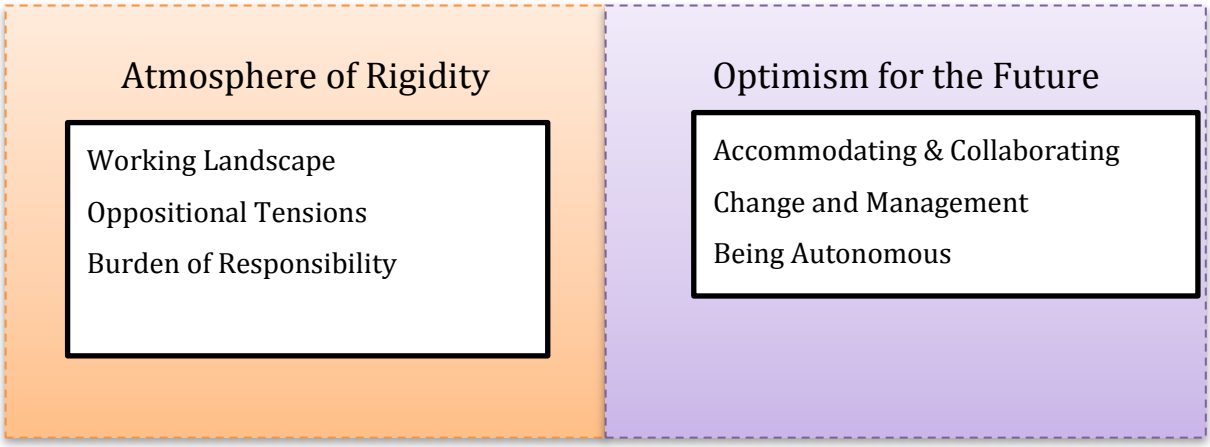


Figure 1:

Categories and subcategories

Foundational Knowledge	Being Valued
Conceptual Comprehension	Confidence or Competence
Choices	Subconscious Reluctance or Active Resistance

Categories and subcategories



Personal Responses

The category of participants' *Personal Responses* was pivotal and fundamental to identifying the knowledge, understanding and views that participants of this study had about the National Maternity Service Plan (NMSP). The subcategories of *Foundational Knowledge, Conceptual Comprehension* and *Choices* illustrate the

participants' understanding of the priorities of the NMSP. The subcategory of *Foundational Knowledge* (see Table 5) provides an overview of the basic knowledge participants possessed about the NMSP, while the subcategory of *Conceptual Comprehension* demonstrates a more profound lack of working knowledge of the NMSP. The final subcategory elicits the role that *Choices* have for the participants transitioning to contemporary midwifery practice.

Table 5:
Personal Responses

Category	**Subcategories**
Personal Responses	Foundational Knowledge Conceptual Comprehension Choices

Foundational Knowledge

The first step in understanding the views of the participants regarding the NMSP was to acquire a broad insight into the first subcategory of their *Foundational Knowledge* regarding the NMSP. Data indicated that there were marked differences in the level of basic knowledge of the participants surrounding the NMSP. The findings from this cohort of seven midwives clearly demonstrated a significant variation of knowledge levels in relation to the NMSP. This variation ranged from no knowledge, to moderate knowledge with only one participant having a notable level of knowledge relating to the midwifery aspects of NMSP. The overall lack of knowledge meant that the participants' held limited views about the NMSP. For instance, some of the participants were unable to explain how the NMSP applied to their practice and work environment.

Of the seven participants, three stated that they had no knowledge of the NMSP until volunteering to be a participant for this study. One participant claimed, "I don't know anything really. You are the first person who mentioned it so, no, I don't know anything about it." The three participants without knowledge of the NMSP (Louise, Susan and Melissa) worked in the same private maternity facility. The three participants with moderate knowledge of the NMSP (Katrina, Beth and Melissa) were able to provide details such as: the NMSP meant that midwives have the capacity to work in private practice; midwives can apply for Medicare provider numbers; and, medicine prescribing endorsement. One participant, Jane, a recent graduate compared to the other participants, had a high level of knowledge regarding NMSP and was able to discuss the scope of practice for autonomous midwifery practice, continuity of care characteristics, the role of an eligible midwife and contractual requirements for collaborative hospital visiting rights for midwives working in private practice. A fundamental outcome that this subcategory revealed was the lack of basic knowledge surrounding the NMSP which subsequently impacted on the participants' ability to conceptualise and comprehend how the priorities of the NMSP could or will affect midwifery practice.

Conceptual Comprehension

The lack of knowledge of fundamental aspects of the NMSP and the participants' inability to conceptualise how midwifery practice will be affected by the implementation of midwifery-specific priorities of the NMSP led to the second subcategory of *Conceptual Comprehension*. Due to the lack of in-depth knowledge of the proposed changes, there was considerable misunderstanding of the meaning of basic terms and concepts such as autonomous midwifery practice and models of midwifery care.

Six of the seven participants did not understand the basic structure of future midwifery models of care, in particular, the participants who were midwives in the private maternity facility. One participant, Melissa, repeatedly answered questions with her own questions and voiced her overwhelming perplexity of how reforms could work in a private maternity facility. Melissa stated, "What's wrong with the system that we have now?" Additionally Louise, from the same facility, said, "I can't imagine how it will work in a private setting".

The three participants with moderate awareness of the NMSP had difficulty with detailed working knowledge of midwifery continuity of care models and also struggled to comprehend how reforms would change the way they conducted their professional work. Susan stated,

> I would have to know a little bit more about it because I can't quite get in my head how it would work in a private setting … Is it because there's a push for us not to go in that area? Is it because I'm in a private setting that I don't know about it?

A comparable concern was echoed by Beth who shared, "I'm not sure how it would go, if we were able to do it within our setting … We don't even have any [midwifery models of care] available to us to even work in". However, two participants who had a moderate knowledge of the NMSP had differing views. For instance, Kylie stated, "I think they're very idealistic, I think they sound fantastic and I think it'll be totally unworkable". In contrast, Jane was able to discuss in detail aspects of the NMSP with the following explanation;

> Among many, many, other things but mostly applicable to midwives, they have created the possibility for midwives to be eligible which suggests they would have a Medicare provider number so would be able to, under government funding or public funding, provide midwifery care to women across-the-board of maternity; so in antenatally, at labour and birth and postnatally,

> with the expectation that labour and birth occurs in hospital setting. So birth with a few conditions placed on them, among them the condition that there is an arrangement or agreement with a medical practitioner. So some kind of referral agreement and an agreement with the hospital that allows you visiting rights to the hospital.

While the participants' *Conceptual Comprehension* was limited and posed many questions about the NMSP, this enquiry led to further discussion surrounding the participants' views about choices. The participants considered how the NMSP would impact on their choice of practice as a midwife and who would choose midwifery models of care.

Choices

The third subcategory was termed *Choices* because of the participants' perception of the varied views about stakeholders' (the midwives and the women) choices that would impact in the implementation of midwifery models of care. Three participants indicated that it was important for women to have choices in how their care is provided. Susan articulated, "I think women need choices and the more choices they can have the better, and access to choices is great as well … it's about choice for women and where I work their choices are limited". Louise's view was, "… I like that idea of them having more of a choice in their care, them [women] to have a *voice* and not be afraid". Conversely, Beth, Katrina and Kylie strongly indicated their views about midwives having choices in being part of a continuity model of care, with Katrina sharing her personal situation, "I really feel that I'm at the stage of my career I'm prepared to leave that [caseload] for the young ones. I don't want to do shift work. I did do shift work for 30 years, I feel I've served my penance'. Further, Beth took a broader approach that involved considering her midwifery colleagues, "I don't know if anyone should be forced to work in that sort

of environment if they don't want to." Therefore, Beth, Kylie and Katrina felt choice was a pivotal aspect for midwives in relation to working according to the NMSP priorities.

The three subcategories outlined in the category titled *Personal Responses* indicated that a major factor in this study that impeded participants being able to discuss their views of the NMSP was their knowledge deficit and lack of understanding. Furthermore, it was evident that the majority of participants (six of the seven midwives) could not comprehend how the NMSP priorities would apply to their future midwifery practice.

Sense of Purpose

The category, *Sense of Purpose*, emerged from the data as particularly relevant. Having a sense of purpose was identified as a fundamental component of a midwife's philosophy of practice. Having a sense of purpose illustrated the complexities of how these participants perceived themselves in relation to future professional practice and their ability to sustain professional partnerships in collective participation. Collective participation is the engagement or participation of midwives and a willingness to progress as a group in professional development. The sub-categories for Sense of Purpose (see Table 6) are *Being Valued, Confidence and Competence* and *Subconscious Reluctance or Active Resistance* in relation to the NMSP.

Table 6:
Sense of Purpose

Category	Subcategories

Sense of Purpose	Being Valued Confidence and Competence Subconscious Reluctance or Active Resistance

Being Valued was identified by the participants as an intrinsic and crucial feature to *being* a midwife regardless of how many years of experience each participant had attained. All participants were passionate about their profession notwithstanding their limited knowledge of the NMSP. Despite their lack of awareness surrounding the direction of the profession, the participants voiced the need to be valued for their contribution to midwifery with regard to their present circumstances, their past contributions, and most significantly, the future of midwifery.

Another subcategory, *Confidence and Competence*, reflected the participants' views of what was integral to practicing midwifery. The participants were aware of how competence levels impacted on their confidence when working in clinical practice, in their ability to teach and mentor, and form relationships within their work environment. The final subcategory of *Subconscious Reluctance or Active Resistance* signified the struggles the participants envisaged in relation to their role in the implementation of the NMSP.

Being Valued

This subcategory of *Being Valued* was both personal and professional and is an important aspect of one's self worth. The data revealed that being valued in their professional setting was important to the participants. The participants claimed they had made a meaningful contribution to current midwifery practice and to meeting future needs of midwifery. Additionally, the participants acknowledged that it was

crucial that they leave a lasting legacy to the midwifery profession. All of the participants stated that *Being Valued* not only related to performing in their role as midwives but it is fundamental to passing on intrinsic skills they had developed throughout their years of practice. *Being Valued* encompassed being valued by each other as midwives, being valued by doctors for possessing clinical judgment and being valued by women.

The seven participants involved in this study consistently stated that they experienced joy and passion when working with women and their families. The participants also identified a need to either leave the profession in capable hands or believe they made a valuable contribution to midwifery. Beth said, "I feel with my experience in antenatal education and birth suite as well as postnatal and my lactation, I think I would do well with caring for a woman in a caseload (model)." Katrina shared this view of Beth's and stated,

> I thought, maybe I can contribute and make a bit of a difference, just from an older person's perspective … I just think, I've got over 30 years' experience as a midwife and have seen huge changes in midwifery ... I'd like to leave an impression that I've left something and contributed to midwifery.

Furthermore, journal notes recorded after a visit to recruit participants at a private hospital illustrated that some midwives felt marginalised by other midwives. The following account was documented:

> Prior to ward handover: Five midwives present, one from previous dayshift. Discussion: One midwife felt that they gave great care the way they currently work; felt that "outside" midwives considered private hospital midwives were 'not real midwives', she felt they gave great care. I felt there was a sense of not being valued in this setting.

From the journal notes recorded, the five participants did not appear to feel valued and this had consequences and impacted on their emotional commitment to midwifery.

For instance, not being valued led to a feeling of disengagement of one of the participants and resulted in one midwife contemplating transitioning out of midwifery. Kylie's views were compelling and are important to acknowledge, "I am just getting out of midwifery actually because I'm so angry at the way we are being treated, with the lack of consultation and maybe that's a lack of participation on my part, of getting involved".

Therefore, *Being Valued* is not to be underestimated when considering the impact that reforms will have on the emotional wellbeing of midwives. *Being Valued* is a key component of *being* a midwife and reflects competence and confidence in midwifery practice.

Confidence or Competence

The subcategory of *Confidence or Competence* illustrated the correlation between the participants' competence regarding midwifery skills and personal confidence. *Confidence or Competence* related to the participants perceived capacity to transition to contemporary midwifery practice as required by the NMSP. The broadening scope of midwifery practice outlined in the NMSP was a feature that drew reflection on professional and personal goals for the participants of this study. Five participants made similar comments about this notion. For example Susan commented,

> I'd be a little bit floundering because I haven't worked in some areas and I'd feel inadequate, that I wouldn't have the skills to completely follow through as well as I'd like to … just my experience and competence level in that area [labour and birth] is diminished ... I just feel that I wouldn't have the skills … I always

> like the comfort of relying on someone else, being the lackey, working for someone who is going to take the rap if things don't come out … I just feel I don't have the confidence … I feel I would need a lot of up-skilling to do it … I haven't felt the autonomy, perhaps I'm not one who likes autonomy … So I guess I've had that mindset and probably haven't developed enough independence in thinking even, in that way.

Additionally, Melissa indicated a level of confidence in her current skills and a willingness to advance these skills when she said,

> I'm not too *au fait* with the normal blood tests of the antenate … you would also have to have plenty of experience postnatally … I like working with labouring women and this would put me out of my comfort zone, doing postnatal care and antenatal care … At this stage of my life, with my experience, I would be happy to do it. I think I would be competent enough.

Further, Jane identified her midwifery-colleagues played a pivotal role in progressing contemporary midwifery practice within the health care setting she was employed. Jane stated,

> I think having a midwife come in and guide the care and guide what will happen to a woman in her own right might be challenging … I have just joined a group of midwives who do postnatal only … many of them do not want to do antenatal care, do not want to do labour care. I think they will be quite happy to remain as core midwives and to be supported and acknowledged and recognised for the contribution they do as core midwives.

Building competence and confidence was identified as important features of contemporary midwifery practice by a number of participants in this study. However, not all participants in this study shared the same desire to progress their professional midwifery goals and therefore displayed levels of reluctance and resistance.

Subconscious Reluctance or Active Resistance

Subconscious Reluctance or Active Resistance subcategory indicated the

participants' uncertainty and differing views surrounding the changes inherent in the NMSP. For instance, two participants indicated an active resistance to engage in reforms, and the remaining five participants indicated a subconscious reluctance to engage in reforms. Data collected suggests that there exists a subconscious reluctance to be proactive and participate in the proposed NMSP changes and that leaving the profession is a more viable option than having to change. Additionally, three of the participants perceived that many midwives are not current in their practice and are cognisant of the demands and requirements of contemporary midwifery practice. Louise stated,

> I would imagine that those who haven't been that interested in keeping *up to date* with current trends or how things are going, would find it challenging, because I'm sure they only feel comfortable doing things the way that they have always done things … they feel uncomfortable, very willing to criticise new … I think that those particular people would leave rather than change… I'm sure we will see an exodus of people who are so close but they don't want to change.

Beth agreed, "I do know a lot [midwives] who haven't worked in a birth suite for 15 years or haven't worked in a postnatal ward for 15 years and are not comfortable in that situation [working across all areas.]" The two statements above reveal that some midwives may believe their sense of purpose and their scope of practice are being challenged by the reforms of the NMSP.

The Category of a *Sense of Purpose* revealed an element of vulnerability for the participants during this period of reform. The participants' attitudes and values are significant in relation to the future outlook of being a midwife. Therefore, being a midwife and incorporating conceptual knowledge and procedural skill is being challenged. As such, relationships with fellow midwives, doctors and women contribute to midwives' sense of purpose and is confronting in terms of professional

growth. Overall, findings suggested that professional relationships and other more complex factors stifle professional growth due to elements of rigidity associated with change.

Atmosphere of Rigidity

The third category that emerged from the data is the *Atmosphere of Rigidity*. The participants identified factors related to inflexibility and rigidity that they perceived hindered professional growth and development. The subcategories (see Table 7) of *Working Landscape, Oppositional Tensions and Burden of Responsibility* illustrated elements that oppose the inherent nurturing and professional culture that are core principles of midwifery. The subcategory of *Working Landscape* revealed that the physical environment impacted on midwifery practice. Additionally, the internal maternity unit infrastructure and organisational governance support or lack of support for best practice and contemporary midwifery practice is a significant issue.

Table 7:
Atmosphere of Rigidity

Category	Subcategories
Atmosphere of Rigidity	Working Landscape Oppositional Tensions Burden of Responsibility

Oppositional Tensions was a subcategory that was employed to explain the continuing struggle between the biomedical model and the more holistic and woman centred midwifery philosophy. Finally, the subcategory of *Burden of Responsibility* outlined numerous perceived barriers and obstacles that the participants believed

would be required to be addressed to transition to the midwifery priorities outlined in the NMSP. All of the subcategories indicated that there exist many potential and actual factors within the working landscape that impacted on midwifery practice.

Working Landscape

The participants identified the subcategory of *Working Landscape* to illustrate how the work environment contributed to an atmosphere of rigidity. The work environment encompassed the physical environment and the emotional space that midwives practice within. The emotional space comprised of the equitable treatment of midwives such as equity with relation to allocation of shifts and recognition and support of midwifery practice by a governance infrastructure that supported midwives.

Four participants identified that provision of a suitable physical environment impacted on their workplace performance. For example, Louise suggested that providing a safe environment is not a reality. "I *like the idea* of providing a safe environment for the mother and baby with what the mother would like to do". Further, the participants articulated the need for birthing environments to be contemporary, such as providing baths for women, in addition to overarching policies that support safe practice. As pointed out by Louise, there was not a reality in providing a bath, merely an idea.

Similarly, workplace demands and equity was, at times, conflicting and appeared to affect the emotional environment. Four participants voiced that although shift work could be viewed as restrictive especially when repeatedly rostered to late and night shifts, it also provided predictability so that family life could be arranged around rostered shifts. The rostered approach to managing workloads is in opposition

to the flexible nature of working with women. Beth's comments support this analysis as she said,

> You seem to get a lot of stints doing the same sort of shift and there's not one of movement … a lot of people get stuck doing a lot of night shifts and you only get one or two day shifts … I don't know if there are a lot of people who are interested in caseload or work within it or just want to work within postnatal ward and know what they're doing every day.

Additionally, inequitable workloads also created an issue of contention for all seven participants. For instance, Katrina stated, "We've been having to work with less people and they're putting more and more pressure onto midwives to say you've got to do all these things". Melissa claimed, "The new graduates, some of them don't want to be doing the extra shifts, they don't want to do call back times". Therefore, issues of inequitable workloads revealed an infrastructure that was rigid compared to a more harmonious and contemporary environment that could exist following the implementation of NMSP guidelines.

Furthermore, rigidity was noted in relation to governance development and ultimately the environmental infrastructure that affected contemporary midwifery practice. Four participants identified that protocols related to risks were developed and ratified by doctors and hospital executive without midwifery engagement. This lack of engagement with midwives, who are advocates for women, indicated a discord between organisational goals and midwifery goals. Louise described the lack of engagement associated with potential or actual risks surrounding midwifery practice as follows:

> Whenever there's a major incident, things are looked at and new policies are put into place. It's always in the end not what the midwifery staff feel should happen … we don't seem to have a say … they've [medical staff and hospital administration] got a different focus to midwives … all our policies need rewriting,

> they're an embarrassment to show students and they're not current practice.

Therefore, the *Working Landscape* was a significant factor in restricting contemporary midwifery practice. Workplace demands created uncertainty and discontent. Further, development of risk-averse policies and structures were major factors in fostering an environment where the differing and often strained philosophies of midwifery and medicine caused interdisciplinary, oppositional tensions.

Oppositional Tensions

The subcategory and term *Oppositional Tensions* encompasses the philosophical disparities between the disciplines of midwifery and medicine and the silo effect this disparity has on professional and interpersonal relationships. A silo approach promotes or encourages "territorial" ownership of birthing and women as opposed to an inclusive and interprofessional approach to a woman's experience. Today, a neutral environment exists whereby an interprofessional approach to birthing is uncommon despite the two disciplines of midwifery and medicine inhabiting the same environment with pregnant women.

Five participants openly indicated the opposing tensions between midwifery and medicine. Louise commented, "We do lots of things that aren't done standardly in public hospitals and that's accepted as normal … it could be said that epidurals are encouraged by certain staff members". Susan supported Louise's statement stating, "I work in a private hospital, you are subject to the obstetricians in that environment…it's very much an obstetric model where I work… obstetricians that determine how it [practices] works". Interestingly, Melissa identified that medical

influence extended to conditioning women to favour medical models of care. Melissa also added, "Some of the women want to be cared for by the obstetrician, so I guess they wouldn't be going for this model. Obstetric influence, they want them to do everything".

Similarly, Katrina discussed the impact of midwifery autonomy in relation to the potential for eroding the control doctors have over pregnancy and birthing. Katrina commented,

> I do wonder how the midwifery group practice and caseload, where they're [midwives] taking more autonomy, is going to go down with some of these older obstetricians … you still have the older group of obstetricians that are quite traditional in that 'I want to take control, I'm the obstetrician, you're the midwife' … there is still a group [obstetricians] who struggle with, that midwives can do a good job.

The data also indicated that tensions exist between midwives that practice as a result of the restructuring of maternity care under the terms of the NMSP and midwives who are entrenched in standard midwifery practice structures. Meaning, professional jealousy and tensions are apparent between midwives involved in standard care and continuity of care midwives despite sharing the same work-scape. Jane commented,

> Midwives who move into group practice models, it tends to come with a little bit of animosity from the other midwives … they kind of go 'oh, you're a midwifery princess' kind of thing … jealousy maybe or a look of us-and-them kind of thing between the core midwives and the group practice midwives … I witness a sense of jealousy … we see a personal relationship that has evolved, a friendliness that has evolved between them … it can be a bit challenging when you come to really want to establish a rapport and a relationship with a woman as well and gaining her trust. So I can understand the jealousy but I can't say I have felt it myself.

Therefore, findings indicate that *Oppositional Tensions* intruded into the emotional space that midwives share with woman, other midwives and health professionals. The notion to change the current environment was overwhelmingly met with comments that anticipated difficulties and complexities that needed to be overcome to achieve midwifery autonomy. Moreover, changes and growth within the midwifery profession would be associated with midwives being burdened with further responsibilities.

Burden of Responsibility

The third subcategory of *Burden of Responsibility* included a range of issues that the participants identified as impinging on growth of the midwifery profession. One such issue was the perception that there was a burden of responsibility in relation to business management skills needed for midwives to practice more autonomously and independently such as in private practice. For example, the participants identified many issues related to the logistics of Medicare eligibility for midwives in addition to establishment of a business model to practice midwifery independently. Knowledge surrounding business management principles such as managing client numbers, cost of services, insurance, venue, financial advice and relationships were raised as issues by these participants.

In some instances, the ability to imagine how midwives would function both autonomously and or as midwives in private practice was so difficult that participants asked questions instead of providing comments. For example, Susan was one of three midwives who appeared to struggle with the logistics of autonomous practice and questioned, “How does it all work financially for patients, private health cover, or how is the midwife paid, who sets the rate of pay of the midwife in private practice?” Jane believed that the professional requirements for midwifery practice posed a

challenge, “The next barrier is the midwifery practice review that you have to undertake, and I find that I started looking into it but it was extremely resource intensive and time intensive work”. Meaning, as midwives traverse the processes to become eligible, there are numerous hurdles that are both time consuming and costly.

There was also an overarching concern to the achievement of a healthy work-life balance for these participants. Five participants indicated that there would be difficulty in managing autonomous midwifery practice with their home life. Kylie stated,

> … Because you couldn’t devote yourself to your job and your family, can’t serve two masters, and I think midwifery is one of those. It’s not a profession, it’s a vocation and the midwives that are in it are passionate about what they do and it takes up so much of their time and energy. You have to be lucky to have an understanding social support background to be able to practice, how you would like to.

Furthermore, five of the seven participants specifically identified the importance of having “back-up” for midwives who are engaged in autonomous practice. Louise claimed, “… doing each other’s time off, delivering them [women] and visiting them at home afterwards… that there is back up when something goes wrong or does need intervention for a *real* reason”. Therefore, the participants were concerned that support was needed to truly engage in midwifery autonomous practice and that was a need for ongoing and professional education.

The cost of and access to education for some midwives to maintain skills that aligned with autonomous midwifery practice and professional development were issues identified by participants. In particular, the medication prescribing course that was essential to practice as an eligible midwife was an issue identified by Jane who stated,

> The course [prescribing course] will take a lot of time, the cost involved in that is a definite hurdle…they wanted $9000…I know I will need the prescribing course and I need to spend all that money for which I'm not sure when the return will come, if at all.

Two participants also suggested that there existed ramifications to practicing autonomously such as potential disciplinary review and risk of litigation should an adverse clinical outcome occur. In particular, if there were an adverse outcome during labour and birthing as this would be a deterrent to working autonomously. Jane claimed,

> Midwives have just recognised that they really are not well supported. The threat and the possible overarching kind of possibility and potential propensity of having disciplinary action or some other 'please explain' kind of thing and then being completely unsupported when that happens… in labour and birth where you are truly exposed and it is truly stressful and you are exposed professionally as well.

The participants identified a number of obstacles to their professional growth and autonomy. For instance, a number of perceived challenges identified included deficits in conceptual (theory) and procedural (practical) midwifery skills. More complex issues involved ideological differences, between midwives, doctors and hospital administrators, establishment of territorial boundaries and oppositional tensions in relationships. Although the participants identified numerous barriers in the transition to autonomous midwifery practice, more barriers were outlined than enabling factors. However, the participants were generally eager to embrace change aligned with the NMSP.

Optimism for the Future

The category of *Optimism for the Future* describes the vision, willingness and resilience of participants to embrace and enact changes necessary to progress the profession of midwifery recommended by the NMSP. The subcategories in this

category include *Accommodating and Collaborating*, *Change and Management* and *Being Autonomous* (see Table 8).

Table 8:
Optimism for the Future

Category	Subcategories
Optimism for the Future	Accommodating and Collaborating Change and Management Being Autonomous

The subcategory of *Accommodating and Collaborating* illustrates factors that facilitate midwives employed in hospitals and the wider community, to progress to a collective identity in relation to the NMSP reforms. A collective identity is characterised by a sense of belonging and group identification with the NMSP reforms. The subcategory of *Change and Management* relates to what the participants identified as bringing about change in a meaningful, acceptable and sustainable manner. The final subcategory of *Being Autonomous* describes a multi-layered framework that would support priorities from the NMSP and aligns with the same priorities associated with *Accommodating and Collaborating.*

Accommodating and Collaborating

The participants described *Accommodating and Collaborating* as the ability to facilitate a more collective identity, engagement and implementation of the NMSP priorities in particular, focusing on midwifery models of care. Collaboration refers to the work still to be achieved through education and re-education of midwives, doctors, women and hospital executives. Beth's simple statement summarised the very complex evolutionary phase needed to consolidate maternity care in relation to NMSP guidelines when she stated, "it's a whole process, having a baby". Overall,

participants identified elements to support change which included education to improve clinical skills and changing underlying systems and frameworks to benefit women. One significant component identified by the participants as fundamental was the need for a review of the provision of interprofessional education. Louise identified that having an improved and multidisciplinary approach to education would be rewarding and facilitates interprofessional respect. Louise said,

> I suppose more information and support from my workplace like education … a great model and we all attended it [neonatal resuscitation course] together, from the registrars, residents were there that work in the place, all the different nursing staff from the different areas, everyone was enthusiastic.

Five participants identified that there exists the need to financially support the process of change to meet contemporary midwifery practice in accordance to the NMSP reforms. The participants believed that financial support to establish, implement and maintain a new infrastructure to enable effective transition to contemporary midwifery practice was a priority. Jane summarised this complex point when she stated,

> I'm willing to do and to pass [university courses], to put the investment into getting through all of these hurdles, but I would love to know that at the end of that there is a hospital or hospitals that are welcoming midwives that have eligibility … "we will support you, we will cover for you, we will actually work with you for the benefit of the women and their choices".

Finally, four participants identified mentoring new graduates as significant in enabling midwives' professional development and facilitate autonomy. Professional development was viewed as a vital component for midwives to mentor and nurture midwifery students and new graduates. Katrina observed, "I think the midwives need to have more mentoring, more support ... and also our new graduates … need much

more support". Therefore, findings suggest that current professional development of practicing midwives and the mentoring of new graduates does not align with the implementation of NMSP reforms and does not accommodate collegial collaboration.

The subcategory of *Accommodating and Collaborating* identified the need to involve all stakeholders in the journey toward effective changes in maternity care in Australia. As such, a significant part of this process will involve ensuring change is managed whereby all stakeholders, education and strategic planning will occur to prevent division and marginalisiation of the midwifery profession during a period of change.

Change and Management

The subcategory of *Change and Management* emerged from the data as a result of identifying mechanisms to craft meaningful changes due to the NMSP priorities. Understanding "why" there is a need to change is pivotal in engaging stakeholders and ensuring a collective action to implement changes. Some factors identified by the participants to enable effective change included communication, education and marketing the new models of midwifery care; in addition to total engagement in change, mutual respect and professional regard.

The participants identified that some of these aforementioned factors were currently absent and this had a negative impact on decisions individuals were making regarding remaining as a practicing midwife. For instance, communication is a vital component of engagement in change management strategies. Jane was insightful and stated,

> It is important to introduce a new thing, you introduce a new model, you manage the change with a look at gaining a really good

> communication between the people who are involved and who are in the change. So it's about really good change management and cultural workplace management.

Further, Kylie identified the complexities of change management and suggested a cautionary approach to change,

> I think that any change is really hard and it doesn't matter how old you are, I think the older you are, the harder it is because people think, 'why bother' … education of doctors as well as midwives is going to help with any kind of acceptance or any change … I think that we should maybe try and fix what we've got before we throw the baby out with the bathwater and change everything. Have a look at what's actually working rather than just toss the whole lot.

In effecting change, there needs to be a multi-layered approach and vision that is "vertical". Participants indicated that there needed to be an approach from administration down to clinicians and vice versa; additionally, change needed to adopt a "horizontal" approach from clinician to clinician to enable a collective action. Louise commented,

> To aid us to change the model of care, we certainly need to have things explained to the doctors and have them more on a level playing field … The hospital and whoever is in charge of our unit would have to have strong discussions with the obstetricians about these federal changes … there can't be change with level one or two midwives in a private hospital unless there is shared enthusiasm from all above us.

Additionally, Beth indicated that decisions needed to be supported at an administrative and governance level when she said:

> Hopefully if it's well managed and well organised we'll see women birth the way they want to and with who they want…having money available to both train midwives as well as support them in continuing to be able to function.

The subcategory of *Change and Management* identified numerous factors that these participants perceived were a priority in effecting meaningful change according to the NSMP. Significantly, effective communication, education and collaboration were vital to enable progression of future midwifery practice in particular, autonomy.

Being Autonomous

Participants identified the subcategory of *Being Autonomous* in midwifery practice as encompassing attitudes, willingness and commitment of hospitals and other health professionals to be supportive of autonomous midwifery practice. The concept of what autonomous midwifery practice encompassed was outlined by Louise who reflected,

> I think it sounds amazing, exciting … I see the midwife as the perfect people to help women through their pregnancy and their labour…the whole caring sense of the midwife and wanting to help, wanting to explain things in a better way…I eagerly await to see what the future holds. I see it as exciting for the future generation coming through and any slight influence and help that I can have with that, will be good.

Similarly, Melissa could see that autonomous midwifery practice was about the relationship between the woman and mother and she shared this insight,

> How fantastic it would be to be able to build up a rapport with the woman and to plan what's going to happen during the delivery and be able to assist her with the delivery that she wants, and to be able to look after her post-delivery with the baby care and making sure she's ok…It would be an interesting high to go out on.

Being Autonomous was a complex subcategory that identified attitudinal, practical and emotional factors will enable midwives to provide holistic, woman

centred care. For most midwives, these factors will provide a foundation to a more positive and rewarding experience for users and providers of maternity care.

The category of *Optimism for the Future*, revealed that the participants envisioned and articulated measures they felt were important to drive change to ensure autonomous midwifery, woman centred care for the future of midwifery. The process of change requires effective communication to all stakeholders of maternity care, women, midwives, doctors and hospital administrators. Additionally, there is a need for stakeholders to contribute to the establishment and maintenance of processes to ensure sustainability of autonomous midwifery practice. Factors identified as being required included, a change of attitude and practice by midwives to develop professionally, to be supported by colleagues and hospital administration to enact contemporary midwifery practice and foster more positive and collegial relations between service providers. Overall, there was a collective desire of these participants that all midwives should practice at the best possible professional level to benefit women.

Conclusion

The data identified that the participants held a vastly different knowledge base in relation to the impending implementation of the NMSP. There existed a significant difference between the knowledge and awareness of the NMSP for participants working in a private maternity facility compared to the participants employed in the public sector. Generally, the depth of knowledge relating to contemporary midwifery practice was absent or superficial, whereby a lack of understanding as to the impending changes to maternity service provision was paramount throughout the data. Additionally, there was a strong sense of purpose

surrounding the role of the midwife today, and in the future, evident in the views of each participant regardless of the care setting in which they were employed or their years of practice. Being valued by midwifery colleagues was equally important to the participants as was being valued by other health professionals and women who they may care for during pregnancy and birth.

A sense of purpose and being valued was a significant issue that was very meaningful to the participants in this study. Clinical competence was linked to the need for midwives to be confident and autonomous practitioners was another factor identified by participants as being notable. Likewise, it was identified that there was a significant level of reluctance and even resistance to engage in change by the participants. Additionally, the data indicated that a division in relation to autonomous midwifery practice and acceptance of the NMSP reforms may prove to be divisive and damaging for all midwives. The participants' readily recognised barriers to progressing the NMSP priorities such as restrictive access to professional development and inflexible working environments. Implementing reforms could also be impeded by a governance infrastructure that is heavily influenced by risk-aversion rather than a woman centred philosophy. However, the key barrier identified throughout the findings was the lack of in-depth knowledge of the NMSP and how the priority areas will impact on contemporary midwifery practice.

Despite a significant variation in the participants' knowledge of autonomous midwifery practice, the participants identified numerous obstacles that need to be overcome in order to enable meaningful change. These obstacles include oppositional tensions between midwives and doctors and the potential for marginalisation of midwives by other midwives. Similarly, there were disparities between midwifery, medical and organisational ideologies that require sensitive and

respectful collaborative mediation. In addition, autonomous midwifery was identified as the standard for providing woman centred care. Participants indicated a desire to work in collaboration with medical officers, but believed that there needs to be a shift towards a collaborative model of midwifery care to ensure women are the focus. Furthermore, there needs to be a major shift in governance and professional education to support midwives in their endeavour to provide autonomous midwifery practice.

In conclusion, the findings outlined in this chapter indicate that the implementation of NMSP reforms were not clearly known, understood, or comprehended by the participants in terms of current and future directions of midwifery practice. Although the NMSP reforms are significant in terms of contemporary practice in private and public health care organisations, these participants could not articulate the impact of the NMSP to their practice and the benefits to women. The following chapter discusses the underlying interpretations of the data in relation to available literature and in the context of contemporary midwifery practice.

CHAPTER FIVE
DISCUSSION AND RECOMMENDATIONS

Introduction

Throughout the past decade, the provision of maternity services in Australia, has experienced a number of national and state reviews culminating in the National Maternity Services Plan (NMSP). The NMSP consists of four priorities specifically designed to change the delivery of maternity services to women and their families (CoA, 1998, 1999, 2011; Hirst, 2005). The relevance of the NMSP priorities is to significantly amend midwifery practices and care.

Currently in many Australia maternity facilities, standard maternity care provided to women is fragmented and disjointed as women often encounter a number of health professionals throughout their pregnancy, labour, birth and during their postpartum period. Both doctors and midwives provide this fragmented care and the level of satisfaction for women receiving this type of care is less than optimal (CoA, 2011; Hirst, 2005).

The impetus for this research was based on the premise that there will be significant changes and subsequent challenges to future midwifery care as indicated by the priorities of the NMSP. The challenges will be congruent with modifications to skills, knowledge and cultural changes required by midwives. Of particular note is the widespread impact the NMSP will have on midwifery practice. The majority of midwives currently practice within a hospital system that is not fully supportive or able to offer or provide the full-scope of midwifery practice intended for the future (CoA, 1998; 1999; 2011; Hirst, 2005).

Aligned with the priorities of the NMSP, will be a transition period whereby midwives will need to undergo a substantial shift in the manner in which they provide midwifery care. This shift will fundamentally require midwives to move away from the current fragmented model of standard care into a more contemporary, autonomous model whereby the woman is central to her own care and the midwife manages the woman's care in her own right. However, little is known about the views of midwives in relation to the NMSP or how they perceive they will be enabled through this transition process to autonomous, contemporary practice (CoA, 2011).

This research explored the views of seven midwives working in standard maternity care settings during a period of national reform. Exploration of the experiences of midwives who currently provide care in standard maternity settings illuminated the large variance in the understanding of some midwives regarding the priorities of the NMSP. Findings also identified the need to design and implement educational, managerial and governmental strategies to enable and enhance the transition of midwifery care to meet the maternity reforms. Overall, the identification and interpretation of the views and experiences of midwives can be used to assist in the promotion of a universal autonomous midwifery culture to enrich and consolidate professional status and the reputation of midwives. Finally, the findings from this study provide invaluable data to inform undergraduate and post-graduate education program developers and providers and state and national professional bodies. Findings can inform and guide strategic planning.

Research design reasoning

This research adopted case study methodology utilising semi-structured questions to explore the views of seven midwives (participants) during a period of reform. The participants were asked to outline their knowledge of the NMSP, the NMSP's impact on the way they provide care and what they perceived would support their transition to providing more autonomous care. Case study methodology was chosen for this research because it provided the opportunity to gain an insightful appreciation and understanding of this complex issue from the perspective of midwives employed in standard maternity care settings. This research involved a bounded system, which is at the core of case study methodology, to explore the views of midwives working in public and private maternity settings.

Data collection included face-to-face interviews, open-ended semi-structured questions, journaling and informal observation of participants throughout the interview phase, in addition to observation of midwives during the recruitment phase during the handover time in the hospital setting. Processes and procedures surrounding data collection and data analysis informed the rigour and credibility of this case study research. These processes, as outlined in Chapter 3, Design of the Study, included purposive sampling, semi-structured questions, pattern matching and member checking. Interviews were recorded on a digital recorder and transcribed verbatim by the researcher adding to the integrity of the research. All data was managed using NVivo 10™.

Key and critical findings summarised

This research has led to a number of key findings that were interconnected. One major finding was the overwhelming lack of in-depth knowledge and

understanding of the NMSP priorities. Notably, midwives from the private maternity facility were uninformed about the NMSP. However, these midwives were also the most eager to change and practice autonomously and wanted education, support and a change management process implemented by hospital executives.

The NMSP has specific priorities in relation to midwifery practice and broader priorities for all maternity care providers. Midwives involved in this research had insufficient knowledge of NMSP in such a way that their responses evolved from a vicarious exposure rather than a direct and meaningful experience. Furthermore, the overall lack of awareness and comprehension of the NMSP has potential to impede the implementation of the NMSP by midwives in a collective manner due to the lack of engagement. Furthermore, the lack of awareness of the NMSP requires a strategic plan from a notable and respected authority to raise the level of knowledge of the reforms, unify midwives and inform the changes necessary to transition Australian maternity services.

The findings from this research indicate that an underlying social and cultural conditioning of midwives continues to subordinate autonomous midwifery practice. Today, like in the past, cultural conditioning of midwifery practice has been dominated by the biomedicalisation of childbirth and nursing regulation (Reiger & Lane, 2009). This study's findings suggest that historical, cultural conditioning, may contribute to midwives not seeking knowledge and being unaware of the midwifery specific priorities of the NMSP. There is a need to significantly shift current midwifery workplace culture, philosophy and practice to develop, autonomous midwives who work collaboratively and effectively in a maternity environment focused on providing safe woman centred care.

Further, in the current climate of participants, cultural conditioning appeared to emerge from three areas:

1) medical dominance,
2) hospital governance and
3) midwife to midwife.

Midwives need to further develop their clinical and critical analysis skills accordingly to enable autonomous midwifery practice. The participants acknowledged the need to be mentored to enable them to care for women in a one-on-one, reciprocating mutuality within the partnership. The participants identified the need to be exposed to working and developing skills in all aspects of care for pregnant women across the childbearing spectrum. In general, the participants noted they require support in the form of education in some clinical areas in addition to supportive measures from hospital establishments. Specifically, the participants identified educational components of being skilled in diagnostic measures and prescribing of medications, caring for women who require complex care and further skills in lactation management. In terms of systematic support, they articulated midwives' roles in stakeholder contribution to governance surrounding midwifery models of care. Additionally, midwives want more input into developing hospital infrastructures that clearly accommodate and define the role of the midwife within a midwifery model of care.

Findings in Detail

Data analysis enabled findings to be organised into categories and subcategories. The four categories were *Personal Responses, Sense of Purpose,*

Atmosphere of Rigidity and finally, *Optimism for the Future*. Each of the categories had subcategories that will be now be summarised.

Participants' Personal Responses highlighted a significant and underlying weakness in the preparation to transition to autonomous midwifery practice. Foundational Knowledge of the NMSP was significantly limited which restricted the participants' ability to conceptualise what the consequences of the NMSP priorities mean in the provision of maternity services. However, participants were able to identify what was needed to bring about change. This finding is in contrast to Sidebotham et al. (2015) appreciative inquiry study which outlined that midwives could not conceptualise their contribution to change. It is difficult to rationalise why the midwives in this study knew so little about the NMSP and there is little data in the literature to draw any conclusions. Moreover, there is an absence of any information in Australian literature in relation to how midwives view the reforms.

The findings of Personal Responses indicated that this group of midwives and possibly other midwives are not aware of current professional practice issues. Therefore, it is essential that further research into why midwives are seemingly unaware of significant changes to maternity services in Australia is undertaken. Noseworthy and Phipps (2013) identified that inconsistencies in knowledge leads to a complex and inadequate process in decision-making. The successful implementation of the reforms would be hindered by poor decision-making and lack of process. However, Grigg and Tracy (2013) claim that as midwives have worked across standard care and continuity of care, there is a greater awareness and respect for the differences in midwifery practice, leading to a collective engagement and action to implement change.

Of note, the participants were able to recognise the importance of recruiting women into appropriate models of care and the need for midwives to work effectively in these models of care. Further, as previously identified by Donnolley et al. (2015) and Hartz et al. (2012), this study concluded that there exists confusion and lack of clarity in relation to definitions and understanding types of midwifery models of care. Donnolley et al. (2015) and Hartz et al. (2012) found that inconsistency in definitions of models of care impacted on choices and informed decision-making in relation to accessing models of care by consumers and engaging in models of care by midwives. The lack of clarity surrounding what constitutes continuity of care may explain why participants were reluctant to change from a known way of practicing to an unknown way of practicing. To further support the findings of this study, the NMSP identified that the lack of consistency with a definition of continuity of care was a major factor to standardising characteristics of models of care. For instance, inconsistency could impact on the implementation of changes and prevent contemporary midwifery practice evolving (Commonwealth of Australia, 2011).

The second category of Sense of Purpose can be strongly linked to the earlier claims of McAra-Couper et al. (2014) who found that midwives possess passion and commitment to the midwifery profession and the women in their care. For example, the subcategories of Being Valued revealed that the participants' desire and need to be recognised and acknowledged for their contribution to midwifery was very significant. Similarly, Cox and Smythe (2011) discuss the retention of the midwifery workforce based on experiences in the workplace as key to sustaining a satisfied and healthy workforce.

The subcategory of Confidence and Competence linked the close association between being clinically competent and feeling confident to perform as an autonomous practitioner. The findings surrounding confidence and competence concur with research conducted by Hammond et al. (2013) and McKellar et al. (2014) who reported that working within a continuity of care model required significant facility support to ensure success. Subconscious Reluctance or Active Resistance contrasted the differences between midwives who were eager but cautious to undertake professional development to enable them into midwifery models of care and those who were actively prepared or were preparing to leave the profession if they felt forced into change. However, Hunter and Warren (2014) would suggest that reluctance and resistance to challenges are reflective of a beginning process to engage with change and develop personally and professionally through a journey of self-discovery, adaption and resilience.

The findings presented in the category of Atmosphere of Rigidity align with the work of Colvin et al. (2013) and the research by Donald et al. (2014). For instance, Colvin et al. and the study by Donald et al. recognise the multi-faceted processes associated with changing a workforce from one model of care to a more contemporary model. Furthermore, Colvin et al. and Donald et al. propose that solutions to potential and actual problems need to utilise the existing workforce to ensure the development of capacity within that workforce during a period of change. Participants in this study like those of Colvin et al., (2013) and Donald et al., (2014) but unlike the participants in the study by Sidebotham et al. (2015), were able to identify barriers to task shifting and measures required to achieve change. Barriers to autonomous practice were discussed in a systematic review by Colvin et al. (2013) who claimed midwives adjusted to new situations within the clinical environment

however, strategic planning was pivotal to success. The understanding of the participants of this study (in relation to the changes necessary to implement the NMSP) was consistent with the findings of Colvin et al. whereby the majority of participants commented on the need for organisations and managers to plan for the changes. Further, the participants of this study recognised the importance of effective communication strategies during this time of change which could lead to a highly emotional terrain. Furthermore, effective communication needs to be reinforced within and between professions to promote reciprocity as suggest by McAra-Couper et al. (2014) and Donald et al. (2014).

Hunter and Seagrott's work in 2014 found that professional boundaries between midwives and doctors highlighted differences in ideologies and relationships which corresponded with the findings presented in the category Oppositional Tensions. For example, participants consistently questioned what doctors would think of midwives who cared for women in their own right. Likewise, there was potential for a divisive and marginalised state between midwives resulting in a divergence in midwifery ideologies which was also presented in Hunter and Segrott's (2014) research. As identified in this study, relationships between midwives and between midwives and doctors are essential to a harmonious working environment (Hunter & Segrott, 2014). However, the participants attributed that a large portion of responsibility rested with them to conduct midwifery practice in a different context and this aligned with the findings of Colvin et al's. (2013) study. Finally and corresponding with Gilkisen et al. (2015) participants identified that a major burden midwives could experience was their capacity to practice within their profession and within a business framework. Midwives were inexperienced in establishing such things as professional indemnity insurance, managing financial

arrangements and the cost associated with professional development that would be required for autonomous practice. Equally as important was the ability to forge a work-life balance that maintained a satisfying work life and home life that was reflective of the findings of Cox and Smythe, (2011).

The final category was Optimism for the Future, which revealed the participants' willingness and eagerness to embrace the priorities of the NMSP. With the exception of two midwives the participants were visionary in their approach to the NMSP. Hunter and Warren (2014) link a failure of collective identity with barriers to professional progress. Similarly, the importance of the midwifery profession moving forward with a unified aim is pivotal. Participants of this study identified measures such as education, mentoring, developing professional relations with colleagues and effective change management strategies as key factors to contemporary practice, strategies previously outlined by Henshaw et al. (2013) and McInnes and McIntosh (2012). However, a key finding that requires further research is the need to investigate why there is a lack of collective identity by the midwifery profession to the NMSP and for strategies to be developed to assist midwives transition.

In summary, the findings from this research indicate that strategies need to be developed and implemented to assist midwives adopt and adapt to the NMSP priorities. As indicated by Hammond et al. (2013), Hunter and Segrott, (2014) and McAra-Couper et al. (2014), contemporary midwifery practice is dynamic and undergoing significant change. Therefore, it is essential that a skilled and motivated workforce lead the way for change and maintenance of a collective midwifery ideology. In keeping with evidence of what is a "good midwife" (see Table 1), the

majority of participants (five of seven) were optimistic and eager about changing their practice and the thought of developing professionally.

Participants of this study specifically identified educational support in the form of prescribing courses, screening and diagnostics and lactation education to assist them in meeting the challenges of change. Support through mentorship and supervision of midwives in clinical settings across the childbearing continuum will require clinical leadership to sustain contemporary midwifery practice. Furthermore, education in the management of boundaries to address the physical and emotional demands of midwifery continuity of care is vital to prevent burnout and enhance resilience amongst midwives. Additionally, education courses need to focus on interprofessional and interpersonal relationship building and entrepreneurial aspects such as business management principles to capacity build the midwifery workforce for working in a variety of settings. The findings from this research are significant to education providers and will assist in supporting midwives for transitioning to contemporary midwifery practice.

Limitations

The key limitation of this research is the lack of generalisability due to the small number of participants. However, the lack of generalisability and small cohorts are typical and synonymous with qualitative research (Creswell, 22013; Liamputtong, 2013; Schneider, 2013; Yin, 2014). Small participant numbers can only provide a snapshot in time and are not representative of all midwives. However, readers of this research may form a general identity with some of the findings, in particular, but not limited to, the views of the midwives working in the private maternity facility.

The potential for bias on behalf of the researcher and the impact that this may have on the participants was considered. Of note, the researcher did not disclose any professional background to the participants until after the interviews were completed so as not to influence the participants' responses. The previous knowledge and experience of the researcher had the potential to positively influence this study by seeking clarity of the participants' responses during interviews and deeper exploration of participants' comments resulting in a greater depth of data.

Future Recommendations

Of most significance, further research needs to be undertaken to identify strategies and processes midwives use to access information surrounding their profession and future professional practices. Future research needs to be directed at identifying how midwives access information surrounding their profession and future professional practices. Investigation of a larger cohort of midwives from diverse settings across Australia, including midwives working in private facilities, would be of benefit to gain a deeper understanding of how midwives can be facilitated into working more autonomously. For instance, a quantitative study could be conducted to examine the processes employed to expand the knowledge and skills of midwives. Alternatively, an audit could be undertaken by regulatory authorities to investigate the professional development strategies midwives had undertaken in one year. Additionally, determining midwifery managers' understanding of the NMSP and implementation processes within maternity facilities would aid in transitioning change management activities.

It is imperative to understand the level of knowledge and understanding about the NMSP reforms within the profession of midwives. The reforms will impact all

aspects of maternity service providers and users. As it is unclear why some midwives are not informed about important and noteworthy changes that will be implemented and will impact on everyday practice of midwives, it is imperative that data is gathered and analysed about this topic. Further research into why some midwives are not informed about major changes to practice is highly recommended. Furthermore, dissemination of information, professional development, and motivation to take responsibility for lifelong learning are other topics that require further exploration. Of benefit to further explore the implementation of the NMSP would be to investigate the proportion of midwifery continuity of care models in private and public hospitals compared to standard care.

There needs to be a well-informed, strategic, targeted and structured approach to implementation of the NMSP priorities and a well-educated and informed midwifery workforce. A strategic approach should include scoping the midwifery workforce to identify what educational components are required to enable midwives to shift from their current cultural perspective. A strategic and well-managed approach with a supportive infrastructure will promote collective engagement and action by midwives and maternity facilities. Education providers are in the unique position to develop education programs that will enable and support midwives to transition to full scope practice such as clinical and analytical skills and leadership courses. Programs that incorporate prescribing courses and business management skills for midwives will assist in professional development of midwives so they are able to practice in an effective midwifery model of care to role model and shape midwifery students and new graduates.

Future studies could also investigate factors that contribute to and or hinder progress to implement changes to maternity care. For instance, consumers of

maternity services, hospital decision makers, clinical governance and medical officers need to be engaged in the change process and contribute to the implementation. However, there is minimal data available that clearly articulates factors that impede change in maternity settings. Planning and implementation phases for transition to the autonomous midwifery practice require clear and deliberate communication to all stakeholders to engender a collective identity with the NMSP. This can be achieved whilst simultaneously educating a willing midwifery workforce to promote a culture supportive of autonomous midwifery practice. Prior to the instigation of a strategic education program, there needs to be a consensus and uniformity with terminology to give clarity to the professional role of the midwife in continuity models of care. Furthermore, the inconsistencies with the terminology associated with the definition of models of care have potential implications on the ability to gather and report on national maternity data sets and requires urgent attention (AIHW, 2014).

Finally, it is imperative to recognise the emotional terrain in which midwives work when encountering the challenges of change in order to preserve the deep sense of purpose that midwives feel in relation to their profession. The design and implementation of change management courses by organisations to facilitate effective and quality change processes will assist interprofessional relationships between maternity service providers. Further, building strong collegial relationships is needed during the changeover process assimilated with the NMSP priorities. Of particular note, relationship building between medical management teams and midwives is imperative as this issue continues to affect midwifery practice (Downe et al., 2010; Monk et al., 2013; Reiger & Lane, 2009). At present there is little

research surrounding the division between midwives during the process of developing autonomously practicing midwives.

Conclusions of the Study

In conclusion, this research has revealed that the participants of this study, employed in standard care maternity settings, were significantly unaware of national reforms relating to maternity services. As a result of this lack of knowledge, the participants were not cognisant of the subsequent impact that these reforms will have on midwifery practice. Basic knowledge of the NMSP was limited and therefore impacted on the more in-depth conceptual comprehension needed to inform change processes to contemporary, woman centred, and autonomous midwifery practice.

A valuable attribute of the participants of this study was a deep sense of purpose regarding being a midwife. Correspondingly, the participants recognised that professional development to increase competency in midwifery skills promoted their willingness to transition to contemporary practice. The participants identified a range of barriers that impeded progression during a time change that included a working environment that supported contemporary practice. Barriers within the workplace were perceived as preventing midwives from providing more autonomous midwifery care.

Additionally, other factors such as professional development, logistics of the location of consultation rooms, equipment, administration staff, and workplace and professional insurance proved to be a burden of responsibility to moving towards contemporary practice. Although these factors were viewed as challenges during a time of change, participants had mixed views regarding the impending changes. Most significantly, the midwives working in a private hospital were unanimously

eager to change. Conversely, two midwives working in the public sector were preparing or were prepared to leave the midwifery workforce rather than accommodate the changes due to the reforms.

Finally, the intent of the national reforms needs more strategic dissemination to other health professionals working in maternity settings, to the community and to midwives, including greater proactive communication to all practicing midwives using a noteworthy medium. The implementation of these reforms will forge a meaningful change to maternity services for users and providers in Australia. The implementation of the priorities of the National Maternity Services Plan will ensure that tomorrow's midwives will practice with greater autonomy and provide women and their families with contemporary, high quality care.

OFFICE OF RESEARCH
Human Research Ethics Committee
PHONE +61 7 4631 2690| FAX +61 7 4631 5555
EMAIL ethics@usq.edu.au

UNIVERSITY OF SOUTHERN QUEENSLAND AUSTRALIA

4 April 2014

Mrs Bridget Roache
Faculty of Health, Engineering & Sciences
University of Southern Queensland
Fraser Coast Campus
PO Box 910
HERVEY BAY QLD 4655

Dear Bridget

The USQ Human Research Ethics Committee has recently reviewed your responses to the conditions placed upon the ethical approval for the project outlined below. Your proposal is now deemed to meet the requirements of the *National Statement on Ethical Conduct in Human Research (2007)* and full ethical approval has been granted.

Approval No.	**H14REA067**
Project Title	Stretching the comfort zone: Enabling and enhancing the midwife-woman relationship
Approval date	4 April 2014
Expiry date	4 April 2017
HREC Decision	**Approved**

The standard conditions of this approval are:

(a) conduct the project strictly in accordance with the proposal submitted and granted ethics approval, including any amendments made to the proposal required by the HREC
(b) advise (email: ethics@usq.edu.au) immediately of any complaints or other issues in relation to the project which may warrant review of the ethical approval of the project
(c) make submission for approval of amendments to the approved project before implementing such changes
(d) provide a 'progress report' for every year of approval
(e) provide a 'final report' when the project is complete
(f) advise in writing if the project has been discontinued.

Appendix 2

Participant Information Sheet

Stretching the comfort zone: Enabling and enhancing the midwife-woman relationship

Dear Participant

You are being invited to take part in a study titled "Stretching the comfort zone: Enabling and enhancing the midwife-woman relationship". Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please contact me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The purpose of this Information Sheet is to explain as succinctly as possible all the procedures involved in this qualitative phenomenological research design that is being undertaken to explore the experiences of midwives working in a standard care environment during a period of national maternity reform. This information is being provided to you to enable you to make an informed decision as to your participation in the study.

Once you feel you have sufficient information about the project and you are willing to take part, you will be asked to sign the Consent Form. You will be provided with a copy of the signed Consent Form and you can retain the Information Sheet for your records.

About the Project

The purpose of this project is to identify the strengths and weaknesses in the preparedness of midwives to transition from standard midwifery care to more autonomous midwifery practice, in line with the National Maternity Services Reform process, in order to inform midwifery course providers. The broad aim is to identify educational and clinical opportunities to support midwives during this transition process.

Understanding the experiences of midwives who currently deliver standard care in a maternity setting during a period of reform will help to identify the support processes for transition as outlined in the national maternity reforms. These experiences can then be interpreted and incorporated into midwifery courses and clinical areas so that midwives will be more adequately supported into autonomous practice. Identification and interpretation of these experiences will assist in promoting a standardised autonomous midwifery culture to enhance and consolidate the professional status and reputation of midwives who practice to the full scope of the midwifery scope of practice.

Procedures

Participation in this study is voluntary and will involve attending one (1) face-to-face interview that will be conducted for approximately 40 minutes, no longer than 60 minutes at a location and time for your choice. All interviews will be recorded and recordings transcribed by the researcher. The interview will consist of semi-structured questions to promote conversation. The purpose of recording the interview is for data collection and analysis and to maintain the essence and accuracy of the information provided.

There are no risks beyond those of normal day-to-day living associated with your participation in this study. In the event of emotional distress the participant or researcher may interrupt or cease the interview. Participants will be offered access to their General Practitioner or Life Line (ph: 13 11 14).

Confidentiality

All information collected during this research project will be kept strictly confidential. No personal information will be published with the data. Each participant will have their identifiable information such as name, location of work, de-identified and will only be referred to using a pseudonym. A different pseudonym will be allocated by the research to each of the participants. Only the researcher will know the identity of the pseudonym. Any information about the participants will have details removed so that you will not be recognised from it. The data will be used in journal publications and conference presentations. In accordance with research requirements, research data will be kept in a secure location for a period of 5 years from the date of the completion of the study. Audio recordings and transcriptions will be stored on a computer with password access known only to the researcher.

Voluntary Participation

Participation in this qualitative phenomenological research is entirely voluntary. **You may decide to stop being a part of the research study at any time without explanation.** If you decide to take part in this study and later change your mind, you are free to withdraw from the study at any stage. However, contributions will be retained if data has been analysed and findings documented but all personal details will have been de-identified. Prior to analysis of findings, data, traceable only by the researcher, will be located and destroyed or deleted at the request of the participant. Withdrawal from the study can be made by request to the researcher.

You are welcome to ask for any additional information. Please sign the Consent Form only when you have had a chance to review the Participant Information Sheet, raise any questions and receive satisfactory responses. You have the right to have your questions about the research process answered. If you have any questions as a result of reading this Information Sheet, you should ask the researcher prior to the study beginning.

Queries or Concerns

Should you have any queries regarding the process, progress or conduct of this research, you can contact the principal researcher or associate researchers:

Bridget Roache

Midwifery Lecturer

School of Health, Nursing & Midwifery

Faculty of Health, Engineering and Sciences (HES)

University of Southern Queensland

West Street, Toowoomba, Qld, 4350

Phone: +61 419955664

Email:d1010917@umail.usq.edu.au

A/Professor Jennifer Kelly

A/Director of Sciences (Fraser Coast)

Discipline Leader (Midwifery)

School Coordinator Learning & Teaching (HES)

School of Health, Nursing & Midwifery

Faculty of Health, Engineering and Sciences (HES)

University of Southern Queensland

PO Box 910, Hervey Bay QLD 4655

Phone: +61 7 41943121

Fax: +61 741943103

Email: jennifer.kelly@usq.edu.au

If you have any concerns about the ethical conduct of this research you are advised to contact the Ethics Coordinator below:

Ethics and Research Coordinator
Office of Research and Higher Degrees
University of Southern Queensland
West Street, Toowoomba 4350
Ph: +61 7 4631 2690
Email: ethics@usq.edu.au

Appendix 3

University of Southern Queensland

The University of Southern Queensland

Consent Form

Full Project Title:	**Stretching the comfort zone: Enabling and enhancing midwife-woman relationship.**
Principal Researcher:	**Bridget Roache, Faculty of Health, Engineering and Sciences**
Associate Researcher(s):	**A/Professor Jennifer Kelly, School of Health, Nursing and Midwifery, University of Southern Queensland.** **A/Professor Jillian Brammer, School of Health, Nursing and Midwifery, University of Southern Queensland.**

1. I have read the Participant Information Sheet and the nature and purpose of the research project has been explained to me.
2. I have been informed of and understand the purpose of the study.
3. Any questions that I have asked have been answered to my satisfaction.
4. I understand that the individual face-to-face interviews will be audio recorded.
5. I understand that participation involves no foreseeable risk but that I do experience slight discomfort, counselling will be available to me.
6. I understand that the researcher will maintain confidentiality and that any information I supply to the researcher will be used for the purpose of the research only.
7. I understand that I may withdraw from the research project at any stage without prejudice.
8. I confirm that I am over 18 years of age.
9. I understand that the results of the study will be published so that I cannot be identified as a participant.
10. I agree to participate in the study as outlined to me

Name of participant ……...

Signed…….**Date**……

If you have any ethical concerns with how the research is being conducted or any queries about your rights as a participant please feel free to contact the University of Southern Queensland Ethics Officer on the following details.

Ethics and Research Coordinator
Office of Research and Higher Degrees
University of Southern Queensland
West Street, Toowoomba 4350
Ph: +61 7 4631 2690
Email: ethics@usq.edu.au

Research Project
University of Southern Queensland

AN INVITATION to TAKE PART in a MIDWIFERY RESEARCH PROJECT.

The broad aim of this project is to identify educational and clinical opportunities to support midwives during the transition process aligning with national maternity reforms.

The aim of this project is to explore the experiences of midwives working in any area of a maternity facility of a public hospital:

- Antenatal clinic
- Birth suite
- Postnatal unit

You are asked to participate in an interview of no more than 60 minutes (average 30 – 40 minutes).
It will be confidential and all personal details will be de-identified.

You can join if you:
Have worked in any or all of the above areas of a maternity unit.
Have *not* worked in a team or midwifery group practice.

For more information contact:

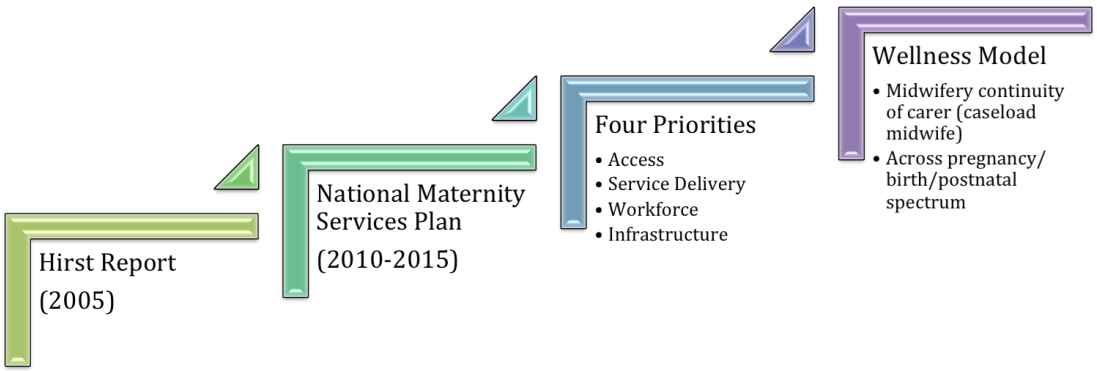
Bridget Roache
0419 955 664
u1010917@umail.usq.edu.au

Ethics approval number: H14REA067

Appendix 5

1. Can you tell me the area of maternity care you predominantly work?
2. What do you enjoy most about that area of your work?
3. What do you enjoy least about that area of your work?
4. Can you tell me what you know about the National Maternity Reforms?
5. Can you tell me how do you think these reforms will impact on the way you practice midwifery?
6. Can you tell me your thoughts about moving into practicing in a new model of care such as group practice or caseload?
7. What are barriers do you think exist in moving from the current model of care you work in a model that reflects the reforms?
8. What do you think will enable you to move into a new model of care?
9. Any last comments about your current position and the National Maternity reforms?

Overview of the National Maternity Services Plan



Caseload midwifery is a model where women are cared for by a primary midwife (with one or two back- up midwives) throughout pregnancy, birth and the early postnatal period.

(COSMOS, 2012)

Reference List

Ajjawi, R. & Higgs, J. (2007). Using phenomenology to investigate how experienced practitioners learn to communicate clinical reasoning. *The Qualitative Report 12*(4), 612-638.

Andrews, M., Brewer, M., Buchan, T., Denne, A., Hammond, J., Hardy, G., Jacobs, L., McKenzie, L. & West, S. (2010). Implementation and sustainability of the nursing and midwifery standards for mentoring in the UK. *Nurse Education in Practice 10*, 251 – 255. Doi: 10.1016/jnepr.2009.11.014.

Anthony, S. & Jack, S. (2009). Qualitative case study methodology in nursing research: An integrative review. *Journal of Advanced Nursing 65*(6), 1171 - 1181. Doi: 10.1111/j.1365-2648.2009.04998

Aune, I., Dahlberg, U., & Ingebrigtsen O. (2012). Parents' experiences of midwifery students providing continuity of care. *Midwifery, 28*, 432 – 438. Doi: 10.1016/j.midw.2011.06.006.

Australian Health Ministers' Advisory Council, (2008). Primary Maternity Services in Australia: A Framework for Implementation. *Australian Health Ministers' Advisory Council.*

Australian Commission on Safety and Quality in Health Care. (2010). *Australian safety and quality framework for health care. Putting the framework into action: getting started.*

Australian Institute of Health and Welfare. (2014b). *Australia's Health 2014.* Australia's health series no. 14. Cat. no. AUS 178. Canberra: AIHW.

Australian Institute of Health and Welfare. (2014a). *Nomenclature for models of maternity care: Literature review.* Canberra: Australian Institute of Health and Welfare.

Australian Institute of Health and Welfare (2015). *Maternity model of care – extent of continuity of carer, code N[N]* Retrieved on 24 March, 2016 from http://meteor.aihw.gov.au/content/index.phtml/itemId/562423.

Baxter, P. & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report 13*(4), 544 – 559.

Beasley, S., Ford, N., Tracy, S., & Welsh, A. (2012). Collaboration in maternity care is achievable and practical. *Australian New Zealand Journal of Obstetric and Gynaecology, 52*(6), 576 – 581. Doi: 10.1111/ajo.12003.

Beckman, M., Kildea, S., & Gibbons K. (2012). Midwifery group practice and mode of birth. *Women and Birth, 25,* 187 – 193.

Begley, C., Oboyle, C., Carroll, M., & Devane, D. (2007). Educating advanced midwife practitioners: A collaborative venture. *Journal of Nursing Management 15,* 574 – 584.

Borelli, S. (2014). What is a good midwife? Insights from the literature. *Midwifery, 30,* 3 – 10. Doi: 10.1016/j.midw.2013.05.019.

Brown, M. & Dietsch, E. (2013) The feasibility of caseload midwifery in rural Australia: A literature review. *Women and Birth, 26,* e1 – e4. Doi: 10.1016/j.wombi.2012.08.003

Brown, J. & Taylor, J. (2014). 'It's a good thing…': women's views on their

continuity experiences with midwifery students form one Australian region. *Midwifery, 30,* e108 – e114. Doi:10.1016/j.midw.2013.11.006.

Byrom, S., & Downe, S. (2010). 'She sort of shines': Midwives' accounts of 'good' midwifery and 'good' leadership. *Midwifery 26,* 126 -137.

Cambridge Dictionaries Online (2016). *Meaning of "Skype" in the English dictionary*. Retrieved from http://dictionary.cambridge.org/dictionary/english/skype January 26, 2016.

Cammarata, L. (2013). Phenomenology and hermeneutics. *The Encyclopedia of Applied Linguistics.* Doi: 10.1002/9781405198431.wbe10905.

Carolan, M. (2013). 'A good midwife stands out': 3rd year students' views. *Midwifery 27,* 503 – 508.

Carolan, M. & Hodnett, E. (2007). "With woman" philosophy: Examining the evidence, answering the questions. *Nursing Inquiry 14*(2), 140-152.

Cheung, N., Mander, R., Wang, X., Fu, W., & Zu J. (2009). Chinese midwives views on a proposed midwife-led normal birth unit. *Midwifery 25*, 744 – 755. Doi:10.1016/j.midw.2008.01.009.

Collins, K & Draycott, T. (2015). Measuring quality of maternity care. *Best Practice & Research Clinical Obstetrics and Gynaecology,* 1 – 7. Doi: 10.1016/j.bpobgyn.2015.03.021.

Collins, C., Fereday, J., Pincombe, J., Oster, C., & Turnbull, D. (2010) An evaluation of the satisfaction of midwives' working in midwifery group practice. Midwifery, 26, 435 – 441. Doi: 10.1016/j.midw.2008.09.004.

Colvin, C., de Heer, J., Winterton, L., Mellenkamp, M., Glenton, C., Noyes, J., … Rashidian, A. (2013). A systematic review of qualitative evidence on barriers

and facilitators to the implementation of task-shifting in midwifery services. *Midwifery, 29,* 1211 – 1221. Doi: 10.1016/j.midw.2013.05.001.

Commonwealth of Australia, (1996). *Options for effective care in childbirth.* National Health and Medical Research Council.

Commonwealth of Australia, (1998). *Review of services offered by midwives*. National Health and Medical Research Council.

Commonwealth of Australia, (1999). *Rocking the cradle: A report into childbirth procedures.* Commonwealth of Australia.

Commonwealth of Australia, (2008). *Improving Maternity Services in Australia: A Discussion Paper from the Australian Government*. Commonwealth of Australia.

Commonwealth of Australia, (2009). *Improving Maternity Services in Australia. The Report of the Maternity Services Review.* Commonwealth of Australia.

Commonwealth of Australia, (2011). *National Maternity Services Plan 2010.* Commonwealth of Australia.

Cox P. & Smythe, L. (2011). Experiences of midwives' leaving lead maternity care (LMC) practice. *New Zealand College of Midwives Journal 44*, 17 – 21.

Creswell, J. (2013). *Qualitative inquiry & research design: Choosing among five approaches (3rd Edition).* London: Sage.

Dahlberg,U. & Aune, I. (2013). The women's birth experience – the effect of interpersonal relationships and continuity of care. *Midwifery 29*, p407- 415. Doi.org/10.1016/j.midw.2012.09.006.

Davies, R (2003). *"She did what she could"…A history of the regulation of midwifery practice in Queensland 1859 – 1912*. (PhD thesis). Queensland University of Technology, Brisbane, Australia.

Davis, L. & Walker, K., (2010). Case-loading midwifery in New Zealand: Making space for childbirth. *Midwifery 26,* p603-608. Doi:10.1016/j.midw.2009.01.004.

Dawson, A., Brodie, P., Copeland, F., Rumsey M., & Homer, C. (2014). Collaborative approaches towards building midwifery capacity in low income countries: A review of experiences. *Midwifery, 30,* 391 – 402. Doi: 10.1016/j.midw.2013.05.009.

Dawson, K., Newton, M., Forster, D., & McLachlan, H. (2015). Exploring midwifery students' view and experiences of caseload midwifery: A cross-sectional survey conducted in Victoria, Australia. *Midwifery, 31,* e7 – e15. Doi: 10.1016/j.midw.2014.09.007.

De Vries, R., Nieuwenhuijze, M., & Buitendijk, S. (2013). What does it take to have a strong and independent profession of midwifery? Lessons from the Netherlands. *Midwifery 29,* p1122-1128. Doi.org/10.1016/j.midw.2013.07.007.

De Wit, L. & Ploeg, J. (2006). Critical appraisal of rigor in interpretive phenomenological nursing research. *Methodological Issues in Nursing Research*. Doi: 10.1111/j.1365-2648.2006.03898.x.

Denzin, N & Lincoln, Y. (2003). *Strategies of Qualitative Inquiry.* Thousand Oaks CA: Sage.

Donald, H., Smythe, L., & McAra-Couper, J. (2014). Creating a better work-life balance. *New Zealand College of Midwives Journal*, 49, 5 – 10.

Donnolley, N., Butler-Henderson, K., Chapman, M., & Sullivan, E. (2015). The development of a classification system for maternity models of care. *Health Information Management Journal* p1 - 8. Retrieved from http://dx.doi.org/10.12826/18333575.2015.0010.Donnolley on October 10, 2015.

Downe, S., Finlayson, K., & Fleming, A. (2010). Creating a collaborative culture of maternity care. *Journal of Midwifery & Women's Health 5,* p250–254. Doi:10.1016/j.jmwh.2010.01.004.

Drennan, V., Davis, K., Goodman, C., Humphrey, C., Locke, R., Mark, A., … Traynor, M. (2007). Entrepreneurial nurses and midwives in the United Kingdom: An integrative view. *Journal of Advanced Nursing 60(5),* 459 – 469. Doi: 10.1111/j.1365-2648.2007.04458.x.

Earle, V. (2010). Phenomenology as a research method or substantive metaphysics? An overview of phenomenology's uses in nursing. *Nursing Philosophy, 11*(4), 286-29. Doi: 10.1111/j.1466-769X.2010.00458.x.

Edmondson M. & Walker, S. (2014). Working in caseload midwifery care: The experience of midwives working in a birth centre in North Queensland. *Women and Birth, 27,* 31 – 36. Doi: 10.1016/j.wombi.2013.09.003.

Fahy, K. (2007). An Australian history of the subordination of midwifery. *Women and Birth, 25,* 25 – 29. Doi.org/10.1016/j.wombi.2006.08.003

Fahy, K. (2012). What makes a midwifery model of care safe? *Women and Birth 25,* 1-3. Editorial. Doi: 10.1016/j.wombi.2011.12.003.

Fereday, J., & Oster, C. (2010). Managing a work-life balance: The experiences of midwives working in a group practice setting. *Midwifery 26*, 311-318. Doi:10.1016/j.midw.2008.06.004.

Forster, D., Newton, M., McLaughlin, H. & Willis, K. (2011). Exploring implementation and sustainability of models of care: Can theory help? *BioMed Central 11*(Supp 5) available at: http://www.biomedcentral.com/1471-2458/11/S5/S8.

Gray, D. (2009). *Doing research in the real world* (2nd edition). London: Sage.

Gilkison, A., McAra-Couper, J., Gunn, J., Crowther, S., Hunter, M., Macgregor, D. & Hotchin, C. (2015). Midwifery practice arrangements which sustain caseloading lead maternity carer midwives in New Zealand. *New Zealand College of Midwives Journal 15*, 11 – 16.

Grigg, C. & Tracy, S. (2013). New Zealand's unique maternity system. *Women and Birth 26*, e50-e64.

Gu, C., & Zhang, Z. & Ding, Y. (2011). Chinese midwives' experiences of providing continuity of care to labouring women. *Midwifery, 27,* 243 – 249. Doi: 10.1016/j.midw.2009.06.007.

Halldorsdottir, S. & Karlsdottir, S. (2011). The primacy of the good midwife in midwifery services: An evolving theory of professionalism in midwifery. *Scandinavian Journal of Caring Sciences*, *25*, 806 – 817. Doi: 10.1111/j.1471-6712.2011.00886.x.

Hammond, A., Foureur, M., Homer, C., & Davis, D. (2013). Space, place and the midwife: Exploring the relationship between the birth environment,

neurobiology and midwifery practice. *Women and Birth 26,* 277 – 281. Doi: 10.1016/j.wombi.2013.09.001

Hartz, D., Foureur. M, & Tracy, S. (2012). Australian caseload midwifery: The exception or the rule. *Midwifery, 25,* 39 – 46. Doi: 10.1016/j.midw.2011.01.001.

Hartz, D.L., White, J., Lainchbury, K.A., Gunn, H., Jarman, H., Welsh, A.W., … & Tracy, S.K. (2012). Australian maternity reform through clinical design. *Australian Health Review 36,* 169 – 175. Doi:10.1071/AH11012.

Henshaw, A-M., Clarke, D., & Long, A. (2013). Midwives and supervisors of midwives' perceptions of the statutory supervision of midwifery within the United Kingdom: A systematic review. *Midwifery*, 29, 75 – 85. Doi: 10.1016/j.midw.2011.11.004.

Hirst, C. (2005). *Re-birthing. Report of the review of maternity services in Queensland,* Available at: http://www.qcmb.org.au/media/pdf/Rebirthing%20report.pdf (accessed 29 October 2013).

Homer, C. (2006). Challenging midwifery care, challenging midwives and challenging the system. *Women and Birth 19*, 79-83. Doi: 10.1016/j.wombi.2006.07.002

Homer, C., Passant, L., Brodie, P., Kildea, S., Leap, N., Pincombe, J., Thorogood, C. (2009). The Role of the midwife in Australia: Views of women and midwives. *Midwifery 25*, 673-681. Doi: 10.1016/j.midw.2007.11.003.

Huber, U & Sandall, J. (2009). A qualitative exploration of the creation of calm in a continuity of carer model of maternity care in London. *Midwifery, 25,* 613 – 621. Doi: 10.1016/j.midw.2007.10.001.

Hunter, B. (2004). Conflicting ideologies as a source of emotion work in midwifery. *Midwifery, 20,* 261 – 272. Doi: 10.1016/j.midw.2003.12.004.

Hunter, B. & Seagrott, J. (2014). Renegotiating inter-professional boundaries in maternity care: Implementing a clinical pathway for normal labour. *Sociology of Health & Illness, 36, 5,* 719 – 737. Doi: 10.1111/1467 – 9566.12096.

Hunter, B & Warren L. (2014). Midwives' experiences of workplace resilience. *Midwifery,* 30, 926 – 934. Doi: 10.1016/j.midw.2014.03.010.

International Confederation of Midwives. (2011). *ICM International definition of the midwife.* The Hague: International Midwives.

International Confederation of Midwives. (2013). *Essential competencies for basic midwifery practice*. The Hague: International Midwives.

James, L. (2013). Nurturing the next generation: Midwives' experiences when working with third year midwifery students in New Zealand. *New Zealand College of Midwives Journal, 47,* 14 – 17.

Jenkins, M., Ford, J., Todd, A., Forsyth, R., Morris, J., & Roberts, C. (2014). Women's views about maternity care: How do women conceptualise the process of continuity? *Midwifery,* 1 – 6. Doi: 10.1016/j.midw.2014.05.007.

Kim, K., Lee, A., Eudey, L., & Dea, M. (2014). Improving clinical competence and confidence of senior nursing students through clinical preceptorship. *International Journal of Nursing, 1(2),* 183 – 209. Doi: 10.15640/ijn.v1n2a14.

Kitto, C., Chesters, J. & Grbich, C. (2008). Quality in qualitative research. *The Medical Journal of Australia 188*(4), 243 – 246.

Lane, K. (2006). The plasticity of professional boundaries: A case study of collaborative care in maternity services. *Health Sociology Review 15*, 341-352.

Lane, K. (2012). Dreaming the impossible dream: Ordering risks in Australian maternity care policies. *Health Sociology Review 21*(1), 23 – 35.

Langdridge, D. (2007). *Phenomenological psychology*. London: Pearson Prentice Hall.

Larsson, M., Aldegarmann, U., & Aarts, C. (2009). Professional role and identity in a changing society: Three paradoxes in Swedish midwives' experiences. *Midwifery, 25,* 373 – 381. Doi: 10.1016/j.midw.2007.07.009.

Liamputtong, P. (2013). *Qualitative research methods* (4th edition). Australia: Oxford Press.

Lundgren, I. (2007). Central concepts in the midwife-woman relationship. *Scandinavian Journal of Caring Sciences 21*. 220-228.

McAra-Couper, J., Gilkison, A., Crowther, S., Hunter, M., Hotchin, C., & Gunn, J. (2014) Partnership and reciprocity with women sustain lead maternity carer midwives in practice. *New Zealand College of Midwives Journal, 49,* 29 – 33.

McCool, W., Guidera, M. Reale, B., Smith, A, & Koucoi, J. (2013). Professional issues related to obstacles to midwifery practice in the Americas: A pilot study. *Midwifery, 29,* 838 – 844. Doi: 10.1016/j.midw.2012.08.007.

McInnes, R. & McIntosh, C. (2012). What future for midwifery? *Nurse Education in Practice, 12,* 297 – 300. Doi: 10.1016/j.nepr.2012.04.011.

McIntyre, M., Francis, K., & Chapman, Y. (2012). The struggle for contested boundaries in the move to collaborative care teams in Australian maternity care. *Midwifery 28,* 298 – 305. Doi: 10.1016/j.midw.2011.04.004.

McKellar, L., Charlick, S., Warland, J., & Birbeck, D. (2014). Access, boundaries and confidence: The ABC of facilitating continuity of care experience in midwifery education. *Women and Birth, 27,* e61 – e 66. Doi: 10.1016/j.wmobi.2014.08.005.

McLachlan, H., Forster, D., Davey, M., Farrell, T., Gold, L., Biro, MA., … Waldenstrom, U. (2012). Effects of continuity of care by a primary midwife (caseload midwife) on caesarean section rates in women of low obstetric risk: The COSMOS randomized controlled trial. *BJOG, 119,* 1483 – 1492. Dpi:10.1111/j.1471-0528.2012.03446.x .

McMurray, A., Chaboyer, W., Wallis, M., & Fetherston, C. (2010). Implementing bedside handover: Strategies for change management. *Journal of Clinical Nursing 19,* 2580-2589. Doi:10.1111/j.1365-2702.2009.03033.x.

Merriam, S. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Wiley.

Mills, A., Eurepos, G. & Wiebe, E. (2010). *Enyclopedia of case study research: L – Z, Volume 2.* Thousand Oaks, CA: Sage.

Ministry of Health. (2012). *Midwifery continuity of carer model tool-kit*. New South Wales.

Miyazaki, A. & Taylor, K. (2008). Researcher biases and business ethics research: Respondent reactions to researcher characteristics. *Journal of Business Ethics 81*(4), 779 – 795.

Mollart, L., Skinner, V., Newing, C., & Foureur, M. (2013). Factors that may influence midwives work-related stress and burnout. *Women and Birth 26*, 26-32. Doi: 10.1017/j.wombi.2011.08.002.

Monk, A., Tracy, S., Foureur, M., & Barclay, L. (2013). Australian primary maternity units: Past, present and future. *Women and Birth 26*, 213–218. Doi.org/10.1016/j.wombi.2013.06.001.

Munro, S., Kornelson, J., & Grzybowski, S. (2013). Models of maternity care in rural environments: Barriers and attributes of interpersonal collaboration with midwives. *Midwifery*, *29*, 646 – 652. Doi: 10.1016/j.midw.2012.06.004.

National Health and Medical Research Council (NHMRC) (1996). *Options for effective care in childbirth.* Canberra: NHMRC.

National Health and Medical Research Council (NHMRC) (1998). *Review of services offered by midwives.* Canberra: NHMRC.

National Institute for Health and Care Excellence (NICE) (2015). *Safe midwifery staffing for maternity settings.* Retrieved on 24 March 2015 from https://www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-51040125637

Newnham, E., (2010). Midwifery directions: The Australian maternity services review. *Health Sociology Review 19*(2), 245-259.

Newton, M., McLachlan, H., Willis, K., & Forster, D. (2014). Comparing satisfaction and burnout between caseload and standard care midwives:

Findings from two cross-sectional surveys conducted in Victoria, Australia. *BioMed Central Pregnancy & Childbirth, 14:426,* 1 – 16. Doi: 10.1186/s12884-014-0426-7.

Nicholls, l., Skirton, H., & Webb, C. (2011). Establishing perceptions of a good midwife: A Delphi study. *British Journal of Midwifery 19(4), 230 – 236*

Noseworthy, D., Phibbs, S., & Benn, C. (2013). Towards a relational model of decision-making in midwifery care. *Midwifery 29*, e242-248. Doi.org/10.1016/j.midw.2012.06.022.

Nursing and Midwifery Board Australia (2010). *A midwife's guide to professional boundaries. N*ursing and Midwifery Board of Australia: Melbourne.

Nursing and Midwifery Board Australia (2010). *National competency standards for the midwife.* Nursing and Midwifery Board of Australia: Melbourne.

Nursing and Midwifery Board Australia (2013). *Statistics Nurse and Midwife – Registration Data – March 2013*. Retrieved from website: http://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx.

Nursing and Midwifery Office Queensland, (2013). *Maternity care options.* Viewed 30 October 2013, http://www.health.qld.gov.au/nmoq/midwifery/care-options.asp.

Ouyang, Z., Sang, J & Peng, J. (2015). Organisational justice and job insecurity as mediators of the effect of emotional intelligence on job satisfaction: A study from China. *Personality and Individual Differences 76*, 147 – 152. Doi: 10.1016/j.paid.2014.12.004.

Patel, N. & Rajasingam, D. (2013). User engagement in the delivery and design of maternity services. *Best Practice & Research Clinical Obstetrics and Gynaecology, 27,* 597 – 608. Doi: 10.1016/j.bpobgyn.2013.04.006.

Pugh, J., Twigg, D., Martin, T., & Rai, T. (2013). Western Australia facing critical losses in its midwifery workforce: A survey of midwives' intentions. *Midwifery, 29,* 497 – 5505. Doi: 10.1016/j.midw.2012.04.006.

Queensland Health (2000). *Changing models of care framework.* Brisbane, Queensland Government. Available at: https://www.health.qld.gov.au/publications/change_management/Care_Framework.pdf Accessed 26 January 2016.

Rawnson, S. (2011). A qualitative study exploring student midwives' experiences of carrying a caseload as part of their midwifery education in England. *Midwifery, 27,* 786 – 792. Doi: 10.1016/j.midw.2010.07.004.

Renfrew, M., McFadden, A., Bastos, M., Campbell, J., Channon, A., … Declercq, E. (2014). Midwifery and quality care: findings from a new evidence-informed framework for maternal and newborn care. *Lancet, 384(9948),* 1129 - 1145. Doi: 10.1016/S0140-6736(14)60789-3.

Reeves, S., Kuper, A., & Hodges, B. (2008). Qualitative research methodologies: Ethnography. *The British Medical Journal 337.* Doi: http://dx.doi.org/10.1136/bmj.a1020.

Reiger, K. (2006). A neoliberal quickstep: contradictions in Australian maternity policy. *Health Sociology Review, 15,* 300 – 340. https://www.google.com.au/search?q=a+neoliberal+quickstep%3A+contradicitons+in+australian+matenrity+policy&oq=a+neoliber&aqs=chrome.0.69i59j69i57j0l2j69i64.7517j0&sourceid=chrome&ie=UTF-8.

Rigg, E., Schmeid, V., Peters, K., & Dahlen, H. (2015). Not addressing the root cause: An analysis of submissions made to the South Australian Government an o proposal to protect midwifery practice. *Women and Birth, 28,* 121 – 128. Doi: 10.1016/j.wombi.2014.12.005.

Sandall, J. (2012). Every woman needs a midwife, and some women need a doctor too. *Birth 39,* 323 – 326.

Sandall, J., Devane, D., Soltani, H., Hatem, M., & Gates, S. (2010). Improving quality and safety in maternity care: The contribution of midwife-led care. *Journal of Midwifery & Women's Health 55*, 255–261. Doi:10.1016/j.jmwh.2010.02.002

Sandall, J., Soltani, H., Gates, S., Shennan, A., & Devane, D. (2013). Midwifery-led models versus other models of care for childbearing women (Review). *Cochrane Database of Systematic Reviews, 2013*(8), 1-107. Doi: 10.1002/14651858.CD004667.pub3.

Schmeid, V., Mills, A., Kruske, S., Kemp, L., Fowler, C., & Homer, C. (2012). The Nature and impact of collaboration and integrated service delivery for pregnant women, children and families. *Journal of Clinical Nursing, 19,* 3516 – 3526. Doi: 10.1111/j.1365-2702.2010.033291.x.

Schneider, Z. & Whitehead, D. (2013). *Nursing and midwifery research: Methods and appraisal for evidence-based practice. 4th edition.* Sydney: Elsevier.

Sidebotham, M., Fenwick, J., Rath, S., & Gamble, J. (2015). Midwives' perceptions of their role within the context of maternity service reform: An Appreciative Inquiry. *Women and Birth, 28*(2), 112–120.

Skinner, J., & Foureur, M. (2010). Consultation, referral, and collaboration between

midwives and obstetricians: Lessons from New Zealand. *Journal of Midwifery & Women's Health 55*,1. Doi:10.1016/j.jmwh.2009.03.015.

Smith, A., Dixon, A., & Page, L. (2009). Health-care professionals' views about safety in maternity services: A qualitative study. *Midwifery, 25*, 21 – 31. Doi: 10.1016/j.midw.2008.11.004.

Smith, R., Leap, N., & Homer, C. (2010). Advanced midwifery practice or advancing midwifery practice? *Women and Birth 23*, 117 – 120. Discussion. Doi:10.1016/j.wombi.2009.11.002.

Stake, R. (1995). *The art of case study.* Thousand Oaks, California: Sage.

Sullivan, K., Lock, L., & Homer, C. (2011). Factors that contribute to midwives staying in midwifery: A study in one area health service in New South Wales, Australia. *Midwifery 27*, 331-335. Doi: 10.1016/j.midw.2011.01.007.

Sutcliffe, K., Caird, J., Kavanagh, J., Rees, R., Oliver, K., Dickson, K., … & Thomas, J. (2012). Comparing midwife-led and doctor-led maternity care: A systematic review of reviews. *Journal of Advanced Nursing* p 2376-2386.

Tracy, S., Hartz, D., Tracy, M., Allen, J., Forti, A., Hall, B., … & Kildea, S. (2013). Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *The Lancet* 1-10 Published online September 17, 2013. http://dx.doi.org/10.1016/S0140-6736(13)61406-3.

Tracy, S., Welsh, A., Hall, B., Hartz, D., Lainchbury, A., Bisits, A. … Tracy, M. (2014). Caseload midwifery compared to standard or private obstetric care for first time mothers in a public teaching hospital in Australia: A cross sectional study of cost and birth outcomes. *BioMedical Central Pregnancy &*

Childbirth 14 (46).

United Nations Population Fund (UNFPA). (2011). *The state of the world's midwifery 2011. Delivering health, saving Lives.* United Nations Family Planning Association.

United Nations Population Fund (UNFPA). (2014). *The state of the world's midwifery. A universal pathway. A woman's right to health*. United Nations: USA.

Van kelst, L., Spitz, B., Sermeus, W., & Thomson, A. (2013). A hermeneutic phenomenological study of Belgian midwives' views on ideal and actual midwifery care. *Midwifery*, *29*, e9 –e17. Doi: 10.1016/j.midw.2011.10.002.

Walsh, D., & Devane, D. (2012). A metasynthesis of midwifery-led care. *Qualitative Health Research, 22*, 897 – 910. Doi: 10.1177/1049732312440330.

Warmelink, J., Hoijtink, K., Noppers, M., Wiegers, T., de Cock, T., Klemp, T., & Hutton, E. (2015). An exploratory study of factors contributing to the job satisfaction of primary care midwives. *Midwifery, 31*, 482 – 488. Doi: 10.1016/j.midw.2014.12.003.

Williams, K., Lago, L., Lainchbury Lainchbury, A., & Eager, K. (2010). Mother's views of caseload midwifery and the value of continuity of care at an Australian regional hospital. *Midwifery 26*, 615 – 621. Doi: 10.1016/j.midw.2009.02.003.

Wood, S., & Bhatnagar, S. (2015). Resilience to the effects of social stress: evidence from clinical and preclinical studies on the role of coping strategies. *Neurobiology of Stress, 1*, 164 – 173. Doi: 10.1016/j.nstr.2014.11.002.

World Health Organization, (2010). The Global Numbers and Costs of Additionally Needed and Unnecessary Caesarean Sections Performed per Year: Overuse as a Barrier to Universal Coverage. *World Health Report (2010) Background Paper*, 30. World Health Organization.

Wright, S., Cloonan, P., Leonhardy, K., & Wright, G. (2005). An international programme in Nursing and midwifery: Building capacity for the new millennium. *International Nursing Review, 52,* 18 – 23.

Yoshida, Y., & Sandall, J. (2013). Occupational burnout and work factors in community and hospital midwives: A survey analysis. *Midwifery, 29,* 921 – 926. Doi: 10.1016/j.midw.2012.11.002.

Young, C. (2011). *The experience of burnout in case loading midwives*. (Unpublished doctoral dissertation). Auckland University of Technology, Auckland. Retrieved from http://aut.researchgateway.ac.nz/bitstream/handle/10292/2447/YoungC.pdf?sequence=3&isAllowed

Yin, R. (2014). *Case study research design and methods (5th edition).* Thousand Oaks, California: Sage.

Yoshida, Y., & Sandall, J. (2013). Occupational burnout and work factors in community and hospital midwives: A survey analysis. *Midwifery 29*, 921-926. Doi.org/10.1016/j.mimdw.2010.11.002.

Zucker, D. (2009). How to do case study research. *School of Nursing Faculty Publication Series*. Paper 2. Retrieved on 26 June, 2014 from http://scholarworks.umass.edu/nursing_faculty_pubs/2.