RENOVATING MIDWIFERY CARE: THE COMPLEXITY OF ORGANISATIONAL CHANGE FOR MIDWIVES IN VICTORIA, AUSTRALIA

by

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CERTIFICATE OF AUTHORSHIP / ORIGINALITY

I certify that this thesis has not previously been submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged.

In addition, I certify that all information sources and literature used are indicated in the thesis.

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There are many people that I would like to acknowledge and thank for their support, advice and guidance throughout my professional doctorate journey. First and foremost I would like to thank those midwives who took the time to share their experiences with me. I hope that changes that are continuing in maternity service organisation in Victoria provide a choice of midwifery practice to suit you all.

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To my daughter-in-law Emma thanks for your valued editorial advice. Hopefully you learnt a little about midwives and midwifery as you proof read this document. As we enter the next stages of our lives, you to become a mother and me a grandmother you will be glad to hear that I will now have time to baby sit.

Finally, I would like to thank all my friends, work colleagues and fellow students for their support, suggestions and words of encouragement that have all been much appreciated.

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ABSTRACT

The importance of the role of the midwife in providing safe, quality care for women has until recently, been underrated in Victoria, Australia. Acknowledgement of the need for midwife-led models of care in state maternity service policies provided opportunities for midwives to become recognised within the healthcare system and the wider community. This professional doctorate aims to examine the ways in which the role of the midwife and her[1] practice has been impacted on by organisational renovations of midwifery care. It identifies the complexity of the factors that affect the midwife's ability or choice to work in midwife-led models of care. Furthermore this doctorate highlights the need for ongoing debate into midwifery in Australia.

Concepts related to midwifery practice are examined as they form the foundations for the research and policy components of the portfolio. This includes an exploration of midwifery philosophy, the antecedents to autonomous practice and the experience midwives have of midwife-led care. An examination of the concepts of continuity of care and woman-centred care provides a platform upon which to review models of midwifery care. This review highlights the development of an ongoing relationship as a source of satisfaction for midwives and women.

The second part of the doctorate reviews policies that guide the provision of maternity services in Victoria. Analysis of these policies using Kingdon's multiple streams framework identifies the problems, the political actors and the policy developed, establishing the context for organisational change in maternity care. The antecedents for successful integration of organisational change are explored through a review of change theory and leadership.

A case study approach utilised for the research component of the doctorate provides insights into organisational change that occurred at two maternity sites in Victoria. The findings of the study suggest there was a dichotomy between those midwives desiring autonomous practice and wanting to work in midwife-led care and those wishing to remain in one specialised area. Recommendations stemming from these findings

[1] The feminine pronoun will be used throughout the portfolio as 99% of midwives in Australia are women. This is not meant to discriminate against male midwives.

include the need for sufficient education and support during change, a review of terminology used to describe midwifery models of care and research into the use of integrated maternity units.

Complexity science is examined in order to bring the different strands of the doctorate together, providing an explanation for the different outcomes that occur despite the implementation of similar models. The connective leadership model was suggested as the means to provide leadership that is inclusive of providing direction, mentoring new leaders and providing support and opportunities for midwives to become empowered to practice autonomously. Attention to the complexity of organisational change is vital to ensure the future of midwifery.

CHAPTER ONE

PORTFOLIO INTRODUCTION

1. Introduction

This portfolio is the culmination of work completed towards a Professional Doctorate of Midwifery. At the time that I enrolled in the professional doctorate program I was employed in a clinical role and the program provided the opportunity to explore aspects of maternity care more broadly than a PhD might. The professional doctorate program includes study related to midwifery knowledge, policy, leadership and research. The importance of having an understanding of the processes that underpin midwifery practice in the clinical area cannot be understated. There are several difficulties in the clinical arena in getting research into practice, it is not only difficult because of individual resistance, but requires, in many instances, attention to other factors like leadership and understanding policy formulation. Completion of this professional doctorate has enhanced my ability to introduce and support change in the clinical field.

The catalyst for undertaking this professional doctorate was the need to understand the interactions and resistance to change that I had observed within a maternity unit undergoing organisational change. This change included expanding midwifery services, a move to an integrated ward and development of a new model of care appropriate for the changing environment. It was not the resistance to organisational change per se that surprised me, it was the resistance by midwives to the introduction of continuity of midwifery care models. Prior to introducing the reader to the literature and research presented in this portfolio, it seems appropriate to provide some of the background of my journey to this point as a midwife. The importance of providing my background is not only to acknowledge my beliefs and potential biases but also to provide some insight and reflection on the influences that led to the development of those beliefs for me.

1.1. The Author and Midwifery

I trained as a midwife in the United Kingdom (UK) in the early 1970s, at a time when all women were being encouraged to give birth in hospital. During my community placement there were no home births and few of my peers were lucky enough to have this experience either. Although my siblings and I were all born at home, the main message I heard from my mother was her concerns that the midwife had arrived late and the cord was around my sister's neck and she didn't cry immediately. I developed the opinion that giving birth in hospital or small maternity units was the best option for women. Midwives in the UK at the time of my training did not suture the perineum nor insert intravenous cannulae. Continuous fetal monitoring was becoming more common and I clearly remember the 'sister tutor' bemoaning the reliance on this technology by students she had been assessing at another maternity unit, fearing the loss of clinical skills. Unfortunately I feel that her predictions have come true.

It was soon after qualifying as a midwife that I became actively involved in change by joining a working group to introduce 24 hour 'rooming in' and demand breastfeeding. At times over the last 30 years, when moving between maternity units and countries, I have found myself facing the same arguments raised by midwives opposed to change, as in those early days. Arriving in Australia in the late 1970s, the changes revolved around removing complementary feeds and then in the mid 1980s stopping perineal shaves and enemas. Moving to Hong Kong in 1990 I found myself faced by rigid policies that included four hourly feeding, complementary feeds, soap and water enemas and perineal shaves. In addition, continuous fetal monitoring, epidurals and episiotomies were routine. I have always been active in supporting progress towards improved care for women, influenced initially by other midwives, in particular as a member of the Royal College of Midwives in the UK, to become a promoter of evidence based practice in more recent years. By the time I arrived in Hong Kong I had commenced a Bachelor degree in nursing to upgrade my education to university level, as nursing at that time had moved into the tertiary sector in Australia. It was during that time in Hong Kong, where a combination of tertiary level study and a developing interest in complementary therapies and Eastern philosophy, led me to further challenge medically focused midwifery practice. Although I was challenging routine practices I am not sure that I had fully acknowledged birth as a normal process, so embedded in the medical model was my experience to this time.

Change has been part of my life since I was first born. As a child my family moved house many times and as an adult I have continued that tradition. I have predominantly been employed as a midwife since completing my training, but I have changed my place of employment and role many times. These changes occurred predominantly through choice but included occasions when the decision to move was beyond my control. Three times I have been working in units that were subject to closure, twice I took control and sought out re-employment myself. The third occasion I remained until the bitter end, not only because of the lack of opportunity but because I was unsure of how I wanted my career to develop. Offered a position in a tertiary hospital labour ward, I resisted for several weeks because of my increasing affinity to non-interventional midwifery care and thoughts about moving into education. Eventually I ran out of options so took the position offered. This move actually opened up opportunities that I had not foreseen, including working with students more regularly than when I was in the smaller unit. This led to a joint position with the university as a clinical educator/lecturer. However, after eighteen months the program was discontinued and I once again faced redeployment. This third time rather than be placed back in the labour ward, I took the initiative and found a position as a clinical educator in a different hospital. It was here that many organisational changes were occurring including the introduction of midwifery students, and an attempt to institute rotation of all staff through all wards. It was during my time in this position when the impact of change became my focus of study.

In the year 2000 I became more active in the midwifery profession in Australia, becoming a founding member of a local sub-branch of the Australian College of Midwives (ACM). The active members of this sub-branch come from a variety of maternity units and have enabled networking, sharing of knowledge and support. I became the treasurer, a position I still hold, and am actively involved in organising study days. Our meetings rotate between hospital sites to encourage more midwives to attend. In an effort to become more involved in the leadership of the ACM I nominated for and was elected to the Victorian branch becoming their treasurer for five years. This role provided opportunities to interact with midwives and midwifery leaders from across Australia.

In 2001, on a midwifery discussion site I heard about the introduction of the Advanced Life Support Obstetrics (ALSO) to Australia. ALSO brings together midwives and obstetricians for joint training in management of maternity emergencies. Initiating an ALSO course at my place of work in the first year of its inception into Australia, I participated and was later invited to become an instructor. As an instructor for the last six years the multi-professional interaction is rewarding, stimulating and provides opportunities for gaining a national perspective of the midwifery profession and maternity care.

In looking back I recognise the catalysts that enabled me to develop and change. When confronted with choices that meant restricting my practice to one area, I chose working with birthing women over postnatal care, an area I preferred. This hindsight provides me with some empathy with those midwives who have not experienced different approaches to maternity care as well as with those midwives who prefer one area of practice over another. As a wife and mother, with a husband who travelled frequently for work, I am able to recognise the difficulties some midwives, as women, mothers and wives, have in participating in employment that requires flexibility.

1.2. Outline of Portfolio – Metaphor of House

Throughout my journey, the plans of the layout for this portfolio have changed many times in an attempt to demonstrate learning without leaving the reader pondering the relevancy of the topics. The use of a house as a metaphor for describing the contents emerged from a model provided to explain the process of research (Moss, Crisp, & Foureur, 2007). Within a house there are foundations, a floor, the main building and a roof. Therefore, within this portfolio the foundations as outlined in section one relate to the midwife role; the floor is formed from the policy of section two and the main house became the research project; the roof is formed by the final section that holds the house together (see Figure 1).

This metaphor while providing a structure for the portfolio implies a linearity of the development of the connections between each level. I acknowledge that it does not fully meet the needs of demonstrating the links to complexity theory that I explore in the last chapter but was very useful for me when putting it all together. Therefore,

given that the research project reported relates to changing maternity services and changing practice of midwives I would like the reader to consider the case studies presented as the walls and rooms of the house as a process of renovation. Thus as occurs in renovations, connections are made between the main structure, the foundations and the outside and the types of changes and effects of those changes depend on the strength and rigidity of those foundations and floors.

While the presentation of the portfolio appears to be linear, the complexity of midwifery is such that the content of each chapter is interconnected.

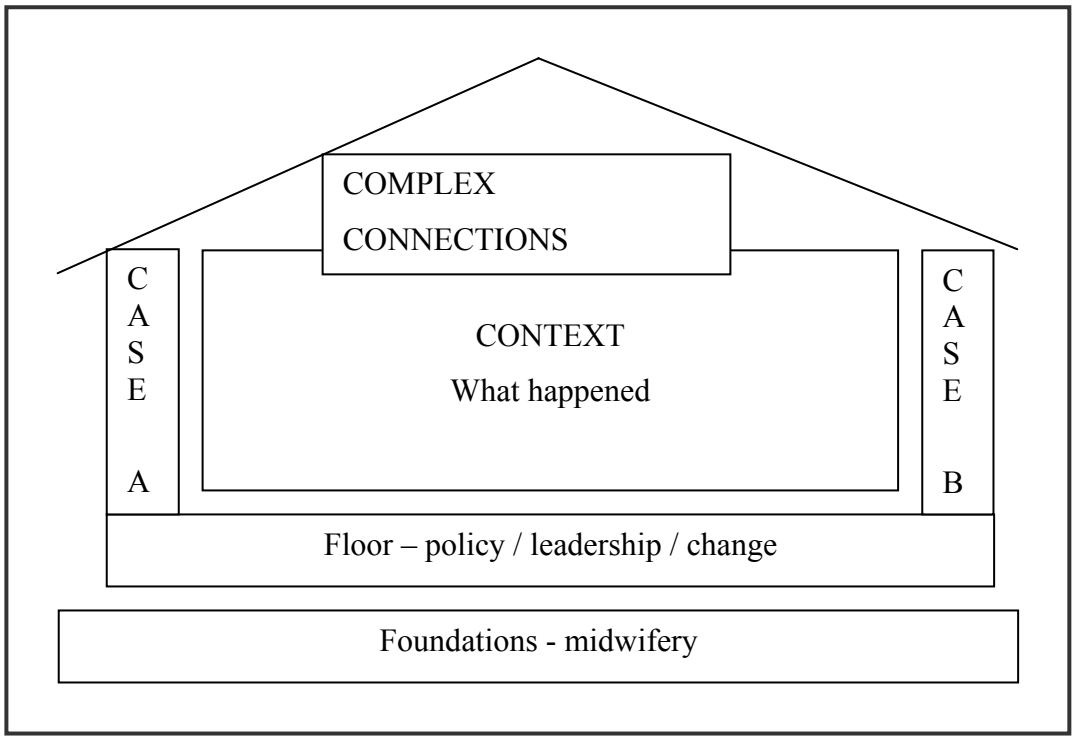

Figure 1: House as metaphor for the portfolio

1.2.1. Section One – The Foundations – Midwifery Connections

The focus of this portfolio is the midwife, but the midwife never works in isolation. She[2] is connected in many different ways to a variety of individuals including colleagues, other health professionals, women and their families. The relationships that midwives have with women, their families and colleagues are important factors in

[2] As the majority of midwives are female the term 'she' will be used throughout this portfolio and is not intended to discriminate against male midwives.

midwives' job satisfaction and hence why they stay in the profession (Kirkham, Morgan, & Davies, 2006). There are many factors that can impact upon these relationships. These include organisational demands and a lack of support in the workplace contributing to midwives' dissatisfaction and attrition from the profession (Ball, Curtis, & Kirkham, 2002). This section sets out to outline different perceptions of the midwife and her connections to women. Chapter Two presents the individual midwife, self-development, philosophy and autonomous practice; Chapter Three brings the midwives together with women through different models and relationships within maternity care.

1.2.2. Section Two – The Floor – Midwifery Context in Victoria

Government and organisational policies provide structure and financial support for maternity services and guide midwifery practice. Section Two provides an overview of the health system in Australia and reviews the policy developments that occurred in the state of Victoria that have underpinned the development of midwife-led maternity services. As these Victorian policies have, to some extent, been the drivers of organisational change, this section also presents literature pertaining to change theory and the importance of effective leadership for successful change.

The literature for sections one and two was identified through a wide search using multiple databases pertinent to midwifery, nursing and health professions as well as those from humanities and social studies. These included CINAHL, MEDLINE, EBSCO and PSYCHLIT, Expanded Academic ASAP, the library catalogue and the World Wide Web. Search terms included midwife, relationships, collaboration, midwifery, partnerships, connections, autonomy and empowerment, philosophy, continuity of care, woman-centred care, biomedical, holistic and change theory and leadership with the terms used singly and in combination. The literature presented in section one provides the basis for many of the concepts discussed in section three, that is the research project.

1.2.3. Section Three – The House – Research Project

Case studies of organisational change that occurred in two maternity units in Victoria are presented in this section as the research arm of the professional doctorate. The discussions about the midwife, models of care and the health system provide the context for the research project reported in Section Three, Chapters Five to Nine. The literature is presented throughout the sections on midwifery connections and policy in Sections One and Two.

A case study approach was chosen in recognition of the complexities of change within maternity services. Chapter Five provides the rationale for this choice and the methods used to collect the data. The results are presented across Chapters Six, Seven and Eight, in line with the case study approach and the use of multiple data collection tools, including a survey, focus groups, interviews and analysis of documents in the public domain, followed by a discussion chapter.

1.2.4. Section Four – The Roof – Connections

Chapter Ten explores complexity science as a framework on which to understand midwives and midwifery, and to provide a greater understanding of the findings of this research project. The web of complexity science is alluded to in each chapter throughout the portfolio.

Individual midwives, maternity units, hospitals and health systems can be regarded as Complex Adaptive Systems, whereby each element in the system is connected to another (Anderson & McDaniel Jr., 2000). Interaction between these elements leads to mutual co-evolution and adaptation. The application of Complex Adaptive theory to the various sections of the portfolio provides insights into the difficulties faced by organisations seeking to change. The outcomes of implementation of organisational change cannot be predicted. Therefore, transfer of one midwifery model of care in its entirety from one setting to another, does not guarantee the same positives for women or midwives.

SECTION ONE

THE FOUNDATIONS – MIDWIFERY CONNECTIONS

Throughout Section One the importance of the connections that exist and develop within the midwifery role will be demonstrated as a foundation for the rest of the portfolio.

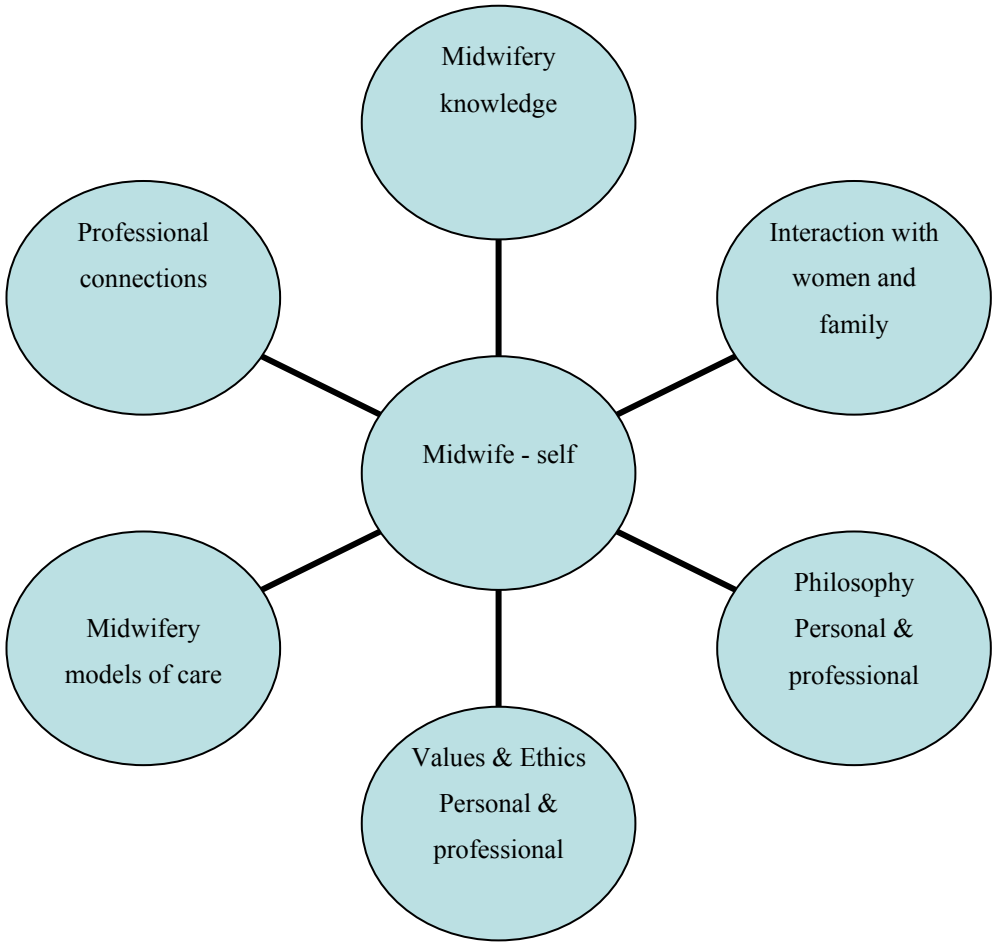

Figure 2: Relationships and beliefs that inform a midwife's practice

Chapter Two focuses on the midwife herself as a connected individual.
Chapter Three focuses on the models of care that midwives work in and the connection they have with colleagues and women.

CHAPTER TWO

THE MIDWIFE

2. Introduction

This chapter discusses the midwife as an individual. The focus is on personal development, professional philosophy, professional autonomy and satisfaction for individuals within the role of the midwife. My perception is that satisfaction with the midwife's role is related to the beliefs and opportunities for practice within those beliefs. A midwife's professional stance and self-concept influence how organisational change is accepted and implemented by an individual. This chapter therefore provides some insights for the research component of this portfolio that focuses on organisational changes that occurred for midwives that were directly related to midwifery practice.

The first section provides an overview of the development of personal values, beliefs and ethical stance. This is followed by description of the concepts of a personal philosophy leading into a discussion around the philosophy of midwifery practice that an individual might adopt. The final section relates to the ability of the midwife to be an autonomous practitioner.

2.1. The Self-Identity of the Midwife

Midwives come to the profession from different backgrounds. Why an individual becomes a midwife and how she acts and reacts as a midwife is embedded in her personal values and ethical perspectives. This self-identity has been developed through her upbringing and acculturation into the norms and values of the wider society during work, education and other social interactions (Kupfer, 1990; Symonds & Hunt, 1996). Individuals who conform become integrated and accepted by the social group, those who do not conform may be rejected (Brodsky, 1976; Symonds & Hunt, 1996). However, as Marshall (2005) points out conformity maintains the status quo and may reduce opportunity for change. Conflict may occur for an individual midwife both

internally and in interactions with others, where personal beliefs of midwifery practice do not match those of colleagues.

Philosophies are beliefs that guide us in the way we live and work (Compact Oxford Dictionary, 2006). A paradigm is a model or pattern of knowledge upon which a philosophy is built (Kuhn, 1996). Changes in paradigms occur as new knowledge emerges but as Kuhn (1996) purported a revolution or crisis needs to occur before new paradigms are widely accepted. The recognition of childbirth as a normal life event is the paradigm that underpins midwifery philosophy and practice in many countries (ACM, 2007b; College of Midwives of British Columbia, 2006; New Zealand College of Midwives, 2002b). Midwives develop their philosophical stance through education, exposure to clinical experience, and socialisation into the midwifery profession (Siddiqui, 2005). They are further influenced by their own personal values and ethical reasoning (Symonds & Hunt, 1996). Despite university midwifery course curricula embedded with midwifery philosophy (ACM, 2006b), the main influence on student midwives in Australia, is that of the dominant medical paradigm.

2.2. Childbirth Paradigms

Two main paradigms of maternity care, the medical model and the social model, have been identified by Wagner (1994). Davis-Floyd (2001) provides a view of three paradigms, a technocratic model, a humanistic model and a holistic model. The technocratic model is likened to the medical model, the humanistic model has many similarities to the social model and the holistic model provides a wider perspective of connections to the whole universe (Davis-Floyd, 2001). Davis-Floyd (2001), Lane (2002) and Walsh and Newburn (2002b) view these paradigms as existing along a continuum, although it is argued below that it might be more appropriate to view these paradigms within a circle connected like a spider web. These differing paradigms are presented below and provide some insight into the way midwives view themselves.

The midwife is a member of one of the oldest recorded professions but her ability to practice is dependent on the dominant beliefs within society. Midwifery evolved from a feminine, intuitive perspective (Achterberg, 1990) but in the seventeenth century a paradigmatic revolution occurred (Kuhn, 1996). Women's healing which was

associated with the spiritual and seen as close to nature, was subjugated and dominated by man (Achterberg, 1990) with the introduction of 'masculine' sciences (Donnison, 1988). The worldview of science and knowledge in western society became based on the Cartesian dualistic perspective of a separate mind and body (Capra, 1992; Davis-Floyd, 2001). Within this perspective, the emergence of Newtonian mechanistic physics provided credence to the body as being synonymous to a machine capable of being repaired. This has progressively led to an understanding of the human body by reducing it to its smallest parts (Achterberg, 1990). The acceptance of these beliefs led to the emergence of the biomedical model as the dominant paradigm for health and illness in Western society (Davis-Floyd, 2001; Davis & George, 1988). Thus, obstetrics evolved from within this worldview with knowledge firmly based in a reductionist, mechanistic, Newtonian paradigm (Wagner, 1994). This biomedical paradigm can be seen as synonymous to the technocratic model described by Davis-Floyd (2001).

Within the biomedical paradigm the focus is on cure that is, fixing those parts of the body that are not functioning. Although birth may be acknowledged as a natural process, it can only be viewed as normal after the event. Interventions are used to control the process of nature in order to make it better (Davis-Floyd, 2001). Within the biomedical model, birth is viewed as a medical event, the safest place to give birth is in hospital and support is provided by professionals with the use of technology and control (Walsh & Newburn, 2002a). While interventions are communicated to women as providing them some degree of security and protection against poor outcomes (Kringeland & Möller, 2006), they may also be viewed as the means to protect the practitioner in the litigious society that has developed. Where society relies so heavily on scientific evidence to explain outcomes it is unsurprising that the use of restrictive practices become the mainstay to reduce stress for the anxious health practitioner, doctor or midwife.

Not only has birth been medicalised but as some would argue (Barker, 1998; Willis, 1990) western culture has ceded scientific knowledge the authority and power to dominate our lives. Women are socialised in western society into accepting that pregnancy, birth and post birth care are dominated by the biomedical model (Maher, 2003). Midwives are subject to the same pressures to conform. It is probable that many midwives have never had the opportunity to participate in a truly physiological birth and

lack an understanding of how women can be empowered by this experience. As Wagner (2001) argues '*Birth attendants, be they doctors, midwives or nurses, who have experienced only hospital based, high interventionist, medicalised birth cannot see the profound effect their interventions are having on the birth'* (p.S26). Therefore, it is unsurprising that many midwives have their practice embedded in a biomedical model.

Improved mortality and morbidity rates has legitimised medical science (Parker & Gibbs, 1998) even when these health improvements were associated with improved public health (Barker, 1998). Davis-Floyd (2001) links the ready acceptance of the increasing use of technology by the medical profession to the super-valuation of such technology within the scientific paradigm, despite the lack of evidence of its efficacy. That is if technology is available it should be used regardless of demonstrated usefulness in all situations. Fredriksen (2006) cautions us that while on the one hand technology is used to give us control over the future it can actually lead us to become more insecure. Feeling insecure can then lead to a perceived need for more technology. As Barker (1998) recognised, the enculturation of women into accepting the authority of the biomedical model leads to increasing use of technology. There is no doubt that there are occasions when interventions are essential and save lives. The medical paradigm then is one whereby health is seen as a problem that must be fixed. In contrast, a social model of health focuses on normality and the environmental factors that determine an individuals' well-being (Wagner, 1994).

A social model of health acknowledges birth as a life event, where home is a safe place to give birth, support is provided by friends, nature presides and women are treated with respect (Wagner, 1994; Walsh & Newburn, 2002a). Historically, birth in Western society occurred in the home but with the increased domination of medicine, has moved into the hospital sector (Donnison, 1988). A decrease in perinatal mortality occurred at the time when births moved into hospital leading to an assumption that they were a safer place to give birth. However, other social changes were occurring at that time that reduce the accuracy of those deductions (Symonds & Hunt, 1996). Midwifery recognises this social impact on women and much of the midwifery philosophy of working with women comes from a social health approach (Walsh & Newburn, 2002a). It must be acknowledged that the medical profession does not ignore these social factors. While Davis-Floyd (2001) suggests that many practitioners have moved

towards a more humanistic approach to birth, Reibel (2005) and Lane (2006) point out that obstetricians focus is on 'risk' assessment and safety. This focus on risk medicalises social problems without addressing the underlying issues (Symonds & Hunt, 1996).

One element that appears to be missing or not clearly identified within a social model of health is that of the spiritual. Achterberg (1990) highlights one consequence of the scientific revolution '*…not only were mind and matter disjoined but spirit was conceptually eliminated from matter. The separation of mind, body, and spirit tore at the very fabric of women's healing power'* (p.103). It is within this concept of connection that Davis-Floyd's (2001) holistic paradigm rests. The concept of holism within a social paradigm is recognised in midwifery (Walsh & Newburn, 2002b) and appears to be more closely aligned to the concepts of a mind/body connection than to the concepts explored by Davis-Floyd in her holistic paradigm. A holistic paradigm incorporates the spirit into the oneness of the mind and body. As Davis-Floyd (2001) explains:

> Where the technomedical model is rigid and separatist, the holistic model recognises no sharp divisions or distinct boundaries. This is another reason why holism is so threatening: in many people's minds, to trifle with boundaries is to invoke chaos. And indeed, chaos theory and systems theory both inform and underpin the holistic paradigm and its insistence on the oneness of body, mind and spirit (pp.S16-17).

Many midwives incorporate complementary therapies into their practice and may consider themselves as acting within a holistic paradigm. Kakkib Li'Dthia Warrawee'a (2004), a Traditional Aboriginal Healer, cautions that practitioners who take elements of 'traditional' medicines are no different to reductionist medical practitioners, as frequently they concentrate on one aspect, such as a herb and neglect the whole picture. He argues that alternative practitioners recognise the mind/body/spirit as holism, and medical practitioners recognise holism as mind/body/social elements. Accordingly Kakkib Li'Dthia Warrawee'a (2004) states that holistic practice should encompass the '*…Physical, Psychological, Socio-environmental and Spiritual'* (p.10) but that the

ability to cope with all these elements in a holistic manner is often beyond the ability of the practitioner. Davis-Floyd (2001) addresses all of these elements of holism in her holistic paradigm. It could also be argued that these elements are included within the Australian College of Midwives philosophy (2007b, see Appendix A) but identifying the individual elements as important does not provide midwives with the knowledge or ability to understand the connectedness of each element, that is holistic practice is more than the sum of each part.

Midwives and obstetricians do not practice in isolation. The concepts that inform their practice are not as dichotomous as they might appear with practitioners sharing skills and knowledge (Davis-Floyd & Davis, 1996). Fielding, Kirkham, Baker and Sherridan (2004) argue that by thinking in opposites, difference is polarized into black and white, when the complexity of reality is shades of grey. The constructs of midwifery care incorporate both scientific and naturalistic knowledge. Several authors posit that by viewing healthcare paradigms as existing on a continuum provides recognition for the commonalities of practice that exists between health professionals (Davis-Floyd, 2001; Lane, 2002; Rooks, 1999; Dennis Walsh & Newburn, 2002a). Although if midwives argue the case that midwifery is both science and naturalistic knowledge, then being situated at either end of a continuum lacks acknowledgement of the complexity of the interaction between these two concepts (Fielder et al., 2004). Davis-Floyd (2001) identifies that the holistic paradigm is underpinned by chaos and systems theories. While both these theories are encompassed by complexity science, systems theory provides a clearer perspective for midwifery whereby the human is a complex adaptive system (Plsek & Greenhalgh, 2001) connected to the whole universe through an invisible web (Capra, 1996). Fielding et al. (2004) echo the need for viewing relationships within midwifery as a web, acknowledging complexity rather than thinking in opposites. This concept is explored further in Chapter Ten but in essence is consistent with non linear interactions. Therefore the connections between the above paradigms are more synonymous with a web although visually this is difficult to portray. Figure 3 below portrays these paradigms as concentric circles as an attempt to demonstrate the merging of concepts.

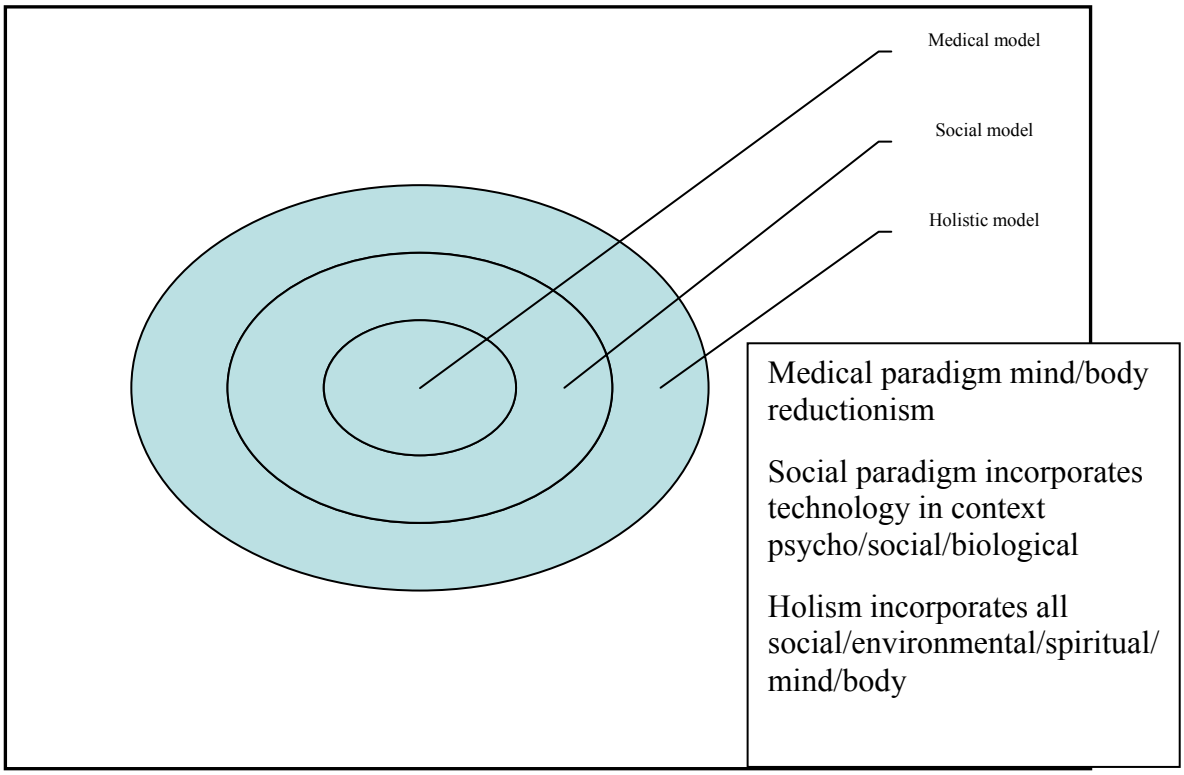

Figure 3: Medical / Social / Holistic Paradigms Interaction

Although midwifery philosophies might espouse the holistic paradigm it is important to discover in what ways midwives themselves align their beliefs and interpret philosophies developed by professional organisations. The next section reviews the research literature to ascertain where midwives beliefs are aligned.

2.3. Midwives' Beliefs

The literature was reviewed to gain an insight into how midwives describe their philosophical stance. Only three studies were found that specifically explored midwives' self-identity in relation to medical or midwifery paradigms, one set in Australia (Lane, 2002) and two from the United States of America (Foley & Faircloth, 2003; Scoggin, 1996).

Lane (2002) interviewed 22 midwives from a variety of practice settings in one Australian state to elucidate to what extent midwives identified with either a medical or social model of birth, models that she termed an illness or wellness model. She suggested that the way midwives identified with these two competing models was related to their perception of the body, either as a body that failed to work or as a body

that was affected by external factors. Lane (2002) did not go into great depth to explain the differences between the two models other than as comparative discourse between the ways of knowing from either an objectivist or productivist perspective. She presented the models as a continuum, with midwives as obstetric assistants at one end and as autonomous practitioners at the other. As many of the midwives used language that moved them from a social model to one that legitimated the obstetric perspective Lane (2002) identified a third view, that of the 'hybrid' midwife. The majority of midwives interviewed fell into this 'hybrid' paradigm, neither fully aligned with either the medical or the midwifery paradigm (Lane, 2002). This view that midwives did not fall into one particular category was similar to arguments presented by Davis-Floyd (2001) and Walsh and Newburn (2002a). Parker and Gibbs (1998) argue that in this postmodern age pragmatically and strategically, positioning midwives within a hybrid space between the medical and holistic paradigms is essential for midwives to enable women from diverse backgrounds and beliefs to experience a sense of ownership over their birth. Their use of the term space however, does not infer that midwives should be positioned on a continuum but rather provides a connection for women between the different ways of knowing, the science and the art of midwifery.

Lane (2002) found that midwives' beliefs were influenced by age, experience and place of employment. However, it is possible that midwives choose employment that matches as far as possible their personal belief systems and enables them to practice midwifery in the way they want (Stevens & McCourt, 2002b). Where conflict exists between a midwife's personal philosophy and her place of employment there is a greater likelihood of her leaving the midwifery profession (Ball et al., 2002). The educational background of the midwives was not discussed but as there was no direct entry program in Australia at the time of Lane's study, the majority of midwives in Australia were also nurses (Leap, 2002). It seems likely to me that the majority of these midwives, as nurses working within the hospital system dominated by medicine, came to midwifery with a philosophy grounded in the medical model.

In the USA, certified nurse-midwives (CNM) also come to midwifery grounded in the medical model. Scoggin (1996) interviewed 20 CNMs from different practice settings and different states of the USA, to determine characteristics of their occupational identity. The ideological constructs of midwifery practice identified were 'advocacy,

normalcy, competency, autonomy and authority' (Scoggin, 1996, p.38) and a survey tool was developed to test these constructs. The survey was mailed to 300 CNMs with an excellent response rate of 85%. Major limitations of the study identified were the development and use of a new survey along with the difficulties faced in objectifying such subjective constructs (Scoggin, 1996). It was not clear how the sample was chosen and it clearly only included CNMs although a small number of these had been licensed or lay midwives previously. However, the majority of midwives in the USA are also nurses (Scoggin, 1996). A major difficulty for making comparisons with either Lane's study or the previously discussed childbirth paradigms was the lack of clear definitions between medical, nursing and midwifery models of care.

Scoggin (1996) found that the majority of the respondents identified more closely with midwifery than either nursing or medicine. It was not clear why the option included a comparison with the medical profession. Although a majority recognised midwifery as a separate profession, they also enjoyed the nursing part of their role. Experience and agreement with the midwifery philosophy and values was predictive of a positive midwifery identity (Scoggin, 1996). Scoggin (1996) highlights that occupational identity does not rest solely with individual perspectives but incorporates how an occupation defines itself as a whole. However, occupational identity not only reflects how members define it but legitimation of that definition by others. While midwifery remains 'invisible' (Brodie, 2003) development of midwifery as an autonomous profession is at risk.

The third study under discussion was that of Foley and Faircloth (2003), who as part of a larger study in Florida, USA explored midwifery practice with 26 CNMs, licensed midwives and students. The participants came from a variety of midwifery contexts including independent practice. The narrative report of the findings included sufficient context to ground the interpretation for the reader (Foley & Faircloth, 2003). Midwives used medical discourse both as the means to legitimise their practice as well as to establish differences between medical and midwifery practice. The medical model was not seen as being at odds with midwifery practice but as a resource that midwives draw upon according to time and context (Foley & Faircloth, 2003). As with Scoggin (1996) there was no clear definition of a medical or midwifery model other than potentially being in direct opposition. The changing discourse of the midwives moving from the

language of normal midwifery to the concepts and terminology of the medical model resonates with the 'hybrid' model described by Lane (2002). However, Foley and Faircloth (2003) interpreted this use of language as the means midwives used to establish their occupational identity. They found few clearly identifiable differences between the self-identity of midwives who were nurses and those who were not. They argued that the medical and midwifery models should not be viewed in an oppositional framework but as the means to construct the midwifery identity (Foley & Faircloth, 2003).

Midwifery is connected to the medical world if only because difficulties do arise that require more specialised assistance. As demonstrated by Foley and Faircloth (2003), Lane (2002) and Scoggin (1996), midwives provide discourse based on the biomedical model while self-identifying as midwives. From Foley and Faircloth's (2003) perspective midwives, even those who clearly practice autonomously, use biomedical language depending on the context. To enable all health professionals to work together collaboratively and safely there is a need for a common language to ensure effective communication. Therefore for midwives to be able to demonstrate safe, quality practice they need to be able to use the language of the medical profession (Foley & Faircloth, 2003).

Midwives may identify as practising within a holistic paradigm (Davis-Floyd, 2001), a humanistic (Davis-Floyd, 2001) or social paradigm (Walsh & Newburn, 2002a) and be recognised by others as midwives. However, for midwives to self-identify with the medical paradigm creates a paradox as midwifery is seen as the dichotomous opposite of medicine (Annandale & Clark, 1996; Foley & Faircloth, 2003; Turner, 2004). An image of philosophical paradigms displayed as a web of interconnections (similar to figure 3), rather than as a continuum going in opposite directions, provides greater diversity and acknowledgement of the usefulness of using concepts from a range of paradigms. In acceptance of differences midwifery is viewed as a profession, with recognition of similarities providing midwives and obstetricians a meeting place for collaborative practice.

Regardless of the philosophy that underpins their practice, the main role of midwives involves being with women through the experience of childbearing. There are many

variables that impact on the interactions and relationships that develop between midwives and women. The models of care that affect these relationships are discussed in the next chapter but how they are implemented relates directly to the professional stance of the midwife. Scoggin (1996) identified autonomy as an important construct of midwifery practice. Autonomy is explored in the next section both in relation to the profession of midwifery and to the individual midwife in order to identify the constructs necessary for midwives to demonstrate autonomous practice.

2.4. Autonomy

Defining autonomy as a construct for midwives is difficult due to the complex context of midwifery practice (Fleming, 1998a; Pollard, 2003) and the organisational constraints placed on midwives (Ledward, 2004; Marshall, 2005). Etymologically the word autonomy is from the Greek for auto (self) and nomos (law) (Dworkin, 1988) and variously referred to as 'the right of self-government', 'self-rule' (Scott, 1998), 'independence', 'freedom of will' and 'sovereignty' (Dworkin, 1988). Dworkin (1988) identifies several other terms equated with autonomy such as actions, thoughts and principles although he concludes that it is unlikely that there is a core meaning for its full usage. This lack of core meaning underpins the difficulty in clearly identifying the concept of autonomy for midwives. Kupfer (1990) describes an autonomous person as '*…one who chooses for himself what to think and what to do. He is self-governing in that his actions spring from interests and values that he has in some sense decided upon. Moreover, his beliefs are arrived at independently, by means of critical reasoning'* (Kupfer, 1990, pp.9-10). He argues that autonomy as a concept of self-determination with freedom from interference, is a Western value that has taken on greater significance within modern philosophy (Kupfer, 1990). Others agree and identify the importance that other cultures place on community values (Macklin, 2006) and family (Furlong, 2003). This may present difficulties for individuals to act in an autonomous way such as when presented with expectations of health professionals to participate in decision making.

Several conditions need to exist for autonomous self-determination (Dworkin, 1988; Kupfer, 1990). They are referred to briefly here and considered in more detail later. Autonomous individuals must have the ability to make judgements and the willingness

to act on them. They should reflect and critically analyse information received from others in order to rationalise their decision making from within a firm knowledge base (Dworkin, 1988; Kupfer, 1990). Individuals therefore need to be sufficiently educated and sufficiently assertive to act autonomously. Where individuals rely on others for critical analysis, they are considered constrained by their dependence and therefore not autonomous (Kupfer, 1990). Though it should be remembered that recognition of individuals as autonomous does not mean that they are totally independent of others (Dworkin, 1988). Nor does it mean that by acting in an autonomous manner that they their actions are morally and ethically appropriate. Furlong (2003) cautions that only focusing on the autonomous individual, fails to acknowledge the importance of relationships and context.

Having the knowledge to make decisions is not sufficient for autonomy. There is a need for action, that is a choice needs to be made (Kupfer, 1990). Pollard (2003) identified that autonomous action cannot occur unless there is a need for a decision but as pointed out by Dworkin (1988) the requirement to make a decision infers that there is a choice. There is also an expectation of making a morally correct choice (Holden, 1991; Kupfer, 1990; Marshall, 2005) but choices cannot be made unless the individual has sufficient information. In addition, the provision of more choices to individuals does not come without costs. The decision to make the right choice can vary on what might be right in the short term but not so good in the long term (Veatch, 2006). For example, a midwife might choose to take a position where she is paid more per hour on a temporary three month contract over long term permanent employment that pays much less. The cost may be long term unemployment for short term financial gain. Acting autonomously and being free to make decisions does not come without responsibility for those decisions (Kupfer, 1990). So decisions that may be right for one midwife are not for another and they are relative to the information available and the context in which they are made. It should however, be remembered that the provision of choices to individuals can at times be overwhelming, as they take responsibility for outcomes that may in reality be outside of their control (Furlong, 2003). Furlong (2003) argues that by insisting on individual autonomy and ignoring our connections to others we may be unduly burdened by responsibility for all our actions. That does not mean an individual can avoid responsibility simply by claiming they were only following orders (Dworkin, 1988).

The paradox is that autonomy, or the ability to be self-determining, is related to the influence of society on an individual's growth and development (Dworkin, 1988). However, these external factors do not necessarily affect each individual in the same way. The medicalisation of childbirth socialised midwives into dependency on the medical profession and has restricted midwives' ability and right to make and act upon their own decisions. Rowland-Serdar and Schwartz-Shea (1991) and Bernstein (1993) argue that women tend to define themselves in terms of their relationships to others such as being a mother, daughter or wife. Bernstein (1993) claims that this presents difficulties for women not only in being recognised as autonomous but in acting autonomously. I argue that because midwives are predominantly women they may have these same difficulties. It may not be that individual midwives describe themselves in relation to doctors but that the invisibility of midwifery prevents others identifying them as practitioners in their own right. Although midwives are becoming more visible in Australia, autonomous role models are essential if midwives are to become autonomous practitioners.

In the next section the characteristics that are associated with autonomy are used to discuss professional autonomy and the midwife.

2.5. Professional Autonomy

Midwifery is defined as an autonomous profession by the International Confederation of Midwives (ICM) (ICM, 2005b), although they clearly recognised that being a midwife does not automatically imply that all midwives are autonomous practitioners. Clarke (2004) argues that midwifery as an autonomous profession in the UK is a myth. She identifies '*the legacy of subservience and powerlessness*' as '*responsible for the absence of professional, clinical and moral autonomy of midwives*' (Clarke, 2004, p.228), with little evidence to demonstrate otherwise (Fleming, 1998a). The argument Clarke presents resonates with my Australian experience, where similar barriers exist for midwives to become autonomous.

It is important therefore to clarify how professional autonomy is understood and demonstrated. Draper (2004b) states that '*Professional autonomy refers to the freedom to exercise judgement related to one's profession within the bounds of one's*

professional expertise' (p.6). However, as Marshall points out '*…the degree that midwives are able to demonstrate their autonomy …is variable and depends on the extent of authority given to them by the organisation in which they work, as well as their own personal willingness to accept such freedom'* (Marshall, 2005, pp. 13-14). The concept that autonomy does not necessarily mean full independent practice is echoed by Curtis (2007). Davis-Floyd (1996) purports that '*…true autonomy of practice requires not only independence of thought but also good collaborative working relationships with other practitioners*' (p.2). Ledward (2004) concurs in pointing out that professional autonomy is not limitless, with collaborative practice a necessity. It is important that midwives understand the concepts involved in autonomy in order to provide woman-centred care in an ethical manner that enables women to make informed decisions (Jones, 2000).

It has been found that midwives do not have a clear understanding of what autonomous practice involves, particularly because of restrictions imposed on their practice (Fleming, 1998a; Pollard, 2003). Pollard (2003) found that some midwives viewed independent practice as the only way to practise autonomously, although there were a few who recognised the ability to be autonomous within a hospital setting. Although there are many reasons why individuals might not act autonomously, having the freedom to make choices without the ability to act out those choices is also valueless (Kupfer, 1990). Section 2.4 identified some of the characteristics associated with individual autonomy. These characteristics have been usefully summarised by Pollard (2003) and are presented in Table 1 below. These four characteristics are used as a framework for the ensuing discussion on autonomous midwifery practice.

1. Determining the spheres of activity under one's control
2. Having the right and the capacity to make and act upon choices and decisions in this sphere
3. Having this right acknowledged by others affected by or involved in these decisions
4. Taking responsibility for decisions made

Source: (Pollard, 2003, p. 115)

Table 1: Characteristics associated with autonomy

2.5.1. Characteristic One – Determining the Spheres of Activity under One's Control

The ICM definition of a midwife (see Appendix B) clearly identifies the spheres of activities, including the rights and responsibilities that are encompassed within the scope of midwifery practice (ICM, 2005a). Although the majority of midwives in Australia do not work across the full scope of the midwife as determined by the ICM, as services change across Australia (DHS, 2004a; NSW Health Department, 2003b; Queensland Department of Health, 2005) the opportunities to do so are increasing. That is not to say that just because midwives only work in one specific sphere of the role, that they cannot be autonomous within that defined role. However, it may be more difficult, because of the overlap of responsibilities, where there is fragmentation of care (Clarke, 2004; Draper, 2004b).

While the scope of midwifery practice is clearly defined, intrinsic factors may prevent individual midwives acknowledging control within their practice boundary. It may be that professional socialisation into a medical model has provided some midwives with a mindset whereby they either do not perceive that they have the opportunity to oversee their own practice or do not wish to be autonomous (Fleming, 1998a; Pollard, 2003; Shallow, 2001a). This is demonstrated in the research project reported later in the portfolio, where midwives working in a maternity unit where midwife-led care was introduced either failed to recognise that they could make decisions without referring to the medical personnel or resisted the change and acceptance of the responsibility of making decisions. However, where policies relating to midwifery practice are developed with no or minimal midwifery input, the scope of practice clearly remains under the control of others (Clarke, 2004). Thus midwives may feel constrained by these policies and confused about what is within their control. Where midwives are clear about their scope of practice, they need to demonstrate that they have the right and ability to make and act on their decisions.

2.5.2. Characteristic Two – Having the Right and the Capacity to Make and Act Upon Choices and Decisions in this Sphere

This second characteristic of autonomy contains two factors to be discussed, those of 'the right' and 'the capacity' to make and act on decisions. Regulation and registration

by the profession and where a midwife is employed by an organisation, the authority delegated to her position, support the right of the midwife to practise autonomously (Marshall, 2005). Education, professional socialisation and self-development of the individual provide a midwife with the capacity to make and act on decisions.

In Australia, the medical domination of midwifery (Reiger, 2008; Willis, 1990), the lack of community awareness of the midwife's role (Brodie, 2003) and until recently the lack of self-regulation (Brodie & Barclay, 2001) has meant that midwives lack widespread recognition of their right to professional autonomy. Midwifery regulation once under the control of individual state nursing boards as a speciality of nursing (Donnellan-Fernandez & Eastaugh, 2003) is moving towards greater recognition as a profession in its own right. Most of the states with the exception of Victoria (VIC), Queensland (QLD) and Tasmania (TAS) have now included midwifery within the title of their nursing registration boards (ANMC, n.d.-b). Despite these changes at the time of writing the majority of state boards maintain combined registers, with midwifery remaining as a speciality of nursing, although at least one, that of NSW, maintains separate registers for nurses and midwives (Nurses and Midwives Board NSW, n.d.). However, as from July 2010 national registration will be implemented with separate registers for nurses and midwives (Australian Health Workforce Ministerial Council (AHWMC), 2009) and will be a big step forward in enabling midwives to be able to register as midwives without having to also register as nurses.

At the turn of the century Brodie and Barclay (2001) found that regulatory guidelines across Australia were inconsistent making it difficult to compare the qualifications of midwives across states. However, many changes have occurred since then and with the impending move to national registration in Australia standards for initial registration, re-registration and accreditation of educational standards will be consistently applied across all states. The Australian Nursing and Midwifery Council (ANMC) works in collaboration with the Australian College of Midwives, the Royal College of Nurses Australia as well as the state nursing and midwifery boards to establish national consistency through the development of regulatory frameworks for nursing and midwifery (ANMC, n.d.-a). Since Brodie and Barclay's (2001) study, the state boards have adopted the ANMC national competency standards for the midwife (ANMC, 2006), and codes of ethics (2008a) and professional conduct (2008b). While positives

of national registration are the standardisation of registration, regulation and accreditation, providing midwives with the ability to move between states without the need to re-register (National Health Workforce Taskforce, 2008) a negative appears to be the continuing linkage of midwifery to nursing potentially maintaining the belief that midwifery is a speciality of nursing.

A key factor in gaining the right to be an autonomous practitioner is gaining the knowledge and critical thinking skills necessary to enable a midwife to function autonomously. Midwives without these skills, who willingly accept another's interpretation, can not be deemed as autonomous (Kupfer, 1990). Therefore it is essential that midwifery education includes the preparation for midwives to gain an understanding of research and evidence based practice. Midwives need well developed critical thinking skills to enable healthy debate (Baird, 2007; Raynor & Bluff, 2005). Gaining an understanding however, is insufficient on its own if additional skills are not taught to prepare midwives to act to provide 'best practice'.

The Australian Midwifery Action Project (AMAP) education review found inconsistencies in midwifery education between universities and between states (Leap, Sheehan, Barclay, Tracy, & Brodie, 2003). Since the AMAP education report (Leap, 2002) there have been several changes across Australia. These included the development, by the Australian College of Midwives, of standard curriculum guidelines for the introduction of the Bachelor of Midwifery program (ACM, 2006b). As yet no national guidelines for post graduate course accreditation exist but they are being developed and are expected to be released in 2009 (ANMC, 2008c). This was an endeavour by the profession to control midwifery practice and ensure that new courses were consistent nationwide. There were however, no guarantees that the state nursing and midwifery boards would adopt all the recommendations.

In 2000 in Victoria, a consortium of universities worked collaboratively to develop an undergraduate course based on the ACM guidelines (Cutts et al., 2003). There were many challenges to be overcome in implementing a course through three different universities but the positives outweighed the negatives with collegial sharing of ideas (Rolls & Seibold, 2005). This consortium has now ended and from 2009 the three universities involved will run separate courses. As an academic in one of those

universities I anticipate that the collegial relationships will continue through the membership of a midwifery academic group[3]. Continuous professional development and education is essential for midwives to demonstrate and maintain their ability to practice autonomously.

The ANMC (2006) in collaboration with the ACM, developed national competency standards for the midwife, as a framework by which to assess student and graduate midwives' competency to practice. These standards set an expectation that the midwife is able to work in accordance with the internationally accepted definition of the midwife. The four domains of legal and professional practice, midwifery knowledge and practice, midwifery as primary healthcare, and reflective and ethical practice (ANMC, 2006) encompass the ideals of the autonomous practitioner. Therefore it might be expected that midwives who meet these competencies should be versed in the skills considered necessary for autonomous practice. Whether Australian midwives who completed their education prior to the introduction of the ANMC competencies, are cognisant of them and able to demonstrate that they meet them has yet to be tested.

At least two Australian states already conduct practice audits to ensure that midwives can demonstrate that they are meeting the competency standards (Nursing Board of Tasmania, 2007). Continuing education and demonstrating continuing competence is expected to be part of national registration (Nursing and Midwifery Board of Australia, 2009). However, being able to demonstrate knowledge and evidence of current employment are insufficient on their own to demonstrate midwives are acting autonomously, or are capable of acting autonomously. Midwifery Practice Review is a process by which midwives demonstrate their ability to practice professionally, confidently and safely and are facilitated to plan their future development (ACM, 2007c). In Australia, Midwifery Practice Review is entirely up to the individual midwife and potentially those midwives who work autonomously may be more motivated to participate in this process. In New Zealand, where midwives have greater opportunity to be autonomous practitioners, regular practice review is necessary for re-

[3] The formation of a midwifery academic group allied to ACM in 2007 has led to academics from all the universities in Victoria who provide midwifery education working together collaboratively. The aim is to work with stakeholders to seek best ways of utilising available clinical placements, including the development of common assessment tools across postgraduate and undergraduate courses.

registration (New Zealand College of Midwives, 2005). However, a potential consequence of establishing essential ongoing education raised by Leyshon (2002) is the devaluing of education so that it is only completed to gain an outcome for monitoring without valuing the content. The continuing practice development program standards, MidPlus (ACM, 2008), recently developed by the ACM, potentially overcomes this issue by including the need for learning objectives and reflection on the planned education activities. However, I have already had conversations with colleagues about the need to develop learning objectives to match the education completed. That is, many of the educational sessions participated in by midwives appears to me to occur because of its availability rather than to meet particular needs.

Education is important to provide midwives with the skills to work autonomously (Baird, 2007; Currie, 1999; Pollard, 2003). There was some expectation with the move of nursing and midwifery education into the tertiary sector that students would become empowered and enabled to become autonomous practitioners (Leyshon, 2002). Leyshon (2002) raised concerns that the nursing profession places too many expectations on the ability of nursing students to practise autonomously when they graduate without sufficient support in practice. Similar concerns could be applied to midwifery students. Leyshon (2002) cautions that education should not be relied on as the main facilitator of change. Further, educators who do not themselves feel empowered will be unable to facilitate students to become empowered (Leyshon, 2002). Thus if midwifery educators who are supporting students in clinical practise are not empowered to work autonomously as midwives then it is unlikely that their students would become empowered. Despite the move of the midwifery education in the UK into the tertiary sector, Pollard (2003) found that midwives lacked a clear understanding of autonomy and felt underprepared to practise autonomously. Midwifery students also did not feel that they were being adequately prepared for practising autonomously (Baird, 2007; Currie, 1999). Baird (2007) found that students could not clearly define autonomy although they did use terms such as responsible and competent. The students felt that they had not been provided with sufficient theoretical components of autonomy to enable them to put it into practice. However, it may not be the lack of theoretical teaching that students had but the way it was taught or the availability of role models for students to observe autonomy in action.

Barriers to autonomous practice identified by Baird (2007) and Pollard (2003) in the UK included the dominant medical model paradigm and a lack of autonomous practitioners as mentors. Similar barriers to the establishment of midwife-led care have been identified in Australia (Brodie, 2002). Students become socialised into not questioning to avoid conflict with the organisational need to follow policies (Currie, 1999) preventing them from gaining the ability to become autonomous. Community placements were found to provide greater opportunities for students to be exposed to autonomous practice (Baird, 2007; Currie, 1999) and potentially act as an enabler to gaining the ability to develop those skills. In Australia, the opportunities for clinical experience in community practice is unfortunately extremely limited as the models of care are closely aligned to hospitals. The majority of births in the state of Victoria in 1998 occurred in hospitals, with only a small percentage of women cared for within a midwifery-led model of care (Halliday, Ellis, & Stone, 1999). Although midwife-led models are increasing throughout Australia (DHS, 2004a; NSW Health Department, 2003b; Queensland Department of Health, 2005) suitable midwife-led clinical placements for student midwives remain severely limited.

Midwives who act in a ritualistic manner, such as, when following unwritten local practices instead of challenging these perceived norms, might be viewed as lacking judgement and cannot be viewed as autonomous practitioners (Holden, 1991; Kupfer, 1990). This may occur due to a perceived lack of ability to create change or by innate personal beliefs. By the same token, behaviour that occurs impulsively, motivated by personal desire denotes a lack of due consideration for the act (Holden, 1991; Kupfer, 1990), a lack of moral reasoning and therefore of moral autonomy (Dworkin, 1988). An example of a midwife acting impulsively might be where she acts aggressively towards colleagues in an attempt to demonstrate her knowledge and improve her own self-esteem without due consideration to appropriate ways of communicating.

Personal development, social and cultural influences affect an individual's self-identity and ability to be autonomous (Dworkin, 1988). Midwives' perceived lack of self-esteem has been suggested by Shallow as one factor that reduces their ability to make and act on decisions (Shallow, 2001a). Self-esteem is an intrinsic factor that may be related to the social, educational and professional background of individuals. It is not only psychological socialisation into non-autonomous behaviour that may occur during

childhood, but also the character of the person, such as being innately shy and unable to express oneself, that can determine an individual's ability to be autonomous (Kupfer, 1990). Empowerment of the mind, that is an individual's ability to stand up for themselves, is seen as a requisite of autonomy (Baird, 2007; Rowland-Serdar & Schwartz-Shea, 1991). In contrast, autonomous practice can also be viewed as an element of feeling empowered (Hayhurst, 2007). Confidence and competence are also associated with empowerment and autonomy leading to increased satisfaction with midwifery practice (Shallow, 2001a). Kirkham and Stapleton (2000) purport that a supportive environment where midwives feel valued and trusted is empowering. From a similar perspective Hayhurst (2007) argues that organisations seeking a more empowered and autonomous workforce need to provide professional development initiatives as an enabling strategy to improve their confidence and competence.

Empowerment however, is not a commodity that can be transferred rather it is the development of the self to have the capacity to act and think autonomously (Leyshon, 2002). Strength of character and the ability to stand up for oneself was recognised by students as a requirement for autonomous practice (Baird, 2007). Marshall (2005) promotes the need for midwives to be assertive and challenge practices. Timmins and McCabe (2005) support this view and identify the need for training to enable students and midwives to become more assertive. There is a risk however, that aggressive behaviour can be mistaken for assertiveness and may result in midwives taking over the role of the oppressor towards both other midwives and the women they care for (Hadikin & O'Driscoll, 2000). Bullying behavior unfortunately is well documented in midwifery (Curtis, Ball, & Kirkham, 2006; Hastie, 2006; Kirkham, 1999) and is unacceptable as it leads to lowering of self-esteem and a lack of autonomy (Hadikin & O'Driscoll, 2000).

Midwives need to reflect on their beliefs and values to redefine their self to enable them to be autonomous. Autonomy is a continuous process through reflection, judgement and response, as to do otherwise would be reacting in a habitual way (Kupfer, 1990; Rowland-Serdar & Schwartz-Shea, 1991). Unless midwives are able to challenge the beliefs associated with the medicalisation of birth and develop a sense of self that enables them to respond to people (health professionals) and situations instead of reacting in an habitual manner, then they will not become autonomous practitioners.

Midwives who retain their beliefs and practice within a medical model pass on those behaviours to the next generation of midwives (Currie, 1999).

The ability to make autonomous decisions alone is insufficient to improve autonomous practice. Individuals need to be supported and to feel connected to the whole (organisation) in order to be able to work independently (Hayhurst, 2007; Kirkham & Stapleton, 2000). A further constraint to midwives ability to act autonomously is the hierarchical structure of health organisations. Midwives have been found to defer to a higher authority when making decisions, not because they were uncertain but because a specific action was suggested by a more senior midwife (Hollins Martin & Bull, 2004). In contrast, where there is a lack of hierarchy amongst midwives they are more likely to identify that they practice autonomously (Pollard, 2003). These behaviours most likely occur because individuals are known to change their behaviour to match those that are acceptable to the person or group with whom they are socialising (Bernstein, 1993).

Individuals in Australia, by completing appropriate education and registering with their local authority have the right to practice as a midwife. To what extent that practice is autonomous may depend upon the place of practice, the ability of the individual to make and act on decisions and the recognition by others of the midwife's right to be an autonomous practitioner.

2.5.3. Characteristic Three – Having the Right to Autonomy Acknowledged by Others Affected By or Involved in These Decisions

Midwives need to have their right to autonomous practice acknowledged by a wide range of people and organisations. These include government bodies, healthcare organisations, other health professionals, colleagues and, most importantly, by women themselves. The right for midwives to act autonomously is recognised by the ICM (2005b) and acknowledged in the ANMC (2006) National Competency Standards for the Midwife discussed in the previous section.

Midwife-led models of care provide midwives with opportunity to be autonomous practitioners. The recent recognition in a number of Australian states of the importance of these models for women (Department of Health W.A., 2007; DHS, 2004a; NSW

Health Department, 2003) acknowledge the right of midwives to be autonomous. On a national perspective, a review of maternity services was recently released the recommendations of which included developing national maternity services plan, extending women's access to midwife-led care and limited prescribing rights for midwives (Commonwealth of Australia, 2009). This wide ranging review has the potential to bring greater recognition of midwives as autonomous professionals through authorisation to prescribe specific routine medications and pathology tests and claim services through Medicare[4].

Midwives need to have their right to autonomy acknowledged by the organisation that employs them. Within healthcare organisations midwives working in certain models of care, such as caseload,[5] or holding a position such as midwife consultant, may have the right to autonomy embedded within their position description. As these roles are formalised within the organisation other members of that organisation should also recognise that these midwives practice autonomously. The inclusion of specific authorisation to autonomous practice for certain roles within an organisation might restrict the ability of other midwives within the same organisation to be recognised as autonomous.

The participation in developing policies to guide practice is essential to be recognised as an autonomous profession (ICM, 2005b). If policies relating to midwifery practice are developed with no or minimal midwifery input, the sphere of midwifery practice clearly remains under the control of others (Clarke, 2004). If the opinions of midwives are not sought in the development of such policies then the organisers are demonstrating they do not recognise the right of the midwife to be autonomous. Hayhurst (2007) argues that members of policy committees provide evidence of their right to be recognised as autonomous practitioners by demonstrating their ability to exercise judgement. Pollard (2003) views participation in multi-disciplinary committees as an opportunity for the development of trusting collaborative relationships. Members of committees have the

[4] Some organisations have standing orders in place to enable midwives to order medications and pathology tests without constantly getting a medical officer's signature. Medicare is the Australian government system for reimbursement of a percentage of the costs of community health care services. Health care providers recognised to claim medicare rebates are at present primarily restricted to medical practitioners. Certain allied health practitioners may hold a provider number for a restricted number of services.

[5] Midwife-led models of care are discussed in Chapter Three.

opportunity to define both their individual responsibilities and shared responsibilities, leading to recognition and respect for each others' skills (Pollard, 2003). However, while being part of the decision process for policy development is essential for members of an autonomous profession, the restrictions that policies place on independent decision making can inhibit personal autonomy. The increasing risks of medico-legal litigation have led to the expectation by organisations, that midwives and doctors will follow policy. The implication is that if policies are not followed it denotes potential negligent practice and thus policies are legitimised by the risk of court proceedings. Therefore the insistence of organisational management on compliance with local policies and procedures might lead to a loss of autonomy for both midwives and obstetricians.

Midwives who do not recognise the rights of other midwives to be autonomous can impede an individual's autonomy. This can occur through peer pressure to conform, and may be overtly recognisable as bullying behaviour leading to loss of self-esteem and the inability to function autonomously (Hadikin & O'Driscoll, 2000) as previously discussed. However, peer pressure is not the only way individual midwives' right to autonomous practice might be impeded by other midwives. The majority of midwives in Australia are employed within healthcare organisations so their individual roles will differ according to management structures. Different positions within a hierarchy provide differing opportunities to be autonomous (Jenkins, 1994). Where midwives supervise other midwives there is the potential for either supporting and acknowledging individual midwives' right to be autonomous (Kirkham & Stapleton, 2000) or the use of authoritative power to restrict individuals' autonomy (Hollins Martin & Bull, 2004). Potentially, senior midwives restrict other midwives right to an opportunity to work autonomously because they do not perceive them to be capable of making and acting on decisions. Midwives who do not have the opportunity, in a trusting supportive culture, to develop skills may never be viewed as having the right to be autonomous.

Women are the principle people affected by midwives' ability to be autonomous. Midwives are to a greater extent invisible in the public domain not only in Australia (Brodie, 2003; Donnellan-Fernandez & Eastaugh, 2003) but also in the UK (Pollard, 2003). Although they are clearly recognised as assisting the obstetrician, for the most part, they continue to be recognised as a speciality of nursing both by the general public

and other health professionals (Brodie, 2002; Donnellan-Fernandez & Eastaugh, 2003). Certainly women who seek out independent midwives for their maternity care recognise the authority of the midwife to be autonomous. For example, women in New Zealand have the authority to choose a practitioner and the government reimburses similar maternity services at the same rates regardless of provider, midwife or obstetrician (New Zealand College of Midwives, 2002a). The primary framework for midwifery practice is partnership allowing for joint decision making between the midwife and the woman (Pairman & Donnellan-Fernandez, 2006). This framework can be viewed as recognition of the right of both the midwife and woman to autonomous decision making in a collaborative relationship.

In Australia, the Australian College of Midwives and consumer groups, such as Maternity Coalition, are working towards making the midwife more visible but greater recognition through financial recompense for independent practice is essential. Recognition by others of the midwife's right to autonomy is insufficient for autonomous practice unless the midwife also demonstrates accountability and responsibility for her practice.

2.5.4. Characteristic Four – Taking Responsibility for Decisions Made

The final characteristic for autonomy involves taking responsibility for the decisions made and acted on (Pollard, 2003) with due regard to self-discipline and restraint (Holden, 1991). Midwives in Australia are expected to be accountable and responsible for their own practice in order to meet the national competency standards (ANMC, 2006, Competency Two). However, being accountable and responsible does not automatically imply autonomy.

While autonomy implies the freedom for individuals to act as they wish, there is a moral component to autonomous actions whereby there is a responsibility to act in the best interests of the community (Dworkin, 1988; Kupfer, 1990). Midwives, in ceding their responsibility for a decision to the legitimate authority by following policies, are no longer guided by their conscience but simply acting to fulfill their responsibility to the employing authority (Clarke, 2004; Hollins Martin & Bull, 2005). A midwife is deemed accountable for her own actions, unless she has been forced to follow orders

where if she had a choice she would have acted differently (Draper, 2004a; Dworkin, 1988). However, while acting in response to policies and protocols, a midwife might claim that she had no choice and therefore did not consider herself responsible. She would not be acting autonomously in these circumstances but remains responsible for her actions (Dworkin, 1988). Draper (2004a) suggests that midwives who follow policies blindly, without challenging the assumptions that have informed those policies are acting to maintain the status quo. In making decisions there may be a need to challenge the status quo otherwise there would never be any innovative actions to improve outcomes for women and other midwives (Draper, 2004a). Further, as Hollins Martin and Bull (2005) argue, following guidelines without supporting the informed decisions of the woman place the midwife under the control of the organisation. An exception might be where clearly to do anything other than to follow a policy would put a woman's life at risk. An example of this would be providing an oxytocic[6] drug where a woman is clearly bleeding profusely. Some authorities might argue that not following 'best practice' policies puts a woman's or her baby's life at risk. The debate surrounding the increasing focus on 'risk' is growing but there is no room in this thesis to do it justice. However, the socialisation of midwives in a risk culture potentially affects the way they make decisions and to what extent they do or do not wish to be autonomous.

At this point, the question arises about who the midwife is responsible to for her decisions and actions. Is it the women she cares for, the regulatory authority or the employing organisation? To all intents and purposes, it must be all three. An ethical dilemma arises if the requirements of any one is in conflict with either of the others. Ethically the midwife has a responsibility to the organisation she works for and in following policy might be seen as acting to safeguard her own position (Clarke, 2004) but that does not absolve her of her responsibility to the women she cares for. In addition, it may put her in conflict with her code of practice where to act in the best interests of the woman might be to not follow policy (Clarke, 2004). The Compact Oxford Dictionary (2006) describes being responsible as: '*obliged to do something or look after someone; being the cause of something and so able to be blamed or credited for it; able to be trusted; involving important duties or decisions'* (p.781). It seems that

[6] Oxytocic drugs are used in emergencies to contract the uterus to stop the haemorrhage.

many midwives in their apparent reluctance to accept responsibility interpret it as being the one to 'take the blame'. Midwives have become fearful of working with labouring women (Shallow, 2001a) in part this may be because of the increased focus on risk and complications as opposed to a focus on the normal. Despite the increase in opportunities for midwife-led care in Victoria there is an apparent reluctance for midwives to fill these positions that may be related to the perception of being accountable (see Chapter Six). Midwife-led models of care have been recognised as providing midwives with more autonomy (Sandall, 1995; Stevens & McCourt, 2002b; Walker, Moore, & Eaton, 2004) and thus accountability and responsibility. What is less clear is whether midwives recognise their responsibility within the more medicalised models of care. The overlap of professional boundaries confounds the ability of all health professionals to clearly delineate their responsibilities (Draper, 2004b). The concern is that midwives who defer all decisions to the medical profession are not only failing to act autonomously but are relinquishing all responsibility. In doing so they would not meet the ANMC competency standards.

There are however, some midwives who while appearing to lack the ability to advocate openly for the women that they are caring for, resort to 'acting by stealth' in order to go against policy (Kirkham & Stapleton, 2000; Pollard, 2003). They may be acting in the best interest of the mother but they are acting in a morally deceitful manner (Dworkin, 1988) and thus are not acting as autonomous practitioners nor acting responsibly. By practising outside the policy they may leave themselves vulnerable to a charge of professional misconduct (Clarke, 2004). In addition, it is not clear in the literature as to whether the midwives, when acting by stealth, are acting in response to the woman's wishes or indeed are even keeping her fully informed. It may be that midwives who act in this manner do so in order to maintain some control over their practice but how much it encroaches on the woman's rights is unknown. Although midwives may indicate that they are acting as an advocate for a woman they are merely acting as arbitrators to gain a balance between the constraints of policy and the woman's needs (Warriner, 2003).

There is no evidence to show what midwives fear the most, standing up and stating it is their right to work with women to make a decision or taking responsibility for that decision. It appears to me that it is the latter, fuelled by the continuance of oppression within organisations that is not necessarily driven by the medical profession (Kirkham,

1999). The underlying culture of organisations creates a barrier to autonomous midwifery practice (Kirkham, 1999) but enabling change of the culture is complex and requires a multi-factorial approach. In Australia, an important barrier to autonomous practice has been the limited boundaries of care that midwives have been practising in. Therefore one strategy has been to introduce models of care that enable midwives to work across the full scope of midwifery practice. However, before autonomous practice can be achieved, many midwives need to regain skills that they have lost and for some this includes learning skills never used.

2.6. Midwifery Autonomy and Re-skilling in Australia

The development of midwifery models in Australia, with the intent that midwives work across the full scope of midwifery practice, raises many issues pertaining to the ability of midwives to practise in areas where they lack recent experience. Many midwives therefore, have needed to re-skill and extend their practice, but what many understand as the 'extended role' of the midwife in Australia are skills and activities that in other countries are regarded as normal practice (Watson, Turnbull, & Mills, 2002). While there has been some discussion in the literature in Australia around preparing midwives for autonomous practice through a direct entry course, little has been published pertaining to preparing existing midwives for autonomous practice.

Watson et al. (2002) evaluated the implementation of hospital policies in two maternity services in the Australian Northern Territory, that provided midwives with prescribing rights for certain medications, tests and procedures. The introduction of these policies and standing orders provided the potential for extended midwifery practice and increased autonomy (Watson et al., 2002). Midwives in the sites evaluated were able to self-select to participate in the 'extended practice' project but there was no indication in the paper as to what percentage of midwives were actually chosen to participate. Watson et al. (2002) reported that the midwives '*welcomed the increased autonomy…*' but at the same time '*…described the onus of responsibility*'(p.260) with the need to interpret and act on results. The lack of clarification of the procedures and medications included under the policies implemented, make it difficult to establish to what extent the midwives had become more autonomous, or indeed what was meant by the term autonomy. Legislation does not yet in Australia provide midwives with the authority to

prescribe medications, despite recommendations of the National Health and Medical Research Council (1998) for midwives to have limited prescribing rights. Where policies such as discussed by Watson et al. (2002) exist, they are controlled by medical authorities and only provide midwives with the right to initiate not to prescribe (ACM, 2006a).

Where Australian midwives recognise that they have increased autonomy they also recognise the associated increase in responsibility and accountability (Griew, 2003; Walker, Moore, & Eaton, 2004; Watson et al., 2002). A Victorian study (Watson, Potter, & Donohue, 1999) prior to recent government policy changes, found that although 40 % of respondents cited autonomy as first or second ranked professional attribute only 4% said it was the most satisfying and 7% the least satisfying aspects of their roles. Maintaining control, empowerment and autonomy are all associated with greater satisfaction for midwives in the workplace (Hundley et al., 1995; Stevens & McCourt, 2002b; Walker et al., 2004; Watson et al., 1999). Although a lack of autonomy was associated with midwives leaving the profession (Ball et al., 2002) the question has been raised of whether midwives really want to be autonomous (Baird, 2007; Fleming, 1998a; Pollard, 2003; Watson et al., 2002; Watson et al., 1999). This may be a reflection of the embedded medical domination of midwifery practice (Watson et al., 2002).

2.7. Summary

In summary it would appear that midwives who are confident, competent and have the ability to reflect and critically appraise the choices around decisions under their sphere of practice are more likely to practice autonomously. In addition autonomous midwives need to establish the boundaries of their practice, be recognised as having the right to make and act on decisions, and to take responsibility for those decisions. It would appear that some of the challenges that face individual midwives becoming autonomous are as much to do with internalised beliefs as external factors associated with the medicalisation of birth.

Satisfaction has been shown to be connected to the relationship midwives develop with women. The next chapter explores those connections.

CHAPTER THREE

CONNECTING WITH WOMEN

3. Introduction

Working with childbearing women is the fundamental part of the midwife's role. The previous chapter introduced the concept of the midwife as an individual. This chapter continues to build up the foundation of the portfolio through discussion around the concepts of woman-centred care, continuity of care and the models of care within which connections between midwives and women occur. This chapter is important for clarifying some of the concepts to be used in both the policy chapter and the research project.

Underpinning midwifery philosophy in Western countries is the concept of providing maternity care that is woman-centred (ACM, 2007b; College of Midwives of British Columbia, 2006; Department of Health, 1993; Fleming, 1998a; Hills & Mullett, 2002; Pope, Graham, & Patel, 2001). The next section outlines woman-centred care and continuity of care as a precursor to exploring models of midwifery care, midwifery satisfaction and the midwife-woman relationship.

3.1. Woman-Centred Care

Woman-centred care has been identified in both the UK (Department of Health, 1993, 2007) and Australia (DHS, 2002c, 2004a; NSW Health Department, 2003) as the most appropriate way in which maternity services should be provided. The main concepts identified as supporting the provision of woman-centred care include access to and choice of service, informed shared decision making, access, and continuity of care giver (Department of Health, 1993, 2007; DHS, 2004a; Health Department Victoria, 1990). As this portfolio is focusing on the midwife, then the definition of woman-centred care as provided by the ANMC midwifery competency standards is considered suitable for ensuing discussion and it states that woman-centred care:

- is focused on the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or professions
- recognises the woman's right to self-determination in terms of choice, control, and continuity of care
- encompasses the needs of the baby, the woman's family, significant others and community, as identified and negotiated by the woman herself
- follows the woman between institutions and the community, through all phases of pregnancy, birth and the postnatal period
- is 'holistic' – addresses the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations

(ANMC, 2006, p.3)

These concepts of woman-centred care are similar to those identified elsewhere (Department of Health, 1993; DHS, 2004a; Hills & Mullett, 2002; The Royal College of Midwives, 2001) and provide guidance for all midwives in practice. It has been suggested that not only is there a lack of understanding about what constitutes woman-centred care but many of the concepts such as informed choice should be considered a part of all healthcare models not only in midwifery-led care (Health Issues Centre, 2006). In addition, while the ANMC (2006) claims that woman-centred care implies midwifery care, the concepts apply equally well across other professions and situations (Hills & Mullett, 2002). If woman-centred care is focusing on the woman's needs, expectations and self-determination, and she feels fully informed then obstetric care may fulfil those needs and from her perspective be a satisfying experience and be perceived as woman-centred care. Some women however, do not clearly understand the role of the midwife and the benefits of midwifery care (Carolan & Hodnett, 2007) and thus may resist choosing midwife-led care particularly here in Australia where private obstetric services are widely available.

Halliday (2002) argues that for midwives to be able to provide optimum maternity care they need an understanding of what woman-centred care means and are motivated to provide the quality of service expected. It could be expected that midwives would have an understanding of woman-centred care in Australia as it is a concept that has been discussed for many years and is included in the curriculum of midwifery courses (ACM, 2006b), discussion documents (Health Department Victoria, 1990; NMAP, 2002; NSW Health Department, 2003; Senate Community Affairs References Committee, 1999) and maternity care policies (Department of Health W.A., 2007; DHS, 2002a). There is however, little research to confirm this expectation. Midwives participating in the research reported later in this portfolio were asked to describe what they understood as woman-centred care and their responses are reported in chapter seven (p. 204).

One Australian study has focused on midwives and women's understanding of woman-centred care within one midwifery-led team in Victoria (Health Issues Centre, 2006). They found that midwives identified woman-centred care as individualised care, informed decision making and continuity of care within a philosophy of normality. Women were found to identify good communication, being treated as an individual and a good relationship as being important for their care. Women's expectation of continuity of care focused more on a consistent approach from the team of midwives over the expectation of care from one individual. Although there were similarities between the midwives and women's views, the women's priorities focused on having a safe pregnancy and birth in a hospital setting (Health Issues Centre, 2006). The women interviewed were not directly asked what woman-centred care meant to them and had not appeared to have deliberately chosen this model of care (Health Issues Centre, 2006) so may not have considered it possible to have the same carer throughout the antenatal period. Within this setting it was found that the midwives had difficulty in providing optimum woman-centred care as they felt constrained by the hierarchical and organisational structures (Health Issues Centre, 2006). Although only women and midwives from one hospital were interviewed, the findings about woman-centred care supported existing literature. The recommendations for improvement of services such as education for clinicians to enhance communication skills and the need for local identification of barriers to women making decisions provide guidance for other maternity services.

The environment and model of service undoubtedly impact not only on how motivated a midwife is to provide optimum woman-centred care but also on her ability to do so. Different models of care and settings for birth impact upon the type of relationships that midwives develop with women. Where greater continuity of care exists across the spectrum of maternity care the more likely the midwife is to develop a continuing relationship with a woman. As woman-centred care includes the concept of continuity of care throughout pregnancy, birth and postnatal care (ANMC, 2006; Department of Health, 1993; DHS, 2002c) the next section explores the concepts of midwifery continuity of care.

3.1.1. Continuity of Care in Midwifery

Continuity of care has been identified as an important concept in improving maternity care for women in Australia (DHS, 2004a; Health Department Victoria, 1990; Hirst, 2005; NSW Health Department, 2003b) and in the UK (Department of Health, 1993, 2007). Midwife-led care models, such as caseload, independent practice and team midwifery, have evolved with the intention of providing women with continuity of care from one midwife or a small group of midwives throughout the continuum of pregnancy and birth. Comparisons of different models as well as evaluation of outcomes between different midwifery models of maternity care is difficult due to a lack of clarity or consistency for measuring continuity of care (Green, Renfrew, & Curtis, 2000; van Teijlingen, Hundley, Rennie, Graham, & Fitzmaurice, 2003).

Two key indicators taken to measure continuity of care are those of the number of carers involved and/or the presence of a known or named midwife at the birth. There are difficulties with both of these measurements and of overall evaluation of continuity of care. Firstly, one study found that differences between what a woman reports and an audit of notes, suggest that some women forget who they have met (Farquhar, Camilleri-Ferrante, & Todd, 2000). Secondly, that although a woman may have previously met the midwife attending the birth, they do not necessarily have a relationship that improves the birth experience (Green et al., 2000). Women were not asked how well or what type of relationship they had with an individual midwife so they may only have met her once before. The only indicator used to infer the existence of

continuity of care is that of the number of carers but continuity of care is not a single concept, it is more than having a known midwife at a birth.

3.1.2. Defining Continuity of Care in Midwifery

Definitions of continuity of care across different health disciplines contain several common elements but have not been clearly defined (Haggerty et al., 2003; Hodnett, 2006; Saultz, 2003; Sturmberg, 2003). This section commences with the concepts of continuity of care as identified by Hodnett (2006) within a midwifery context. Her definitions were used to form the basis of analysis for a question on defining continuity of care in the case studies reported in chapter seven (p. 205). This is followed by a brief review of domains of continuity of care that have been found in the literature.

To establish guidelines for choosing papers for a systematic review of continuity of care during pregnancy and childbirth Hodnett (2006) identified four definitions of continuity of care:

> 1) a stated commitment to a shared philosophy of care,
>
> 2) a strict adherence to a common protocol for care during pregnancy and/or childbirth,
>
> 3) a system whereby those who are discharged from hospital are routinely referred to community service,
>
> 4) the actual provision of care by the same caregiver or small group of caregivers throughout pregnancy, during labour and birth, and in the postnatal period.
>
> (Hodnett, 2006, p.2).

Hodnett focused on the fourth definition to guide the choice of research papers. This approach implies that one caregiver or a small group providing care throughout a woman's pregnancy and birth ensures continuity of care. The size of a small group was not clarified. However, the review was unable to clarify whether improved outcomes were due to continuity of care or midwifery care (Hodnett, 2006). Hodnett (2006) did not provide a rationale for why she separated these terms. In concentrating on a

definition that only focuses on care given over time by one or a few caregivers, omits clarification of what that care includes. Other elements such as developing a good relationship and providing care that is consistent (Haggerty et al., 2003) are implicit where only one individual is involved but need to be expanded upon if evaluation of the provision of continuity of care is to be demonstrated.

Measurement of continuity of care is difficult because individuals may view continuity of care differently to those providing it (Haggerty et al., 2003). Reid, Haggarty and McKendry (Haggerty et al., 2003; 2002) completed a systematic review in order to define the concepts of continuity of care. The review explored multi-disciplinary concepts of continuity of care, several nursing papers were included but no midwifery ones. Reid et al. (2002) identified three domains of continuity: informational, management and relational continuity. The first domain was described as informational continuity that included; the medical history; personal events; individual preferences; and knowledge retained in the memory of the health provider. The second domain of management continuity included the need for a '*consistent and coherent'* approach to an individuals' healthcare management, both within and across services. The third domain of relational continuity was described as an '*ongoing therapeutic relationship'* between an individual and one or more carers (Reid et al., 2002). In a later paper, Haggerty et al. (2003) argue that continuity of care is important for individuals and their families as it provides reassurance that they are known by the care provider and that the care proposed is consistent across services. They also argue that continuity is important to healthcare providers, as it provides them with reassurance that they had sufficient information to assist in providing appropriate care for the individual (Haggerty et al., 2003). If the quality of interactions and interventions are not also evaluated then assumptions about the potential of improved outcomes with the provision of continuity of care may not be fulfilled (Haggerty et al., 2003; Reid et al., 2002).

Saultz (2003) also completed a systematic review and identified three domains of continuity that he deemed to be hierarchical and connected. These domains were *informational*, *longitudinal* and *interpersonal*. He acknowledged the similarities to those found by Reid et al. (2002) whose report had recently been released (Saultz, 2003). The first and third levels related directly to Reid et al.'s (2002) informational

and relational domains. The middle level of Saultz's (2003) hierarchy was longitudinal continuity, whereby each individual would have an identified base and team responsible for their care. Longitudinal continuity as a concept was included as an element across all three domains of continuity described by Reid et al. (2002). Saultz (2003) purports that his perspective of continuity presents an advantage over Reid et al's (2002) perspective through focusing on the interpersonal continuity at the top of a hierarchy. He alludes to Reid et al's (2002) report as describing care co-ordination rather than defining continuity of care. However, Reid et al. (2002) make it clear that relationships provide a connection between all elements of the domains. More recently in a collaborative paper by these authors they reiterate that relational continuity is the most important of the domains (Guthrie, Saultz, Freeman, & Haggerty, 2008) but that continuity is a total package.

Presentation of the domains of continuity as a hierarchy seems to imply linearity, where one builds on another and lacks connectivity. Sturmberg (2003) argues against a purely linear perspective of continuity. He contends that continuity of care should be viewed as existing within a complex adaptive system where '*the relationships between the components of a system are more important in understanding the system than the components themselves*' (Sturmberg, 2003, p.139). That is, the members of the healthcare team are the Complex Adaptive System with continuity of care as an outcome (see Chapter Ten). Depending on the quality of interactions within a relationship, the feedback and adaptation that occurs may reduce or enhance the perceived outcome of continuity (Sturmberg, 2003). Haggarty et al. (2003) to some extent also describe continuity as an outcome and recognise the need for care to be experienced as '*connected and coherent*' (p.1221). Viewing healthcare within a framework of a Complex Adaptive System acknowledges the complexity of the factors involved in the provision of continuity of care, and the difficulties in measuring it.

Evaluation of continuity of care is not easy and relying on evaluation of only one domain is insufficient to provide a clear picture of what continuity of care means for either the individual or the healthcare provider (Haggerty et al., 2003; Saultz, 2003). It has been recognised within the midwifery literature that key performance indicators, to measure continuity or to establish whether women are being provided with woman-centred care, are not in themselves guarantees that such care is being delivered (Brown

& Bruinsma, 2006; Pope et al., 2001) but no alternative methods of measuring continuity of care in maternity care have been suggested.

In reviewing the above work it becomes clear that the four definitions provided by Hodnett (2006) are all elements of continuity. All four are important but individually do not necessarily result in continuity of care as an outcome (Sturmberg, 2003). Where maternity care is provided by one midwife it would be anticipated that all the elements of continuity would be achieved, although the quality of the whole experience for the woman depends on the relationship that has developed. However, as soon as groups of midwives share the provision of care, the elements such as shared protocols, access to written information, co-ordination of follow up and the development of trust, embedded in Reid et al's (2002) three domains rise in importance. Team members need to have shared goals and values as otherwise the team may only act as a group without the cohesiveness of a team (Wilson, 2005) that is necessary for ensuring continuity of care.

The provision of continuity of care within maternity services has been acknowledged across Australia as important for women (DHS, 2004a; NMAP, 2002; NSW Health Department, 2003; Queensland Department of Health, 2005). Although the focus of continuity of care is primarily on the provision of care by either an individual or a small team, other elements of continuity are recognised but not specifically acknowledged as necessary for improving continuity of care (DHS, 2004a; Queensland Department of Health, 2005). In the public maternity services in Victoria, management continuity is acknowledged through the increasing focus on consistent protocols and guidelines, health professional education and referral pathways to community services (DHS, n.d.) (see chapter four p.97). The rationale appears to be to reduce the provision of conflicting information to women, by developing a consistent and coherent service across the whole of the public maternity sector in Victoria. Further research is necessary to determine how successful this strategy has been.

Informational continuity has also been addressed in Victoria with the introduction of the client held Victorian Maternity Record (VMR) (DHS, n.d.). The aim is that each person who sees a pregnant woman will document what has occurred, the woman is able to document her own preferences so any healthcare provider reading the notes will have full information. Women will retain the records and be able to produce them at the next

pregnancy or for any medical occurrence that requires a history of her childbirth experience. However, it has been found in studies of hand held records that women do not necessarily understand their ability to write in them, doctors do not always write in them, and women forget to bring them to appointments (Hart, Jones, Henwood, & Shiers, 2003; Patterson & Logan-Sinclair, 2003), issues that are more likely to relate to failure of process by the health professional than the woman (DHS, 2008). Unfortunately it has been my experience that despite much testing and education on the VMR many maternity care providers are not at the time of writing using the document.

Relational continuity in midwifery care occurs where the midwife develops a relationship with the woman. This is more likely to occur where the midwife is providing care throughout the whole pregnancy, birth and postnatal care. Caseload and team midwifery models are two examples of midwife-led care where relational continuity would be expected to occur and as previously discussed are recognised as an important choice for women in Victoria (DHS, 2004b). The next section provides a review of midwife-led care.

3.2. Midwife-led Care

Midwife-led care occurs when midwives are the primary caregivers for childbearing women. The midwifery literature consistently describes continuity of midwifery-led care as the provision of care by one or a small group of caregivers (Benjamin, Walsh, & Taub, 2001; Biro, 2000; Homer, Matha, Jordan, Wills, & Davis, 2001b; Shallow, 2001c). Several models are described including those that provide continuity of caregiver such as caseload (Homer, Brodie, & Leap, 2008), partnership (Guilliland & Pairman, 1995), and one-to-one practice (McCourt, Page, Hewison, & Vail, 1998). Models providing continuity of care shared between a small group of midwives are commonly known as; team midwifery (Waldenstrom, McLachlan, Forster, Brennecke, & Brown, 2001), birth centre models (Barlow, Marion, Conroy, & Lennan, 2004; Kirkham, 2003a) or midwife-led units (Page & Drife, 2007).

One objective of the Changing Childbirth report in the UK was that women '*should be cared for in labour by a midwife whom they have come to know in pregnancy*' (p.17). Although there were many objectives identified in the UK report (Department of

Health, 1993) the concept of having a known midwife at the birth has become the main focus of evaluating continuity in models of maternity care in the UK. The evidence suggests that with a caseload model women are more likely to have met the midwife present during their labour and birth experience compared with either team (Benjamin et al., 2001; Morgan, Fenwick, McKenzie, & Wolfe, 1998) or standard models of care (Johnson et al., 2003; Page et al., 1999; Spurgeon, Hicks, & Barwell, 2001). A weakness in these studies is the failure to establish how well a woman knew the midwife who attended the birth. That is, to what extent a relationship existed to be able to call it continuity. While there are some indications that knowing the midwife present at birth is less important to women than having a midwife who is caring (Green et al., 2000; Halliday, 2004), the evidence needs to be tempered by findings from other studies that women who do not know anything different will be satisfied with the system that they know (Hundley & Ryan, 2004; van Teijlingen et al., 2003).

There is some evidence that women who have experienced a continuity of care model during pregnancy are more satisfied with their care than those who did not (Biro, Waldenstrom, Brown, & Pannifex, 2003; Homer, Davis, Cooke, & Barclay, 2002; McCourt & Pearce, 2000). There was no clear evidence that having a midwife known to the woman during labour improved satisfaction (Green et al., 2000). To some extent findings related to satisfaction are confounded by evidence that women who are satisfied with the model of care that they have experienced are less likely to want a different model (Green et al., 2000; Hicks, Spurgeon, & Barwell, 2003; van Teijlingen et al., 2003). There is some suggestion that a continuing relationship leads to the development of trust and consequently an improvement of the women's experience (Shallow, 2001a). However, development of a trusting relationship depends upon the communicative ability of the individual midwife (Homer et al., 2008). One aspect of women's care that may affect their satisfaction is the perception of safe care for their baby (Health Issues Centre, 2006). I suggest that there is not only a need to build trusting relationships but for women to view midwifery care as safe then the profession needs to become more visible and accepted as the 'norm' for maternity care.

Continuity of midwife care has been found to be as safe for women and babies as standard care (Farquhar, Camilleri-Ferrante, & Todd, 1998; Farquhar et al., 2000; Hart, Pankhurst, & Sommerville, 1999; Homer, Davis, Cooke, & Barclay, 2002) although

how standard care is defined might be deemed as troublesome as defining continuity. Generally however, these studies are attempting to compare women who are at similar risk of complications whose care is provided in different models. Although the international definition (ICM, 2005a) of a midwife does not restrict midwife–led care to women at low risk of developing problems, the majority of midwife-led models of care are governed by strict guidelines and policies restricting care to 'low risk' women (Hundley, Milne, Glazener, & Mollison, 1997; Mahmood, 2003; Rogers, 2002; Waldenstrom, Brown, McLachlan, Forster, & Brennecke, 2000). However, guidelines are very idiosyncratic and what may be allowed at one unit will be restricted in another (Walsh & Downe, 2004). For example in one health district in the UK, women who are ineligible to book for births at the local-stand alone midwifery managed unit (MMU) because they are having their first baby are able to book a home birth. It appears that the community midwives, who may also admit women to the MMU, are not constrained by the same protocols for home births (Fraser, Watts, & Munir, 2003). There are examples of collaborative obstetric and midwifery teams that enable women who are deemed to be at greater risk of complications to receive midwifery continuity of care (Biro, 2000; Tucker, 2000).

A recent systematic review found that midwife-led care confers benefits for childbearing women (Hatem, Sandall, Devane, Soltani, & Gates, 2008). However, the issue of continuity of care or midwife care being the factor that supports those findings remains undetermined. Hodnett's (2006) review of continuity of caregivers was subsumed into Hatem et al.'s (2008) review. This suggests that midwife-led care is the concept on which to focus research, particularly as continuity of care is a more complex concept than described by relationships alone (Sturmberg, 2003). The reader is referred to Hatem et al (2008) for full details of the improved benefits for women of midwife-led care. As the focus of the portfolio is the individual midwife the next sections explore the literature focusing on midwife-led models of care from the perspective of midwives.

3.2.1. Caseload Models

This section provides a brief description of types of midwife-led models followed by a review of the literature. For the purposes of this section, except where discussing specific schemes, models that are intended to provide continuity of carer will be referred

to as caseload. Each midwife in a caseload model is responsible for providing the majority of maternity care for a number of women, thus has a personal 'caseload' (McCourt et al., 1998; Rosser, 2003). The midwife usually works in partnership with another midwife, but may work in a group practice of two or three (Homer et al., 2008). Small group practices enable the midwives to share being on call, provide support for each other whilst minimising the number of carers seen by a woman throughout the continuum of her care (Benjamin et al., 2001; The North Staffordshire Changing Childbirth Team, 2000). Most commonly reported caseloads are between 35 to 45 per year, per full time equivalent midwife in the UK (Page, 2003; Rosser, 2003; The North Staffordshire Changing Childbirth Team, 2000) but has been found to be lower in independent practice (Milan, 2005). In New Zealand there are reports of midwives having caseloads of up to 110 per annum although most ranged between 26 and 75 (Wakelin & Skinner, 2007). In Australia, caseload models are not widely available within the public system, although a few programs have been established including a community program in WA (Thorogood, Thiele, & Hyde, 2003) and the Ryde integrated program in NSW (Tracy, Hartz, Nicholl, McCann, & Latta, 2005). Presently in Victoria, a few rural centres offer midwifery caseload model in collaboration with the general practitioner as the main option (DHS, 2004a) and one of the tertiary hospitals recently commenced a large randomised controlled trial of a caseload model (Midwifery Academics (Victoria), 2008).

3.2.2. Midwife-led Team Model of Care

Team midwifery evolved in an attempt to improve continuity of care for women (Flint, Poulengeris, & Grant, 1989). Evaluation of a small team of four midwives found that the attempt to provide continuity over a 24 hour period led to occasions when midwives worked long hours without formal back up. Flint et al.(1989) recommended that expansion of the team to five or six midwives would provide greater flexibility with the provision of a second midwife as back up. However, it was acknowledged that larger teams had the potential to reduce continuity (Flint et al., 1989). When there are more than six members in a team there is a danger of care remaining fragmented and based on organisational needs rather than on those of the woman (Sandall, 1999; Stock, 1994).

The term ‘midwifery team’ covers a wide variety of meanings including teams providing hospital care only, or community care only, or providing both community and hospital care that is fully integrated (Stock, 1994). As Australia does not have a recent history of community-based midwifery the development of integrated teams provides new experiences for most of the midwives involved. With the re-organisation of midwifery services in the case studies reported later the term ‘team’ was used to describe two different models (see chapter six p.151). Inconsistency in the use the term makes it difficult for midwives and potentially women to determine what model suits them.

3.2.3. Midwives’ Experience of Midwife-led Care

In reviewing the literature it was not always clear whether the models being described related to continuity of carer as in a caseload model or continuity of care with a team model. Eighteen studies have been reviewed, six discuss caseload models and eleven pertain to team models of midwife-led care and one surveyed midwives across all models of care. Table 2 provides a description of each study, the models of care studied and the research methods. The majority of studies were conducted in the UK with four from New Zealand and three from Australia. Kirkham’s (2003b) book on birth centres provides information on midwife-led care within a birth centre model from several countries but only three of the chapters provided research findings of midwives experiences that were included in the review. Although there may be studies from other countries where independent midwifery is more common, none focusing on the midwives’ experience were found published in English.

Researcher	Methods	Models
Stevens & McCourt 2002a, b, c, d UK	Ethnographic individual and focus group interviews All midwives in scheme = 36 Sample community & hospital midwives	Caseload 20 midwives in partnerships within groups of 6-8 individual Personal caseload 40
Rosser 2003 UK	Mixed methods Evaluation Interviews -7 midwives	Caseload
Engel 2003 NZ	Narrative Interviews - 5 midwives	Independent midwives from separate group practices
Hunter 2003 NZ	Qualitative Interviews 10 midwives	Independent midwives using one of three small maternity units
Barlow et al. 2004 NZ	Evaluation midwifery services Mixed methods Interviews Focus groups - 30 midwives + 1 student	Stand alone Midwife-led unit Core midwives Independent midwives
Wakelin & Skinner 2007 NZ	Telephone Survey 94 midwives contacted and agreed to participate	Independent midwives with access agreements to health facilities of 1 district in NZ
Stock 1994 UK	7 case studies	No clear picture of the teams studied (summary only)
Hundley et al. 1995 UK	Pragmatic RCT Randomisation of women to midwife-led unit or obstetric unit Staff survey completed for each woman	Rotation of all midwives between midwife-led unit and obstetric labour ward Unclear if any midwives also provided antenatal care
Turnbull et al. 1995 Scotland	Prospective cohort study Comparison 21 midwives from midwifery development unit with 64 non MDU midwives Survey - Both groups - before & 15 months after model commenced MDU midwives surveyed every 3 months with extra questions	21 midwives FT Caseload – named midwife 19-39 (1st year) Care shared with 4 associates Non-MDU midwives – some community based, some hospital based

Table 2: Studies reviewed of midwives' experience with midwife-led models

Researcher	Methods	Models
Brodie 1996 Australia	Evaluation of team Qualitative, Grounded theory	Team - 7 FTE
Warriner et al. 1998 UK	Mixed methods Evaluation pilot project Interviews - all team midwives at beginning and end project Individual or group interview -31 non-team midwives	Team - 7 FTE
Todd et al. 1998 UK	Evaluation Survey Interviews to develop survey plus previously validated survey tool items	7 teams x 7 FTE Ward based teams
Sandall 1999 UK	Survey - organisation of work and stress Sample 800 midwives across UK	Variety of work environments including team, caseload, community based and hospital based
Haith-Cooper 1999 UK	Qualitative Exploratory Focus groups x 2 - 9 midwives	4 teams x 8 FTE Community based On-call for intrapartum care
Shallow 2001 UK	Qualitative Interviews - 6 midwives Purposive sampling	Integrated teams Up to 20 midwives in each team
Griew 2003 Australia	Interviews Focus groups 13 midwives	Birth centre midwives Some worked in teams some had caseload
Fraser et al. 2003 UK	Case study evaluation Surveys Focus groups Document analysis Interviews 26 midwives of MMU	Midwife Managed Unit (MMU) 16 part or full time midwives employed in MMU 10 community based midwives offer MMU births
Walker et al. 2004 Australia	Qualitative Focus groups x 4 - 22 midwives	2 Teams - 8 FTE 8 + 9 midwives Birth centre - 4 FTE 5 midwives Home team - 16.8 FTE - 18 midwives

Table 2: continued

Most of these studies used a qualitative approach to explore the views of the midwives. Those studies that used a survey tool that enabled statistical analysis (Hundley et al., 1995; Sandall, 1999; Todd, Farquhar, & Camilleri-Ferrante, 1998; Turnbull, Reid, McGinley, & Shields, 1995; Wakelin & Skinner, 2007) were limited by the lack of the qualitative midwife voice. Five studies (Hundley et al., 1995; Sandall, 1999; Todd et al., 1998; Turnbull et al., 1995; Warriner, Pearce, Fraser, & Ullman, 1998) made some comparison between midwives working in different models. The majority of studies were evaluations of specific projects or services. Some studies (Barlow et al., 2004; Fraser et al., 2003; Rosser, 2003) included clinical audit and interviews or surveys of women and other health professionals, the findings of which are not discussed here. The different research methods, different midwife-led models and lack of clarity over the type of models discussed make direct comparisons between studies difficult. Table 3 lists the positive benefits associated with midwife-led care and Table 4 lists the negative. These tables identify where findings are similar between different models. They also demonstrate the overlap of attributes within models that contribute in some cases to improved job satisfaction for some midwives and reduced job satisfaction for others.

Positive findings related to midwife-led care	Model	Study
Woman centred philosophy	Caseload BC Team	Barlow et al. 2004 Rosser 2003 Stevens & McCourt 2002 Griew 2003 Brodie 1996
Professional fulfillment / greater use of skills	Caseload Team	Rosser 2003 Stevens & McCourt 2002 Wakelin & Skinner 2007 Barlow et al. 2004 Stock 1994 Stevens & McCourt 2002 Brodie 1996 Warriner et al. 1998 Todd et al. 1998 Haith-Cooper 1999 Shallow 2001 Walker et al. 2004
Relationships with colleagues / collegiality within team	Caseload Team	Barlow et al. 2004 Stevens & McCourt 2002 Walker et al. 2004
Being with women led to greater satisfaction	Caseload Birth centre Team	Engel 2003 Rosser 2003 Stevens & McCourt 2002 Griew 2003 Brodie 1996
Organisational issues Liked more flexibility	Caseload Team	Rosser 2003 Stevens & McCourt 2002 Haith-Cooper 1999
Autonomy Accountability & responsibility	Caseload BC Team	Rosser 2003 Wakelin & Skinner 2007 Barlow et al. 2004 Stevens & McCourt 2002 Hunter 2003 Griew 2003 Walker et al. 2004
Job satisfaction	Caseload Team	Rosser, 2003 Haith-Cooper 1999 Stock, 1994 Walker et al. 2004
Salary / funding model	Caseload	Rosser 2003

Table 3: Positive attributes of midwife-led care

Negative findings of midwife-led care	Model	Study
Impact on social life / work life balance	Caseload Team	Stevens & McCourt Wakelin & Skinner Rosser Haith-Cooper 1999
Balancing demands of woman	Caseload	Engel 2003 Wakelin & Skinner Stevens & McCourt
Size of caseload / workload	Caseload	Stevens & McCourt 2002 Wakelin & Skinner
Salary / funding model	Caseload Team	Wakelin & Skinner Rosser Haith-Cooper 1999 Stock 1994
Less continuity for women – as compared to caseload / community	Team BC	Shallow 2001 Haith-Cooper 1999 Todd et al. 1998 Fraser et al. 2003 Griew 2003
Conflict with those not in team / between teams / isolation	Team	Stock 1994 Brodie 1996 Walker et al. 2004 Warriner et al. 1997
Lack time for professional development / loss confidence in complex	Team	Haith-Cooper 1999 Shallow 2001
Responsibility	Caseload	Hunter 2003
Burnout was greater when: low grade low control lack freedom to make decisions long working hours	greater in new C of C schemes than traditional care and greater in hospital based teams	Sandall 1999

Table 4: Negative attributes associated with midwife-led care

Continuity of carer is the basis of caseload practice (Rosser, 2003) therefore it is not surprising that several of the studies found that midwives had chosen this model of care in order to provide continuity (Engel, 2003; Stevens & McCourt, 2002b; Wakelin & Skinner, 2007). In defining continuity as the means to establish a relationship of trust (Rosser, 2003), there is a fundamental recognition that relationships with women are a major source of satisfaction for midwives (Engel, 2003; Rosser, 2003; Stevens & McCourt, 2002a, 2002b; Wakelin & Skinner, 2007). Balancing the demands of women with the needs of the midwife were found to present conflicting tensions for the

midwife (Stevens & McCourt, 2002a; Wakelin & Skinner, 2007). In order to maintain a work-life balance midwives needed to set boundaries, such as appropriate times and reasons to call the midwife (Engel, 2003). Such boundary setting was found to be essential in managing demanding women (Stevens & McCourt, 2002c; Wakelin & Skinner, 2007). Another finding associated with maintaining boundaries was the difficulty some midwives found to 'let go' (Engel, 2003), with some midwives experiencing feelings of loss if they did not attend the birth of a woman they had built up a good relationship with (Stevens & McCourt, 2002c). This might explain why Wakelin and Skinner (2007) found that almost half of the midwives who allocated themselves set time off continued to remain on call for births, with 30% of their respondents having no structured time off at all.

The flexibility of working hours and ability to have some control over organisation of work in caseload practice was seen as a positive by some midwives (Rosser, 2003; Stevens & McCourt, 2002c). It was found that in team midwifery where there was less flexibility and control there were higher rates of burnout (Sandall, 1999). However, not all midwives are able to be flexible (Stock, 1994) and may have difficulty providing the on call necessary to provide continuity of care (Rosser, 2003). The on call arrangements were found to negatively impact on work-lifestyle balance and were a major contribution to attrition from the caseload model (Stevens & McCourt, 2002b; Wakelin & Skinner, 2007).

The ability to work within a shared philosophy of normal, providing all aspects of care for women, was found to be an important factor for midwives who participated in caseload practice (Barlow et al., 2004; Rosser, 2003; Stevens & McCourt, 2002c). The provision of holistic practice encompassed the idea of working as a 'real' midwife with the enhancement of skills that led to professional fulfillment (Stevens & McCourt, 2002c; Wakelin & Skinner, 2007). Other factors for professional fulfillment included being autonomous practitioners where they were responsible for own practice decisions (Barlow et al., 2004; Rosser, 2003; Stevens & McCourt, 2002c; Wakelin & Skinner, 2007) and the development of collegial relationships (Barlow et al., 2004; Stevens & McCourt, 2002c).

Many of the negative aspects of caseload practice are associated with organisational issues. These included the long hours, on calls, need for more pay and a smaller caseload (Stevens & McCourt, 2002c), and lack of backup (Wakelin & Skinner, 2007). In New Zealand, the funding model was important in maintaining a work-life balance (Engel, 2003) and contributed to midwives leaving caseload practice (Wakelin & Skinner, 2007). The lack of sick or pension rights for self-employed midwives was found to be a concern for some midwives in the UK (Rosser, 2003). However, being self-employed provides greater independence and control over clinical practice at all times (Engel, 2003; Rosser, 2003).

As identified in Table 3 and 4, many of the findings from the evaluations of team midwife-led care from the perspective of the midwife were similar to those studies that focused on evaluating caseload models.

Turnbull et al (1995) developed a survey tool to compare changes in professional attitudes of two cohorts of midwives before and after the implementation of a midwife-led model of care. The survey tool was informed by focus groups and validated by midwives from a range of clinical practice. The four themes identified as subscales of the tool were professional satisfaction, professional support, client interaction and professional development (Turnbull et al., 1995). Many of the findings from the other studies reviewed here correlate to Turnbull et al.'s themes.

Midwives who volunteered for the Midwifery Development Unit (MDU) in Turnbull et al.'s (1995) UK study scored significantly lower on the professional attitude scales prior to the implementation of the new model compared to the control group. Turnbull et al. (1995) suggest that one reason the midwives joined the program was to improve their morale and skills. They found that fifteen months after implementation of the model, the scores of the midwives in the MDU had improved significantly whereas the midwives in the control group demonstrated little change (Turnbull et al., 1995). As the midwives had self-selected for the project, the improvement in the professional attitude scales might have been related to change and stimulation, in which case an initial rise and then subsequent fall in the attitude scales might be expected. As the MDU midwives were surveyed several times throughout the implementation there were dips in aspects of the scales (Turnbull et al., 1995). The researchers explain these as being

related to organisational changes. At the end of the study, despite some difficulties in the integration of the MDU within the main hospital, the midwives in the MDU wanted to continue in that role (Turnbull et al., 1995). The Turnbull et al. study could be strengthened with qualitative data to explain not only why the midwives chose the model but what they liked about it.

Hundley et al. (1995) also evaluated a midwife-led model of care using a survey tool and comparing the views of midwives who worked in either a midwife-led unit or a traditional labour ward. Although the women were randomised to receive either midwife-led care or traditional care the midwives apparently rotated between the two units (Hundley et al., 1995). Data were collected from the midwives after each birth and there was a lack of clarity to what extent the same midwives were being compared. Hundley et al (1995) found that job satisfaction was significantly greater in the midwifery unit (MU) compared to the hospital labour ward. As this study was evaluating each midwife for each birth and the midwives rotated between the units, midwives were potentially being compared against themselves. Regardless of the group, MU or labour ward, the best predictors of improved midwife satisfaction were the midwife being responsible for all management decisions and being the prime caregiver at the birth. Those in the obstetric labour ward who took responsibility for decisions may have been the same midwives who worked in the MU, who continued to practice midwifery in the same way regardless of setting. Alternatively midwives may have changed the way they practiced according to the setting, supporting the impact a different setting can have on women, midwives and decision making (Freeman, Adair, Timperley, & West, 2006).

Todd et al. (1998) also in the UK, found no difference in job satisfaction between midwives on community teams and hospital team midwives. This may be because these groups of midwives did not have a significant difference in their perceptions of levels of responsibility (Todd et al., 1998) one of the predictors for satisfaction identified by Hundley et al.(1995). Several UK studies found that midwives who had moved from the community to integrated teams were less satisfied than those who had previously been hospital based (Fraser et al., 2003; Haith-Cooper, 1999; Shallow, 2001b). It was suggested that the loss of individual caseloads (Fraser et al., 2003) and reduced continuity in the antenatal and postnatal period (Haith-Cooper, 1999; Shallow, 2001b)

were the reasons for this difference. However, most team midwives enjoyed their work and had a high level of job satisfaction (Haith-Cooper, 1999; Warriner et al., 1998), and in several studies satisfaction was clearly associated with the ability to use the full range of midwifery skills (Haith-Cooper, 1999; Stock, 1994; Walker et al., 2004).

Walker et al. (2004) found that the midwives demonstrated their greater accountability through improved documentation and collaboration with medical colleagues. Several participants had also recognised they had developed a wider skill base with consequent improved confidence in ability to practice. Both Todd et al. (1998) and Haith-Cooper (1999) found that team midwives were more likely to use all of their skills than hospital based midwives and had greater opportunity to develop skills. Haith-Cooper (1999) however, found that some teams were not as flexible as others in providing time for professional development. Shallow (2001a) found that where midwives had been working in a model of normality within the community, being placed back into a medicalised hospital initially led to loss of confidence and increased anxiety when working in these areas. This was compounded by the focus of competence on the technological marginalising knowledge of normal (Shallow, 2001d).

As with caseload models, organisational issues were the main reasons for discontent with team models. Haith-Cooper (1999) found contrasting opinions where some midwives found the team work flexible and preferred on call to night shifts, others found it more disruptive to family life. Although team midwifery does not suit all midwives (Stock, 1994), the ability to provide care across the full spectrum of midwifery is preferred to a return to fragmented care where midwives work in one specialised area only (Haith-Cooper, 1999). Shallow (2001d) found that, although the midwives interviewed indicated that midwives worked best in an area they preferred, there was a lack of sympathy for those expected to make changes after being in one area for many years.

Differences in grades was an issue in some UK teams where some midwives felt they had the same level of responsibility but were employed at a different grade and pay level to others in the team (Haith-Cooper, 1999; Stock, 1994). Midwives were divided on whether those on the lowest grade (indicating they had less experience), should be working in teams (Haith-Cooper, 1999), but Stock (1994) found that the employment of

midwives on lower grades were used as developmental posts for some teams. Sandall (1999) found that midwives of lower grades, were at greater risk of burnout than those of higher grades. It is unclear why this occurs but may be due to insufficient support (Shallow, 2001a). While no significant differences were found between the amount of responsibility experienced between team and hospital midwives, the hospital midwives felt they had less control over their practice because of strict hospital guidelines (Todd et al., 1998).

Working within a team structure responsibility is shared and informational continuity across multidisciplinary teams has the potential to be reduced (Farquhar, Camilleri-Ferrante, & Todd, 1998). Therefore it is important that in collaborative team practice there are shared values, respect for each team member, open communication and support for each other (Stapleton, 1998). Although Stapleton was referring to collaboration with different health professionals the concepts underpin any team network (Mickan & Rodger, 2000). The larger the midwifery teams the more difficult it becomes for consistency within team practices. Freeman, Miller and Ross (2000) found that differing philosophical beliefs could adversely effect the effectiveness of teamwork. While their study was focused on multi-professional teams, potentially the differing philosophical beliefs of midwives as discussed in the previous chapter might impact on the effectiveness of a midwifery team model. Some of the studies reviewed found that there was some degree of conflict between midwives of teams and non-teams (Stock, 1994; Walker et al., 2004). However, while Fraser et al. (2003) found that communication between health professionals had deteriorated at one stage it had gradually improved and Todd et al.(1998) found that both groups of midwives surveyed felt they had good relationships with colleagues.

As a midwife's satisfaction may be linked to her remaining in the profession (Ball et al., 2002) the next section focuses on that concept of the midwife's role.

3.3. Job Satisfaction

The section above identified the positives and negatives of working within midwife-led models of care. These same issues have been recognised as contributing to job satisfaction of midwives affecting either retention (Kirkham et al., 2006) or attrition

(Ball et al., 2002) of the workforce. Organisational changes have been identified as affecting satisfaction (Ball et al., 2002) and with the number of changes occurring in Victoria it is important to review the midwifery literature pertaining to satisfaction to clarify the issues involved.

Job satisfaction has been suggested as being determined by the difference between how much a person wants or expects from a job and how much they receive (Steers 1988 cited Laschinger, Shamian, & Thomson, 2001). In nursing it has been found that greater professional autonomy, greater control over work practices and relationships are associated with greater job satisfaction (Adams & Bond, 2000; Curtis, 2007; Laschinger et al., 2001; Shader, Broome, Broome, West, & Nash, 2001). These same factors were acknowledged as the positive aspects of midwife-led models of care (Barlow et al., 2004; Rosser, 2003; Stevens & McCourt, 2002c; Walker et al., 2004). However, there were also indications that if the negative issues overwhelmed the positive, midwives left the service, although not necessarily the profession (Engel, 2003; Wakelin & Skinner, 2007).

In a review of the midwifery literature, few papers were found that directly addressed the issue of satisfaction for midwives. A couple of papers identified improved satisfaction for midwives who had extended their skills (Rogers, Bloomfield, & Townsend, 2003; Stewart & Wheeler, 2004; Watson et al., 2002). While improved job satisfaction was recognised in some team models of midwife-led care (Haith-Cooper, 1999; Stock, 1994; Walker et al., 2004), in others there was either a mixed response within the teams (Shallow, 2001d; Warriner et al., 1998) or no difference between team and non-team midwives (Todd et al., 1998). As with the nursing literature the attributes of satisfaction appear to be complex (Curtis & White, 2002) with multiple factors contributing towards individuals decision to leave because of dissatisfaction (Ball et al., 2002).

Ball et al. (2002) interviewed midwives who were no longer practising, as the first part of this study in order to develop a survey. Surveys were mailed to all midwives who did not re-notify their intention to practice in the UK in 2001. Limitations that were recognised included difficulties with the mail out and a recognition that the database used for the survey distribution was not as accurate as expected. It was found that some

midwives had continued to register their intention to practice despite having left the profession more than 12 months previously and others were still practising and had registered their intent to do so. Despite this, the 50% (978 respondents) response rate could be deemed satisfactory for such a postal survey. Dissatisfaction was cited by almost 30% of the midwives surveyed but it was also found to have contributed to the decisions of many of the other respondents to leave. There were several factors that contributed to overall dissatisfaction including the organisation of midwifery care and the role of the midwife. Ball et al. (2002) point out dissatisfaction was widespread amongst all the respondents regardless of their main reason for leaving midwifery. They identified that many difficulties that midwives were having was with the introduction of integrated teams and the rotation of staff, with community based midwives more satisfied than hospital based ones. These same concerns of reduced continuity for community midwives when they moved to integrated teams, lack of flexibility, loss of confidence and lack of support have been found by some authors as negative findings of team midwifery (Fraser et al., 2003; Haith-Cooper, 1999; Shallow, 2001a; Stock, 1994).

Having identified the factors that lead to midwives leaving, Kirkham et al. (2006) used a similar methodology to discover the factors that keep midwives in practice. Interviews of English midwives were used to develop a postal survey. A randomised sample of 5% of the midwives who had re-notified their intention to practice in England, were mailed surveys, with a 62% (562 respondents) response rate. Although this appears a suitable size for analysis there were fewer respondents than the previous study but representing a larger potential population. Kirkham et al. (2006) found that relationships with clients and colleagues were the main source of job satisfaction and the respondents were highly motivated midwives who enjoyed their work. While they found that some midwives were planning to leave because of the stresses and strains similar to those identified by Ball et al. (2002), the vast majority were staying because '*the good days outweighed the bad*' (Kirkham et al., 2006, p.20). Ensuring a work-life balance was found to be important (Kirkham et al., 2006). The impact on social life and the work-life balance was identified as a negative in caseload and team midwifery models (Haith-Cooper, 1999; Rosser, 2003; Stevens & McCourt, 2002c) with the lack of flexibility in all working settings contributing to attrition (Ball et al., 2002).

Lavender and Chapple (2004) also explored the views of midwives working in England. Their use of purposive sampling was used to ensure a representative sample of midwives from different settings. However, not all participants volunteered as some were nominated by heads of departments (Lavender & Chapple, 2004) raising questions about the potential of coercion by management to participate or of potential bias towards the management's perspective. The discovery aspect of their questioning raised the need for cultural change, identifying that the embedded medical model was maintained not only by the medical profession but by senior midwives. Their findings of lack of effective management, devaluing of midwifery care, lack of confidence in the normal and poor support (Lavender & Chapple, 2004) echoed the findings of others (Ball et al., 2002; Shallow, 2001d). The participants suggested that promotion and support of a philosophy of normality required strong leadership, role models, adequate education in the normal and appropriate allocation of low risk women to midwife care (Lavender & Chapple, 2004).

While the overall findings of the three studies above pertain to midwives employed in the UK where grading and employment models are different to Australia, the fundamental factors such as organisational culture, support in the workplace, pay and staffing levels that contributed to dissatisfaction (Ball et al., 2002) might be found anywhere. In particular, the embedded medical philosophy of care potentially impacts on midwives in similar ways to those found by Lavender and Chapple (2004) and the need for strong midwifery leadership recognised previously to assist in overcoming the barriers to midwife-led care (Brodie, 2002).

One Australian study that has looked at the satisfaction of midwives was a survey conducted in Victoria (Watson et al., 1999). The survey was developed to explore midwives knowledge of a birthing services review to evaluate the impact, if any, it had on them along with establishing levels of job satisfaction. There was little information on how the survey had been developed and tested. While the initial response rate was a very good 72% the database it was drawn from was unable to distinguish between those with midwifery qualifications and those actually working as midwives. The final sample of working midwives represented only 24% (240 respondents) of the original mail out (Watson et al., 1999). Watson et al. (1999) found relatively high satisfaction rates for which they provided two possible theories, one being that with the closure of

units and re-organisation of the health sector that was occurring in Victoria at the time of the study, midwives might have been satisfied that they at least had a job. Alternatively, they suggested that midwives interactions with women, an attribute that had been ranked highly by most participants, were so satisfying that it overrode all the less satisfying aspects of the role (Watson et al., 1999). Relationships with women has been found by others as a major source of satisfaction for midwives (Brodie, 1996; Engel, 2003; Griew, 2003; Kirkham et al., 2006; Rosser, 2003) supporting the second supposition. Watson et al. (1999) found that the least satisfied midwives were those working in rotating positions or the neonatal nursery with the labour wards and rural settings the most satisfying. Autonomy was not associated with satisfaction, although it was ranked second as an important attribute for the midwifery role. Watson et al. (1999) seemed surprised that autonomy was ranked first by only 12% of the respondents. They felt that midwives may have been reporting their actual situation rather than the ideal. The lack of a definition for autonomy was seen as a limitation as midwives may have interpreted it differently (Watson et al., 1999). Although how this would have affected the findings of the study is unclear because there was no understanding of what the authors meant by autonomy. Less than 4% of the respondents of Watson et al.'s survey appeared to indicate they worked in such a model. The data was collected in 1995 when midwives experience of continuity of care and autonomous practice would have been limited by the few midwife-led models in existence in Victoria at that time.

About half of the respondents in Ball et al's (2002) study had worked in some form of team but it was not clear whether these may have been team midwifery or caseload practices. Dissatisfaction was associated with frustrations over lack of control over work and requirement to work across all shifts (Ball et al., 2002) as well as the need to rotate through all areas of clinical practice (Ball et al., 2002; Watson et al., 1999) all factors associated with burnout (Sandall, 1999). While both Ball et al. (2002) and Sandall's (1999) surveys were large and included a variety of workplaces across England, it is not possible to discern whether their findings are more related to the state of the National Health service in the UK or to the models of practice. Given the complexity of any working situation both are important factors for UK midwifery but may not be so for Australia.

Relationships with women and colleagues have been found to be the key to midwives satisfaction and remaining in the profession (Kirkham et al., 2006). The integration of community midwives into hospital practice highlighted the focus on obstetric skills (Shallow, 2001a) to the detriment of skills related to communication and relationship development (Ball et al., 2002). Working in the community was associated with greater satisfaction for midwives because the provision of care to women was deemed as less fragmented, midwives had more autonomy and had the ability to build relationships (Kirkham et al., 2006). Despite the rhetoric of woman-centred care being paramount for the provision of maternity care in the UK, the institutionalisation of childbirth continues to impact upon the ability of midwives to provide optimal care within a midwifery framework (Kirkham et al., 2006).

Conceivably if the reasons for high satisfaction levels can be determined then organisations could put into place strategies to improve satisfaction levels and reduce attrition. Thus, if midwives in Australia do not expect to be autonomous because of the long standing medical domination, then lack of autonomy might not affect their overall satisfaction.

Women when given the choice, prefer to have a midwife at the birth who they have an ongoing relationship with (Perkins & Unell, 1997). However, in Australia, choices related to place of birth and model of care are limited by several factors that include financial, place of abode, perception of obstetric risk, and the limited availability of midwife-led care. The concept of woman-centred care implies the need for an on-going relationship. The midwife-woman connection can be termed a relationship so this concept is explored next.

3.4. The Midwife-Woman Connection

Midwives work with women and during that time, however brief a relationship may be seen to occur. The extent and type of relationship depends on many factors including individual personalities, model of midwifery care, environment and the time frame of the interaction. One definition of a relationship is '*the way in which people or things are connected*…'(Compact Oxford Dictionary, 2006, p.768). All midwives working in a clinical role interact and therefore connect with women however brief. The quality of

that connection or relationship could be said to be directly related to the overall satisfaction of the experience for both women and the individual midwife. The midwife-woman relationship might continue over several years, for a number of babies or for as short as a few hours. The woman and midwife may interact for only one aspect of the childbirth experience or across the continuum of the pregnancy, birth and postnatal care. The assumption underpinning midwife-led continuity of care models is that a trusting relationship develops across time. I could find little in the midwifery literature in relation to the midwife-woman interaction within a midwife-led model that discusses poor relationships.

The midwife-woman relationship is fundamental to the provision of optimum care (Kirkham & Stapleton, 2000; Page, 2003). Page (2003) recognised the important role the midwife had as a member of the community for building relationships, that was lost when maternity care moved into hospital. She further identifies that one-to-one midwifery models provide the means to restore these important personal relationships (Page, 2003). Despite the recognition of the need for improved continuity of care (Department of Health, 1993, 2007; Department of Health W.A., 2007; DHS, 2004a; NSW Health Department, 2003b) there is a dearth of literature that directly addresses the midwife-woman relationship. A review of the literature found several studies that explore the woman's experience of continuity of care models (Biro, Waldenstrom, Brown, & Pannifex, 2003; Farquhar et al., 2000; Health Issues Centre, 2006; Hundley, Milne, Glazener, & Mollison, 1997) primarily presenting aspects of women's satisfaction and achievement of continuity of care. Continuity of care was primarily measured through the attendance of a known midwife at the birth that, as discussed previously, is not a good measurement. Few articles were found that directly addressed the concepts that exist in a relationship.

Two theoretical propositions provide some insight into the meaning of a relationship within a continuity of midwifery care model. Guilliland and Pairman (1995) theorised that the midwife-woman relationship is a partnership, based on equality and shared decision making. In contrast, Walsh (1999) argues that the midwife-woman relationship is based on friendship. It may be that the difference between these two stances is that Guilliland and Pairman (1995) developed their theory from the midwife's perspective, as compared to Walsh's (1999) view which came from the woman's

perspective. When Pairman (2000) later explored the partnership theory with women and midwives, she found that the women described the relationship as friendship, which with further analysis she interpreted as another way of expressing partnership. Wilkins (2000) found that while the relationship is important and personal, it is similar to a friendship but different. She was talking about community midwives and asserts that in the community the midwives are more supportive and context aware, that makes the relationship more personal than is seen in other community professions such as the General Practitioner or Health Visitor (Wilkins, 2000). The actual terms of partnership or friendship might therefore be construed differently according to the perspective of each individual involved and the context of where that relationship occurred.

3.4.1. The Midwife-Woman Interface

This section continues the discussion of the midwife-woman connection through a review of the literature of women's views. The interface is the 'where' and 'how' of an interaction that underpins the development of a relationship. Only two published studies were found that have explored in a dyadic way, the experience of the midwife-woman relationship with both women and midwives (Fleming, 1998b; Lundgren & Berg, 2007).

Fleming (1998b) interviewed 219 women and 250 midwives from New Zealand and Scotland, to gain an understanding of the midwife-woman relationship. Six paired concepts of interaction were developed by Fleming into a model to explain the midwife-woman relationship. These concepts included attending / presencing, supplementing / complementing, reflectiveness / reflexiveness and were linked by a common thread of reciprocity, that included the exchange of ideas and interconnectedness (Fleming, 1998b). These same concepts emerged from both midwifery continuity of care models, and obstetric models of midwifery care. That is, Fleming identified many commonalities between midwives in different contexts. She also recognised that some responses were clearly underpinned by the local context, that is they reflected the differences between midwifery in New Zealand and midwifery in Scotland (Fleming, 1998b). It is apparent that context is important, not only in interpreting data but in applying midwifery models developed in one context, to midwifery care provided in a

different context. That is, models need to be assessed in context and modified accordingly.

Lundgren and Berg (2007) also identified paired concepts of the midwife-woman relationship following secondary analysis of eight studies that one or both had conducted with Swedish women and midwives. The women and midwives came from a variety of low risk and high risk settings and had experienced different approaches to midwifery care. Not only did Lundgren and Berg identify common concepts across different local contexts, several of their concepts were similar to those identified by Fleming (1998b). One of the main paired concepts found by Lungren and Berg (Lundgren & Berg, 2007) was that of participation-mutuality, where they identified that women wanted to be involved in the childbearing process, including being fully informed. From the midwife's perspective, mutuality was related to being a shared responsibility and being open and giving (Lundgren & Berg, 2007). Not only was this similar to Fleming's concept of reciprocity but it supports Guilliland and Pairman's (1995) view of a partnership being a process of mutuality and shared responsibility. An important concept that was not raised by either Fleming or Lundgren and Berg is that of power within the relationship and is deserving of more attention in future relationship studies.

Hunter (2006) has also found that context is important when considering relationships within a hospital context where the focus is on organisational processes. Within a hospital setting, the relationships between midwives and their managers and peers were of greater importance than with women. Emotional reward occurred with the completion of tasks and women being discharged home safely (Hunter, 2005). In contrast, emotional reward for midwives in community settings was suggested by Hunter (2006) as being more likely to occur from the continuing relationships developed with women. Although as she highlights, midwives in community settings may also be task-focused and midwives in hospital can be woman-focused (Hunter, 2006). The papers reviewed in the earlier section suggest that the interaction between women and midwives was one of the primary sources of satisfaction, regardless of model and setting, although this occurred more often with the caseload models (Engel, 2003; Rosser, 2003; Stevens & McCourt, 2002b) than the team (Brodie, 1996) or traditional hospital care models. There is an underlying assumption that all

relationships are rewarding. However, Hunter (2006) found through a process of observation and interview, that the degree of reciprocity within relationships, impacts on the degree of emotional fulfilment. She suggested that midwives use '*self-protective strategies, such as professional detachment, distancing and task orientation*' (Hunter, 2006, p. 319) to manage their emotions within difficult relationships, that ultimately may impact on the quality of care perceived by women.

Stevens and McCourt (2002c), Engel (2003) and Wakelin and Skinner (2007) all recognised difficulties within the midwife-woman relationship and similarly to Hunter (2006) identified the establishment of boundaries as an important factor in caseload practice. At whatever stage in the childbearing journey, in whatever model of care, the ways midwives relate to women are important factors in the development of a trusting relationship.

3.4.2. Trusting Relationships

Some research suggests that women do not identify that they want the same sort of relationships or partnerships with midwives as midwives want with women (Fleming, 1998a; Halliday, 2004). Midwives want to work in partnership with women but at times act as though they expect compliance rather than negotiation. Midwives want women to trust them and women respond by conforming to midwives' expectations (Kirkham, Stapleton, Curtis, & Thomas, 2002). Trust was found to be an important factor both in midwives' and women's views of woman-centred care (Halliday & Hogarth-Scott, 2000). The provision of woman-centred care requires midwives to embrace the concept of trust.

Midwives need to trust women to make informed decisions. Women need to trust their midwives and doctors to provide accurate information and all groups need to trust women's bodies to do what is natural (Kitzinger, Green, Keirse, Lindstrom, & Hemminki, 2006; Leap, 2000). Halliday and Hogarth-Scott (2000) suggest that women place the decisions about their pregnancy and birth into the hands of the midwife because they trust implicitly in the expert knowledge of the midwife and that she will do what is best. The context for trust in midwifery care is the knowledge of the provider not the development of a relationship (Halliday, 2004; Thorstensen, 2000). If trust is a

concept that exists at the beginning of women's interaction with health providers, there is the possibility, that if a relationship does not develop there may be a loss of trust. Halliday (2004) did not find a loss of trust with midwifery per se but with the person. That is they were prepared to rebuild trust by seeking out more information from the midwife or by establishing trust with a different midwife (Halliday, 2004). In Australia, the invisibility of midwifery as a profession might not bring these same results. Not only do the majority of women have little choice for antenatal care but many do not recognise the important role the midwife has in the overall childbirth experience.

3.5. Shared or Opposing Values

Whether women want to be involved in decisions around their childbirth experience or are not interested in being involved, the one value they share with midwives is the desire for a live healthy baby (Halliday, 2004), but other values may not reflect those of the midwife. As Foley and Faircloth (2003) argue the way to providing woman-centred care is by '*setting aside values and focusing on what the woman thinks and wants*' (p.178). Some women want risk-free birth, and many want pain relief and the same technological interventions that their friends had (Layne, 2003). There is an expectation in Western society that all births result in healthy, live babies with little or no acknowledgement that loss can and does occur. Therefore, a blame culture has developed where if it is not the doctors' or midwives' fault then maybe it is the woman's (Layne, 2003). Finding someone to blame has led to an increasing litigious society. This in turn, has led to maternity care being provided from the perspective of risk management.

The influence of the place of midwifery practice over the way midwives practice cannot be underestimated. Midwives working primarily in a community setting are more likely to have a woman-centred approach compared with midwives based in a hospital setting who by necessity focus on the needs of the institution above the needs of the woman (Hunter, 2004). That is not to say that midwives working in hospital settings do not want to construct their practice within a holistic woman-centred model but they are constrained by policy and protocols introduced as a risk management approach. The conflict between a midwife's core values and those of her place of work leads to

dissatisfaction and frustration with their work (Hunter, 2004; Thompson, 2003). Midwives and midwifery students who are constantly observing the routine implementation of interventions, are not receiving experience in supporting women with normal physiology (Reibel, 2005). The lack of mentors who are valued for their expertise in the normal devalues the work that midwives do best. It has to be questioned if there is any point in changing the models of maternity care, if the context for the provision of those models remains firmly based in a philosophy of medicalisation of birth.

3.6. Summary

This chapter focused on identifying woman-centred care and defining continuity of care as the concepts that are deemed important not only for midwife-led care but for providing care across the continuum of maternity services. The literature around midwifery-led models of care pertaining to the midwife's perspective was discussed. This review identified some of the positive and negative aspects of the different ways of working, and midwives satisfaction in their working role. Connecting with women and the ways of working together presented the importance of building a trusting relationship.

The majority of midwives in Australia work in a hospital setting. The next section looks at policies relating to maternity services in the state of Victoria that relate specifically to midwives working in the public health system.

SECTION TWO

THE FLOOR – MIDWIFERY CONTEXT IN VICTORIA

Maternity services in the public sector of Victoria health care sector are guided by government policies. This section provides insights into the development and implementation of midwifery services in relation to maternity service policy. The implementation of new models of care led to organisational change. While policy provides the floor on which to build new models of care, it is important to implement change using strategies that support success. The latter part of Section Two briefly reviews strategies for change, including an introduction to leadership styles.

CHAPTER FOUR

POLICY AND CHANGE IN MATERNITY SERVICES

4. Introduction

Government policy is a significant factor in the development of maternity services. This chapter uses Kingdon's (1995) approach to policy analysis to explore the processes and influences that underpinned the development and implementation of maternity services policy in the state of Victoria. A brief explanation of the levels of government who are responsible for funding the Australian health system is presented to provide some context for the chapter. An outline of the Australian political system has also been provided in Appendix C. Kingdon's (1995) policy analysis framework is explained prior to an analysis of the Victorian maternity services policy that was introduced in 1998 and known as the Maternity Services Enhancement Strategy (MSES). As this policy led to organisational change and the introduction of new midwifery services the final part of the chapter focuses on the literature related to the implementation of change and leadership.

4.1. Policy in Maternity Care

For many years, midwives and women have sought to place birth within a social framework of normal life processes (Gosden & Noble, 2001; Walsh & Newburn, 2002a) and this attempt has been advanced where governments have developed policies that support midwifery practice. Reviews into maternity care such as the 'Changing Childbirth' report in the UK (Department of Health, 1993) and across Australia (Health Department Victoria, 1990; Hirst, 2005; Senate Community Affairs References Committee, 1999; Tucker, Macdonald, & Burke, 2004) have informed the government and drive policy changes. Improvement of midwifery care does not only depend on policy changes for basic services but may also require reform of financial reimbursement for midwives as occurred in New Zealand (Guilliland, 1999) or legislation, as in the case of Canada (Van Wagner, 2004), to legalise the role of the midwife.

In Victoria the state government's policies related to improving women's health (DHS, 1998, 2002b, 2004a) have led to the introduction of an increasing number of midwifery-led maternity services. However, improvements in maternity services also rely on funding from the Australian federal government. Responsibility for financing and developing health policy in Australia is presented next.

4.2. Health Policy Responsibility

Policy has been defined as '… *a guide to action to change what would otherwise occur, a decision about amounts and allocations of resources: the overall amount is a statement of commitment to certain areas of concern; the distribution of the amount shows the priorities of decision makers. Policy sets priorities and guides resource allocation'* (Milio, 2001, p.622). Policy makers have the responsibility for making appropriate decisions to guide and fund actions that are supported by the government (or organisation) establishing the policy. While a government might initiate health policies there are no guarantees that they will be implemented.

In Australia, the states and territories are primarily responsible for the acute services of healthcare but remain economically dependent on the federal government, thus making health policy highly complex (Gardner & Barraclough, 2008). The complex funding and responsibility for healthcare often leads to conflict between the states, territories and federal[7] government with each blaming the other for insufficient services, leading to prolonged bargaining and inactivity (Parliament of Australia, 2006). This effect on services has been recognised in a report aptly named 'The Blame Game' that recommended the development of a National Health Agenda to rationalise and improve long term sustainability of the health system as a whole (Parliament of Australia, 2006). In the 2007 federal election the Australian Labor Party (ALP) were elected to become the federal government. For a short time the ALP controlled the governments of all states and territories until 2008 when Western Australia elected the Liberal party into government. Conceivably where the same political party is in power at both levels the development of a national policy should be easier to achieve. The implementation of

[7] Also known as the Australian or Commonwealth Government http://www.australia.gov.au/Commonwealth_Government. The terms are used interchangeably in this portfolio.

such a policy however, may be constrained locally by other political processes (Gardner & Barraclough, 2008), including the potential for a change of government.

Health policy does not sit in isolation but is integrated within a wider system that includes regulation of healthcare providers, education, workforce and supplies of equipment. All these various components are interrelated through the health systems network (Duckett, 2007). Policy development occurs through interaction of the socio-political environment with political and social support plus feedback from output and outcomes of existing health strategies (Duckett, 2007). Evaluation of policies involves the measurement of both the outputs of health services and the outcomes of health services. If the policy is not supported at ground level or by certain sectors, then implementation can be thwarted (Kingdon, 1995).

Policy related to maternity services can be determined at either or both levels of government. Development of policy at one level can be blocked by the lack of funding or agreement at the other. Gaining the attention of government to establish the need for a policy may be confounded by more pressing issues or because of a more powerful lobby group (Kingdon, 1995). Misinterpretation of data such as an increase or decline in births may shape political decisions that suggest a lack of forward planning and impact on the potential quality of outcomes for women. A recent example in Victoria was the opening of a new maternity hospital, planned at a time when there was a declining birthrate but opened when births had been climbing steadily for several years. It now faces the risk of being unable to cope with the increased demand on its services (ABC News, 2008).

The next section outlines the framework used for analysing the development of the Victorian Sate maternity policy using Kingdon's (1995) approach to policy analysis.

4.3. Kingdon's Approach to Policy Analysis

Kingdon's (1995) multiple streams model presents policy development as three discrete but interconnected processes that may occur simultaneously, the 'problem stream', the 'political stream' and the 'policy stream'. Policy implementation occurs when 'windows of opportunity' arise as all three streams come together (Kingdon, 1995).

Policy windows may occur for a variety of reasons. There may be a focusing event such as a major disaster that highlights deficits in management. Changes in routine indicators can open a window, particularly where comparisons are made with other states or countries (Barraclough & Gardner, 2008). For example a rising caesarean section rate may provide a window for policy development in maternity care. Alternatively, the window may occur due to persistent feedback about perceived problems (Bakir, 2003). Problems also tend to become highlighted during an election or during times of political change (Kingdon, 1995). It was the looming 1999 Victorian State election that provided the window for highlighting problems in maternity care and led to the development of the maternity services funding policy described in this chapter.

One factor that Kingdon (1995) highlights as being necessary for promoting the agenda to the government is the use of a policy entrepreneur, a person who is an advocate for a policy recognises windows of opportunity and seizes the initiative to create connections between the streams. Travis and Zahariadis (2002) argue that entrepreneurs are less important in some arenas of policy making, for example they purport that policy advocates do not play a role in the formulation of USA foreign policy as it is different to that of domestic policy. It may be that there are occasions when there is no need for an entrepreneurial role. Although the Australian political process is different to that in the USA there may be occasions when making use of windows of opportunity fall onto a 'champion of the cause'. There did not appear to be a 'champion' for the policy under discussion in this chapter. The key points of Kingdons (1995) multiple streams model is presented in Table 5.

Streams	Components	Windows of opportunity
Problems	Identification • indicators • focusing event • feedback	Three streams aligned presenting an opportunity such as occurs with: • Routine evaluation • Election Policy entrepreneur recognises and acts on opportunity
Politics	Agenda setting • mood of electorate • key politicians/officials • specialist groups	
Policies	Formulation • alternatives • economic concerns	

Table 5: Kingdon's (2003) multiple streams framework for agenda setting

Policy development is a complex process that can be analysed from a variety of perspectives. The process of policy development from an applied problem solving perspective is widely accepted and depicted as stages of a policy cycle (Barraclough & Gardner, 2008; Howlett & Ramesh, 2003; Kingdon, 1995). These stages include agenda setting, policy formulation, decision making, policy implementation and policy evaluation. Each stage of the policy cycle can be examined as the means of determining influences that were brought to bear upon the process. That is, clarifying what the problem was, who was driving the agenda and why those choices were made at that time. The agenda can be viewed as the topics or problems that government officials are paying particular attention to, with the aim being to create change. Setting the agenda refers to identifying the process by which those topics become the focus of government attention (Kingdon, 1995). Despite the apparent linearity of the model, in reality, policy making is more complex and less systematic than the model implies (Howlett & Ramesh, 2003). Kingdon provides a perspective of the policy cycle that demonstrates the complexity and interconnectiveness of policy making.

While problem identification would appear to be the first action in the process (Howlett & Ramesh, 2003), the problem not only may be identified more clearly after identifying the solution (Kingdon, 1995) but the process of getting the issue onto the agenda may depend on the perspective of the problem (Gardner & Barraclough, 2008). There are many categories that problems may fall under such as economic, workforce, values and

regulatory (Gardner & Barraclough, 2008) and while some issues may more readily relate to the workforce, getting the problem onto the agenda may be more successful from an economic stance. Kingdon's (1995) view is that the individual processes of the cycle may occur in any order or simultaneously. Thus, there may be a solution without a clearly delineated problem. Broadly speaking, political activity occurs to highlight the problem within a framework that is widely accepted by the actors involved (Barraclough & Gardner, 2008; Kingdon, 1995). Although Kingdon (1995) acknowledges that his multiple stream model appears complex and chaotic, he recognises that many processes involved are in reality predictable and routine. Kingdon's multiple streams model has been used extensively as an analysis framework in a variety of contexts worldwide (Bakir, 2003; Travis & Zahariadis, 2002) and, despite being based on empirical studies conducted in the United States of America, is clearly useful for analysing policy development in Australia. It does not however, provide a pathway for evaluating the success of a policy in addressing problems.

The following section presents the Maternity Services Enhancement Strategy (DHS, 1998) as a major influence for the introduction of midwife-led care in Victoria. Using Kingdon's (1995) model of multiple streams, the next sections provide analysis from the perspectives of the policy, problem and political streams. The aim is to provide a picture of why and how maternity services were placed on the policy agenda and to discuss the window of opportunity that led to implementation of the policy that became known as the Maternity Services Program (DHS, 2002a). This is followed by a discussion of how well the policy responded to the problems identified, although evaluation of the actual implementation is outside of the constraints of this doctorate.

4.4. The Policy Stream – Maternity Services Policy in Victoria 1998-2007

In 1998, the Victorian government included over A$12 million in the budget to stimulate innovative development of maternity services (Press Release, 1998). At the time, the budget papers clearly identified proposed ongoing funding for the maternity services enhancement strategy, increasing over the next four years (DHS, 1998). However, just over twelve months later and immediately prior to a state election, funding for a further four years was announced for the *Maternity Services Enhancement Strategy* (MSES) (Press Release, 1999) that, without reference to the previous year's

budget, made it sound as though it was an additional initiative. While improving services for women was the selling point to the public, some of the underlying discourse might equally identify the policy as an economic or workforce issue.

A potential economic savings would be the diversion of women from the more costly medical care to a cheaper option of midwifery care. Economic savings would not only be in relation to salary differences but also because of the evidence that midwifery care leads to less intervention (National Health and Medical Research Council, 1998). This aspect tied in with a need for midwifery care from a workforce perspective as midwives could fill the gap left by the shortage of doctors ideally with each group working in a collaborative partnership (DHS, 2004a; Weaver, Clark, & Vernon, 2005). The difficulty that arises with this argument is that there was also a shortage of midwives (Australian Health Workforce Advisory Committee, 2002). Whatever the political motives were at the time, the incoming state Labor government maintained the strategy and has continued to develop new policies for women, both in maternity services (DHS, 2004a, 2004b) and for women in general (DHS, 2002c). Much of the problem identification processes occurred at time when the Australian Labor Party had been in government previously suggesting prior commitment to the issues.

The MSES had clear objectives. These were: to improve maternity services for women with different needs; provide information to women to enable informed decision making and the promotion of evidenced-based practice (DHS, 2002a). With funding directives, guidance for collaboration and consultation, and planned evaluation, the MSES was both a process and a framework for action. Thus it meets the parameters of a policy as defined by Milio (2001) in that it sets priorities and guides resource allocation. With implementation of the policy, it became known as the Maternity Services Program (MSP) and there was an expectation for the funding to become embedded within the hospital budgets by the end of four years (DHS, 2002a). However, the complexity of establishing who was responsible for funding different parts of the services provided under the program proved difficult owing to the nature of health funding from different sources (Health Outcomes International, 2002). One of the concerns raised by stakeholders in a review of the funding relates to the lack of control by government of where hospital budgets were spent. The funding review board identified that there was a potential risk, if funding for the new maternity service programs was included in the

general budget, that hospitals would make cuts in maternity services in order to support other services in the hospital. Therefore, it was recommended to continue the MSP grant for an additional year to enable the government time to work through the recommendations of the review board (Health Outcomes International, 2002).

The development of the MSES was informed by the Victorian Ministerial Review of Birthing Services, referred to as Birthing Services Review (see p. 85) from here forward (Reiger, 1999), and surveys of new mothers conducted in 1989 and 1994 (Brown, Darcy, & Bruinsma, 2002). A further survey of mothers conducted in 2000 provided a baseline by which to measure the impact of the MSES in the future (Brown et al., 2002). Despite an expectation that surveys of new mothers would be completed every few years no further published studies have been found. Although an initial evaluation of the program was completed midway (Keleher, Round, & Wilson, 2002), continuing evaluation appears to be through key indicators, such as waiting times for antenatal appointments, rates of inductions and caesarean sections, breastfeeding initiation and provision of domiciliary postnatal care (DHS, 2007), and not through direct interaction with women. Further discussion about the impact of the Victorian maternity services policy is beyond the constraints of this portfolio other than with the findings from the research component in later chapters.

While the MSES is said to have come from the issues raised by the Birthing Services Review (Reiger, 2006) not all issues identified in the Birthing Services Review were addressed by this policy. That is because some of the issues raised referred to education and workforce issues that do not directly sit under the quality framework of health policy, although continuing education for midwives and doctors has emerged within maternity services policies (DHS, n.d.). Undoubtedly some issues raised in the Birthing Services Review did fall under other department agendas and required different strategies to gain elevation to the government agenda.

The MSES (DHS, 1999) became implemented as the Maternity Services Program (MSP) with broad objectives (Table 6) that were expected to improve maternity services for women (DHS, 2002a).

- To promote measurable improvements in the continuum and quality of antenatal, intrapartum and postnatal care that meets the clinical and psychosocial needs of women;
- To provide women with better information about their care choices, and with evidence based information on the benefits and risks associated with different care options;
- To encourage service providers to improve models of care in line with best available evidence on service effectiveness; and
- To improve services and health outcomes through further development and use of performance measures and service audits.
(DHS, 1999, appendix 5 p.117)

Table 6: Objectives of MSP

The MSP did not offer guidance for actual initiatives other than the development of programs needed to meet local needs in order to achieve the best outcomes. Each maternity service provider was required to make separate applications for funds for each program that they planned to provide.

Following the MSP, further women's health and specific maternity service policies were released. The *Victorian Women's Health and Wellbeing Strategy* was released in 2002 and provided guidance for improving the health of all women complementing the policies specific to maternity care (DHS, 2002c). This was followed in 2004 by *Future Directions for Maternity Services in Victoria* that was focused on providing woman-centred care, choice, continuity, access, equity and appropriate levels of expertise. This policy statement recognised both the expertise of the midwife and the need for more general practitioners capable of practising obstetrics and anaesthetics in rural areas, needs that had not been addressed in earlier policy documents. Further, to enable midwives to assume their role across the full scope of midwifery practice, there was need for ongoing education. A detailed six point plan of action as outlined in Table 7 provided the direction the government was taking to meet their objectives (DHS, 2004a).

- Establishing primary maternity services in metropolitan Melbourne
- Supporting the provision of maternity services in rural Victoria
- Undertaking workforce training and support
- Investing in the tertiary maternity services
- Providing emergency consultation and co-ordination
- Calling on the Australian Government to provide more flexible funding. (DHS, 2004a)

Table 7: Future Directions for Maternity Services in Victoria - 6 point plan

The *Rural Birthing Services a capability based planning framework* (DHS, 2004b) was released shortly after *Future Directions* provided guidance for safe obstetric practice but has the potential to close or reduce the services of more rural maternity units due to rigid requirements for specialist cover.

1998/9	- *Maternity Services Enhancement Strategy*
2000	- Implemented as maternity services program
2002	- *Victorian Women's Health and Wellbeing Strategy Policy*
2004	- *Future Directions for Victoria's Maternity Services*
2004	- *Rural Birthing Services a capability based planning framework*

Table 8: Timeline of maternity services policies in Victoria

Despite the development of government policy related to improving the quality of maternity services (DHS, 2002c, 2004a) some of the issues identified by the Birthing Services Review, such as high intervention rates (Davey, Taylor, Oats, & Riley, 2008), remain essentially unchanged. Before focusing on the issues identified as forming the 'problem stream' of Kingdon's (1995) framework, the 'political stream' will be addressed as it is useful to gain a picture of why maternity services came under the spotlight and who were the actors involved in the process.

4.5. The Political Stream – Getting Maternity Services onto the Government Agenda

This section explores the processes by which the improvement of maternity services came onto the Victorian State Government agenda in 1998. Commencing with a brief outline of Australian processes, the key informants of the Birthing Services Review (Health Department Victoria, 1990) are identified followed by a review of the political 'windows of opportunity' that appeared and disappeared during the 1990s.

The 'political stream' is the way in which the political agenda is formed, that is, the way issues come under a government's gaze (Kingdon, 1995). Although in democratic countries this process may appear to be similar, differences in the power structure of governments affects the way information is collected and used (Hazlehurst, 2001). Hazlehurst (2001) suggests that Australia falls between the closed system of the UK where all power is held by the government of the day and that of the open system of the USA. In Australia, while political power is in the hands of the party in government there are opportunities for outside influences to affect policy (Hazlehurst, 2001). Although lobbying is not an effective method (Jaensch, 1988) it does still occur, not to the extent of in the USA but more than in the UK (Hazlehurst, 2001).

The Australian government more frequently gains information through the process of ministerial reviews (Barraclough & Gardner, 2008). While reviews provide opportunities for interested parties to be heard, there is no guarantee that all relevant stakeholders will have their view considered. Not only might some perspectives be missed, either by accident or deliberately excluded, but the identification of a problem does not ensure action. If the economic or political ramifications are too great the government might choose to ignore a problem or certain solutions (Barraclough & Gardner, 2008).

Concerns about maternity care and the medicalisation of childbirth, in particular the increasing use of technology, were increasingly raised in the global forum during the late 1970s to early 1980s (Perkins, 2004; Wagner, 1994). At that time, Australia was a world leader in developing a separate women's policy department that placed gender issues firmly on the government agenda (Sawer, 1999) but not apparently women's experiences of birth (Reiger, 1999). However, although there was no particular focus

on birth, the many narratives about poor birthing experiences revealed during the Victorian Women's Health Review of 1988 provided the impetus for a review of the Victorian birthing services (Reiger, 1999).

4.5.1. The Victorian Birthing Services Review

The Birthing Services Review included a survey of new mothers, interviews and submissions from a broad spectrum of stakeholders, plus information gathered by five working groups set up to explore specific issues (Health Department Victoria, 1990). The review identified many issues related to the provision of maternity services that not only existed in Victoria but have also been raised as national and global concerns (Department of Health, 1993; Senate Community Affairs References Committee, 1999; Wagner, 1994). The recommendations were firmly based on the best evidence available (Health Department Victoria, 1990). Despite the recognition of the importance of using research evidence to inform policy development, Gardner (2008) argues that implementation of evidence-based policy is similar to that of evidenced-based medicine and has been slow to be accepted.

The Birthing Services Review (Health Department Victoria, 1990) provided evidence to the Victorian government of the need to improve the provision of maternity services for women. The review process drew on submissions from many stakeholders and political actors who came to the table with their own often conflicting agendas (Reiger, 1999). The medical profession not only complained about a lack of representation on the review committee to gain greater access for themselves (Reiger, 1999), but they also responded to the initial report as being unscientific with too many quotes (Health Department Victoria, 1990). The qualitative reporting style was defended in the report, as the means of representing both sides of the story, to enhance the statistics and to more truly present the reality that existed for women (Health Department Victoria, 1990). This debate over the reporting style demonstrates the differences between the reductionist medical model and the social philosophical stance of midwifery. It was not only the midwives and obstetricians who differed there were also consumer groups who had different priorities. Some women wanted greater access to midwife-led services and others wanted better access to medical care. While it is to be expected that there would be different views presented, ensuring a balanced report was more difficult given

the pressure from the more powerful players (Reiger, 1999). As happens frequently in policy processes the problems raised had not suddenly appeared (Kingdon, 1995) they had previously been raised in a variety of forums (Wagner, 1994; Willis, 1990) acting as an ongoing process for politicising the issues.

Although the Birthing Services Review was widely cited throughout the 1990s, improvements for women in the provision of maternity services were not clearly evident (Brown et al., 2002). Watson et al. (1999) surveyed midwives five years after the report was released and found there had been very little impact for midwives, with less than half of the respondents having even read it. No reasons were suggested by Watson et al. (1999) as to why so few respondents had read the report but potentially it may have been lack of access to the document. Changes that had occurred in the clinical field, such as earlier discharge of women, may not have been attributed to the review by the respondents or may not have occurred in response to the review. However, Watson et al.'s (1999) findings of little change, is supported by Brown et al. (2002). The reasons for this lack of progress might have been the strong influence that more powerful actors had within government.

4.5.2. Influential Political Actors pre-1998

There is no clear evidence available as to who were the most influential actors during the 1990s. However, owing to the medicalisation of birth, an assumption is made that those actors were most likely to be members of the medical profession. Lewis and Considine (1999) sought to determine the influential actors in the health services in Victoria during the period 1991-1993. This was the period of time immediately following the Birthing Services Review when potentially there had been an opportunity for maternity issues to be placed on the government policy agenda, setting the scene for the development of future maternity policies.

Lewis and Considine (1999) claim that generally the prominent ideology in modern democracies is one of pluralism, where power is spread across groups with no one group dominant. From a pluralist perspective, interest groups compete to get their issues on the agenda (Gardner & Barraclough, 2008) and no one group dominates. This would suggest that, in maternity services, midwives, consumers and obstetricians might

have an equal voice. Lewis and Considine (1999) argue that health politics are different in that power remains concentrated as elitism. Gardner and Barraclough (2008) support this view to some extent but suggest that the medical professions' autonomy is increasingly regulated by the government, potentially reducing their influence. They do however, recognise that elite groups with access to the inner workings of government can effectively block issues from the agenda or manipulate others to accept their views (Gardner & Barraclough, 2008). As elite groups are defined through their professional position, policy making influenced by elite groups is not based on pluralism but reflects the earlier class differentials of Marxism (Lewis, 2006). The dominance of the medical model of health throughout the provision of maternity services (Wagner, 1994) suggests that obstetricians remained an elite group able to influence government agendas in the 1990s and potentially remain so.

From the premise that influential actors of a policy network would be able to identify others within the network, Lewis and Considine (1999) approached specialist health journalists and asked them to nominate as many individuals as they knew who influenced the health policy development in Victoria. This was repeated with the individuals identified, until they had built up a picture of policy actors for the three years 1991-1993. Their study covered the broad perspective of health policy and therefore may well have missed those most influential in specific areas of health such as maternity care. Indeed, the potential to have missed some actors was acknowledged by the authors. At the same time actors from some specialist areas may have more influence than others. Maternity care has a lower profile than some of the other specialties and therefore may be a lower priority for governments. Lewis and Considine (1999) interviewed those actors identified as the most influential to discover what issues they were focused on. They found that the main issues were of a general nature with no mention of any specialist areas. However, the main issues raised included those of workforce and education, equity of access, effects of technology and quality of care (Lewis & Considine, 1999), themes that had also been identified in the Birthing Services Review (Health Department Victoria, 1990).

Between 1991 and 1993, immediately following the Birthing Services Review, the majority of those recognised as influential actors in policy development were members of the medical profession who were predominantly in management or academic

positions. However, by 1993 there had been an increase in the proportion of economists deemed to be influential (Lewis & Considine, 1999). At that time the state government was embracing economic rationalism so potentially was seeking more advice from economists at the time. Changes occurring during this period included the introduction of casemix[8] funding and the rationalisation of the workforce that had led to closures and redundancies across the nursing and midwifery workforces (Palmer & Short, 2000). Postnatal domiciliary visits were introduced and extended during the early 1990s. This may have been in response to issues raised in the Birthing Services Review (Victorian Government, 1993), or the driver may have related more to economic rationalisation than consumer demand. However, the perception that there are large savings with domiciliary programs needs to be tempered by the additional costs incurred with home visits (Health Department Victoria, 1990). Whether the change in government influenced further changes or whether the increase in influential economists reflected the governments needs at the time is unknown, but by 2001 the percentage of influential actors who were from the medical profession had increased again (Lewis, 2006).

Despite the apparent consumer demand for changes to maternity services (Reiger, 1999) individuals from consumer organisations did not appear as influential policy actors (Lewis & Considine, 1999). Various consumer groups made submissions to the Birthing Services Review (Health Department Victoria, 1990) but outside of such consultative reviews may not have been heard. The Victorian Branch of Maternity Coalition[9] was formed in 1989 but did not become a national voice for consumers until the early 2000s (Vernon, 2002-3). Although improving maternity services in Victoria might be viewed as a local issue, given the relationship with the federal government for health service funds (Duckett, 2007), it was very clearly a national issue. The Maternity Coalition brought together key individuals from consumer and midwifery groups to develop a national vision, the National Maternity Action Plan (NMAP, 2002) but this important document was not released until 2002, after the Maternity Services Program had been implemented in Victoria. Maternity care was not totally missing from the

[8] ***casemix:*** A means of classifying hospital patients to provide a common basis for comparing cost effectiveness and quality of care across hospitals. http://www.aihw.gov.au/publications/health/ah96/ah96-x04.html

[9] In 1988-9 known as the Maternity Alliance. Maternity Coalition is a national umbrella organisation committed to the advancement of best-practice maternity care for all Australian women and their families. http://www.maternitycoalition.org.au

national agenda as federal funding, through the Alternative Birthing Program, was available for projects focusing on community and Indigenous maternity programs (Reiger, 2001). However, these projects were fragmented and the funding short term, leading to the eventual loss of some of these programs as they had not become embedded in local service funding structure.

Midwives had a voice in the Birthing Services Review through a variety of forums and individual representation. These voices however, had conflicting opinions on the need for change (Reiger, 1999). All midwives registered in Victoria at that time were nurses before becoming midwives and primarily based in hospital settings where medical practice dominated. Midwifery was regulated as a specialist arm of nursing (Brodie & Barclay, 2001) and lacked leadership voices at government levels. Antrobus (1997) argued that nursing in the UK is marginalised in policy development because of the humanistic nature of nursing and the lack of a common language with those of the new managerialist politics. Midwifery in Australia in being allied to nursing could be said to be similarly marginalised. During the 1990s, despite the Australian College of Midwives being based in Victoria, gaining access to and influencing state government was difficult. The ACM relocated to Canberra in early 2000s for greater opportunities in lobbying the federal government (ACM, 2007a).

The final actors in the 'political stream' are the government itself and changes that are occurring within the wider political scene impact on which issues appear on the policy agenda. Despite the many recommendations of the review it is difficult to gain a picture of how well the government accepted the need to act. Certainly by the time of a second survey of new mothers in 1994, little if any, change had occurred for women (Brown & Lumley, 1994). For midwives however, education was transferred from being hospital-based to the tertiary sector (Watson et al., 1999) but whether this was in response to the recommendations of the Birthing Services Review is unknown. It may have occurred as a consolidation of postgraduate courses within nursing, as an economic rationalisation of cost shifting from health services to education, or inline with international and Australian trends.

In 1989, when the Birthing Services Review was initiated the Australian Labor Party was in government in Victoria as well as at a federal level. Women's issues, although

not specifically maternity care, were clearly on the political agenda with the establishment of a National Women's Program (National Women's Health Program Evaluation Steering Committee, 1993) and a Victorian review of Women's Issues through which the Birthing Services Review was initiated (Reiger, 1999). In the early 1990s, a Liberal government was elected in Victoria. A few years later the federal Labor government was replaced by a Liberal/National coalition that heralded the curtailment of many women's programs (Palmer & Short, 2000). The 'windows of opportunity' in relation to maternity services gaining a voice in the public policy agenda in 1998 are discussed in the next section.

4.5.3. Windows of Opportunity

The Birthing Services Review in Victoria could be viewed as a window of opportunity to get maternity services onto the policy agenda but the changing ideological stance of the liberal government towards economic rationalism (Palmer & Short, 2000; Reiger, 2006) closed the window. The market approach of the new government included changes to the organisation and funding of the public hospital system (Palmer & Short, 2000). Budget cuts and the re-organisation of the public hospitals into networks impacted in several areas. There was a loss of a large number of women's programs (Gray, 1999), closure of maternity services, midwifery redundancies and increased pressure on the remaining services both in the hospital and community where Commonwealth funding had also been cut (Stanton, 2001). Thus it is not surprising that improving maternity care disappeared from the agenda. That is not to say that the issues disappeared or that the political actors gave up their appeals for change. Political actors would have continued gathering evidence and lobbying the government in preparation for another window of opportunity (Kingdon, 1995).

The limited progress that did occur in relation to implementation of the recommendations of the Birthing Services Review appears likely to have been cost driven. For example, the introduction of casemix led to earlier postnatal discharge from hospital and the greater availability of shared antenatal care saw the costs for these services shifted to the community and thus to federal funding (Lumley, Brown, & Gunn, 2003). Therefore, with the liberal government committed to a competitive market framework, it was surprising to find specific funding for maternity services

embedded within their 1998 funding guidelines (Reiger, 2006). It is difficult to ascertain what the driving force was behind the re-emergence of maternity services onto the policy agenda. It may be that following several years of cutbacks, the Premier recognised the potential loss of support and votes leading to the development of several initiatives in the pre-election period (Bennett & Newman, 2000). The impending state election, at a time when the economic reserves were replenished to a level where spending was inevitable, provided a window of opportunity.

It is probable that the issues that the Maternity Services Enhancement Strategy (MSES) (DHS, 1998) attempted to address, had not disappeared from the agenda but had simmered in the policy background waiting for the appropriate solution. Reiger (2006) felt that it was put together in an ad hoc way but this may be because of the suddenness of maternity funding from a government that was more renowned for cutting services rather than developing new ones. While the MSES was directly informed by the Birthing Services review, the second survey of recent mothers in 1994 and a similar study with women from non-English speaking backgrounds (Brown et al., 2002), other reviews and reports were published either just before or just after the MSES release. These included the 'Review of services offered by midwives' (National Health and Medical Research Council, 1998), 'Options for provision of midwifery services in Victoria' (Johnston, 1998), mapping of the models of care available for women in Victoria (Halliday et al., 1999), and the Senate review of birthing services (Senate Community Affairs References Committee, 1999). Internationally, New Zealand had reformed their midwifery services (Guilliland, 1999) and there had been a review of services in the UK (Department of Health, 1993). All these activities may have influenced the recognition of the need to place maternity services firmly on the agenda again.

4.6. The Problem Stream – The Issues Evident in the Provision of Maternity Services in Victoria

This section explores the issues raised by the Birthing Services Review and other indicators of the problems evident in the provision of maternity services in Victoria. The issues that require the support of policy to address form the third arm of analysis the 'problem stream' (Kingdon, 1995). Policies are the result of decisions about

possible solutions to problems (Kingdon, 1995). Through identification of the issues, a policy can later be analysed to establish to what extent it has met those needs. Although it is beyond the scope of this portfolio to evaluate to what extent the aims of the MSES policy have been met, where indicators exist comment has been made in this section and within future chapters related to the research project.

The issues or problems that informed the Maternity Services Enhancement Strategy (MSES) were, as previously mentioned, identified for the Victorian context through a review of birthing services and surveys of new mothers (Brown et al., 2002). It might be expected that the MSES addressed those issues. Given that it had taken eight years to respond to the key report of the Birthing Services Review, it was perhaps not surprising to find that women's experiences had not improved in that time (Brown et al., 2002; Bruinsma, Brown, & Darcy, 2003). Indicators of increased use of technology, such as the rates of induction of labour and caesarean sections had continued to rise in the 1990s (Riley, Davey, & King, 2005). What remains to be seen is to what extent the ongoing focus on maternity services policy (DHS, 2002c, 2004a) improves women's experiences and maternity outcomes. This section discusses some of the issues raised in the Birthing Services Review and explores in what ways the MSES implemented as the Maternity Services Program (MSP) (DHS, 2002a) addressed the problems.

Briefly, the main issues pertained to the satisfaction with, accessibility and type of, services available for women. These related to the medicalisation of birth leading to high levels of intervention rates, over-servicing of maternity care by obstetricians and the lack of midwifery services. There was perceived inequity of access to appropriate and/or choice of services, in particular for women of non-English speaking backgrounds, Indigenous women and young women. The quality of maternity care was deemed inadequate, particularly in the postnatal period (Health Department Victoria, 1990). It was clear that the issues did not sit in isolation with solutions readily available. They were complex, interrelated and not specific to Victoria or Australia.

4.6.1. Increasing Use of Technology

As was discussed earlier in the portfolio, the knowledge and beliefs that underpin childbirth consist of two competing ideologies, the biomedical model versus the social model. Reiger (1999) points to the overwhelming bias towards the biomedical model as contributing towards the discontent with maternity services felt by many of the women who contributed to the Birthing Services Review. The review did not specifically discuss these differing philosophies although they did recognise that the continuing debate was influenced by women's, midwives' and doctors' experiences (Health Department Victoria, 1990). While the review did not specifically use the term medicalisation of birth it identified many factors that imply such medicalisation including the increasing numbers of interventions in birth.

The appropriateness, safety and cost of interventions such as induction of labour, augmentation of labour, assisted vaginal birth and caesarean section formed the discussion of the increasing use of technology in birth during the Birthing Services Review. The need for evidence to inform practice was clearly recognised as an important basis for all maternity care (Health Department Victoria, 1990). Much of the technology that has crept into mainstream use in obstetrics has not produced the anticipated results of improved outcomes for either mother or baby and has contributed to increased intervention and morbidity for women (Wagner, 1994). Despite the call for evidenced-based practice there continues to be a dearth of well conducted research into care in birth. In addition, where the evidence does exist there is great difficulty in getting research recommendations into practice (Lumley et al., 2003). The need for recommendations based on research was recognised within the MSP (DHS, 2002a) but resistance to implementation is not so easy to overcome.

At the time of the Birthing Services Review in 1990, intervention rates in hospitals across Victoria varied widely. The caesarean birth rate was 15.9% and rising (Health Department Victoria, 1990). By 1998 when the MSES was released it had risen to 21% and was still rising (Riley & Halliday, 2001). Despite the implementation of a variety of MSP projects and subsequent policies (DHS, 2002c, 2004a) that supported increased numbers of midwife-led care, the caesarean birth rate continued to rise and by 2006 it had reached 30.6% (Davey et al., 2008). Both elective and emergency rates of caesarean births have almost doubled since 1988. The increasing rates are shown in

Table 9 below. Although women giving birth in private hospitals have a greater chance of having an intervention the increasing trends for caesarean births are similar, with public caesarean section rates rising from 12.1% in 1988 to 26.9% in 2006 (Davey et al., 2008; Health Department Victoria, 1990).

Intervention \ Year	**1985**	**1988/9 BSR**	**1990**	**1995**	**1998 MSES**	**2000 MSP**	**2006**
Induction of labour	24.2%	19.2%	19.2%	22.7%	26.9%	27.3%	24.9%
Augmentation	20%	17.6%	15.1%	12.3%	11.8%	19.1%	20%
Forceps & Vacuum births	16.3%	14.3%	13.4%	12.4%	13%	12.8%	13.2%
Caesarean births	15.3%	15.9%	16.7%	19.1%	21%	23.4%	30.6%

Table 9: Rates of interventions in Victoria 1985-2006

Sources: Davey et al., 2008; Health Department Victoria, 1990

Discourse around provision of services and appropriate models of care revolve around perceptions of risk and safety (Reibel, 2005). There is little room here to expand on the risk discourse but to raise awareness of it as a factor in the development and implementation of maternity care in Victoria. While the premise is that women should be provided sufficient information to participate in the decisions about her care (DHS, 2004a), the availability of choices remain firmly controlled within a risk framework. The development of policies to include women in the process of informed choice might be an attempt to return responsibility to the woman and potentially reduce litigation. Women need to fully understand the risks to enable them to take responsibility for their decision. However, if women weigh up the risks and then make a decision against the advice of the health professional, there is a potential that they will be labelled as non-compliant and stigmatised for their view. It has been suggested that stigmatisation and the response to a perceived danger may continue despite evidence that demonstrates it is not as dangerous as previously thought (Calman, 2002; Gregory, Slovic, & Flynn, 1996). Risk can be viewed as the main concept around which birthing services are organised and that from the medical point of view childbirth is inherently risky.

Women's perceptions of risk however, are either ignored or overruled as uninformed in a paternalistic manner.

The MSP's (DHS, 2002a) emphasis on safety, although appearing to provide choice for women, places the program firmly within a discourse of risk. Further, the emerging education programs (DHS, 2005, n.d.) and the recommendations for rural maternity care (DHS, 2004b) demonstrate the value placed on emergency response over ability to provide support for normal physiology.

4.6.2. Inappropriate Servicing by Obstetricians

One problem identified during the Birthing Services Review was that of inappropriate servicing by obstetricians that is, provision of care by specialist obstetricians to women within the public sector who could more appropriately be cared for by a midwife or general practitioner (Health Department Victoria, 1990). There is evidence that women who are cared for by private obstetricians in the private sector are more likely to have an intervention than women cared for in the public system (Roberts, Tracy, & Peat, 2000).

Women in the 'Recent Mothers' surveys were overall more satisfied with private obstetric care than women in the public system (Bruinsma et al., 2003; Laslett, Brown, & Lumley, 1997), potentially this was because they had the ability to choose the model of care. Environmental conditions, such as better accommodation and food, may have contributed towards this preference but women were less satisfied with postnatal care than antenatal or intrapartum care (Bruinsma, Brown, & Darcy, 2003), when environment might have been more likely to affect satisfaction levels. It is likely that continuity of antenatal care provided by private obstetricians contributed to the difference in satisfaction rates.

At the time of the last 'Recent Mothers' survey in 2000 there were limited opportunities for women to choose midwifery-led continuity of care models within the public system and none within the private hospital system. Only 5.9% of women who gave birth in Victoria in 1998 were cared for by midwives antenatally (Halliday et al., 1999). This had increased from 2.9% in 1988 (Health Department Victoria, 1990) and included a small percentage of home births that appear to be static across the time frame.

The 'Recent Mothers' surveys of 1993 (Laslett, Brown, & Lumley) and 1997 (Brown, Lumley, Bruinsma, & Darcy, 2001) found some increase in shared care arrangements with general practitioners but little improvement overall in satisfaction for women. In addition, instead of reducing the number of women unnecessarily receiving specialist care the movement had been away from the public antenatal clinics (Laslett et al., 1997). The findings from these surveys prompted a specific review of shared care arrangements in Victoria (Dawson, Brown, Gunn, McNair, & Lumley, 2000) included in the MSES. The government was committed to improving the quality of care for women and shared care was recognised as part of this strategy (DHS, 1998; Knowles, 1999). Shifting antenatal care to general practitioners from hospital clinics would reduce the cost to the state as the federal government provides funding for these services through the Medicare rebate. However, it also potentially increases the costs for women who are required to pay the difference between the GP fee and the medicare rebate (Keleher et al., 2002) unless they are able to find a GP who bulk bills where there is no additional cost. While a reduction in women receiving unnecessary specialist care in public hospital clinics might have been achieved, many women continued to receive public care with specialist obstetricians external to the hospital (Halliday et al., 1999). The MSES provided the potential to establish midwifery-led antenatal clinics thus improving the range of choices available to many women.

4.6.3. Equity and Access to Maternity Services

Access to the variety of maternity care models in Victoria was found to be limited by a variety of factors including geographic, lack of knowledge, medical risk criteria, lack of social and culturally appropriate services and cost (Health Department Victoria, 1990). In particular, it was recognised that there were several specific groups of women who required additional support during pregnancy and birth, these included young women, women from non-English speaking backgrounds, rural women, chemically dependant women and women on low incomes (Health Department Victoria, 1990). The MSES recognised this need by directing the funding towards initiatives that would support women who have additional needs (DHS, 1998).

A range of specialised clinics and continuity of care models for chemically dependent women, young women and Indigenous women were developed. Community-based

antenatal clinics were extended in some areas both metropolitan and rural. A government website now provides information for women about the various services however, this information is restricted to those who read English, have access to a computer and are able to find the site. The site does provide a wide range of information from types of care, where the services can be accessed and other important links (DHS, n.d.). Literature in different languages and the availability of interpreters is the responsibility of individual hospitals (DHS, 2007) and varies according to local community needs. The provision of interpreter services for women who need them antenatally has improved from 42% in 2002-3 to 86% in 2006-7. No record is kept of the rates of these services being provided during the intrapartum or postpartum period.

The need for ongoing consultation with consumers was recommended by the Birthing Services Review (Health Department Victoria, 1990). However, few of the projects initiated under the MSP were found by the mid-term review of the MSP to have demonstrated commitment to consumer input (Keleher et al., 2002). Barriers were suggested to be because the culture of hospitals was not generally conducive to consumer participation and there was little guidance about the best approach (Keleher et al., 2002). It is unknown whether any improvement has occurred since the mid-term review of the MSP. I suggest that consumers still lack a voice in health services planning.

4.6.4. Consistent Guidelines

The mid-term report also recognised the lack of guidelines for establishing programs within the MSES policy. It recommended a more consistent approach to the development of best practice policies and protocols to reduce duplication in the development and implementation of services (Keleher et al., 2002). Government-funded projects have since led to the development of consistent multi-disciplinary guidelines for practice across several areas of maternity care. These include antenatal care guidelines from a collaboration of the three tertiary hospitals, the development of a common Victorian Maternity Record (VMR) and a variety of education programs available to all midwives and doctors in the state (DHS, n.d.). The greater openness of sharing guidelines across organisations reduces the expense and time put into duplication of resources. The advantages are consistency of advice and a more

equitable service because of the sharing of knowledge. Access to consistent education and guidelines does not necessarily ensure compliance with best practice. Conversely health professionals and/or organisations may implement guidelines so rigidly that attention to individual needs is ignored.

4.6.5. Insufficient Support in Postnatal Period

Lastly, insufficient postnatal support was highlighted as a problem in the Birthing Services Review (Health Department Victoria, 1990). The review recognised a need for improvements both for in-hospital and community postnatal care. Not only had the postnatal hospital stay for women reduced from ten days to five-seven days but other social services had also been reduced (Health Department Victoria, 1990). One change that did occur before the MSES was the introduction of funding for postnatal care in the home (Victorian Government, 1993). However, it would appear that the changes that occurred came about through a rationalisation of services that also appeared to meet the needs of women. The proposal was that the costs of the program would be covered by the present hospital funding. With the change to case-mix funding in the early 1990s, hospitals were funded according to the diagnosis of the patient (Duckett, 2007). Payments were based upon the average stay for a particular diagnosis. Hospitals received the same amount of money regardless of the length of stay, thus they gained financially if the patient was discharged early and lost for a longer stay. Potentially, it was more economical to care for patients at home than in hospital.

In Victorian maternity care, women who had an uncomplicated birth and recovery period were funded for five days of postnatal care. Women who went home prior to day five were entitled to postnatal care at home up to and including that fifth day. It was anticipated that the money saved from early discharge would cover the cost of a home visit (Victorian Government, 1993). This program was implemented in 1993 with a few hospitals providing their own services and others outsourcing to the Royal District Nursing Service. Whilst initially this option was a choice with access to one home visit from a midwife, it soon became the norm. Therefore, as women had little choice in this policy initiative it is not surprising that the repeat survey of recent mothers in 1999 found that women's satisfaction with postnatal care was worse than for antenatal or

intrapartum care, and demonstrated no improvement between 1993 and 1999 (Bruinsma et al., 2003).

By 1998 the average length of postnatal hospital stay for women having a vaginal birth in the public sector had reduced for most women to three-four days, although the percentage of women staying longer than six days had remained static because of the rising caesarean section rate (Riley & Halliday, 2001). The MSES focused on improving services for postnatal care by providing funding for all hospitals to set up their own home care services. The aim was to improve continuity of care for women. Although initially this was related to improved co-ordination and communication between service providers (DHS, 1999) with the later 'Future Directions' policy the emphasis was on the importance of continuity of carer or team of carers (DHS, 2004a).

The Birthing Services Review reported that breastfeeding women were receiving inconsistent advice and recommended improved breastfeeding education for midwives and doctors. The MSES policy supported improved dedicated breastfeeding support services and recognised the need for hospitals to work towards attaining Baby Friendly Hospital Status[10] (Keleher et al., 2002). Although the mid–term review of the implementation of the MSP found improved lactation services, there appeared to be a reluctance by some hospitals to become Baby Friendly (Keleher et al., 2002). The development of key indicators to measure hospital's compliance with the *Ten Steps for Successful Breastfeeding* (BFHI, n.d.) has improved this compliance, but does not provide evidence of improvement in breastfeeding rates across Victoria.

Despite the findings of the Birthing Services Review (Health Department Victoria, 1990) and surveys of 'New Mothers' (Bruinsma et al., 2003), concerns raised by midwives in a recent *Review of in-Hospital Postnatal Care* (PinC) in Victoria, suggest that postnatal care for women is not a priority within organisations (Forster, McLachlan, Yelland, Rayner, & Lumley, 2005). Issues raised in the PinC report included the busyness of the wards and the low staff to woman ratios (Forster et al., 2005). These

[10] A 'Baby Friendly' facility is one where a mothers' informed choice of infant feeding is supported, respected and encouraged. Baby Friendly accreditation is a quality improvement measure. Becoming accredited demonstrates that a facility offers the highest standard of care to all mothers and babies. http://www.bfhi.org.au/

ratios were introduced as part of the nurses, including midwives, pay award negotiated by the ANF. In 2000, staffing levels in postnatal wards were established at one midwife to five women (plus babies). Surgical wards however, had morning shift ratios set at one nurse to four patients, a ratio that given the rising caesarean birth rate should also have been applied to postnatal care. So where the implementation of ratios was a positive outcome for nurses, improving workplace conditions and quality of patient care (Buchanan, Bretherton, Bearfield, & Jackson, 2004), it had a negative impact for some midwives and potentially reducing the quality of care provided to women.

Research in the USA and UK has demonstrated associations between high nurse to patient ratios with dissatisfaction among nurses, and increased morbidity and mortality rates (Aiken et al., 2002; Sheward, 2005). It is important for authorities in Australia to continually review midwifery staffing levels as research in the UK has found that staff shortages were the main factor for midwives deciding to leave the profession (Ball et al., 2002). The midwife to woman ratios was viewed negatively by midwives at one of the cases studied for this portfolio (see Chapter six). While the implementation of nurse patient ratios in Victoria has brought nurses back to nursing (Buchanan et al., 2004) there appears to be a risk that if the midwife to woman ratios do not improve that midwives will leave the profession. While the most recent nurses' pay award for nurses and midwives in Victoria included improved midwife to woman ratios for postnatal care (ANF Vic., 2007), the chronic shortage of midwives suggests hospitals may have difficulty meeting staffing needs to implement the ratios (Midwifery Academics (Victoria), 2008).

Whilst there is ongoing evaluation of the services provided by hospitals using Key Performance Indicators (KPIs) (DHS, n.d.), what is not clear is whether these indicators measure what is important for women, for hospitals or for the government. The latest report identifies an improvement in the provision of postnatal home visits and hospitals meeting the breastfeeding KPIs (Veitch, Davey, & King, 2007). Though the KPIs might measure improvement in service provision there is no data as yet to demonstrate improvements to the health and wellbeing of women.

4.6.1. Midwives and Maternity Services Policy

The MSES was a policy designed to improve care for women. It also responded to the recognition of a need to provide greater options for women including access to midwifery care. Thus it provided an opportunity for midwives not only to provide midwifery-led care but to be involved at the 'grass roots' of establishing new services. This should be viewed as a formal acknowledgement of the value of midwifery care and a step towards accepting midwifery as a profession separate from nursing, even if potentially the 'window of opportunity' was economic rationalisation. However, there remain many barriers to overcome. Without legislative changes to enable midwives to practice autonomously, the extent of their practice will continue to depend upon their relationships with the medical profession and the formalised healthcare services structure.

Table 10 summarises the problems identified by the Birthing Services Review, the recommendations of the Birthing Services Review and the response to these problems by the MSES policy.

The introduction of new models of care are not the only organisational and practice changes that are occurring for midwives in Victoria. The next section explores the literature on change theory including the effect of change, successful change strategies, barriers to change and adaptation to change. A final section explores leadership as the way forward for supporting change.

Problem[11]	Recommendation of BSR	Services implemented or extended since MSES
Fragmentation of care	Personal antenatal card throughout Vic	Victorian maternity record – pilot and implementation roll out in progress
Availability, & access to, particular models of care	Midwives antenatal clinics	Team[13] models of care developed at several hospitals
Appropriate utilisation of the different skills of maternity care givers	At least 2 Team midwifery options in each health region	Joint emergency, antenatal care and fetal surveillance workshops have been developed
Provision of choice for women	Joint training programs for doctors and midwives	
Lack of information	A variety of information strategies video, pamphlets etc be available for women re options, in variety of languages	Individual hospitals developed own pamphlets, Web site for women 'Having a Baby in Victoria'http://www.health.vic.gov.au/maternity/
Lack of access, appropriate cultural care for women from non English speaking backgrounds (NESB) , Indigenous women, Young women, women with disabilities and rural women	Improve responsiveness to Women with specific needs e.g. Young, disabled, rural, indigenous and those from NESB	Extension of specialised continuity care services for women with special needs.
High Intervention rates, inconsistent across hospitals	Monitoring of appropriate use of interventions within and across hospitals	Establishment of key indicators and reporting across hospitals
Need for support when women discharged early[12]	Community support programs for women following early discharge in postnatal period	Postnatal home visiting extended, out sourcing to RDNS reduced to improve continuity
Midwives lacked knowledge of lactation, inconsistent advice	All hospitals develop consistent breastfeeding policies and respect women's right to choose own method of feeding	Establishment of breastfeeding services & policies, key indicators relate to BFHI indicators

Table 10: Problems addressed by the Victorian maternity services policy

[11] Problems identified and recommendations of the Birthing Services Review were more extensive than reproduced here, focus is on the MSES response.
[12] Majority of women stayed in hospital after birth for 5-7 days at the time of the review (Health Department Victoria, 1990).
[13] Some of the teams implemented in Victoria consist of more than 7 midwives leading to a potential reduction in continuity of care.

4.7. Concepts and Theory Related to Change

The changing maternity services policies along with changing views on maternity care provision have led to several organisational changes for healthcare providers in Victoria. Although there is a vast amount of literature related to change management and theory, I have focused my review of the literature on change within healthcare organisations and, where possible, related it to midwifery.

Change and the frequency with which it now occurs has become an almost continuous feature of organisational management (Bamford & Daniel, 2005; Burke, 2003; Porter-O'Grady, 2003a) and increasing the complexity of the demands on managers (Hooijberg, Hunt, & Dodge, 1997). Change occurs in different ways however, and takes many forms, making development of strategies to manage successful change difficult. Change management is a term that is used widely but it has become associated with downsizing and restructuring that has imposed negative connotations (Garside, 1998). Factors identified as important for successful change include identifying the reason why change is necessary, a vision for the future, and a clear path for getting there (Bamford & Daniel, 2005; O'Shea, Mcauliffe, & Wyness, 2007; Porter-O'Grady, 1996; Stewart & Kringas, 2003). The linkage of these factors through effective communication provides a more positive image to the term change management for employees (Garside, 1998).

Change is presented in much of the literature as a linear process. There is increasing recognition of the complex nature of change and the ensuing difficulties in comparing strategies across different contexts (Pettigrew, Woodman, & Cameron, 2001). Before presenting theoretical models of change it is useful at this point to identify what is meant by the term change.

4.7.1. What is Change?

In many respects, change is a process that can be viewed as continuous in our lives, both as individuals and in our relationships with others (Whiteley & Whiteley, 2007). As humans we are continually adapting to our surroundings. This may occur automatically through

internal temperature control or subconsciously such as when driving. This may be planned change or in reaction to external factors. In the literature, the terms found to describe change include planned, emergent, episodic, continuous, strategic or transformational (Iles & Sutherland, 2001). Thus, it can be seen that in organisational change the same processes of change occur as for individuals. However, these processes do not occur in isolation. Planned change might also provide an opportunity for emergent innovative change. That is, through the process of planning other more innovative options are recognised. Strategic change more commonly occurs in a planned episodic fashion. Some changes will appear to occur continuously without planning or forethought as a response to local conditions. At the same time there is the potential for an unexpected transformational change because of unplanned external influences.

Discussion of organisational change in the literature most frequently refers to planned change such as restructuring, downsizing or outsourcing (Whiteley & Whiteley, 2007). Structural organisational change is most often implemented by management and viewed as imposed change by the individuals who are affected. That is, it is a top down approach. It is suggested that a bottom up approach, whereby employees are involved in the planning of change, is more successful for some types of change (Graetz, Rimmer, Lawrence, & Smith, 2006). Many of the changes that occurred in the 1990s in Victoria related to restructuring of the health services (Hancock, 1999; Palmer & Short, 2000). Those changes included closure of maternity units, retrenchment of midwives and tightening of all healthcare budgets (Bennett & Newman, 2000). Potentially midwives who were affected or saw colleagues affected during the 1990s economic rationalisation would have negative impressions of change.

The more recent changes to maternity services in Victoria have been a combination of planned and emergent processes. The processes used to implement maternity care that is woman-centred and midwife-led have included planned change that has been primarily episodic with financial resources to support many of the changes (DHS, 1998). Other changes have emerged because of the increasing evidence available supporting midwifery led care along with attitudinal change within the midwifery profession. Many of these

changes would conceivably been received positively by the staff involved as they presented opportunities to set up new services (DHS, 2002a) and were not imposed upon midwives. However, as these services were bedded into regular maternity funding, change continued to occur as part of regular budget constraints. Further, external factors such as the implementation of nurse-patient ratios (Victorian State Government, 2002) impacted on the provision of services with a reduction of midwives in many areas, in contrast to an increase in the number of nurses (personal experience). The imposition of organisational change, such as new models of midwifery care provoked a variety of responses from midwives. Some whole heartedly embraced new ways of working, while others were lost from the profession due to an inability to cope with changing organisational expectations. Where change is planned, the approach taken to implement the change is perceived as affecting the outcomes of achieving change and the effect on those involved (Burnes, 2004; Graetz et al., 2006).

The next section presents a brief overview of theoretical approaches to change as an introduction to the steps for successful change.

4.7.2. Theoretical Models Related to Change

Kurt Lewin is recognised as the leader of the development of change theory (Baulcomb, 2003; Burnes, 2004; Graetz et al., 2006). Lewin developed several different applications to change including the three-step approach to planned change, force field theory, group dynamics and action research (Burnes, 2004; Graetz et al., 2006). Although these applications are often presented and critiqued as separate models, Burnes (2004) argues that they should be viewed as one approach where each element supports and complements the other. By viewing these approaches in combination it becomes clear that although Lewin's work has been criticised for being too prescriptive, in actuality he recognised the complexity of the change process (Burnes, 2004). Although some change processes do proceed in a linear fashion (Redfern & Christian, 2003), more commonly the process incorporates movement in several different directions for progress to occur (Boyatzis, 2006; Iles & Sutherland, 2001). Lewin's different approaches are useful for evaluating or planning individual aspects of the change process (Baulcomb, 2003) and form the basis of

several other models including systems theory, organisational development, and the concept of the learning organisation (Burnes, 2004; Graetz et al., 2006; Shanley, 2007). Boyatzis (2006) argues that many theories of organisational change lack credibility because the idea of continuous smooth change does not match the reality that most individuals experience. Thus complexity science is increasingly purported to be a more appropriate approach to understanding change (Boyatzis, 2006; Houchin & MacLean, 2005; Pettigrew, Ferlie, & McKee, 1992; Plsek, 2003; Stacey, 2005; Whiteley & Whiteley, 2007).

There is widespread support for viewing organisations as Complex Adaptive Systems (CAS) (Cilliers, 2000; Halmi, 2003; Plsek & Greenhalgh, 2001; Stacey, 1996; Wheatley, 2006). The concepts of CAS and complexity science are explored in greater depth later in the portfolio (see Chapter Ten) but briefly, change is a process of adaptation to the environment and can be viewed as an emergent process (Stacey, 1996). However, Houchin and McLean (2005) argue that organisations are not naturally occurring phenomena and therefore may not act in the same way as CAS. They highlight this possibility in an ethnographic study of a new organisation set up with the idea of developing a flexible, employee-empowered governance. They found that, over time the organisation evolved into a traditional hierarchical structure, in part due to responses to crises based on the managers' previous experience (Houchin & MacLean, 2005). I would argue against their view that the image of organisations as CAS is flawed as their findings are based on only one case study. There was change just not in the direction visualised and the promoters of organisations as CAS (Cilliers, 2000a; Plsek & Wilson, 2001; Stacey, 1996; Wheatley, 2006) do not claim that emergence leads in the direction visualised. Houchin and MacLean do make some valid points about the reality of imposing naturally occurring phenomenon onto the non-natural management structures of organisations as it has been recognised that not all individuals adapt to working in organisations that encourage innovative ways of working (Stacey, 1996). Unfortunately, when change processes do not produce the expected results there is the potential for managers to be blamed. There needs to be an acknowledgement that change is complex and that the wrong direction can be taken without attributing blame (Wheatley, 2006). There are many recognised barriers that might affect successful change. The next section presents some of the factors that have been suggested as being essential for success.

4.7.3. Steps for Successful Change

Much of the literature on change provides guidance on useful strategies for managing change (Kotter, 1995; Porter-O'Grady, 2003a) but lack empirical evidence of their effectiveness (Pettigrew et al., 2001). While theoretical models of change look at the whole process within those processes are individual strategies, many of which are common to all with differences in interpretation. For example, communication is undoubtedly an important factor (Kotter, 1995; Porter-O'Grady, 1996) but this might be interpreted as informing staff of planned changes or recognising the importance of listening to their view (Whiteley & Whiteley, 2007). While all the strategies discussed relate to some form of planned change, the examples of change in the literature vary from implementation of evidence-based practice guidelines (Deshpande, Publicover, Gee, & Khan, 2003; Ferlie, Fitzgerald, Wood, & Hawkins, 2005) to strategic re-organisation (O'Shea et al., 2007; Stewart & Kringas, 2003). While a number of nursing papers (Baulcomb, 2003; Carney, 2000; Curtis & White, 2002; McPhail, 1997; Shanley, 2007) were found there was a scarcity of literature related to strategies and the change process in midwifery. All the strategies and theories presented were derived from the organisational management literature rather than from nursing or midwifery.

Enabling individuals to recognise that there is a need to change can be seen as an important step in gaining their support (Curtis & White, 2002; Iles & Sutherland, 2001). Although the creation of a vision for the future has been proposed as a means to direct the change effort (Kotter, 1990; Porter-O'Grady, 1996), more important is the communication of that vision in a way that creates a recognition of the need for change (Bamford & Daniel, 2005; Graetz et al., 2006; O'Shea et al., 2007; Whiteley & Whiteley, 2007). Communication is widely recognised as an essential strategy (Bamford & Daniel, 2005; Carney, 2000; Kotter, 1990; O'Shea et al., 2007). However, its effectiveness depends upon the quality of the information communicated and the trustworthiness of the person passing on the information (Allen, Jimmieson, Bordia, & Irmer, 2007). A lack of trust can make change insurmountable (Ferlie et al., 2005). Communication needs to be two-way where individuals feel that they have been heard and their contribution acknowledged (Stewart & Kringas, 2003). The use of focus groups may be one tool that enables this two-way process

(Hughes, Deery, & Lovatt, 2002). Good leadership has been recognised as essential for managing change (Bennis, 2003; Cook, 1999; Kotter, 1995; O'Shea et al., 2007; Porter-O'Grady, 1996) with leaders role in facilitating information exchange an important part of the process (Hackman & Johnson, 2004; Redfern & Christian, 2003).

Some strategies relate to successful implementation of change from the organisation's viewpoint, others relate to supporting staff (Bamford & Daniel, 2005). Once change has occurred there is a need for consolidation into the organisation's permanent structures (Kotter, 1995; Porter-O'Grady, 1996) as portrayed in Lewin's 3-step model as refreezing as the new norms (Graetz et al., 2006).

Bridges (2003) suggests that change is situational and it is the transitions or psychological perspective that need to be managed for successful change. He identifies three phases that individuals go through: letting go, adjusting and acceptance. He argues that if organisations fail to take account of these psychological factors then change may fail (Bridges, 2003). In many respects Bridges is describing concepts that Wells, Barnard, Mason, Ames and Minnen (1998) describe as a grief model of organisational change. Wells et al. (1998) explored with a variety of staff, the strategies that had been used to assist their transition to new units following restructuring of one healthcare organisation. The strategies deemed as helpful included providing staff with information before the move, welcoming events in the new department, frequent communication between management and staff, unsolicited feedback about performance, partnering a new staff member with a more experienced staff member and the use of team building exercises to assist the integration of new members into a team. Wells et al. (1998) argued that these strategies were underpinned by the concepts identified in the grief process and serve to assist staff move forward to a resolution and acceptance of change. These strategies were found to be useful for some of the participants of Case B of the research project reported in Chapter Eight. Despite the recognition of useful strategies, both for implementation and assisting staff to transition, the outcomes are not always successful.

Plsek (2003) cautions against the expectation that because the implementation of an innovation worked in one place that, if we just follow the rules, it will work elsewhere. Redfern and Christian (2003) used the same process in nine healthcare settings to initiate and evaluate the introduction of new clinical guidelines. Although the actual guidelines implemented were different for each clinical setting, the underlying concept of introducing evidence-based practice was similar. Evaluation included measuring patient outcomes, staff adherence as perceived by project leaders and a staff self-assessment survey. Redfern and Christian (2003) found that most of the sites demonstrated a linear process, three encountered a more complex process in an environment due to the impact of external factors such as re-organisation of the departments. This finding supports Plsek and Greenhalgh's (2001) view that change tends to be more linear where there are high levels of certainty than where the environment of change is beset with uncertainty. The levels of implementation and acceptance of the new guidelines varied across sites, with some discrepancy between self-identity of adherence and the project leader's evaluation of adherence. Improvements were demonstrated across all sites regardless of the level of adherence to protocol, raising the possibility that patient improvement was associated with other factors and not the intervention (Redfern & Christian, 2003).

There are however, many influences that create barriers to successful change and these are discussed below.

4.7.4. Barriers to Change

Barriers to successful organisational change may relate directly to the organisation (Houchin & MacLean, 2005; Porter-O'Grady, 1996) or to the resistance of individuals (Curtis & White, 2002), although these factors are interrelated and complex (Brodie, 2002). Resistance to change may however, be a necessary part of the change process as it can act as a moderating factor preventing change occurring too quickly in the wrong direction (Graetz et al., 2006).

Organisational barriers include a lack of resources, failure to recognise the need to change (Houchin & MacLean, 2005; Porter-O'Grady, 1996), and the prevailing culture (Brodie,

2002; Hughes et al., 2002; Kirkham, 1999). Resistance to change factors include a lack of knowledge; skepticism; fear of the loss of autonomy (Brockopp et al., 1998; Deshpande et al., 2003); the need to reduce disruption in the workplace; denial of the need for change; lack of ownership; loss of control in how change will be implemented; lack of motivation to change; different perceptions of the affect of the change; and, an inherent resistance to change personality which may exist as part of the local culture (Curtis & White, 2002). Individuals with a predisposition to resist change have however, been found in one study to be a very small percentage of those involved (Bareil, Savoie, & Meunier, 2007). While there are individuals who have positive attitudes towards change and openly embrace change as an opportunity to grow and learn (Wanberg & Banas, 2000), others react more negatively viewing change as a threat (Antonacopoulou & Gabriel, 2001). Individuals who are less accepting of change have been found to have less job satisfaction and stronger intentions to resign (Wanberg & Banas, 2000). The different attitudes towards change potentially relates to the perception of the individual as to whether change is being imposed upon them or they are instigating the change (Kanter 1983 cited Eriksson, 2004).

The implementation of midwifery-led care faced similar barriers to those discussed above (Brodie, 2002; Hughes et al., 2002). Brodie (2002) explored the views of midwives specifically in relation to the barriers to implementation of continuity of midwifery care in Australia. Data for this qualitative study were collected in a variety of ways (Brodie, 2002). Much of the data was collected at conferences and professional gatherings of midwives, and through midwifery journals, there was therefore a potential bias towards the views of midwives who were interested and involved in midwifery development. This in itself is revealing as some of the issues raised included the lack of educational opportunities for midwives and the view that midwives were poorly prepared for practice. These factors not only impact on the ability of midwives to challenge existing services and practices but may serve to limit individuals desire to be involved (Brodie, 2002). Resistance to change was found by Brodie (2002) and others (Ferlie et al., 2005) to exist not only between professions but from within the profession itself. Brodie (2002) recommended organisational change including the provision of resources to implement midwifery models of care, improved education and midwifery leadership as strategies for improving maternity

services for women. As discussed earlier in this chapter, some of these recommendations have occurred in Victoria. It is difficult to find evidence of leadership development programs although there have been an increase in the number of midwifery consultant posts.

In an attempt to involve midwives in the change process, Hughes, Deery and Lovatt (2002) used critical ethnography as the means to gain an understanding of the power relations that were barriers to change. Focus groups provided midwives with an opportunity to be heard and to participate in planning for change (Hughes et al., 2002). This involvement is recognised as important for successful change (Stewart & Kringas, 2003). The initial findings identified similar barriers to change as those found by Brodie (2002) including; staffing levels and mix; organisational issues; working relationships; the working environment and educational needs of midwives. In follow up focus groups a year later, the midwives were deemed to be more politically aware and potentially more able to initiate changes than previously (Hughes et al., 2002). Although there was no clear indication that change continued to occur. Hughes et al.'s findings support Kirkham's (1999) work that not only does the prevailing culture inhibit change but that it also takes a long time to change once movement has begun.

Antonacopoulou and Gabriel (2001) highlight that the '*…reactions to change engender a complex blend of psychological, social, emotional and cognitive factors which can hardly be reduced to a simple dichotomy of resistance or readiness to change'*(p. 447), making strategies for successful change difficult to identify and evaluate.

4.7.5. Evaluating Effect and Effectiveness

One of the difficulties in studying change strategies is the need for a long time frame to demonstrate the effectiveness of change and the long term effects (Pettigrew et al., 2001). Measuring effectiveness is difficult (Iles & Sutherland, 2001) in particular with regard to sustainability as it requires long term commitment (Pettigrew et al., 2001). Long time-frames introduce the risk of findings being affected by factors that cannot be controlled for (Beanland, Schneider, LoBiondo-Wood, & Haber, 1999).

Healthcare environments are complex and implementing change is not easy. They are dynamic systems that can behave in unpredictable and chaotic manners (Plsek & Wilson, 2001). When planning to evaluate change, consideration of controlling for the many potential extraneous variables makes quantitative methods less attractive than those that include social inquiry. Iles and Sutherland (2001) argue that the content, context and process model developed by Pettigrew and Whip is a useful framework for planning change and analysing changes retrospectively. Pettigrew and Whipp (1991) present strategic change as a non-linear, dynamic process that does not proceed in clearly defined phases. Their model's three essential dimensions content, context and process are the 'what', 'context' and 'how' of change and encompasses historical, cultural, economic and political factors. The interaction of these concepts provides some understanding of the complexity, interdependence and fragmentation in the workplace that either support or repel change. Each dimension incorporates the interrelated factors important in shaping performance of a company. These include environmental assessment, human resources as assets and liabilities, linking strategic and operational change, leading change and overall coherence. Whilst this model was developed for the business world, it has successfully been tested within the National Health Service in the UK (Iles & Sutherland, 2001; Pettigrew, Ferlie, & McKee, 1992). Pettigrew and Whipp's framework is used as part of the process of analysis of the case studies reported in later chapters (see page 145).

There are two perspectives to evaluating change outcomes in organisations. One perspective is the measurement of changes in outcomes, such as improved breastfeeding rates. The other is to gain the perspective of the effect on the employee, such as more work space (Stewart & Kringas, 2003). Interpretation of the successful implementation of change might provide conflicting results. For example, an evaluation of savings made in restructuring might appear as a positive outcome from an organisational perspective, but from an employee perspective, greater workload might lead to a reduction in quality. In midwifery, there are many studies evaluating the implementation of midwife-led models of care using measures related to clinical outcomes for women and babies (Biro, Waldenstrom, Brown, & Pannifex, 2003; Farquhar et al., 2000; Homer et al., 2001a;

Waldenstrom et al., 2001). However, fewer have been found that focus on the perspective of change for midwives (Brodie, 1996; Shallow, 2001c; Walker et al., 2004).

The changes that have been occurring in Victoria include the introduction of midwifery models of care that require for many midwives the need to re-skill to enable them to work within areas of maternity care where they have little experience.

4.8. Adapting to Organisational and Professional Change

The psychological change or transition that individuals go through has been described as three phases in the management literature (Bridges, 2003) and likened to the grief process in the nursing literature (Wells et al., 1998). Although not described as such, the terms transition have been used in the midwifery literature (Lindberg, Christensson, & Öhrling, 2005; Stevens & McCourt, 2002a; Wilson, 2000) signaling a recognition that change is not instant. Lindberg et al. (2005) discussed transition as a theme whereby the midwives' views implied they were situated in the past but possessed a vision of the future. Although the midwives could see positive changes for the future they also were anxious about other political decisions that could affect maternity care, but felt powerless to participate (Lindberg et al., 2005); findings that echo Hughes et al. (2002). While some midwives recognised the need to develop new skills, others were found to lack an awareness of the need for new knowledge (Lindberg et al., 2005). However, adaptations occur gradually over time with some more highly visible and immediate such as the choice not to wear uniform, others less obvious such as internalisation of new ways of working (Stevens & McCourt, 2002a). The concept of phases of transforming is suggestive of completion of change as being gradual rather than immediate.

Wilson's (2000) study of the merger of two postnatal wards, identified biculturalism as one way midwives adapt to change. She describes biculturalism as the merging of old values into ways of working within the new culture (Wilson, 2000). Those midwives who adapted to the ward were seen to display some of these bicultural attributes, although the examples given were all from positive viewpoints and little is apparent as to what happened to those who were not adapting to the change (2000). While much of Wilson's findings correspond

to the phases of transition as identified by others (Bridges, 2003; Lindberg et al., 2005; Wells et al., 1998) the concept of biculturalism (Kramer and Schmalenberg 1977 cited Wilson, 2000) is a useful way to view an emerging culture.

4.8.1. Re-skill, Up-skill, Extension of Practice

Wherever organisational change occurs individuals need to learn to work in different ways. This may be as simple as reporting to a different person or becoming familiar with new paperwork. For some individuals it may require the development of new practice skills either, because of lack of recent experience (eg. caring for birthing women), or having no experience (eg. community based midwifery practice). Re-skilling for autonomous practice was discussed in Chapter Two. Issues pertaining to the responsibility of the midwife to maintain competence for registration purposes are important and were identified in Chapter Two. Little was found in the literature directly related to re-skilling midwives.

The Victorian government has developed programs for midwives and doctors in relation to antenatal care, emergency maternity skills and fetal surveillance (DHS, n.d.). Although these programs are widely available throughout the state, their uptake is restricted by the desire of individual services. During piloting of these programs, funding was provided by the Department of Health but individual hospitals now pay a fee (personal communication, fetal surveillance program manager, May 2006). Many of the larger health services provide their own programs and a few have also recognised the need to provide programs supporting normal birth as well as for emergency situations.

Leadership is an important factor in the facilitation of organisational change (Bennis, 2003; Hackman & Johnson, 2004; Redfern & Christian, 2003) thus the following section explores leadership concepts and styles.

4.9. Leadership

In the research reported in Section Three of this portfolio, midwives were asked to identify who they thought were the leaders in their organisation as it went through change. The

majority of midwives who responded provided the names of managers. While leaders are more likely to be those in authority (Bennis, 2003; Lipman-Blumen, 2000b), the development of leadership skills is vital for all midwives to enable them to meet Competency Two of the Australian National Competency Standards for the Midwife (ANMC, 2006). The concepts of leadership as outlined below provide a basis for the discussion of the research findings reported in Chapter Nine. There is a dearth of literature on midwifery leadership (Coggins, 2005; Pashley, 1998; Ralston, 2005) so the majority of this section is informed by the business and management sectors.

There is no clear understanding of what determines effective leadership despite the multitude of literary and theoretical propositions (Cook & Leathard, 2004; Martin & Ernst, 2005; Osborn, Hunt, & Jauch, 2002). There is agreement that leadership is about influencing others to enable achievement of goals (Bennis, 2003; Cook, 1999; Denmark, 2007; Grossman & Valiga, 2000; Manion, 2005). Hackman and Johnson (2004) believe that leadership is about communication and define it accordingly "*leadership is human (symbolic) communication, which modifies the attitudes and behaviours of others in order to meet shared group goals and needs"* (p.12). Their perception of leadership as facilitating an understanding of a common vision is supported by many authors (including, Bennis, 2003; Grossman & Valiga, 2000; Lipman-Blumen, 1996; Malloch & Porter-O'Grady, 2005; Manion, 2005).

In most organisations, the leaders are those who are in formal positions of power across all levels of management (Bennis, 2003; Kelley, 1988; Lipman-Blumen, 2000b; Stacey, 1996). Leadership behaviour also occurs in informal settings where the emerging leader or leaders may not have formal roles (Grossman & Valiga, 2000; Porter-O'Grady, 2003b; Simpson, 2007). While individuals in leadership roles may have sought those positions, they may have arrived there by chance. There is often an assumption that those in legitimate positions of authority are imbued with leadership skills (Manion, 2005). As the majority of leaders in business and health are in positions of authority, it is important to look at what the differences are between leaders and managers. Kotter (1990) describes management and leadership as complementary skills whereby managers maintain order in complex

systems, and leaders lead change. The differences identified by Bennis (2003) listed in Table 11 support Kotter's (1990) view. However, these opposing abilities suggest that leaders who are managers are faced with the paradox of how to fulfil both roles, particularly where the organisational culture is at odds with that of an individual leader. Denison, Hooijberg, and Quinn (1995) found that effective leaders were recognised by their subordinates as those who participated in more complex behaviour, that is integration of the manager and leadership roles into one.

Manager	Leader	Manager	Leader
Administers	innovates	asks how and when	asks why
is a copy	is original	eye is on bottom line	eye is on horizon
maintains	develops	imitates	originates
focuses on systems and structure	focuses on people	accepts status quo	challenges it
relies on control	inspires trust	classic good soldier	is own person
short range view	long range perspective	does things right	does the right thing (Bennis, 2003, p.39)

Table 11: Differences between managers and leaders

Managers may have the authority to sanction change but they may not be able to sufficiently visualise the future in order to influence others to change. Leadership is a process, rather than a position, with the foundation based on knowledge rather than power (Martin & Ernst, 2005). Leadership should be viewed as a behaviour that can be shared and the position of leader viewed as a role (Schruijer & Vansina, 2002) where the leader is a participant as opposed to a director (Malloch & Porter-O'Grady, 2005; Simpson, 2007).

A leader is not a leader without followers (Graham, 1988; Kelley, 1988; Kouzes & Posner, 1987; Popper, 2003). One aspect of leadership is to guide followers into self-leadership (Hackman & Johnson, 2004). The qualities of effective followers are similar to those of effective leaders and similarly being a follower should also be viewed as a role (Kelley,

1988). Leadership and followership are roles that can be played by the same individual at different times throughout the day (Kelley, 1988). Attention needs to be focused on the context of organisations, in particular with a view to recognising the importance of relationships and followership (Grossman & Valiga, 2000; Popper & Zakkai, 1994). Where individuals are provided the opportunity to self-organise, work teams may act effectively without the need for a formal leader (Graham, 1988) although an informal leader might emerge (Simpson, 2007).

Leadership styles can affect how well change is introduced and accepted. The two main styles described in the literature are transactional and transformational leadership. In transactional leadership, both leaders and followers are focused on a task. Completion of the task is paramount, with little common goal or vision (Grossman & Valiga, 2000). Transactional leadership focuses on the self-interest of workers as the motivator to achieve action, providing rewards for good work and penalising poor work (Bass, 1990; Graham, 1988). Little changes with this style of leadership as it seeks to maintain the status quo, and is in reality, management rather than leadership.

Transformational leadership is the style promoted as enabling followers to share a vision and motivating them to work together in achieving a common goal. The motivation of followers depends on the interpersonal skills of the leader and although it may be linked to a 'charismatic' personality these skills can be learnt (Bass, 1990). A transformational style of leadership is frequently promoted as the one necessary to achieve change across health services (Grossman & Valiga, 2000; Lancaster, 1999; Lindholm, Sivberg, & Uden, 2000; Murphy, 2005; Welford, 2002a) including midwifery (Coggins, 2005; Pashley, 1998; Ralston, 2005).

Cook (2001) describes two additional styles, one is the 'connective' style bounded by the concepts of collaboration and interaction and the other a 'renaissance' style uses concepts of empowerment and relationships with patients. Most leaders actually use more than one style with the predominant style reflecting not only their personal values but the environment that they work in (Cook, 1999; Lipman-Blumen, 2000b; Popper & Zakkai,

1994). The connective leadership model described by Lipman-Blumen (1996) incorporates nine different, but previously recognised approaches to leading. These encompass '*networking, relationship building, empowerment and mutual responsibilities for leaders and followers'* (Grossman & Valiga, 2000, p.121). The connective leadership model has its roots in complexity science and is discussed further in Chapter Ten (see page 267) as a model that would provide the midwifery profession with a flexible, adaptable leadership approach in this changing world.

4.10. Summary

The Maternity Services Enhancement Strategy (MSES) (DHS, 1998) was an important policy that provided the basis for development of woman-centred maternity care in Victoria. Since the allocation of these additional funds for maternity care many changes have occurred in Victoria to improve the provision of continuity of care to women across their childbearing experience. There is insufficient evidence to analyse whether the policy has achieved its aims of improving care for women other than the statistics on birth outcomes. I have endeavoured instead to provide a picture of the factors underpinning the development of the MSES.

Three policy streams were identified in accordance with Kingdon's theoretical framework of policy development (Kingdon, 1995). In this instance I presented the policy solution as the aims and objectives of the MSES as a starting point for the discussion. The political actors and windows of opportunity for getting the issues onto the policy agenda were then explored. Finally I presented some of the problems that had been identified during a Birthing Services Review (Health Department Victoria, 1990) and related them to the solutions presented in the policy. The complexity of the issues, the existing medicalisation of birth, power struggles between professionals along with the conflicting attitudes, beliefs and values held towards childbirth all impact on the successful implementation the MSES policy.

The second part of the chapter focused on the theory, effect of and barriers to change. As leadership is an important facilitator for achieving change, different approaches to

leadership were discussed and a connective leadership approach deemed suitable for advancing midwifery identified.

The next section of the portfolio presents the research project completed to fulfil the criteria of the Professional Doctorate. The two case studies presented shed some light onto the complexities of implementing maternity services as recommended by the MSP.

SECTION THREE – THE WALLS

RESEARCH PROJECT

Chapter Six – Methods

Chapter Seven – Results One – The Cases: The Context, Content and Process

Chapter Eight – Results Two – The Survey

Chapter Nine – Results Three – The Interviews

Chapter Ten – Discussion

CHAPTER FIVE

METHODS

5. Introduction

The research project was completed as part of a Professional Midwifery Doctorate. The expectations of a Professional Doctorate include the need to explore midwifery practice, leadership and policy as demonstrated in the earlier sections of my portfolio. Section One explored midwifery connections with a view of the midwife's role, connections with women and models of care. In Section Two I reviewed maternity policy in the state of Victoria that in part, had led to changes in the provision of maternity care. These changes and the effect for midwives was a stimulus for this research project. Section Three presents the empirical research component.

Case study was chosen as the most appropriate means to answer the research questions that are outlined along with the main aims of the study. Discussion of the rationale for using case study approach follows with the final sections explaining the protocol and methods used for collection of data and analysis.

5.1. Development of the Key Research Questions

The literature that underpins the development of this research and informed the research questions has been presented throughout the first two sections of this portfolio. The policy chapter provided insight into the factors that relate to why and in what way maternity services have changed in the state of Victoria. These factors include the opportunity for public health providers to develop their maternity services to suit their own community needs within the guidelines and funding provided by the Victorian state government. The main focus of state policy was to improve the services for women. Changing the way maternity services were provided led to midwives providing more of these services.

Wherever organisational changes occur there is potentially an impact on staff. The literature on change theory was reviewed in Chapter Four to gain some insight into the management of change, barriers and resistance to change and the effect on individuals. The literature around the implementation of midwifery-led care in Chapter Three provided insights into the role and practice changes that occurred. There is limited research into the midwife's perspective of changing models of care but none related to Victorian midwives' experiences. The aims of the research were to:

- Identify the changes that have occurred in midwifery practice for midwives;
- Explore with midwives the experience and effect of changes in maternity services; and
- Identify the strategies used to introduce changes.

Therefore, the key research questions were:

- In what ways have midwives in two units undergoing organisational change altered their practice?
- How do midwives describe the impact of the changing models of care on themselves?
- How do midwives describe the impact of these changes on colleagues?
- How do midwives describe the way the changes to the environment and clinical practice were made?
- How do the leaders and managers describe the strategies used to create change?

The objective of the research was to identify factors that would lead to improved planning for change in the future to improve outcomes for midwives.

Consideration was given to the best approach to answer these questions. Given the many variables suggested by the research questions it was clear that a qualitative research method was the most appropriate approach. As the literature related to midwifery practice in Victoria was minimal it was appropriate to use an approach that was descriptive and exploratory in nature (Cresswell, 1998).

Lincoln and Guba (1985) argue that the world consists of multiple realities as determined by the subjects under study or the lens with which the researcher views them. Paley (2005) counters that there is only one reality that can be measured given the correct instrument, but that there are multiple perspectives. During naturalistic research subjects are bound by time and context such that it becomes impossible to distinguish cause from effect. Descriptive research provides the opportunity to present these multiple facets (Lincoln & Guba, 1985; Sandelowski, 2000). It is this grounding in the real world that makes qualitative research a suitable approach for looking at the effect on midwives of the changes that are occurring in maternity services in Victoria. As there are many qualitative research approaches it was also necessary to choose the one that most suited the research questions. A case study approach enables exploration and description of a subject that incorporates the constraints of time and context (Yin, 2003) and is discussed in the next section.

5.2. Case Study Approach

Case study research has been described by Yin (2003) as providing a complex approach to study complex social situations where there are a large number of variables that are difficult to recognise or control for. Stake (2000) promotes case study research as a choice to study a specific case not a methodological choice. Stark and Torrance (2004) identify case study research as an approach that has been informed by many different theoretical perspectives with an emphasis on 'the case'. Luck, Jackson and Usher (2006) go further by suggesting that the case study approach provides '*a bridge across the paradigms'* (p.104). A case study can be viewed as one that focuses on 'the case', regardless of the methods used to study it. The case study research method is inclusive of research design and data collection strategies and should not be considered as a sub-group of other research methods (Yin, 2003). Yin provides a useful two part definition that encompasses not only the scope but also the strategies for data collection. That is:

> 1. A case study is an empirical inquiry that:
> investigates a contemporary phenomenon within its real life context, especially when the boundaries between phenomenon and context are not clearly evident.
> 2. The case study inquiry:

> copes with the technically distinctive situation in which there will be many more variables of interest than data points;
> relies on multiple sources of evidence, with data needing to converge in a triangulating fashion; and
> benefits from the prior development of theoretical propositions to guide data collection and analysis (Yin, 2003, pp.13-14).

The case study approach has traditionally been utilised for descriptive or exploratory studies but is also gaining recognition as being useful in explanatory research (Fisher & Ziviani, 2004; Kyburz-Graber, 2004; Yin, 2003) particularly where the concepts remain complex (Fisher & Ziviani, 2004) and it is not possible to control all the variables (Lincoln & Guba, 1985).

A case may be an individual, a group, a community or an institution that exists in the real world and can only be understood by examining it within the context of its existence (Gillham, 2000). Each case has boundaries that are used to define and confine it, and integrated working parts so that it can be seen as '*a specific, complex, functioning thing'* (Stake, 1995, p.2) . One of the most important and to some extent most difficult parts of the process is the clarification of the subject under study (Yin, 2003) that is establishment of the boundaries (Stake, 2000). Being too wide can result in too much data (Patton, 2002) and being too narrow can miss vital relationships (Anderson, Crabtree, Steele, & McDaniel, 2005).

Identification of an individual case depends upon the reason for the research. Stake (2000) differentiates between types of case study in three ways, using the terms intrinsic, instrumental or collective. An intrinsic case study is one where the phenomenon under study is specific to one site. Therefore, it is the case itself that is of interest and may have been the catalyst for the study. An instrumental case study is the term used when the phenomenon exists more widely and the study may be used to support understanding of an issue rather than the case being the primary focus (Stake, 2000). Several cases studied to gain a wider understanding of a phenomenon has been termed a collective case study by

Stake (2000) but described by others as multiple case design (Huber & Van de Ven, 1995; Yin, 2003). Multiple cases are used as a means of replication to improve the validity of the findings as opposed to the use of a large sample for validity as used in experimental research (Huber & Van de Ven, 1995).

A multiple case design can strengthen case study findings through the use of comparative case studies in situations where experimental designs are not feasible (Yin, 2003). As the main weakness of case study research is seen as inability to generalise to similar populations (Stark & Torrance, 2004), the use of multiple cases provides a strategy to overcome this (Yin, 1999). Although as Pettigrew (1992) warns, when using comparative case studies there is a need to '*…be aware…*' as '*…many of the supposed similarities turn out on closer scrutiny to be illusory*' (p.30). Multiple cases can be useful not only to demonstrate similarity but also to identify differences, particularly where these relate to context. Orum et al. (1991) also argue that the focus on a single case validates that experience whereas the use of multiple cases can dilute the importance and meaning of the single case. A variation of multiple cases is that of nested cases. Where case studies feature communities, villages or organisations the final case study might consist of several embedded or layered cases (Patton, 2002). Small sub-units of the whole form individual cases that can be viewed individually but also inform the whole (Bergen & While, 2000).

The strengths and weaknesses inherent in case study approach are fundamentally related to the strengths and weaknesses of the methods used for data collection (Gillham, 2000). Advantages of using multiple methods of data collection include opportunities to identify information using one method that was missed in an alternative approach, reducing researcher bias (Axinn & Pearce, 2006) and strengthening the trustworthiness of the data through triangulation (Lincoln & Guba, 1985). The use of combinations of methods enables the strengths of one to counterbalance the weakness of the other (Axinn & Pearce, 2006). Two cases were chosen for this study and the rationale for the research approach is discussed in the next section.

5.3. Rationale for Approach

As changes in Victoria had already occurred and maternity services were continuing to evolve it was clear that a method that would encompass the dynamics of the changing landscape of maternity services was needed. The research questions required a method that would provide an insight into midwifery practice, one that would provide a picture of what had, and was continuing to occur for midwives. There was no opportunity to establish an experimental or even a quasi-experimental approach grounded in objectivity and controlled for extraneous factors. Nor would such an approach have been suitable as the limitations of such quantitative approaches are that they do not reflect the complexities of the real world (Yin, 2003).

A case study approach enables an in-depth analysis using multiple methods of data collection (Cresswell, 1998; Orum et al., 1991; Yin, 2003). It is an approach that supports the importance of context, that includes attention to the social, environment and history of the case (Stark & Torrance, 2004). Case study method can be designed with the use of more than one site to provide replication that strengthens the overall findings. However, comparisons between cases should not specifically look for sameness as meaning can be found in the differences (Yin, 2003).

While the research questions relate to midwives' practice it was impossible to get an understanding of what happened for them without looking at why it happened at that time and place. There are many factors that have led to the redevelopment of maternity services within the public health system of Victoria. The reasons for change and the management of these changes related not only to the individual hospitals involved but had been affected by world views, economics and the developing midwifery profession. From an ontological perspective, social reality is constructed according to the individual's frame of reference within the setting, leading therefore to multiple realities where more than one individual is involved (Lincoln & Guba, 1985). That is consumers, midwives, managers and doctors all have a different perspective of change and construct their own interpretation of events. In this situation, description of the entity represents the multiple constructions of individuals (Lincoln & Guba, 1985). Lincoln and Guba (1985) argue that in a naturalistic setting

where individuals are continuously interacting then epistemologically, mutual simultaneous shaping replaces the concepts of cause and effect. In social settings, these interactions enable or constrain the effect of interventions for change, removing the ability to control and predict (Lincoln & Guba, 1985). The choice of case study, as an appropriate research method for this present study, lay in the need to describe and explain the phenomenon of changing midwifery practice within multiple dimensions of change and interaction.

Having established the rationale for the use of case study approach the remainder of this chapter focuses on the research process and presents the protocols related to quality, ethics, choice of case, recruitment, data collection and analysis.

5.4. Trustworthiness

There are a variety of strategies and operational techniques that can be used to establish quality and rigour within qualitative research (Tuckett, 2005). The positivist stance is presented in terms of validity, reliability and generalisability (Lincoln & Guba, 2000). Parallel concepts deemed more appropriate for use in qualitative research are the concepts of trustworthiness and authenticity that have emerged from a constructivism perspective (Lincoln & Guba, 2000). Regardless of terminology validation is about demonstrating the trustworthiness of the data and its interpretation (Paley, 2005; Rolfe, 2006).

In establishing research protocols for case study approach, Yin (2003) uses a positivist approach in his terminology. Possibly this is in recognition of the common methods that can be used within case study research that are allied to a positivist perspective. Patton (2002) however, argues towards choosing the criteria that reflect the purpose of the inquiry, including the possibility of combining criteria from different frameworks. The risk of using criteria from different philosophical or methodological frameworks is the development of tensions between the approaches that may be difficult to resolve (Patton, 2002). Given the exploratory nature of the research presented here, the criteria used to establish quality and rigour are those proposed by Lincoln and Guba (2000) that despite the discourse on appropriate terms remain the gold standard for qualitative research (Polit & Beck, 2006; Whittemore, Chase, & Mandle, 2001).

Evaluation of a qualitative study's quality is bound up in a demonstration of its trustworthiness (Polit & Beck, 2006). The term trustworthiness has become a parallel term to that of rigour (Patton, 2002). As such it encompasses more than simply demonstrating the validity or truthfulness of the data but includes evaluating the interpretations and findings of a study (Patton, 2002; Polit & Beck, 2006). Trustworthiness includes the concepts of credibility, dependability, confirmability and transferability (Patton, 2002). Each is now discussed briefly and Table 12 illustrates the ways the criteria were fulfilled for this study.

5.4.1. Credibility and Authenticity

Credibility and authenticity relate to the processes taken to maintain confidence in the accuracy of the data that has been collected and interpreted (Polit & Beck, 2006). It can be seen as a parallel to what Maxwell (1992) determines as descriptive and interpretive validity. Validation is a match between the participants view and how they are represented (Tobin & Begley, 2004). The development of a research protocol, to ensure that the data is collected systematically and accurately, enhances believability in the quality of the research. Further steps that can be taken to demonstrate credibility include the use of triangulation, member checks (Polit & Beck, 2006) and maintaining a chain of evidence (Yin, 2003). Throughout the present study information obtained about the process and content of what occurred was checked with the Key informants. Some details such as time frames were able to be cross checked with documents on the case site website.

Credibility is also enhanced when there is no existing relationship between the researcher and the organisation. While a researcher from within an organisation provides easier access to the site, there is a risk of bias from socialisation within the culture (Polit & Beck, 2006). Participants are potentially more likely to be more open and honest in their responses where there is no likelihood of their responses being reported to management. I had no connections to the organisations involved although I did know some of the midwives through professional activities.

The use of member checks assists in confirming the accuracy of the interpretation of the data (Lincoln & Guba, 1985; Patton, 2002). However, providing transcripts for verification can be fraught with difficulties not the least of which is that the interviewee had forgotten what was said at the interview or had even been influenced by it and changed their view (Morrow, 2005). Focus groups can be a useful process for feedback and validation (Morrow, 2005). Therefore participants were not provided with transcripts but were invited to a meeting to enable me to provide feedback on my findings. All midwives were invited to hear the feedback and were encouraged to confirm my interpretation or refute my findings.

5.4.2. Confirmability

Maintaining a chain of evidence or audit trail is also a means to demonstrate confirmability. The audit trail provides evidence that leads from the compilation of the raw data with notes demonstrating the decision making processes that have occurred throughout the collection, analysis and interpretation of the data (Polit & Beck, 2006; Yin, 2003). The computer program NVIVO7, was used to assist with analysis of the data and provided the means to store the data, identify themes and link memos to text.

5.4.3. Dependability

Dependability is similar to reliability and rests on the ability of a different researcher repeating the same study with the same results. Tactics to demonstrate this include the use of a study protocol that lays out the exact steps to be taken and the development of a database or audit trail to enable other researchers to review how and why decisions were made (Yin, 2003).

5.4.4. Transferability

Transferability relates to the relevance of the findings in a different setting. Qualitative research is generally not designed with the intention of the findings to be applied in different settings. The provision however, of sufficient descriptive data of the context may

allow others to decide for themselves whether the findings are able to be transferred to their own situation (Polit & Beck, 2006). While it could not be expected that even in similar contexts every person would act in the same way (Lincoln & Guba, 1985), if the context of two cases are sufficiently congruent then there may be some expectation that a working hypothesis could be extrapolated to the second setting (Patton, 2002).

The ways this study met the criteria outlined above are presented in Table 12 below.

Trustworthiness	Research Strategy	Operational Techniques
Credibility	Field Journal Tape recorder Transcript audit Theme memos	Case selection Two cases Member check Triangulation Audit trail (NVIVO7)
Dependability	Field journal Tape recorder Transcript audit Repetitive listening to tapes Theme memos	Two case studies Data collection protocol Triangulation Audit trail
Confirmability	Field Journal	Audit trail Reflexivity
Transferability	Literature review	Thick description

Table 12: Criteria for trustworthiness and how met throughout study

The quality of a research also rests upon the ethical decisions that have been made (Seale, 1999) that include establishing a protocol that addresses any ethical issues that might impact upon the participants or researcher.

5.5. Ethical Considerations

The sites were chosen to ensure that I did not have a working relationship with the midwives. This removed the possibility of my being in a position of power that could be viewed as coercive. At Case A I was known professionally by only two or three of the

midwives. However, at Case B I was known in a professional capacity by several midwives as treasurer of both the Victorian state branch and the local sub-branch of the ACM. These relationships did not represent a position of unequal power between myself and participants.

The research proposal was submitted to the Human Research and Ethics Committee of the University of Technology, Sydney and approval was given subject to approval from the two sites (see Appendix D). For Case A, senior management reviewed the proposal and in line with their hospital policy accepted the UTS ethics approval without requiring a submission to their full committee[14]. Ethics approval for Case B required a submission to their full research and ethics committee and was granted. As per the research policy at the Case B site, a member of staff was included as a co-researcher. One of the educators employed in the Neonatal Intensive Care Unit of the tertiary referral hospital, who was known to me agreed to assist. As she was not employed within the case site she was not a potential participant, but as a midwife she did have some understanding of what was occurring within the unit. The co-researcher provided assistance with local procedures including preparing for presenting at the research and ethics committee[15], organisation of rooms for interviews, accessing an electronic hospital logo that was necessary for the participant information sheet.

A participant explanatory statement (see Appendix E) about the whole study was circulated with the surveys and provided to the managers/leaders when invited to participate in an interview. At the interviews and focus groups additional sheets were available for anyone who wanted another copy at that time. Implied consent for the survey was assumed with their return. I fully explained the study to the participants of the interviews and focus groups, prior to obtaining their written consent (see Appendix F). The consent included permission for me to audio record each session. Participants of the focus groups also consented to maintain confidentiality outside of the group.

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[14] At the time of this study the standard practice for staff research at Case A only required the Director of Nursing and Midwifery to review the proposal and ensure ethics approval from the university involved (personal communication, Director of Nursing and Midwifery 12/11/2003).
[15] Case B Research and Ethics committee interview all applicants.

Issues of confidentiality and anonymity were identified and discussed with the participants. The survey was completely anonymous. I was aware of who was being interviewed and participants of the focus groups knew who had contributed. All data were considered confidential and it was reiterated when gaining written consent that any identifying data would either be changed in such a way as to obscure the identity of a person or omitted from any report. Prior to obtaining consent from the focus group participants, I discussed the importance for each person present to respect the opinions of the other participants and for the need to maintain confidentiality about the information revealed by group members. Participants were reassured that only myself and my supervisors would have access to the tapes and written data. It was also reiterated that management would only receive the same presentation of findings that was provided to the staff on site. No issues arose during the interviews or focus groups that caused any concerns ethically for me. The next section provides brief information about the two cases and the access to the sites.

5.6. The Cases

The cases were chosen with consideration given to the type of changes that had occurred, the comparability of services offered, comparability of births per year and the ease of access for me. These factors provided boundaries to enable identification of individual cases (Yin, 2003). One additional boundary pertained to selecting cases where organisational change had occurred following recent changes in Victorian maternity policy. Several units in Victoria had established midwife-led models of care prior to 1999 with midwives choosing to be employed in those models. Since the introduction of the Maternity Services Enhancement Strategy (DHS, 1999) there was an expectation by the government that there would be an expansion of midwife-led care across all healthcare areas. This led to the re-organisation of maternity services in some hospitals requiring midwives to work across the full scope of midwifery care regardless of individual midwives' choice (personal experience). This study aimed to focus on midwives in units where organisational change had occurred where midwives had little or no choice.

The two sites had been visited by me, one during recent changes to maternity services at my own place of employment and the other for professional meetings. Both were therefore known to meet the study criteria. The two cases were also chosen because of their similarity in size and the structure of the public hospitals that they are positioned within. Time and financial constraints limited the study to two cases.

Each case was a maternity unit situated in an outer suburb hospital of Melbourne, Victoria but managed by different area health providers. The similarity within each site prior to changes whereby midwives were primarily working in one area provided a foundation for interpreting and understanding similarities and differences. Therefore the boundaries of the cases included management agencies, physical environment, time frame of interest and researcher time available for completion of data collection. The data collected were limited by the length of employment of each participant and hence their experience of any change. It was important to recognise the boundaries of the cases to prevent expansion of the data collection into areas not under study (Yin, 2003). The extrinsic factors that may also have influenced both the management of changing maternity services and the practice of the midwives in the clinical area are common to both cases and have been explored within the literature.

5.6.1. Key Informants

During the planning stages, the contact person at each site was initially the Director of Nursing. Following Human Research Ethics Committee approval, I was provided with contact details of a suitable key informant. These key informants had been chosen by the Directors of Nursing at each site as the most appropriate person to assist in the organisation of the study at the clinical level. Both of these key informants had been fully involved in the change process, although not necessarily in the same role as when the study was conducted and therefore were viewed by me as appropriate as key informants. I had no involvement in recruiting these informants. Both were fully informed about the study and signed consent forms indicating they were willing to participate. These key informants provided legitimate access for me to areas within each site where the interviews and focus groups were to be conducted. They assisted in booking rooms and provided access to

meetings for me to explain the research to the midwives. They provided details of the organisation and changes that had occurred within the study period. Finally, they were available to consult with to verify my interpretation of the data. Contact with the key informants was maintained throughout the study using email, telephone calls and site visits.

The key informants, as with other participants were provided with a survey as well as being interviewed. The data collection methods are explained in the next section.

5.7. Data Collection Tools

The case study approach enables the use of a variety of methods to collect data and its strengths and weaknesses reflect those of the data collection methods utilised (Gillham, 2000). The use of interviews, focus groups and a survey were the main methods of data collection used for this study. A survey was chosen as the means to collect data related to the role of the midwives. The interviews and focus groups were planned as the means to establish what had occurred for midwives at each site. State policies and the literature related to changes in maternity services both globally and locally were reviewed to establish the external context for the cases under study. These multiple methods of data collection provided opportunities for triangulation, strengthening the trustworthiness of the data.

5.7.1. Survey

A self-report survey was chosen as it provided the means to collect data from a larger population than was feasible with interviews. Other advantages of this choice included the total anonymity and the removal of the possibility of bias that can be introduced by researchers in face to face interviews (Polit & Beck, 2006). The use of structured fixed response questions enables the data to be more easily analysed using statistical computer programs. Open ended questions are useful for a wider range of responses but is more time consuming for both the respondent to complete and the researcher to analyse (Beanland et al., 1999).

The disadvantages of surveys include the possibility of respondents misinterpreting the questions and the superficiality of the answers to the structured questions. A potential weakness is the reliance on the participants to return the survey, with the risk of a poor return rate limiting the validity of the data (Beanland et al., 1999; Polit & Beck, 2006). Strategies were put into place in an attempt to optimise the return rate. These included making the survey as easy to complete as possible through the use of structured likert type questions and only a small number of open ended questions. It was estimated that participants would be able to complete it within 20 minutes. Presentations were made to groups of midwives explaining the research before the surveys were distributed in anticipation that they would be more likely to participate if they had an understanding of the aims of the study. It was not possible to send out individual reminders to non-respondents as the surveys were anonymous, however, notices reminding midwives to return their survey were placed around the staff rooms.

All midwives working within the maternity unit of each case were eligible to complete the survey. To maintain confidentiality I was not privy to staff lists to send out personal invitations to complete the survey which may have improved the return rate. As the surveys were to be attached to either the midwives' time sheets or their pay slips it would be difficult to exclude anyone. Therefore, the decision was made to include all the midwives regardless of experience at the site. It was also felt by me that those midwives who had only recently qualified had spent at least one year as students within the clinical field (not necessarily in the same place) and therefore would be able to contribute in some way to the study. Valuing the opinion of all midwives was a fundamental concern of the research and therefore a cross-section of all midwives was needed to provide a true picture.

5.7.2. Survey Tool

The survey used (see Appendix H) was adapted with permission from one used by Watson et al. (1999) to survey midwives in Victoria in 1996. Changes were made to the original survey in order to: remove questions that were not relevant; ensure anonymity; or provide more options. Watson's (1999) study had sought to identify midwives' understanding of *The Victorian Birthing Services Review* (Health Department Victoria, 1990) and other

regulatory changes that were about to occur in Victoria. Therefore questions related to those topics were removed. They were replaced with questions focused on woman-centred care and changing practice, topics relevant to the changes occurring in maternity services in Victoria at the time of this study. Given the choice of case study approach and the limited population to be surveyed, some demographic details pertaining to grade[16] were removed as they may have enabled identification of the respondent. Finally, the format of some questions was altered from being a forced choice response to a 5-point Likert scale.

The survey was then shown to a peer group of educators for readability. Finally it was tested with a small group of midwives (10) in the clinical area where I was employed at the time. Following this some of the wording was altered to clarify one item. It was also returned to Watson (who is a statistician) for comments, she felt that one question was too long and so this was shortened by removing two of the items. Participants were provided statements and asked to what extent they agreed or disagreed, with a mix of positive and negatively worded statements to reduce the likelihood of response bias (Polit & Beck, 2006). The final survey was designed to collect information on the following: demographic details (including age, number of children, country of birth, gender), midwifery qualifications, employment details, current issues, level of satisfaction and related factors, knowledge of woman-centred and continuity of care.

I distributed the surveys at each site. To differentiate between sites, they were printed on different colour paper, pale yellow for Case A and gold for Case B. The surveys were placed into an envelope with an explanatory statement and a form for expressions of interest (see Appendix G) to participate in either a focus group or an individual interview, on pink paper for Case A and yellow paper for Case B. Distribution at each site was slightly different and is explained in the next section.

[16] In Victoria grades represent the employment role of the midwife. For example Maternity Unit managers are designated as Grade 4 or 5. The majority of midwives are designated as Grade 2.

5.7.3. Distribution of Surveys

At Case A, 150 surveys were attached to the time sheets of all the midwives in each area. This included several casual staff who, whilst having time sheets in the folder, may only work occasionally. It is acknowledged that these surveys may not have reached the midwife concerned as the time sheets are discarded at the end of the fortnight if not completed. As midwives from the teams rotated into the Special Care Nursery (SCN) it was decided to distribute the surveys in that area as well. As it was difficult to discern between the permanent staff, some of whom were nurses and not midwives, surveys may have been distributed to staff for whom the study was not relevant. During planning discussions with the key informant at Case A, it was suggested that leaving a box for return of the surveys and expression of interest for interview forms would be a better means of collecting the surveys, than including a reply paid envelope. The inference being that if the midwives saw the box they would complete their surveys immediately and put it into the box rather than take them home and forget. Therefore, three bright red sealed boxes, clearly identified with the name of the study, were placed in the staff tea rooms. I emptied the boxes twice weekly when I was on site to organise and conduct interviews. The pink single sheet expression of interest forms were not attached to the surveys so that the surveys remained anonymous. After one month, in an attempt to improve the return rate, further copies of the survey were placed in each area. At this time, a notice was put up in each staff room thanking those who had participated and reminding others who wanted to have their say to complete a survey and or participate in a focus group or interview.

At Case B site, 95 surveys were attached to the midwives' pay slips at the time that they were delivered to the unit. As agreed with the ethics committee of that site, a reply paid envelope was provided for their return to me. As it was not possible to access the pay slips of casually employed midwives, 10 extra copies were left in each staff room (total 20), with a notice asking the casual staff to take one. Of these, only four were taken. It is unknown how many casual staff members were regularly employed in the area.

The forms inviting an expression of interest to participate in interview or focus group forms contained contact details and therefore were collected separately to the surveys in order to

maintain anonymity. A clearly identified red sealed box was left in the tea rooms for their return.

5.7.4. Focus Groups

A focus group is a '*technique that collects data through group interaction on a topic determined by the researcher*' (Morgan, 1997, p.6). Focus groups have been described as group interviews that explore participants' beliefs and experiences through the use of moderated discussion (Kevern & Webb, 2001). Focus groups are widely used in market research and since the 1980s have become a more frequently used tool within social science research. Not only have they been used as a single method of collecting data but they can also be part a study that uses other data collection tools, qualitative or quantitative (Stewart, Shamdasani, & Rook, 2007). Many different types of phenomena have been explored using focus groups including sensitive subjects where people are seen to talk more freely when with their peers. Focus groups have been useful in critical social research as a means of 'redressing the balance of power' (Kevern & Webb, 2001). In participatory action research they can be a tool to raise critical awareness for supporting change (Barbour, 1999) as used by Hughes et al. (2002) to promote change in a maternity unit undergoing change. The purpose of the focus groups in my study was not to promote change but to explore what had occurred for midwives. It is acknowledged however, that the process of involving midwives in discussion might conceivably '*initiate changes in participants' thinking*' (Barbour, 1999, p.118).

Focus groups are seen as a time efficient and cost effective way of collecting data from several participants in one session (Patton, 2002; Stewart et al., 2007). Although it may be difficult to organise to get sufficient people together at the one time (Morgan, 1997). Between eight and twelve participants are recommended as the most suitable size groups to be both productive and manageable (Kitzinger & Barbour, 1999; Stewart et al., 2007), although smaller and larger groups can be successful (Morgan, 1997). The ideal size of focus groups emerged from the literature on market research but smaller groups of three to six have been found to be more suitable for sociological studies (Kitzinger & Barbour, 1999). The number of groups run is flexible depending on the research question,

population available, time and resources (Morgan, 1997). While homogeneity of group members has traditionally been recommended there can at times be advantages to some diversity (Kitzinger & Barbour, 1999; Morgan, 1997; Stewart et al., 2007), for example an older person can provide a different perspective and stimulate discussion amongst a group of younger participants (Kitzinger & Barbour, 1999). Focus group sessions may be formal or informal and range from being very structured to semi-structured, depending on the topic under study, the facilitator and the participant response (Morgan, 1997).

Convenience sampling was used to recruit to the focus groups in this study. The populations for each case were limited in numbers and I was dependant upon midwives volunteering for the study. The participants were expected to be homogenous to some extent in that they were midwives who had participated in organisational change, with the main differences potentially age, type and length of experience. However, one limitation of convenience sampling is that those who participate might not be representative of the cases (Polit & Beck, 2006) and thus reduce credibility (Patton, 2002). During the sessions to explain the study to the midwives I made it clear that all points of view were welcome.

Managers and perceived leaders of change were excluded from the focus groups but invited to participate in individual interviews, as I wished the participants of the focus groups to talk openly about their experiences. An alternative option of an individual interview was also offered as some potential participants may feel inhibited if others in the group have a different point of view (Patton, 2002). The ability to provide potential participants with a choice can however, be a pragmatic way to improve recruitment (Barbour & Schostak, 2004). It was planned to hold three or four focus groups, with the potential to hold more if new information was continuing to emerge, that is if data 'saturation' had not been reached (Polit & Beck, 2006). Small samples are not considered a major problem in qualitative inquiry as generalisation to a wider population is not intended (Patton, 2002).

An advantage of using focus groups for this study was that I was able to interact with more midwives in a shorter period of time than possible using individual interviews. Changes in maternity services and midwifery practice not only affect midwives as individuals but can

also impact onto the whole working 'team'. Focus groups provide the researcher the opportunity to observe group dynamics and additional non-verbal indications of support or disapproval of a point raised (Stewart et al., 2007). They can also be synergistic in that one participant can stimulate memories that might be missed in individual interviews (Stewart et al., 2007). Reed and Roskell (1997) caution about insufficient time and planning for analysis of the interactive part of the discussion. They argue that researchers frequently lack the ability to demonstrate the richness of the interactions in the reporting of findings (Reed & Roskell, 1997). An attempt was made during the reporting of this study to include expressions that it is anticipated provide a fuller picture for the reader. An example of this might be including aspects from notes such as nodding of heads in agreement, or of other interaction occurring within the group. It is anticipated that the addition of these expressions will provide a more complete picture for the reader of the findings than by extracts from the transcription alone. Patton (2002) highlights the risk of misinterpreting non-verbal expressions within different cultural groups. However, the participants and I were from similar cultural organisations and ethnic origins and thus misinterpretation of non-verbal signs less likely to occur. Where participants are familiar to each other there may be existing power dynamics that are unknown to the researcher that can limit the data collected (Stewart et al., 2007). The risk of only having one facilitator was the possibility of missing subtle communication between participants (Morgan, 1997).

Disadvantages of focus groups include the potential domination of one person, fewer topics might be covered than individual interviews and the possibility of 'group' think (Morgan, 1997). Group think is where there is a tendency towards consensus (Bernthal & Insko, 1993). I was experienced in facilitating groups and therefore was aware of potential difficulties. The completion of a group counselling course together with my previous experience enabled me to develop strategies to manage the groups in a way that enabled everyone the opportunity to contribute in a non-threatening environment. I recognised the need to be reflexive, to recognise potential power discrepancies within the group and the importance of raising the issue with all participants of the need for maintaining confidentiality (Barbour & Schostak, 2004; Stewart et al., 2007). The advantages and disadvantages of the different methods of data collection are summarised in Table 13.

Data collection method	Self-administered survey	Focus Groups – semi-structured	Individual Interview – semi –structured
Advantages	- flexible administration - less expensive than interviews - no interviewer bias - large sample can be accessed to improve generalisability	- cost effective - interactive discussion enhances quality of data - focused on specific topic	- enables clarification of response - systematic data collection
Disadvantages	- tends to be superficial - risk of low response rate - risk of respondent misinterpretation of question - misinterpretation of response - limited response options	- fewer topics covered than individual interview - inhibition to speak by those with opposing viewpoint - risk of 'group think' - risk of facilitator bias - risk of domination by group members - inability to generalise	- time consuming - risk of facilitator bias reducing comparability of responses - important topics may be missed due to set guide
References	(Polit & Beck, 2006; Schneider, Elliott, Beanland, LoBiondo-Wood, & Haber, 2003)	(Axinn & Pearce, 2006; Morgan, 1997; Patton, 2002; Stewart et al., 2007)	(Axinn & Pearce, 2006; Patton, 2002)

Table 13: Advantages and disadvantages of methods of data collection used for the study

5.8. Recruitment Process for Focus Group or Individual Interview

As previously noted, a separate form for expression of interest to participate in a focus group or an individual interview was distributed with the survey. For Case A, a selection of times were provided on this form for when I would be on-site as it had seemed to be more pragmatic to book a room prior to sending out the survey. In reality, due to a poor response, a second option of using pre-existing education times was found to be the most pragmatic means to recruit participants (Barbour & Schostak, 2004).

For Case B, times were not provided in anticipation of improving the response by negotiating times after expressions of interest had been received. As with Case A the most useful strategy was found to be the use of pre-existing education times during double staffing in the early afternoon or prior to the commencement of the night shift.

Initially the focus groups at Case A were timed to enable midwives to participate either before or after a shift. Flyers advertising the project and the times of the focus groups were placed on notice boards in the staff rooms. The midwives were initially offered the choice of four dates and times for the focus group. Due to the minimal response to these times it was suggested by the key informant that the focus groups could be held during allocated education sessions when there was staffing overlap. Although these education sessions were advertised as the research project some of the midwives who attended were unaware prior to their arrival at the room, just turning up because it was education time. Therefore, the midwives who came to the sessions were informed that if they did not wish to participate then they could leave. All the midwives attending the session stayed. Written consent was obtained at this time.

At Case B recruitment and interviewing occurred the month following Case A and the process at Case B was adjusted with focus groups only offered during education time and individual interviews arranged at times to suit participants. Although holding focus groups during education time reduced time available for education, the management considered the project sufficiently important to allow it to proceed at this time. There were difficulties in recruiting at both sites, despite the good reception the project received when it was initially introduced.

5.8.1. Difficulties in Recruiting

Difficulties in recruiting occurred at both cases. Two reasons are offered for this poor response. One suggestion is that midwives were too busy to leave the ward, although as the majority of focus groups were held during allocated education time midwives should still have been able to attend the session. A second suggestion is that midwives were uninterested, although at the information sessions given prior to the commencement of the

study appearing the midwives had appeared interested and eager to assist. A further reason for the midwives at Case A was 'research overload' as another researcher had been interviewing the midwives only a few weeks prior to the commencement of this project. Following a planned focus group where no-one turned up at Case A, no further sessions were organised. At Case B the sessions during education time were limited by previously planned education sessions.

5.8.2. Focus Group Facilitation

The focus groups at both sites were held during the one hour staff education sessions during double staff time in the afternoon or evening. It is generally suggested that two hours are required for running focus groups (Morgan, 1997), but as part of the time is spent introducing participants, and all these participants knew each other, the groups were reduced to one hour. With these time constraints there was a risk of restricting discussion. This did not happen and all of the topics were covered as planned possibly because all the groups were small (three-five participants). Reducing the length of the focus groups also made it much easier to meet the permanent night staff. Midwives on permanent night duty are frequently overlooked and often find it difficult to attend meetings during the daytime or even early evening because of family commitments.

The format of each focus group was the same. I welcomed and thanked the participants for attending, explained the research, handed out a written explanatory statement and obtained written consent. I briefly described my personal interest and background as a midwife and reiterated my intent to maintain a neutral stance so that I was seen as being open to all views. Focus group rules were discussed including allowing each person to speak and the importance of maintaining the confidentiality of all those participating. It was made clear that management would not be privy to any information other than what would be publicly available. It was clarified that any participant who felt uncomfortable revealing a personal issue within the group could contact me privately to discuss the issue. I made a commitment to feedback the initial findings to the midwives so that they would have the opportunity to comment on the validity of the interpretation. It was also made clear that no names would be used in any documents. Finally, each participant was asked to complete a

short survey of demographic data to enable comparison with the general population of midwives who had completed the primary survey.

The group discussion was guided with questions, developed from the literature pertaining to midwives' experience in midwife-led models of care. The prepared questions were used to keep the discussion on track. Although it is useful in focus groups to have an additional note taker (Morgan, 1997) the small groups enabled me to manage without assistance. All sessions were audio-taped and before each session the recorder was checked to ensure that it was in working order. I took notes as the discussion progressed clarifying as necessary. Individual interviews were arranged with those midwives who preferred this option and were held on site at a time agreed to by the participants. The interviews were audio-recorded and notes taken at the time and immediately after.

5.8.3. Interviews with Leaders/Managers

Individual interviews with the managers and leaders who drove the change process were an important aspect of the research to provide a view from both sides of the process. Managers and leaders who were involved with the changing model of care were identified by the key informant for each case. In addition, there was a question on the survey asking the midwives to nominate who they saw as leaders of change. These names were then compared with the names provided by the key informants.

Using the names supplied by the key informants I approached those who were still employed, explained the study and invited them to participate in an interview. These were held on-site either in an education room or in an office as agreed to by the participant. One identified leader, who was no longer employed at Case A, was interviewed at her place of employment. This former leader was informed about the research by one of the midwives, she then contacted me to indicate that she was willing to participate in an interview. While I was unable to directly contact midwives who had left the organisation, it was explained to the midwives that anyone who had left and wished to present their views could contact me. No other midwives or leaders, who had left, came forward to participate in this study.

As I knew some of the participants professionally I had to take extra care during the interviews to keep focused. A list of questions was prepared as a guide to assist in maintaining focus. The interviews were audio recorded and a few notes were taken at the time though it was important to listen to what the participant was saying so that ambiguities could be clarified. Where it was not appropriate to interrupt the flow to ask a clarifying question, a note was made and returned to at a suitable moment.

5.9. Analysis of the Data

The data were in multiple forms, both text and numerical. The numerical data from the surveys was analysed using the statistical computer program SPSS. The majority of data was text, consisting of field notes, transcripts of interviews, answers to open-ended survey questions and documents from the public domain. This qualitative data was analysed in two ways, firstly purely to provide a descriptive picture of events and settings and secondly, inductively, to identify emerging patterns that would provide some indication of the effect of changes to organisational change had on individual midwives.

The factors that affect midwives were complex. Although each case could be perceived as a whole unit, there were also perspectives from elements of the whole that were perceived as layered cases (Patton, 2002) (see Table 14) providing multiple units of analysis (Krippendorf, 2004).

Whole unit	**Case A**	**Case B**
Sub-unit	Organisational change	Organisational change
Sub-unit	Midwives	Midwives

Table 14: Layered cases

Each site was analysed and reported separately following the framework of the Content, Context and Process Model (Iles & Sutherland, 2001). The use of a framework that encompassed the context, both local and global, the process of change and the content of

changes for midwives was utilised to ensure identical processes were completed for each case study and to provide a basis on which to describe the findings. Throughout this process, data from the survey were cross referenced with the data from interviews and focus groups to improve the overall reliability of the findings.

5.9.1. Content, Context and Process Model

The Content, Context and Process Model is a framework developed for planning and analysing changes in the workplace (Iles & Sutherland, 2001; Pettigrew & Whipp, 1991). The model has three essential dimensions content, context and process (Pettigrew & Whipp, 1991). That is the 'what', 'context' and 'how' of change encompassed by historical, cultural, economic and political factors. Looking at how these concepts interact provides some understanding of the complexity, interdependence and fragmentation in the workplace that either support or repel change (Iles & Sutherland, 2001). Each dimension incorporates the interrelated factors important in shaping performance of a company. These include environmental assessment, human resources as assets and liabilities, linking strategic and operational change, leading change and overall coherence. Whilst this model was developed for the business world, it has successfully been tested within the National Health Service in the UK across a wide range of organisational restructuring (Pettigrew et al., 1992). Table 15 outlines the framework and the type of data collected.

Framework	Data Collected	Data Sources
Content	- Description of case sites pre change - Description of case sites post change	- Key informants - Interviews leaders - FGs/interviews midwives - Hospital websites - Site visit
Context	- Literature maternity models of care - Policy global and local - Local historical factors - Organisational support - Local environment factors	- Databases/internet/library - Government websites - Hospital websites - Community websites - Key informants
Process	- Leadership - Management strategies - Midwives involvement - Clarity of goals	- Key informants - Interviews leaders - FGs/interviews midwives

Table 15: Data collected for Content, Context and Process Model

Evaluation of some of the outcomes of maternity service change, such as improved services from the woman's perspective is not the focus of this portfolio but worthy of future attention.

5.9.2. Analysis of the Survey Data

Data from the survey were coded and entered into the Statistical Program for Social Science 11.5 (SPSS). The data entry was double checked for errors prior to analysis.

The quantitative data from the questionnaire was primarily analysed using descriptive statistics. Whilst within group statistical analysis was limited, some comparison of the findings between sites was possible. As most of the data obtained was nominal or ordinal and not normally distributed, non-parametric tests, such as the Mann-Whitney U test or the median test, were used.

Qualitative data were analysed identifying recurrent topics or themes. These themes were then compared with the themes that were identified from the interviews. This strategy

would not only provide confirmation of the interpretation of the interview data but also reveal conflicting stances or silence on issues that might be considered important from previous literature reviews.

Two questions required the participants to provide their own definition or understanding of the terms continuity of care and women centred care. Data from these questions were compared to definitions of the terms (see Chapter Three).

5.9.3. Analysis of Interviews and Focus Groups

I fully transcribed the tape recordings of the individual interviews verbatim. Initially I only partially transcribed the focus group tapes adding to the transcripts as analysis through repeat listening to the tapes continued. Transcriptions were reviewed for recurring ideas that might indicate an emerging theme. Repeated listening to tapes enabled me to get a feel for meaning from cues, such as the intonation of the voice, and to identify group interactions that are lost when only working from direct transcriptions (Bryman & Burgess, 1994). Field notes made during and immediately after the focus groups and interviews provided additional substance to the data.

Written notes were used to confirm the transcriptions and assisted in clarifying meaning where a note was made at the time related to the context. My interpretation of the data through content analysis was strengthened by the combination of factors (Stewart et al., 2007). These included what I heard such as the cues from inflections of speech for example ‘sarcasm’ or ‘anger’, together with field notes that identified participant agreement or disagreement through ‘nodding’ or ‘shaking head’ together with the transcripts.

Transcribed data were organised initially according to the questions asked in the interviews, and then recurring ideas were identified and coded into themes. The steps of inductive analysis as described by Lincoln and Guba (1985) were used. Analysis for this study began in the field with identification of possible themes noted in the field notes. With the use of a semi-directed approach to the interviews it was inevitable that some of the themes identified reflected, to some extent, the questions asked. A computer program, NVIVO7,

specifically for qualitative data was used to assist in this process. This program enabled the development of a database and the ability to move the data around as different themes and sub-themes were identified. The program enabled notations to be made as memos as part of the process of establishing an audit trail. The computer program enabled multiple coding of the same unit of data if it fitted into several categories and recoding at a later stage when some categories were subsumed into one main theme with several sub-themes.

The feedback session with the staff was not taped. Field notes recorded at the time and immediately after the session were reviewed for differences of opinion or agreement with the findings presented. This is particularly important to acknowledge in the findings multiple perspectives of the phenomenon (Patton, 2002). The data from these sessions, one at each case site, provides credibility to the findings. In my role as interviewer, analyst and interpreter, I could be viewed in qualitative research as the research instrument (Patton, 2002). Reliability of coding and interpretation of the data was aided by my familiarity of midwifery language within the Victorian context, (Stewart et al., 2007). At the same time throughout the process of collecting data, analysing and interpreting the data it was important for me to be reflexive and note my own biases to prevent them impacting on the findings.

5.10. Researcher as Instrument

Recognition of personal experience and drawing on that experience in relating to participants is a legitimate source of knowledge and is known as reflexivity (Etherington, 2004; Patton, 2002). Reflexivity is recognised to have occurred where the researcher acknowledges oneself as part of the research process (Finlay, 2002; Koch & Harrington, 1998) and has been defined as '…*thoughtful, conscious awareness*' (Finlay, 2002, p.532). It can be seen as an important part of the way the study is conducted and data interpreted. By declaring ones interests and experience, the study participants can feel empowered to talk more freely (Etherington, 2004). The acknowledgement in the written work of the process by which the researcher became part of the research process can then be seen to improve the rigour of qualitative research (Etherington, 2004; Koch & Harrington, 1998).

5.10.1. Positioning Myself as Researcher

As the researcher I have had experience both as a midwife and with change processes, therefore reflexivity was an important element of the way this study was conducted. *'Self-reflexivity involves a heightened awareness of the self in the process…'* (Grbich, 2007, p.28). It is therefore necessary to describe my previous experience so that the legitimacy of my knowledge and use of self is acknowledged that it assisted in the analysis and discussion that ensues. This I did in Chapter One where I outlined my life experiences to provide background for the development of my personal and professional values, beliefs and midwifery philosophy.

As an outsider in the sites used for the case studies, I could view the impact of changes with new eyes but with an appreciation, due to my previous experience in a unit undergoing change, of the many processes that had occurred. When introducing myself to participants I provided some background to enable them to gain a perspective of my relationship to midwifery in that I had current experience as a practising midwife. I believe that this recent experience as a midwife made me more acceptable to the midwives that participated in interviews than just being an academic researcher might have done.

As a midwife, I believe that changing from fragmented care to midwife-led care is beneficial for both women and midwives. However, I acknowledge that this can be very difficult for those midwives who have spent most of their career within one specific area of midwifery practice.

I made an effort throughout the interviews not to put forward my own perspectives. However, there were times during the data collection when I found myself agreeing with what the participant was saying, either because it matched my beliefs or I recognised what they were saying from my experience. Where I disagreed I kept silent on my views although I made an acknowledgement of what was said. It was those times of disagreement when I needed to rethink more fully my perspective in order to gain an understanding of theirs.

5.11. Limitations of study

As a qualitative study there was never any intention of the findings being generalisable to a wider population. However, as identified earlier in this chapter the provision of 'thick description' of each case enables others to recognise the potential application to their own site (Lincoln & Guba, 1985). The participation rate overall was small but the same information provided in the interviews and focus groups for each case was reiterated in separate interviews. While no new data appeared to be forthcoming, data saturation could not be assumed and is not fundamental to case-study work.

5.12. Summary

This chapter has outlined the method, process and analysis for this study. The literature relating to the external context has been presented throughout Section One and Two of this portfolio and provides background for both the changes occurring at the sites and the effect on midwives. The next chapter provides an in-depth description of the individual cases using the framework of the Context, Process and Content Model (Iles & Sutherland, 2001). Findings from the surveys, focus groups and interviews that describe the effect on the midwives are presented in the two ensuing chapters.

CHAPTER SIX

THE CASES

6. Introduction

This chapter provides the 'thick description'(Lincoln & Guba, 1985) of the context, content of change and the process that occurred at each case study site. The data that inform the findings were obtained from a variety of sources. These included an interview with a key informant, individual interviews with midwives and midwifery leaders/managers, focus groups, a survey, my observation and a review of web-based electronic documents available in the public domain. Some sources of information may not be fully referenced in order to protect the confidentiality and anonymity of either the informant or the case sites.

An overview and comparison of the two cases is provided in Table 15. Each case is then presented separately following the same format that presents the local context pre-change, the processes that occurred, followed by the changes that occurred.

	Case A	Case B
Local community	Multicultural - 28% originating from non-English speaking countries	Multicultural - 52% originating from non-English speaking countries
Hospital type	Public - level two[17]	Public - level two
Nearest tertiary referral centre	20 minutes drive	10 minutes drive
Special care nursery	Accredited to care for babies ≥34 weeks gestation	Accredited to care for babies ≥34 weeks gestation
Births per annum 2004	Approx. 3000	Approx. 2700
Antenatal Care	Public Clinic GP shared care Private obstetricians	GP shared Care Public funded obstetric care in community Private obstetricians
Midwives	Approx. 120 permanent full and part-time employees	Approx. 100 permanent full and part-time employees
Midwifery allocation pre-change	Midwives worked in separate wards birth or postnatal with a few in domiciliary or antenatal	Midwives worked in separate wards either birth or postnatal with a few also providing domiciliary care
Midwifery allocation post-change	4 'Teams' - cover antenatal / birth / postnatal /domiciliary	1 'continuity of care team' - 7 FTE - cover antenatal / birth / postnatal care Majority of midwives - rotate between birth / postnatal / domiciliary
Physical environment after change	- 4 integrated birth/postnatal wards - 3 community midwives antenatal clinics - midwifery / obstetric antenatal clinic on site / GP shared care	- separate birth /postnatal wards - 1 community midwifery antenatal clinic - majority antenatal care in private rooms - obstetric / GP shared care

Table 16: Case Study Sites

[17] Level 1 relates to low risk care only; Level 2 regional hospital; Level 3 tertiary referral hospital

CASE A

6.1. Local Context Case A

Case A was a maternity service located within a suburban public teaching hospital in Victoria. Hospital A had approximately 300 beds and there had been several building improvements and extension to services over the previous five years. A wide range of services were available, including child health, maternity, special care nursery, general emergency, women's health, aged care, palliative care, rehabilitation, general medicine, general surgery, day surgery, and mental health (Hospital A Website, 2005). Clinical practice experience was provided for medical, midwifery, nursing and allied health students from several universities at both undergraduate and postgraduate levels.

6.1.1. Community Characteristics Case A

The hospital serviced a municipality with a population of approximately 175,000 people. This community consisted of a wide range of cultural groups including Vietnamese, Greek, Italian, Chinese, Macedonian, Croatian, Serbian, Arabic and Spanish with increasing numbers from East Africa (Local Community A Website, 2006). At least 16% of patients at the hospital required interpreters. The health authority worked in partnership with local communities to identify specific needs related to the increasing population and their changing demographics. In 2004, a Koori[18] midwife was employed to help support the 0.36% of women in the community who identified themselves as being of Aboriginal or Torres Strait Islander background (Hospital A Website, 2005).

The majority of changes implemented at Case A occurred during 2001. Table 16 below outlines the timeline for the introduction, planning and implementation of changes at Case A. The physical and organisational environments will be described both before and after the changes.

[18] Koori is a term commonly used by Victorian and NSW Australian Indigenous peoples to describe themselves

1998	Maternity services enhancement strategy (MSES) announced (DHS, 1998)
1999	MSES funds distributed – project manager employed / lactation service initiated / birth centre operated for short period of time
2000	Planning commenced for team midwifery – working party formed
2001	Information sessions with staff
2001	March – inconclusive staff ballot April – July – renovations and wards merged July – implementation of new model of care
2002	Final implementation of midwife to woman ratios
2005	March – June data collection

Table 17: Timeline Case A

Case A – Pre-2001

6.2. Physical Environment

Prior to 2001, Case A maternity unit was divided into separate areas on different levels of the hospital building. The labour ward was on the lower level of the hospital and managed approximately 2500 births each year. For a brief period of time there had also been a small birth unit, next to the main labour ward, catering for women identified as low risk[19]. The birth unit was closed in favour of developing a midwifery team model of care across the whole unit (Interview Leader 4, Case A).

A breastfeeding clinic and an antenatal day stay clinic were also on this lower floor near to the 'Hospital in the Home' service. This service managed all home visits by nurses and midwives and was administered separately to maternity services. Only two or three midwives worked within that service providing postnatal home care for women discharged home within 24-72 hours after giving birth. The midwives employed for that service did not rotate onto the wards.

[19] See explanation of levels of risk in Chapter Three

After giving birth, women and babies were moved upstairs to a postnatal ward. On this upper floor there was also an outpatient clinic for women and the special care nursery (SCN). The SCN was accredited to provide care for babies from 34 weeks gestation who did not require ventilation or other intensive care services. Women in premature labour prior to the 34th week of pregnancy were transferred, if birth was not imminent, to a tertiary hospital with neonatal intensive care facilities. Babies born at the hospital who required neonatal intensive care services were transferred out to an appropriate tertiary hospital by the Neonatal Emergency Transport Service (NETS)[20].

6.3. Organisation of Maternity Care

The maternity care options available for women at Case A prior to 2001 were; a public antenatal clinic, primarily for those considered high risk; shared care with general practitioners (GPs) in the community for those considered low risk; or private care with obstetricians[21]. Women defined as high risk were required to be under the care of obstetricians. Women's choice of maternity provider might be restricted by hospital policy in relation to the perception of their risk level. Women who were not considered high risk were by default low risk. Women receiving shared care with their GP attended hospital for an obstetric review three or four times during their pregnancy as per hospital policy. There were, however, many women who were considered low risk receiving their antenatal care from obstetricians in either the public clinic or privately.

Prior to 2001 a study in Victoria identified that at 20 weeks, in the health area where Case A was based, the majority of women (29%) were provided with maternity care as standard hospital care (Halliday et al., 1999). Private obstetric care (23%) was the second preferred option with shared GP care (18%) the third most preferred option. Only 2% of women in this area were seen antenatally by a public hospital midwife at 20 weeks and this percentage dropped if women required obstetric care as the pregnancy progressed (Halliday et al., 1999).

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[20] NETS is a medical retrieval service for sick neonates in Victoria.
[21] Antenatal care is funded by medicare. GPs and private obstetricians may charge over the medicare rebate.

The public antenatal clinics were staffed by midwives who primarily assisted the doctors with clinical examinations. They also provided antenatal care to a small number of women. These midwives did not routinely rotate into the maternity wards (Interview Leader 1, Case A). Each ward or clinic had its own unit manager and staff. Few midwives rotated between areas, the exception being those on a new graduate program who, at the end of the program were allocated to one ward (Interview Leader 1, Case A). The lack of rotations and the overall fragmentation of the maternity services highlighted the lack of continuity of care for women at Case A.

6.4. The Availability of Continuity of Carer for Women

Women in GP shared care programs and those with a private obstetrician received continuity of care with the same medical professional during the antenatal period and for the postnatal follow up visit six weeks after birth. Private[22] obstetricians were also present at the birth and visited women daily during their hospital stay. In contrast, women attending the public antenatal clinic were unlikely to get continuity of carer as they would see the medical officer rostered for that day, who they may or may not have met before. During their hospital stay women were cared for by the rostered clinicians, whom they may or may not have met previously. While women might have the same midwife caring for them as the previous day, more commonly they saw many midwives.

Prior to 2001, midwifery care at Case A was fragmented with very few midwives rotating between areas. Midwifery continuity of carer was only available for a very small number of women in the antenatal period and did not occur for intrapartum or postpartum care. Establishing an ongoing professional relationship has been identified as integral to the role of the midwife (ANMC, 2006) and recognised as an important factor of satisfaction with the role (Ball et al., 2002; Kirkham et al., 2006). At Case A, the midwives and women had little opportunity of establishing such meaningful relationships. Practice was guided by doctors' preferences (Interview Leader 1, Case A). Continuity of care is deemed to consist

[22] Women opting for private maternity care in public hospitals usually have private insurance but may still have additional expenses where the obstetrician, paediatrician or anaesthetist charge more than the insurance company rebate.

of more than just a relationship, although that might be the most important aspect, and includes the need to have consistent and coherent management across a whole episode of care (Guthrie et al., 2008). It is unlikely that many women at Case A could be described as receiving continuity of care.

6.5. Administrative Management

Case A was situated in Hospital A which was financially maintained and administered by the health authority X Health (see Appendix I for diagram of management). The clinical areas of Hospital A were divided, for management purposes, into groups of clinical services according to their specialties. Maternity care was part of the Women's and Children's Services with clinical management occurring in conjunction with a large tertiary maternity hospital situated with a different health authority, Y Health.

6.6. Educational Support for Midwives

Opportunities were available for midwives from Case A to attend education sessions run by Y Health. In addition, the budget provided was sufficient to assist midwives to complete external educational courses. Several midwives became lactation consultants and many completed a pre-discharge baby assessment course with assistance from this educational budget (Interview Leader 1, Case A). Two midwives were employed in the education department at Hospital A. One was the staff development facilitator whose full-time position included research, quality and education portfolios. The other midwife worked part-time and was responsible for the management and clinical support of the graduate midwife program. She also coordinated the midwifery student clinical placements. The universities with whom midwifery students were enrolled provided different levels of support for their respective students. They either paid the hospital for midwife preceptors or provided a clinical educator (Interview Leader 2, Case A).

The 1998 Victorian maternity services policy (DHS, 1999) promoted improved maternity care for women and funding was available for the development of new services. Case A received funding from this source for the appointment of a 'models of care' project officer,

the development of a breastfeeding clinic and the establishment of a birth centre. This occurred at a time of increasing financial constraint and the necessity to implement organisational changes.

6.7. Processes Followed to Implement Changes at Case A

This section identifies the catalyst for the organisational changes and describes the processes followed to implement the 'vision' of improved maternity services that was held by the maternity leaders.

6.7.1. Catalyst for Change at Case A

The catalyst that initiated the rapid development of midwifery-led maternity services at Case A was fundamentally an economic one. The model developed was underpinned by current professional opinion, evidence that midwifery care improved outcomes for women, and consumer demand for improved services (DHS, 2002c). Fiscal constraints meant that the management of X Health needed to reduce costs and improve bed occupancy across the whole hospital. The provision of more beds would potentially assist with reducing the length of stay of patients in the emergency department and enable more elective surgical procedures to be completed. The rationalisation of these beds would enable either additional funding for services provided or a reduction in fines for not meeting the standards of care set by the Victorian government (DHS, 2002b)[23].

As explained earlier, prior to 2001 maternity care at Hospital A was managed by Y Health, but the beds and physical space were administered by X Health. The advantages for maternity care to be managed by an external area health service were the links and support for the midwives and doctors from the tertiary obstetric unit. The disadvantage was balancing the management of services overseen by two masters. X Health relied on appropriate management of beds in order to gain funding from the Victorian state

[23] Management of funding for hospital services in Victoria include the use of Key Performance Indicators (KPI), that if met can lead to payments of bonuses. Conversely, performance below a set level of the KPI can lead to a reduction in budget payment.

government. Although at Hospital A, Women's and Children's Services were clinically managed by Y Health, bed occupancy rates were included in the hospital statistics for X Health. Pressure from X Health management was put on the managers of the maternity wards to allocate beds to medical or surgical patients rather than keeping them empty for maternity care. Bed reallocation could be achieved by either incorporating medical and surgical patients into the existing wards or closing some of the maternity beds and developing a separate general ward. In light of these issues, the directors for nursing, midwifery and obstetrics of the Women's and Children's Services collaborated to redevelop the provision of maternity services (Interview Leader 1, Case A).

6.7.2. Vision for Maternity Services

The vision to develop a midwifery model of care that would improve maternity services was the idea of the Director of Women's Services (Interview Leader 1, Case A). She had discussed her vision with the midwifery managers and educators who fully supported the idea of a midwifery-led model of care. They also had the full support of the Director of Obstetrics. The Director of Women's Services presented the vision of a midwifery-led model of care to the staff in mid-2000. According to one leader, there would be benefits for everyone. The midwives would have the opportunity to regain skills to enable them to practice according to the full scope of the midwifery role. Midwives would provide antenatal care for low risk women, many of whom had previously been seen by obstetric medical officers. Therefore, there would be a reduction in workload for the medical officers, which should enable them to provide better services for the women who needed obstetric care. Women would have more opportunities to receive continuity of care from midwives, and thus there was a potential for improved outcomes for them (Interview Leader 5, Case A).

It was proposed that the labour rooms be integrated into the postnatal area. An integrated unit would reduce the number of beds for the maternity unit with associated economic savings. The bed space in the old labour ward was to be utilised by the hospital as a gynaecology unit, freeing up surgical beds elsewhere. A working party was established to

develop the vision and work with the staff throughout the period of change (Interview Leader 1, Case A).

6.7.3. Working Party

The working party was led by the Model of Care Project Officer, whose position was funded through the Maternity Services Program. All clinical areas related to Woman's and Children's Services were represented on the working party. They included the Nurse/Midwife Team leaders, Nursing Staff Development Facilitator, Maternal Outreach Support Service Coordinator, Divisional Directors of Nursing, Obstetrics and Gynaecology and Child Health, and midwife and nurse representatives from each ward (Hospital A Website, 2005). The Victorian Branch of the Australian College of Midwives (ACM), the midwifery professional body and the Australian Nurses Federation (ANF), the nursing industrial body were also represented (Interview Leader 5, Case A).

A team midwifery-led model of care based within an integrated unit was presented to the midwives as the preferred model. Alternative models had been discussed and a rotation model with the implementation of midwifery-led antenatal clinics, leaving the physical environment unchanged and rotating staff through all the areas was apparently preferred by many of the staff (Interview Leader 3, Case A). A rotation model however, would not have facilitated improved bed management. A caseload model[24] was also discussed but would only be attractive for a small group of midwives. A caseload model would also only improve the options of continuity of midwifery care for a limited number of women. A midwifery caseload model was clearly identified as a model that would be implemented at a later date. The widespread knowledge that Case A planned to develop a model of caseload practice had attracted midwives to work in the unit. By the time of the research however, several midwives, who were frustrated with the lack of progress in establishing a caseload model, had resigned (Interview Leader 4, Case A).

[24] Midwifery Caseload models provide continuity of carer for women whereby the same midwife cares for a woman across her whole pregnancy, birth and postnatal experience.

An alternative option considered was to implement only one team of midwives but as the vision was to provide changes for all women this was not accepted by the working party (Interview Leader 4, Case A). During the planning stage all midwives were invited to attend forums convened to explain the model options and to hear the views of the midwives.

6.7.4. Communication and Consultation

One of the roles of the working party was to communicate and consult with the midwives employed in the unit. Communication and interaction were seen as the means to motivate the midwives to take ownership of the proposed changes (Interview Leader 1, Case A). Forums were held during periods of double staffing to encourage discussion and enable all midwives to be part of the consultative process of change. Other staff members do not appear to have been fully involved in the decision making process of the re-organisation. The Director of Medical Services was a member of the working party but opportunities for the other medical officers to be fully informed appeared to be lacking. Whether this was due to lack of opportunity or lack of interest is not known. Other members of staff, such as the patient service attendants, cleaning staff and ward clerks were apparently told that '*as the changes related to nursing re-organisation it did not affect them*' (Interview Midwife A, Focus Group 1, Case A). The outreach community co-ordinator was included in the working party but there was no community consultation.

The staff development facilitator used the forums to provide education about woman-centred care, continuity of care and midwifery models of care focusing on the International Definition of a Midwife (Interview Leader 6, Case A). The forums were described by several of the participants, in both the focus groups and individual interviews, as being information sessions rather than discussions about options. There was a perception by several of the participants that the midwives' views were ignored. As one explained '*…you know they said they'd talk to us about it and we'd have our input but really there was no staff input. They made all the right noises that you have to make but management didn't really want to hear what we had to say*' (Interview Midwife 4, Case A).

Despite the intention of the working party to communicate with the midwives, the reality was the forums became outlets for many to vent their frustration and disapproval over the proposed changes. The leaders who initiated and were driving the change, were invisible and often not at the forums to respond to questions (Interview Leader 6, Case A). It appeared that communication between the midwives and the working party was inadequate. The leaders spoke about the 'vision' and encouraging the midwives to be involved so that change occurred from the bottom up, as per strategies identified in the change literature (Baulcomb, 2003; Curtis & White, 2002). None of the midwives interviewed mentioned the term vision. I surmise that the communication strategies did not achieve their objective because even the midwives who supported the changes did not identify them as a vision. The passion the leaders inferred to me failed to inflame the midwives.

6.7.5. Ballot for Model of Maternity Care

Consultation with the Australian Nursing Federation (ANF) was an important part of the process and essential for all midwifery workplace agreements in Victoria (personal experience). The management needed the support of the ANF to implement new staff structures and the midwives perceived they needed the ANF to protect their rights as workers.

The ANF organised a ballot for the midwives to vote on the acceptance of the proposed model of care. The participants explained that they were provided with ballot papers to be placed in a locked box provided by the ANF. However, they were all unclear as to the exact options on the ballot form. The ballot papers were then counted by ANF officials. The key informant and several of the research participants indicated that the result of the vote was inconclusive but that changes went ahead regardless. Within three months, the postnatal wards had been renovated, the labour wards relocated and the new model implemented (Interview Leader 3, Case A).

Ultimately the change was seen as being enforced. Pressure from X Health management meant that changes were made regardless of the support of the midwifery staff. The

Australian Industrial Relations Commission Arbitration Tribunal[25] was asked to review the implementation of the changes and found that due process had been followed (Interview Leader 5, Case A). The vision held by a small group produced the momentum to change, apparently without the acceptance of the majority.

6.8. Case A 2001 to 2005

This section reports the changes that occurred to the organisation of maternity care at Case A including a description of the physical environment, the model of care and management changes.

6.8.1. Physical Environment

Renovations commenced in early 2001. During the renovation, each ward was closed in rotation. During this time, extra beds were available, if necessary, for postnatal women in the nearby paediatric ward. Financial constraints existed that may have contributed to the haste in which the changes to the physical environment were approved and implemented. The funds were required to be spent prior to the end of the financial year or the budget for the following year would be adversely affected. The new model of care was implemented on 1st July 2001.

The renovation to the old postnatal wards included converting twelve of the postnatal rooms into birthing rooms and organising the existing space to provide work stations and offices for four teams. Initially, the plan was to divide all the staff into five teams but the extra costs for staffing requirements, such as employment of an additional midwifery unit manager, reduced the final plan to four teams (Interview Leader 1, Case A). Each team was allocated their own physical space (see Figure 4), each with three birthing rooms interspersed amongst five or in one case, six postnatal beds (a mix of single and two bed rooms). The integrated maternity unit was on one level. Teams shared some facilities, such as store rooms, utility rooms and the multi-purpose education room. A staff room at

[25] The AIRC assists employers and employees to resolve industrial disputes by convening an Arbitration Tribunal http://www.airc.gov.au/about/ourrole.htm

either end was shared by two teams. There was little demarcation to identify where the rooms belonging to one team ended and the next began. The birthing rooms were spread throughout each unit and none was adjacent to the neighbouring team's birthing rooms. Access to the teams was through doors at either end of the complex so that visitors for two of the teams had to initially pass through the area of at least one of the other teams. I found visiting these wards quite confusing at the beginning as the reception desks for each team were not clearly defined.

Two bedded postnatal rooms with ensuite bathrooms were converted into birthing rooms, with limited room for extra equipment or furniture. Although oxygen and suction was already available, additional engineering work occurred to pipe nitrous oxide to the rooms. New birthing beds were purchased. The limited budget restricted the renovation to essentials. There was insufficient soundproofing and the television for the second bed in each birth room was left in their original position as it would have been an additional cost to remove them and replaster the ceiling. The storage space was considerably less than had previously been available, which meant much equipment, such as infusion pumps, remained inside the birthing rooms. The neonatal resuscitation equipment remained in the corridor.

The Women's Clinic was situated just outside of the entrance to the wards (see Figure 4). The clinic remained physically unchanged having a large waiting area, a reception desk and assessment rooms. The newly implemented midwife-led antenatal clinics replaced some of the existing obstetric antenatal clinics. These midwife clinics were eventually physically relocated from the women's clinic to the team areas. Community based midwife-led antenatal clinic sessions were gradually implemented with more planned. These settings included community health centres, doctors' surgeries, and maternal and child health centres. The obstetric high risk antenatal and gynaecological clinics continued in the women's clinic area.

The breastfeeding and antenatal day stay clinics were not relocated and continued on the lower level. The co-ordination and delivery of the midwifery postnatal home care service

became an integral part of each team. Initially, the midwives providing postnatal home care for each team were based in the 'hospital in the home' offices but they were later relocated to their individual team areas. Space was at a premium in the refurbished wards, which was compounded when the antenatal clinics and postnatal home care services were also relocated to within the teams' physical environments.

The advantages of having all team services in one area were improved communication and development of team spirit. Several of the participants talked about having an increased understanding of their colleagues' work across the continuum of midwifery care. Advantages for the women attending the on site midwife-led antenatal clinics were that they were able to become familiar with the physical environment where they would give birth. Women who were able to attend one of the community clinics had the advantage of less travel, which is likely to be particularly important for women from low socio-economic backgrounds. Many of these community clinics were specifically targeted for women from non-English speaking backgrounds, in particular, those recently arrived as refugees. Following birth, women remained in the same area with care provided by the same midwives, although not the in same room.

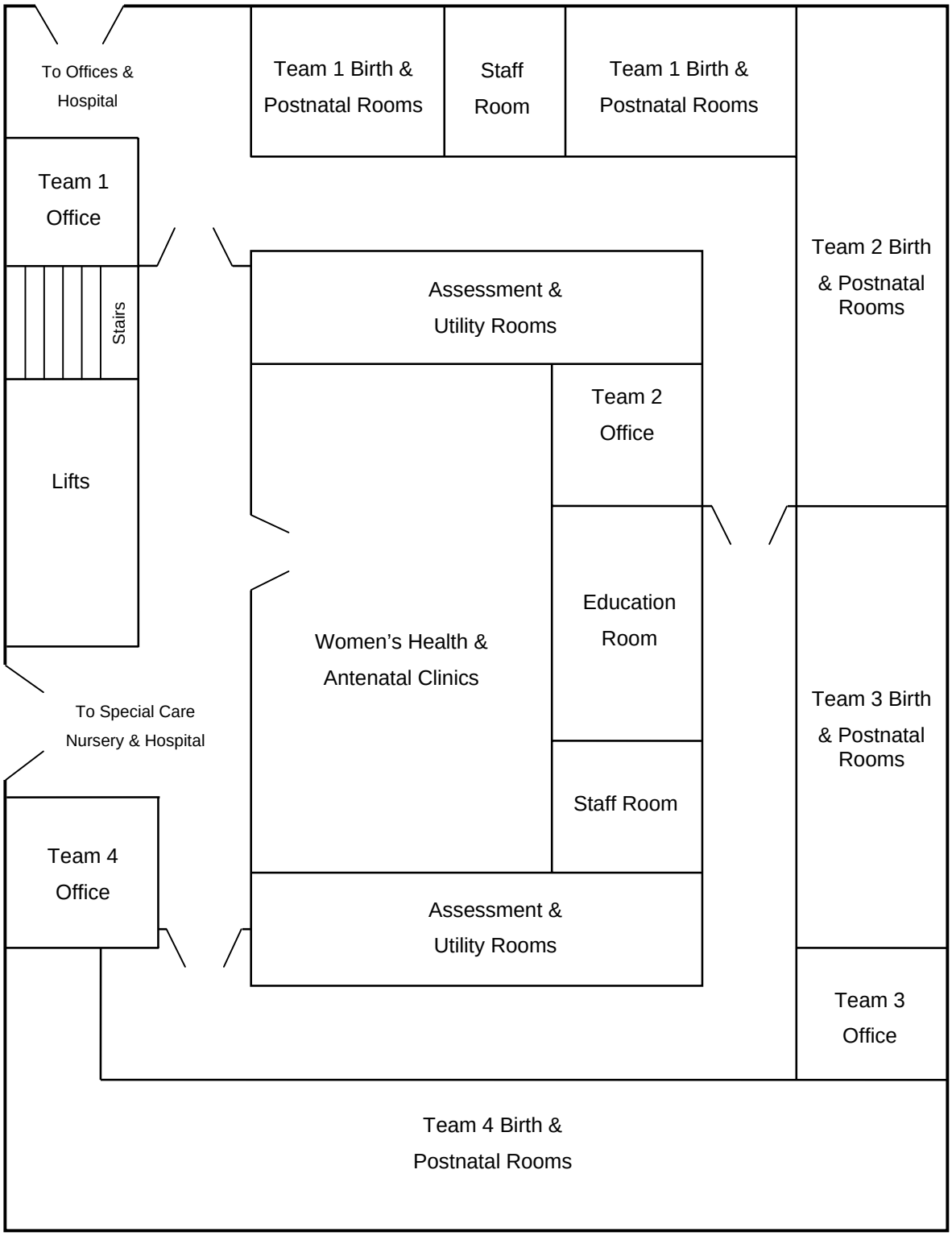


Figure 4: Diagram of Case A floor plan[26]

[26] Not to scale. Approximate layout only.

There were several disadvantages to renovating old wards rather than building new ones. A new specifically designed integrated maternity unit would have met the latest government guidelines (Department of Human Services Victoria, 2004) on size, storage options, access to services, and standards of sound-proofing and body protected electrical areas that were not present in older units. Unfortunately for Case A, the availability of funds or lack thereof meant that renovation was the only available option. The lack of space was challenging, leading to the inability to provide optimum working areas for the staff and creating issues related to adequate storage of supplies. The provision of more services in one area, along with the inadequate provision of noise barriers, contributed to an increase in the activity and noise level in the environment where women were giving birth.

The physical shortcomings were seen as major environmental issues by both the midwives and the managers and impacted on both staff and women. The lack of soundproofing was discussed by virtually all the participants in this study. The noise, particularly from women in labour, was seen to impact upon the women, visitors and the whole working environment. The frustration for the staff working in the refurbished ward was described quite passionately by one leader '…*women screaming, visitors, phone ringing, just bedlam all the time. Not this peace and tranquility that you want* [for women] *that's what I find hard*' (Interview Leader 4, Case A).

Another environmental problem that was identified was the lack of storage space. This meant that equipment, such as infusion pumps, either remained in the birth rooms or were left in the corridors. Ensuring that there were sufficient supplies such as sterile packs, drugs and intravenous fluids became difficult when there were limited places to store stock (Interview Leader 4, Case A). The lack of space was not only frustrating but it was also an occupational health and safety issue for staff, visitors and patients. In emergencies, midwives had to move visitors out of the way to gain access to necessary equipment (Interview Midwife 2, Case A). The new physical layout, with the birthing rooms mixed in with the postnatal rooms, made it difficult for midwives from different teams to provide support to each other. Previously, with all the birth rooms in one area, it was relatively easy for the midwives caring for labouring women to provide advice and assistance to each

other. This is discussed further in Chapter Eight under the theme of achieving and maintaining competence.

There were two main changes for midwives in the provision of maternity care at Case A. The first, that had a major impact for many of the midwives, was the renovation of the old postnatal wards, integrating birthing rooms with postnatal rooms and providing a challenging physical environment for four teams as described above. The second change was multi-faceted with the initiation of midwifery-led care.

6.8.2. Model of Maternity Care Midwifery Perspective

The redevelopment of the maternity unit meant that all midwives, many of whom had worked only in either the postnatal area or the labour ward for many years, were now expected to provide care throughout the childbearing cycle. Women deemed low risk were allocated to midwife-only care on admission in labour. Midwives were encouraged to take more responsibility in managing women's care in labour. Previously doctors were required to review and admit every woman, and frequently midwives called on them to do every vaginal assessment. Although the doctors were no longer required to visit every woman on admission, they remained responsible for ordering medications. Changes to the staffing levels were also implemented at this time compounding some of the difficulties in establishing the new maternity services.

6.8.3. Staffing Issues

At the time of planning, the number of full time equivalent staff required for each team was based on the existing nursing workplace agreements. The existing agreement did not specify ratios of midwives to women. Shortly before the new model at Case A was implemented, the workplace agreement of 2000 (Australian Industrial Relations Commission, 2000) was finally signed by the Victorian government. The introduction of a specific midwife to woman (nurse:patient) ratio system led to a re-organisation of the original plans at Case A in the way the rooms were allocated as either postnatal or birthing. Long term funding and rostering is planned according to the average number of women

who give birth each day as opposed to the number of rooms available to care for them (personal experience). Although there were 12 birthing rooms at Case A they were not all accredited as such for the allocation of midwives. They were included in the postnatal bed count. The extra birth rooms were to allow women to remain longer in the room where they gave birth instead of being moved out to a postnatal room. As the workplace agreement (Australian Industrial Relations Commission, 2000) stipulated one midwife to 1.5 women in labour when planning the roster, only one midwife was required per team to cover the accredited birthing rooms.

The midwives at Case A were divided into four teams, each with a unit manager. Three of the teams had 16.5 FTE (full time equivalent) positions and one team had an FTE of 21 because it had an extra postnatal room. The team concept (see Chapter Three) was promoted to the staff during forums, as a continuity of care model known to improve women's satisfaction with their birth experience (Biro et al., 2003; Tinkler & Quinney, 1998) even though the evidence for this came from research where the teams only consisted of six to seven midwives. As about 70% of midwives work part-time, each team consisted of approximately 30 midwives. The ideal maximum number of midwives on a team has been suggested as six to seven (Flint et al., 1989; Sandall, 1995). The ability for providing continuity of care for women at Case A is severely limited by such large teams. Therefore the expectations of improved outcomes associated with some models of continuity of care (NMAP, 2002) are less likely to be achieved.

With the re-organisation of the new model and the introduction of the staffing ratios, fewer midwives were required for inpatient services. More midwives, however, were required because of the development of midwife-led antenatal clinics. No midwifery positions became redundant and all staff continued to be employed, except for those who chose to leave. Each team was allocated three birthing rooms and five or six postnatal beds. Every shift there was one midwife responsible for the birth rooms, and one for the postnatal rooms for each team. There was also one midwife in-charge for each team, each morning. However, on the evening and night shifts one midwife was in-charge of two teams. The team with six postnatal beds had one extra midwife for each shift. When there was more

than one woman in labour, the midwife in charge and the midwife caring for postnatal women were required to provide support in the birthing rooms. When a team had more than one woman in labour, one on one care during labour was not usually possible. The ward layout made it difficult for midwives from other teams to assist. Each team allocated one or two midwives each day to their antenatal clinics that were conducted on four days a week and also allocated one midwife to postnatal home care each day.

Appointments with a midwife to book into Hospital A to give birth were organised through Patient Services[27]. Patient Services automatically allocated all women to one team regardless of the provider of their antenatal care. Initially, all the women who were considered high risk were allocated to one specific team. This however, had the effect of producing a heavy workload for that team. Therefore, the decision was made to spread the workload more equitably (Interview Leader 5, Case A). This was achieved by allocating women to a team according to their home address. Midwife-led antenatal clinics were established for each team on five days of the week. No clinics were held on a Sunday and each of the teams had one other day without a clinic. At the time of this research, each team either had at least one clinic based in the community or were in the process of establishing one. Since the changes to the model of care occurred, the numbers of births have been increasing. In 2005, over 2900 births occurred which is an increase of approximately 400 births per annum. It was believed that an increase of at least 600 was required to validate the need for an extra team (Interview Leader 5, Case A).

Midwives were gradually rostered to the antenatal clinics and to postnatal home care. Several permanent night staff were employed who were unable to participate in either antenatal clinics or postnatal home care. Midwives were also required to rotate from day shifts onto night duty. The SCN had many permanent core staff, several of whom were not midwives plus each team took it in turn to roster midwives into the SCN.

[27] Patient Services were an administrative department that arranged all in-patient bed bookings.

6.8.4. Choice for Women

It appeared that the choices of models of maternity care available at Case A had increased for those women deemed to be at low risk. The women were now able to choose between: hospital based midwife shared care; community based midwife shared care; GP shared care; or private obstetric care. At the time of this research, the women attending either GP or midwife shared care were required to be seen in the obstetric clinic for a minimum of two visits during their pregnancy. The midwifery shared care model was promoted by the hospital as being one that provided continuity of midwifery care. This raised the expectations by many women that they would see the same midwife throughout, which unfortunately occurred infrequently (Interview Midwife 1, Case A). The obstetric public antenatal clinics that were primarily meant for women deemed to be high risk continued as before. Women attending the obstetric clinics only met one midwife prior to admission, which was when they attended the booking in clinic.

6.8.5. Consumer Forces

The midwifery model developed at Case A was promoted to both women and midwives as providing continuity of care. It is questionable whether it was possible to provide continuity of care with large numbers of midwives on a team and this issue will be explored in the final chapter. The midwives at Case A however, suggested that many of the women who chose midwife shared care over GP shared care did so purely for financial reasons, not for continuity of care. There were no charges for women who attended midwife-led antenatal care, whereas, many women attending GPs for antenatal care were required to pay the difference between the government rebate through Medicare[28], and the GPs' charges. Few GPs offer bulk billing, where Medicare pays the rebate directly to the GP and there are no extra charges for visits.

[28] Medicare is Commonwealth funded medical expenses. The Commonwealth government has set rebates for medical treatment, where GPs bulk bill the patient has no out of pocket expenses. Doctors are entitled to set their own charge on top of the rebate for which the patient is responsible. Doctors who bulk bill receive the government rebate only and their patients have no additional expenses.

There was some reluctance from women to attend the community clinics when they were first opened. This initial lack of support by women for midwifery antenatal care may have been due to an apparent lack of understanding of the role of the midwife, a reflection of the invisibility of the midwife in the Australian community. As one midwife explained;

> … *initially that was a big thing the public didn't understand, there was negativity from here* [hospital staff] *but the women were negative as well. They were getting inferior care, that was their perception and [they were saying] 'I want to see the doctor'.* (Interview Leader 4, Case A)

Other reasons for the reluctance to use the community clinics may have been because women preferred their own GP or that they were not fully informed about the available options. Despite a slow start, by the time of this research the clinics were well attended and many of them were full. Plans for future development of the maternity services were in a state of flux, when this research was completed, with the third re-organisation of senior management since 2001 about to occur.

6.8.6. Hospital Management

The management structure and key personnel at Case A had been through a number of changes since the development of the team model in 2001. These changes included the return of full management of Women's and Children's Services to X Health. The Director of Nursing for Women's and Children's Services had changed twice since 2001, neither of whom was a midwife. Several of the key players, including the project officer and the Director of Women's Services, who were driving the change, were no longer working for X Health. An additional change in management occurred shortly after completion of the data collection for this study, with the loss of the obstetric director who had been very supportive of developing midwifery-led care.

Despite assertions made by members of senior management that any midwife who did not feel capable of working in a different area did not have to, when the changes occurred the midwives stated that they were expected to conform. Both leaders and midwives interviewed described incidents of midwives being reassured that they would not be made

to work with labouring women but were bullied into the change. As one leader remonstrated;

> '…[they were] *promised that they didn't have to do what they didn't want to, which was an absolute lie…'* (Interview Leader 3, Case A)

Once the final decision to go ahead with the model had been made, the rapidity of the re-organisation provided little time for midwives to prepare. Suddenly, midwives were expected to care for women in labour, despite having no recent experience with labour and birth.

6.8.7. Education Preparation and Support for Midwives

As most of the midwives had worked in providing only one aspect of midwifery, there was some recognition of the need to prepare them for their return to working across the full scope of midwifery practice. Approximately a year before the final redevelopment of the maternity services, midwives were provided with the opportunity to rotate between the postnatal and labour wards. Only one midwife out of approximately 100 took this option (Interview Leader 2, Case A). The midwives were also encouraged to go to the other areas whenever possible to gain experience but again the uptake was poor. A lack of motivation, high workload and lack of educational support were reasons suggested by research participants for the poor participation in re-skilling opportunities (Interview Leader 2, Case A; Focus Group 1 Case A). There were no resources available to enable the midwives to work in a supernumerary capacity to gain experience whilst being well supported, either before or after the changes.

At the time of the change to the integrated units, a new full time position of manager of education was created. Three midwifery educators were available on a 24 hour roster for several weeks to provide support and education. Two of the educators worked full-time and one part-time. They carried pagers so that they could be contacted when needed. The educators were underutilised regardless of their availability on the wards (Interview Leader 6, Case A). It was suggested that the reasons for the reluctance of staff to ask for education support was due to the perceived lack of clinical experience of two of the educators. One

had come from a small level one[29] midwifery unit and she was perceived as being incapable of providing adequate support in the larger level two unit. The other one had not worked in the clinical birthing area for many years and had herself recognised that this had been an issue for midwives at the time of the changes (Interview Leader 2, Case A).

After the new model was implemented, education sessions were provided in response to the needs of the midwives. These occurred at the times when there was an overlap of staff, however, they were not well attended (Interview Leader 2, Case A). Some of the participants pointed out that education had been provided but that it takes a lot more than one education session to become competent and confident (Focus Group One, Case A, Interview Leader 3, Case A). There were no formal assessments of competency for the midwives who lacked recent experience. The ability for peer education, and support for inexperienced staff, by colleagues on the same shift, was reduced, both because of the workload and the integrated physical set up of the wards. Previously, with separate wards, there were more experienced staff working together in one area and it was easier to provide ongoing support for the less experienced staff.

Education, at the time of the data collection for this study, was provided by one full-time and one part-time midwifery educator and a policy development manager. The educator positions had been reorganised with only one of the three educators from the time of the redevelopment remaining. These educators provided staff development, a graduate midwifery program, clinical support when requested and co-ordinated the clinical placements for student midwives. The role of the policy development manager was to review and implement policies that were in line with midwifery-led care and provide education to the staff related to these policies.

Shortly after the commencement of the model, the model of care project leader resigned and a new one appointed. The new project leader worked closely with the obstetric director in developing a plan for additional clinical support for the midwives. This led to funding

[29] Level one maternity units only provide care to women deemed low risk and with a minimum of a 37 week gestation. Level two maternity units provide care for women from 34 weeks and those who may be deemed as high risk.

being allocated from the obstetric medical personnel budget for the appointment of four clinical midwife consultants (CMCs). These CMCs were expected to provide support for the midwives, act as role models for enhancing midwifery led care and promote change in practice. They were given few guidelines and, as they were perceived as being outside of the maternity services management, they lacked any power to create change (Interview Leader 5, Case A). Initially they were poorly accepted and many midwives were alienated as they perceived them to be taking the role of the obstetric registrars and acting as 'mini doctors'. Some of the positive changes instigated by the CMCs included a new induction of labour policy in an attempt to reduce the number of inappropriate inductions occurring and conducting morning rounds with the doctors to enable the unit managers to concentrate on their management roles. During the interviews there were suggestions that the CMCs were '*never around when needed'* and that they '*failed to provide sufficient support*' (Interview Midwife 3, Case A; Focus Group 1, Case A). The perception of some of the participants was that while the CMCs did challenge midwives to take responsibility and work to the full scope of their practice, they failed to see the whole picture of how managing the care of a woman impacted on the midwives' workload.

At the time of this study, each of the CMCs was attached to a team, but one was on long service leave, one had just left and was not being replaced and a third was seconded to a state project. It was difficult, for me[30], to determine how effective they were in providing support and education to assist the midwives to develop their skills to be able to work to the full scope of midwifery practice.

6.8.8. Impact on Staff

The midwives were divided between those who accepted and welcomed change and those who had resisted and felt threatened. Many of the midwives reported feeling angry and frustrated. About 10-15% of midwives left in the initial transition period, a not uncommon occurrence with organisational change (Graetz et al., 2006). They either retired or moved

[30] Only one of the CMCs was identified as a leader by respondents of the surveys. They were not directly approached to participate in this research as they had joined the unit after the main reorganisation had occurred but they were given surveys.

to hospitals where they could choose their preferred area of practice. At the time of this study, there were more staff leaving, several due to the lack of progress towards the development of a caseload midwifery model.

When the model of care was introduced there was a clear plan that it would be evaluated (Interview Leader 6, Case A). However at the time of this study, four years after the change, no official evaluation had been instigated by management.

6.9. Summary Case A

This section has provided a description of the physical environment at Case A, the reasons for, and the process of, change. The changes that had occurred were then explained. The impact on the staff although identified to some extent in this section will be expanded on with the findings of the survey in Chapter Seven and the focus groups and interviews in Chapter Eight. Chapter Nine provides a comparison of the two cases. The next section will provide a description and process of the changes that occurred at Case B.

CASE B

6.10. Local Context Case B

Case B was a maternity unit located in Hospital B, a public teaching hospital that was a similar size to Case A. As with Case A, there had been considerable expansion and rebuilding to improve access to health services for the local community (Hospital B website, 2005). In addition to the maternity unit and special care nursery (SCN), the hospital provided a wide range of services, including an emergency department, medical, surgical, orthopaedic, critical care, paediatric, rehabilitation, aged care, diagnostic, allied health and psychiatric services. Hospital B was one of a group that was managed by the area health authority Z Health. Administration for Z Health was located in one of the other hospitals of the group. Similar to Case A, Case B provided clinical practice experience for medical, midwifery, nursing and allied health professionals in collaboration with several universities.

1998-2000	Maternity Services Enhancement strategy implemented
2001-2	Plans for rotating midwives between postnatal and labour wards
2003	April - Implementation of rotation model September - Closure of Hospital C
2004	January - Community Team commenced October - Hospital D opened
2005	Collection of data for study

Table 18: Timeline Case B

6.10.1. Community Characteristics Case B

The community that Hospital B served was one of the most culturally diverse in Victoria with 56% of the population born overseas. Over 52% of the population of 133,000 originated from non-English speaking countries that include Vietnam, India, Sri Lanka, China, Afghanistan, Eastern Europe, Cambodia and increasingly the African continent.

Australian Aboriginal and Torres Strait Islanders comprised only 0.4% of the local population. Specific cultural awareness services were provided by Z health for all hospitals in the community. Services provided included access to a wide range of interpreters, a variety of ethnic-specific programs, access to cross cultural education for staff and an Aboriginal Liaison Service. Many of these support services were community-based. Midwife-led antenatal clinics were provided at one community centre primarily for the Vietnamese and Cambodian community. The midwives at this centre, assisted by ethnic specific development workers, also provided antenatal classes in Vietnamese and Khmer languages (Local government web site, 2005).

Case B – Pre-2003

6.11. Physical Environment

Case B maternity unit consisted of three areas; a birth unit; a maternity ward; and a SCN. The birthing unit had nine birthing rooms and two assessment rooms and catered for about 2700 births per annum. On the same level of the building through an interconnecting door, was the maternity ward that catered for both antenatal and postnatal women. The SCN was situated between the birthing unit and the maternity ward (see Figure 5). Each area had an open reception/work station area and a small staff room. There was a larger general purpose staff room shared by all staff that was used for meetings and education. On a lower level, there was a larger room used for prenatal education. There were no public women's clinics for either antenatal or gynaecological services on site.

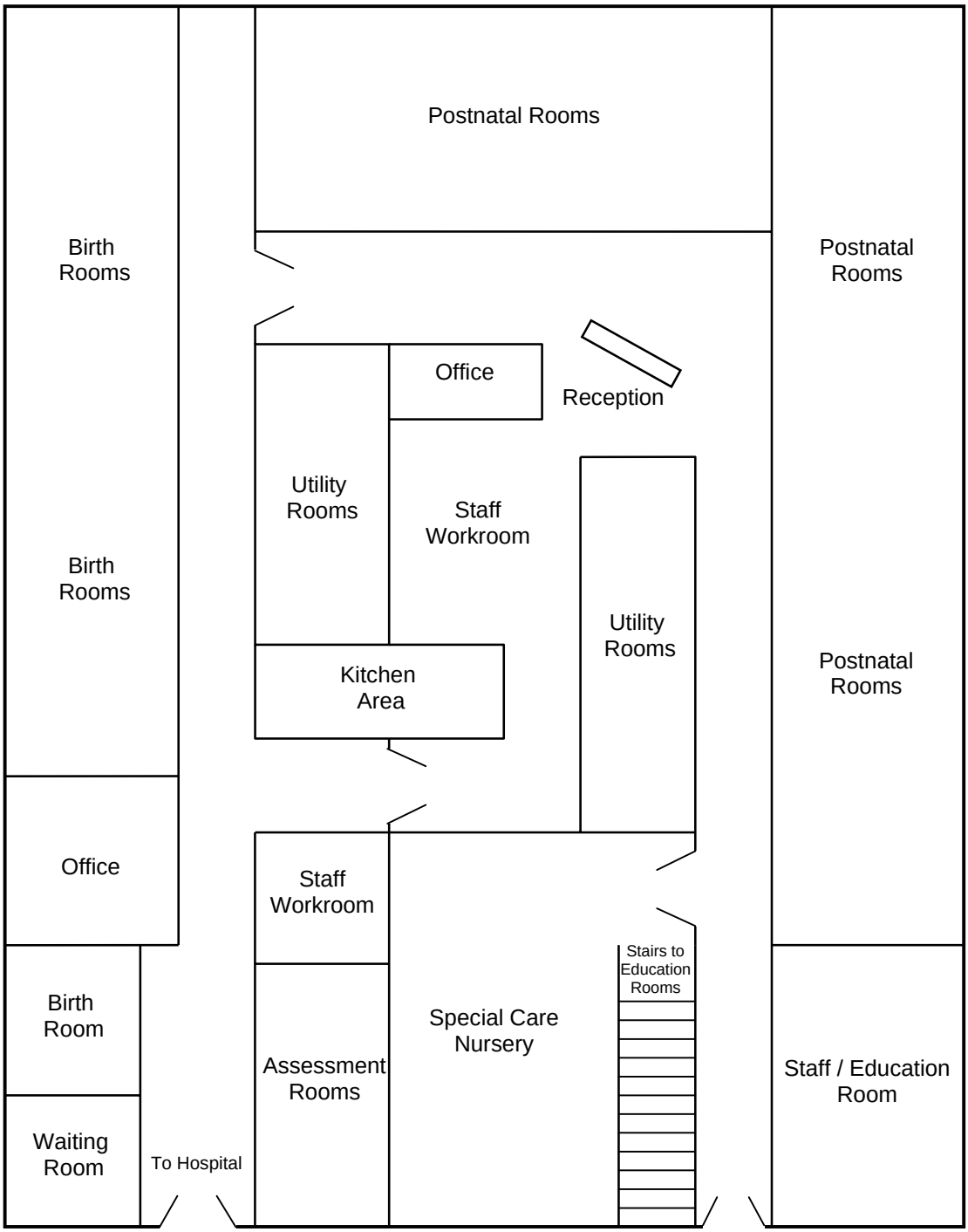


Figure 5: Diagram of Case B floor plan[31]

[31] Not to scale. Approximate layout only

6.12. Maternity Care

There were no public[32] antenatal clinics at Hospital B so all antenatal care was provided in the community by medical practitioners prior to 2003. The women had a choice between shared care with a general practitioner (GP) and public or private care with consultant obstetricians in their consulting rooms. All antenatal care was provided by doctors in their rooms. This meant that, frequently women who were deemed low risk received antenatal care from obstetricians when a primary healthcare provider such as a GP or midwife would have been more appropriate. Women receiving GP shared care who were required to have an obstetric review during the pregnancy would see the consultant obstetrician in his (there were no female consultants) private rooms. Although midwifery antenatal shared care was offered by Z Health at a community centre not far from Case B, these women generally gave birth at one of the other hospitals in the group. These antenatal services were primarily for Vietnamese and Cambodian women, with specialised care provided by midwives, community workers and a visiting medical officer (VMO). Despite plans in 1999 to use funding provided by the Maternity Services Program (DHS, 1999), for the development of midwife-led antenatal clinics at all Z Health maternity sites, none had been implemented at Case B.

Midwives cared for women in labour and during birth. Obstetric cover was provided by obstetric registrars and resident medical officers, supported by the local consultant obstetricians. The majority of women were transferred from the birth unit to the postnatal ward within one or two hours of giving birth. Women who chose to go home within a few hours of birth remained in the birthing unit. Within the birthing unit there was one slightly larger room set aside as a 'family birth room', with a double bed and cradle. The 'family birth' model of care provided women with midwife-led care in labour, followed by early discharge within 24 hours. The woman and her family could remain in the birthing room until she was discharged home. If she wanted or needed to stay longer than 24 hours she was moved into the main postnatal ward. Women were required to meet strict criteria[33], as

[32] Commonwealth funded clinics are known as public care in Australia in contrast to privately funded care.
[33] These criteria related to factors that were perceived to put the woman at greater risk of intervention or complications, including age, gravidity, previous obstetric complications, and existing medical conditions such as diabetes, epilepsy and cardiac disease.

defined by the hospital protocols that identified them as low risk, in order to book into this model of care. They still however, received antenatal care with a medical practitioner. Attendance at a specific 'family birth' model prenatal class was a requirement of booking for this model and it was the only time other than the 'booking in' appointment when women booked into this model met midwives. Postnatal visits at home were by a midwife from the postnatal home care team and not necessarily any of the midwives they had previously met. Funding from the MSP enabled the implementation of a community postnatal care service in 2000[34]. This postnatal service provided community visits for women who had been discharged prior to day five. This service was provided by only two or three midwives who also worked in the postnatal ward.

Women giving birth at Case B were able to choose the medical practitioners for their antenatal care. Women received continuity of carer throughout the antenatal period, but unless they paid for a private obstetrician, care in hospital was fragmented. In hospital, the women would be cared for by the midwives and doctors rostered for that day. Therefore women were unlikely to know the midwife who was with them in labour. They may have met the midwife in labour either during a previous pregnancy or with an earlier admission during this pregnancy.

6.13. Hospital Management

Women's services at Case B were managed by a Program Manager and Obstetric Director based at the nearby tertiary hospital. There was a degree of local management through the on-site Director of Nursing and Director of Obstetric Services. Since 1998, the financial management and strategic control of the maternity services at Case B have changed several times as Z Health reorganised their management structure. The frequent changes of clinical and fiscal management seems to have left the midwives with an apparent lack of direction. There was a perception that they either have no-one taking responsibility for development

[34] Prior to 1999 a limited community postnatal care service had been available through the Royal District Nursing Service.

of the maternity services or that they are continually trying to please 'two masters' (Interview Leader 2, Case B).

6.14. Education Support for Midwives

Education was provided by one part-time midwifery educator who organised staff development. The midwives also had access to midwifery education run by the nearby tertiary centre. There was no specific graduate[35] midwife program for newly qualified midwives, as existed at Case A and in many maternity units in Victoria. Newly graduated midwives were provided the same basic support that all midwives newly employed received. The co-ordination of midwifery student placements was provided by an educator based at the tertiary centre and the students were supported either by a clinical educator from the university or by a midwife preceptor. Midwives interested in becoming preceptors were provided with a short education program through the tertiary hospital.

No major physical changes had occurred at Case B since it was opened in the mid-1990s. The organisational changes that are the subject of this study included the commencement of a rotation model, absorption of midwives from a unit that had closed and the development of a midwife-led model of care. The processes that occurred are outlined in the next section, with description of the changes that occurred and the effect on staff.

6.15. Processes Followed to Implement Changes at Case B

The processes followed to develop and implement changes at Case B were fundamentally similar to those that occurred at Case A. This section commences with an explanation of the catalyst for the initiation of the changes.

[35] 'Graduate' midwifery programs were established in some hospitals in the late 1990s to provide specific support for newly qualified midwives to transition into their new role. These programs have become more widespread since the inception of the direct entry midwifery program in 2002, mirroring similar graduate programs that exist for nurses.

6.15.1. Catalyst for Change

The catalyst for the primary change at Case B, as with Case A, was an economic one. The problem was not one of under-utilised beds but under-utilised staff. There was a perception by senior management that some midwives were doing very little in one area, while it was necessary to employ extra casual staff for the other area. Midwives who do not work across all areas of midwifery care risk becoming de-skilled. The majority of midwives at Case B had apparently not had the opportunity to work in both the birthing and postnatal areas, or had chosen not to. This had contributed to the reluctance of midwives to move between areas to work when the opposite area was busier. This occurred both with postnatal midwives reluctant to go to the birthing unit and the midwives from the birthing unit avoiding the postnatal area (Interview Leader 1, Case B).

With the shortage of midwives it became more difficult to replace shortfalls in staffing levels. In addition, costs for agency[36] staff had risen and government restrictions meant that they could only be used to cover sick leave not shortages within the roster (Auditor General Victoria, 2002). At the same time, nursing and midwifery agencies had difficulty providing professional indemnity insurance cover for their midwives to work with women in labour. This compounded the issue. While agency midwives might be available to work on the postnatal ward to enable midwives to be moved to the birth unit, many of the midwives claimed they no longer felt confident to work with birthing women. The answer to these difficulties was to re-skill midwives to enable them to work in all areas. This strategy was seen as the means to contain the costs of casual staff when one area was quiet. It would also provide the opportunity for agency staff to be used in the postnatal ward freeing staff to move to the birthing unit and thus alleviating staff shortages to some extent. Therefore, the introduction of a rotation model to improve the ability to move midwives between areas was planned as one strategy to reduce spending and better utilise the midwives who were rostered to work.

[36] Agency midwives are employed through a 'nursing agency' external to the hospital and casual rates for these staff are at a higher premium as they include agency fees and rates that are often set higher for staff who are most in demand. Hospitals can reduce the costs attributed to employing agency staff by establishing their own 'bank' of casual staff.

The economic catalyst at Case B was different to Case A but in both cases it led to a re-organisation of the models of care. Although the models that evolved were different the effects for midwives were similar with the expectation that midwives provide care in areas they had no recent experience in.

At the time that the introduction of a rotation model was occurring at Case B, one of the other Z Health maternity units in Hospital C was closed. This led to the relocation of some of the midwives from Hospital C to Case B. The maternity unit at Hospital C was a low risk unit that had provided shared antenatal care by midwives and GPs, with medical cover provided by a consultant from the tertiary centre. The catalyst for the closure of the maternity unit at Hospital C was multi-faceted. Primarily, it was due to the development of a new hospital (D) within the Z Health catchment area (Interview Leader 3, Case B). Hospital D was planned to improve access to all services for the local community.

The catalyst for the introduction of a midwifery-led team model of care at Case B was twofold. There was a necessity to replace the loss of the midwifery model of care from the closure of Hospital C to meet government expectations (Interview Leader 3, Case B). Discussions had occurred for many years at Case B related to developing a midwifery-led care model however, there had been neither sufficient funds nor obstetric support to move forward with planning. With the closure of Hospital C, several midwives relocated to Case B and the opportunity to reallocate funds and services into a midwifery-led model of care at Case B was seized (Interview Leader 3, Case B).

6.15.2. Working Party

A working party was established to plan changes. This group consisted of the unit managers, the director of nursing, the educator and representatives from human resources, the Australian Nursing Federation (ANF) and practising midwives. The working party was involved in the preparation of an impact statement for the ANF, about the affect on staff of the planned changes. Each step of the change was planned and taken to the staff by the leaders of the working party for discussion in open forums. Several models were discussed by the working party and two of these were presented to the staff (Interview Leader 1, Case

B). The planning stage took several months but those interviewed for this study were uncertain of the exact timing or details of the alternative models discussed.

6.15.3. Discussion and Ballot

Many forums were held to present the information to the staff. Discussion papers were handed out related to the reasons for change. Two different models of care were presented that included rotation of all staff and the rotation of staff excluding the associate managers (midwives in charge in absence of unit manager approximately five FTE for each ward) and unit managers. The role of the midwife was discussed in relation to the international definition of the midwife and the need to be competent across the full scope of midwifery practice. It was implied that there was a need for all midwives to maintain competence across the continuum of midwifery care in order that they could call themselves midwives (Interview Leader 1, Case B)[37].

Then as with Case A, a ballot was conducted under the direction and control of the ANF. A model that included the rotation of staff between the postnatal ward and the birthing unit was accepted and is described below. Those interviewed for the study were unable to clearly describe the options only the final outcome. One of the leaders stated that many of the midwives had told her that they had only voted because they could see that change was inevitable (Interview Leader 1, Case B). The midwives who were participating in the new rotation model were to be known as 'the team'. This model of team midwifery did not conform to team standards as described previously (see Chapter Three).

6.15.4. Education Preparation for Change

A sub-committee for education was established to identify learning needs prior to the introduction of the rotation model. A program was developed with learning tools based on a refresher program (Interview Leader 1, Case B). It seemed to me that a lot of time and

[37] Although the staff were told that midwives should maintain skills across the full scope of midwifery practice, there was no strategy to enable the midwifery managers to maintain these same skills. One of the leaders was challenged over this but claimed it was not possible to rotate and work as manager in an area they had not worked in for many years.

effort was put into providing appropriate education, support and supervision at Case B, compared to the planning put into place at Case A.

6.15.5. Changes to the Midwives Employment

The first change that occurred at Case B was the implementation of the new rotation model of employment for midwives. Initially, all midwives except the Unit Managers (UM) and the Associate Unit Managers (AUM) were to rotate between the birthing unit and the maternity ward. Owing to a lot of dissent from midwives who had only worked in one area for a prolonged period of time a further option was developed (Interview Leader 1, Case B). It was unclear at what stage in the process that the final option was developed. My impression was that, as the individual rotations were being introduced the final model emerged through ongoing negotiations with the midwives. Most of the midwives rotated between the birthing and postnatal areas every two weeks. The smaller number of core midwives were also expected to rotate between areas initially for four weeks every three months, but at the time of the study this had been reduced to only two weeks every three months.

There were a few other small changes that were gradually introduced. The midwives in the birthing unit became responsible for the 'booking in' interviews that had previously been completed by a midwife specifically employed for that role. The birthing unit midwives continued to have responsibility for completing postnatal discharge plans with women around 34 weeks. The postnatal home care service continued to be managed through the maternity ward, but all midwives instead of just a select few, were expected to participate in this service. These changes were designed to utilise the staff more efficiently. There was no attempt to promote it as a model of continuity of care for women.

Shortly after the rotation model was implemented at Case B, the maternity unit at Hospital C closed. The midwives who relocated from Hospital C to Case B came from a unit that followed a midwifery focused philosophy of care, into a unit that had a predominantly medical model. The initial understanding of the managers at Case B was that these midwives had experience in both labour and postnatal care and would participate in the new

rotation model. When they were interviewed for this study it became apparent that some of them had primarily worked only in postnatal care (Interview Midwife 2, Case B; Focus Group 1, Case B). In addition, the level of complexity of care for some women was much higher at Case B than most of the Hospital C midwives had experienced for many years. This was because all women at Hospital C who developed complications in pregnancy or women wanting an epidural anaesthetic in labour had been transferred to the tertiary hospital. Initially, some of the midwives from Hospital C had the same reservations about working in the birthing unit, as those midwives at Case B who had also only been working in the postnatal area for many years. Assisted by the introduction of a clinical coach, a new education position, along with the full support of the existing staff, both the leaders and midwives interviewed indicated that the midwives from Hospital C had integrated well with the midwives at Case B.

In 2004, a team midwifery-led model of care, known as the 'community team[38]' was developed and implemented in Case B, as a choice for low risk women. Limited finances and space restricted the midwifery led service to one team of seven FTE midwives, thus reducing the opportunity for other midwives to participate in a midwifery continuity of care model. The expectation was that one midwife would be rostered to the birth unit for each shift, and one each day to the antenatal clinic and one to the postnatal home care service. Antenatal care was provided in the community with obstetric consultation if required, from one of the consultant obstetricians. This model of care was promoted as a continuity of care model (see Chapter Three) with the anticipation that women may have met the midwife who cared for them in labour at least once during their antenatal care. Women who chose this model of care remained within the birthing unit following birth and were discharged home within 24 hours, to be followed up by the Community midwife on postnatal home care.

Not only did the opening of the new unit at Hospital D affect the closure of Hospital C, but it also had an impact on Case B with the '*loss of a lot of midwives'* (Interview Leader 1

[38] Name of team changed to maintain anonymity of case site.

Case B). No-one seemed to be able to determine the exact number. It was reiterated by those interviewed, that most of the midwives who had moved to the new hospital were experienced midwives who had promoted midwifery philosophy and midwifery-led care. Half of the community team midwives had left and not all had been replaced at the time of the study leading to limitations of providing this model (Midwife Focus Group Two, Case B). Therefore, Case B not only had a shortage of staff but also lacked experienced midwives (Interview Midwife 1, Case B).

6.15.6. Models of Maternity Care

The models of care at Case B changed little for women. The main change was the additional choice of midwifery led care with the introduction of the community team in early 2004. This choice was limited to 280 women a year. Case B catered for over 2500 births, therefore only a very small proportion of women would potentially receive continuity of care. The expectations appeared to be that the women who would choose this model of care would be aware of the philosophy of midwifery care and the concept of continuity of care (Midwife Focus Group Two, Case B). It was identified by several of the participants that many of the women choosing this model did so for economic reasons. It was perceived that the community team model, with the expectation of discharge within 24 hours, was not suitable for many of the women who chose it because of their lack of social support (Midwife Focus Group Two, Case B). As with Case A, there were indications that uptake of the model was slow due to a lack of knowledge in the community that it existed. As one midwife explained:

> *I think the choice of [the community team] is great, [but] speaking to a few ladies on maternity [they] haven't even heard of [it]. So I think its great that women have a choice but they're not getting the program out there for people to know about it, to realise that there are now choices…. there should be another program for women who can still get the free antenatal care but aren't in the community team because that's not really what they want. They don't want to go home in 24 hours they don't care who sees them they are not into that philosophy* (Interview Midwife 3, Case B).

Initially, the team positions were filled with some of the midwives from Hospital C and experienced staff from Case B. Several of these midwives resigned when Hospital D opened. Filling the vacant positions on the team had been difficult. At the time of this study the vacancies in the team had led to a reduction in continuity for women managed within this model. One research participant had chosen to come to Case B because she wished to join the community team in the future when she had gained more experience. In the meantime she reported having '*second thoughts*' as the shortage of midwives on the community team was affecting how well it was functioning and how much continuity of care was actually provided (Interview Midwife 3, Case B). Her concerns were that the midwives on the team were missing out on attending women during birth as many women gave birth overnight, with the day staff spending much of their time caring for postnatal women.

6.15.7. Hospital Management from 2003

In 2003, about the time that the first changes to a rotating model were implemented, the Program Director of Women's Services[39] for Z Health resigned. This position was not permanently replaced until late 2004 shortly before the commencement of this study. At Hospital B, a Director of Nursing was appointed in early 2005 just prior to the commencement of data collection for this research. These new appointees both spoke to me about their personal visions for the maternity services, both at Case B and across the whole of Z Health. Both of these leaders were midwives and reported that they supported midwifery models of care. They both recognised the need to develop strategies to retain, retrain and attract midwives to Z Health to reduce the shortfall in positions.

6.15.8. Education Support for Midwives

To support those midwives who had been de-skilled through lack of experience, education sessions were provided on topics such as obstetric emergencies for those moving to the birthing unit and breastfeeding for those going to the postnatal ward. As mentioned

[39] Director of Women's Services was responsible for midwifery services across the whole of Z Health. This position was based in the main hospital of the group.

previously, the educator developed a program to assist and support the midwives to re-skill. Initially, each midwife had two weeks of supernumerary time in the area where they needed to re-skill. They were provided with a learning tool developed by the midwifery educator that provided skills to be learnt and assessed. The educator relied on the preceptor[40] allocated to the midwife to sign off the tool when the midwife had demonstrated ability to meet the established standards.

Shortly before the commencement of this study, there had been complaints from senior staff that some midwives were not working at the level expected of them by that stage, eighteen months to two years after the commencement of the rotating model (Interview Midwife 1, Case B). In reviewing the assessment tools the educator discovered that for some of the midwives these tools were not completed appropriately but that no complaints had been made about the difficulties in completing them at the time (Interview Leader 1, Case B). In addition to the recent concerns about midwives' confidence, a few midwives had been identified as requiring ongoing extra support with labouring women. This extra support for the few was perceived as being to the detriment of the other staff. One midwife described how she had been affected:

> *There's one midwife I've come across who does not want to work in the birthing unit, and the only way she'll work there is with the clinical educator. Which I think is good the clinical educator can do that, but when I was new in maternity I didn't have the clinical educator there because she was in the birthing unit with the other midwife.*
> (Interview Midwife 3, Case B).

The educators were putting a significant amount of time and money into a few midwives for apparently little progress (Interview Midwife 2, Case B).

A new position developed during the changes was that of a 'clinical coach'. The clinical coach was an experienced midwife whose role was to support midwives who were re-

[40] Preceptors provide clinical support to less experienced midwives or students. At Case B they were expected to have completed a course within the hospital providing them with skills to fulfill this role (personal experience with Z Health).

skilling in the clinical area. The development of this role came from funding provided for the relocation of the midwives from Hospital C. Although many of the midwives at Hospital C were experienced in providing care across the full scope of midwifery practice, several had minimal recent experience with labouring women. The aim of the clinical coach was to support midwives while they developed the skills to enable them to provide midwifery care across the full scope of midwifery practice for women.

6.15.9. Impact on Midwifery Staff

Since the introduction of the rotating model, the midwives have developed a better understanding of the workload across the whole maternity unit. This improvement in collegiality was seen in both professional relationships and socially. Previously the birth unit and maternity ward would have separate social events but at the time of the study were running joint ones (Interview Midwife 1, Case B).

One detrimental effect of the introduction of the rotating model was that some midwives resigned from the unit. A few seem to have given up midwifery altogether, with one returning to nursing. Two or three have given up their permanent positions to become casual, thus allowing them to choose which area that they are willing to work in (Interview Leader 1, Case B). The loss of experienced midwives was recognised by several of those interviewed as one of the negatives of the introduction of the rotating model.

> *The negatives were losing some of our experienced staff who just didn't want to rotate. That's probably been the worst. We had some quite scared midwives, I don't think so much from birth unit, it was more maternity midwives who perhaps been there 20 years and just didn't want to come to birth unit. [They] just leave.* (Interview Leader 1, Case B).

6.16. Summary

This section has provided a description of the physical environment at Case B, the reasons for, and the process of, change. The changes that had occurred were then explained. The impact on the staff will be identified through the results of the survey in the next chapter and the focus groups and interviews in the following chapter.

CHAPTER SEVEN

SURVEY RESULTS – CASE A & B

7. Survey

This chapter presents the findings from the survey for both cases. A description of the survey, the distribution processes and the analysis was provided in Chapter Five. Forty-three completed surveys were returned from both Case A and Case B, providing response rates of 29% and 43% respectively. The lower response rate from Case A may have been related to the method of distribution. There were difficulties in differentiating between nurses and midwives as the identifying codes on the time sheets were similar. Therefore, members of staff who were nurses but not midwives may have inadvertently received a survey. Also, the time sheets of midwives on leave or not employed during that time were removed after a month. As a result, some midwives may not have received their survey.

The results are presented in Tables showing a comparison of the data from each Case.

7.1. Demographic characteristics of the respondents

The demographic characteristics of the respondents were similar for Case A and B (Table 19). The majority of respondents worked part-time, were born in Australia and had English as their first language. While for both cases the majority of respondents were over the age of 40 years (mean 43), Case B had twice as many respondents over 50 years than Case A (43% vs 21%).

	A		B	
	n(43)	*%*	*n(43)*	*%*
Employment status			(2 missing)	
- **Part-time**	33	77	29	67
- **Full time**	10	23	12	28
Country of birth				
- **Australia**	31	72	34	79
- **UK**	8	19	3	7
- **Europe**	1	2	2	5
- **Asia**	1	2	2	5
- **Other**	2	5	1	2
- **Not answered**	0	0	1	2
First language				
- **English**	40	93	41	95
- **Other**	3	7	1	2
- **Not answered**	0	0	1	2
Age group in years				
- **20-29**	4	9	5	12
- **30-39**	5	12	8	19
- **40-49**	25	58	12	28
- **50-59**	5	12	11	26
- **60 +**	1	2	2	5
- **Not answered**	3	7	5	12
Age group of children in years				
- **0-4**	3	7	4	9
- **5-9**	8	19	3	7
- **10-14**	11	26	7	16
- **15-19**	5	12	3	7
- **20+**	5	12	13	30
- **No children / not answered**	13	30	13	30

Table 19: Demographic characteristics of midwives responding to survey at Case A and Case B

7.2. Midwifery Education and Experience

The majority of respondents completed their education in Australia (Table 20). Two thirds of the respondents completed their initial midwifery preparation as a hospital certificate. Most were educated in the 1980s, with ranges from 1974 to 2005 at Case A and from 1963 to 2004 at Case B. This is consistent with the age distribution. The post-registration experience as a midwife ranged from six months to 30 years (Case A), compared with one year to 35 years (Case B). Although the numbers were small, more (29%) of the respondents who had completed a hospital course felt 'thoroughly prepared' for midwifery practice by their basic course, than those who had completed tertiary education (16%).

As each case had slightly different models of care and different work environments, the survey sought to establish how many midwives provided care across the full scope of midwifery practice. Therefore, they were asked to indicate each area of midwifery care that they worked in (Table 20). Continuity of care models were not defined as separate areas as the aim was to establish where the midwives worked not the type of model they were employed under.

7.2.1. Continuing Education

The majority of the respondents indicated that they kept up-to-date through education in their workplace (Table 20). More than half also used other means of becoming informed about midwifery, such as accessing journals or attending continuing education sessions outside to the hospital. Only three respondents indicated that they were either 'uninterested' or had 'difficulties keeping informed'. Of these, one worked in the SCN only and indicated that her professional development focused on that area.

	A		B	
	n(43)	*%*	*n(43)*	*%*
Midwifery education				
- **Hospital certificate**	26	61	30	70
- **Postgraduate University course**	16	37	12	28
- **Undergraduate University**	1	2	1	2
Country of education				
- **Australia**	37	86	39	91
- **UK & Europe**	4	9	3	7
- **Other**	2	5	1	2
Years of midwifery experience				
- **≤ 10 years**	16	37	13	30
- **> 10 years**	27	63	30	70
Current areas of work (indicate as many as relevant)				
- **Antenatal Ward**	25	58	21	49
- **Antenatal Clinic**	23	54	7	16
- **Postnatal Ward**	38	88	34	79
- **Birthing**	37	86	36	84
- **Domiciliary – home visits**	16	37	23	54
- **Midwifery education**	4	9	6	14
- **Childbirth education**	9	21	8	19
- **Special Care Nursery**	18	42	2	5
Number of different areas midwives worked in				
- **one**	5	12	6	14
- **two**	5	12	8	19
- **three**	9	21	8	19
- **four**	6	14	16	37
- **> five**	18	42	5	12
Keeping up to date				
- **continuing education at work**	40	93	41	95
- **continuing education elsewhere**	25	58	27	63
- **midwifery journals and/or library member of**	28	65	30	70
professional organisations	22	51	27	63
- **attending professional meetings**	27	63	34	79
- **not really interested or too difficult**	2	5	1	2

Table 20: Midwifery education, work settings & continuing education of respondents Case A & B

7.3. Attributes of Midwifery Practice and Changes over Last Five Years

The midwives were provided with a list of attributes (Table 21) and asked to indicate how important each attribute was for them. Responses were similar for both cases with the majority indicating that all the attributes were important to some extent. Ranking of the attributes using the mean scores identified 'interaction with women' as the most important for both cases. Convenience, work activities and professional status were considered less important by several midwives, but still considered of 'some importance' by most respondents.

Attributes		Importance of attributes: very important or important		neither important nor unimportant		unimportant or very unimportant	
		n(43)	*%*	*n(43)*	*%*	*n(43)*	*%*
Professional status	**Case A**	38	88	2	5	1	2
	Case B	32	74	4	9	6	14
Interaction with women	**Case A**	41	95	0	0	0	0
	Case B	41	95	0	0	1	2
Collegiality	**Case A**	39	91	4	5	0	0
	Case B	41	95	1	2	1	2
Collaboration	**Case A**	38	88	3	7	0	0
	Case B	39	91	3	7	1	2
Work activities	**Case A**	35	81	6	14	0	0
	Case B	36	84	2	5	4	9
Autonomy	**Case A**	37	86	4	5	0	0
	Case B	41	95	1	2	1	2
Convenience	**Case A**	35	81	6	14	0	0
	Case B	37	86	5	12	1	2

Table 21: The importance of the attributes of midwifery practice for respondents

The midwives were then asked to indicate to what extent the attributes had changed with the changes in maternity services of the last five years (Table 22). A majority of respondents (55%) indicated that 'interaction with women' and 'autonomy' had improved. Over a third agreed that 'professional status' and 'collegiality' had also improved.

Attributes		Change to attributes: Greatly improved or improved n(43)	%	No change n(43)	%	Deteriorated or greatly deteriorated n(43)	%
Professional status	**Case A**	17	40	19	44	5	12
	Case B	17	40	21	49	4	9
Interaction with women	**Case A**	23	54	7	16	10	23
	Case B	24	56	14	33	3	7
Collegiality	**Case A**	16	37	17	40	9	21
	Case B	17	39	16	37	9	21
Collaboration	**Case A**	13	30	15	35	13	30
	Case B	13	30	20	47	7	16
Work activities	**Case A**	16	37	7	16	19	44
	Case B	13	30	14	33	14	33
Autonomy	**Case A**	24	56	14	33	3	7
	Case B	23	54	14	33	4	9
Convenience	**Case A**	7	16	28	65	7	16
	Case B	5	12	23	54	14	33

Table 22: Respondents' perceptions of changes of the attributes of midwifery practice

7.4. Satisfaction and Vision of Midwifery Work

Midwives were asked how satisfied they were with their present role, to state what aspects were the most or least satisfying and to describe what their ideal role would be (Table 23). The majority of respondents were either 'very satisfied' or 'somewhat satisfied' with their present position. Almost twice as many from Case A (40%), compared to Case B (21%), were dissatisfied to some extent.

Respondents were asked to provide their own reasons for the most and least satisfying aspects of their role. The data were content analysed and grouped into themes (Table 23). The most frequently mentioned satisfaction factor was 'working with women and families'. These were identified by a third of respondents. Work related activities, such as model of

care and use of skills, was the next most frequently mentioned, followed by autonomy, colleagues and convenience. Some of the other factors mentioned were 'working with babies', 'educating midwives' and 'being respected as a professional'.

	A		B	
	n(43)	*%*	*n(43)*	*%*
Satisfaction with professional life				
- **very satisfied**	9	21	11	26
- **somewhat satisfied**	17	40	23	53
- **somewhat dissatisfied**	16	37	9	21
- **very dissatisfied**	1	2	0	0
Most satisfying aspects of midwifery position (more than one*)				
- **working with women and families / birth**	13	30	15	35
- **working in all areas /continuity of care / use of skills**	10	23	12	28
- **autonomy**	7	16	3	7
- **colleagues**	5	12	0	0
- **convenience – choice of shifts**	2	5	3	7
- **other**	6	14	8	19
Least satisfying aspects of midwifery position (more than one*)	27	63	13	30
- **staffing issues / ratios / workload**	2	5	10	23
- **shift work**	6	14	8	19
- **changes to model of care / affect on staff**	3	7	6	14
- **medicalisation / lack of autonomy**	7	16	11	26
- **other**				
Vision of midwifery in an ideal world				
- **a very good match**	3	7	0	0
- **a good match in some ways, but not in others**	24	56	36	84
- **hardly at all a good match**	13	30	7	16
- **no response**	3	7	0	0
Vision of ideal workplace				
- **midwifery led care – caseload / independent practice**	19	44	18	42
- **hospital setting – wards / choice**	5	12	8	19
- **suitable workload**	7	16	4	9
- **convenience – shifts / near home**	0	0	3	7
- **other – research / more confidence / specific places**	6	14	5	12
- **non response**	6	14	5	12

Table 23: Satisfaction and vision of midwifery work

*NB. % may add up to >100

The factors most frequently cited as the least satisfying were 'staffing levels and workload', which were identified by twice as many respondents from Case A, as from Case B. The next most frequently cited factor at Case B was 'shiftwork'. This was followed by 'changes to model of care' that was cited by similar numbers for each case.

The majority of respondents (73%) indicated that their present practice 'matched their ideal' to some extent. Almost twice as many from Case A responded that it was 'hardly a match at all' compared with Case B. While the ideal workplace for over 40% of respondents was a midwifery led model of care, 12% of respondents at Case A and 19% at Case B would prefer to have separate wards with a choice of working in one specific area of midwifery only. There were a variety of other responses including a few who identified a specific place.

7.5. Changes in the Work Environment for Midwives Since 2000

The survey asked the midwives to respond to what extent they agreed with statements that related to change in the midwifery environment (Table 24). The majority of respondents agreed that midwives have extended their practice and disagreed that work conditions had improved. There were more respondents from Case A (40%), than B (16%), who agreed that midwifery is less medicalised, and more from Case A (40%), than B (14%) who agreed that there is less clinical education support. Overall the respondents indicated that midwives are more politically aware and that there is greater use of midwives within maternity services (Table 24).

To what extent do you agree with the following statements?		Agree		Neither agree nor disagree		Disagree	
		n(43)	*%*	*n(43)*	*%*	*n(43)*	*%*
Government policies support midwifery care	**Case A**	17	40	12	28	13	21
	Case B	22	51	8	19	12	28
Midwives are more politically aware	**Case A**	21	49	17	40	4	9
	Case B	18	42	15	35	9	21
More research is occurring in midwifery areas	**Case A**	23	54	11	26	7	16
	Case B	17	40	16	37	9	21
Greater utilisation of midwives in maternity care	**Case A**	24	57	9	21	9	21
	Case B	25	56	5	12	12	28
Midwives have extended their scope of practice	**Case A**	35	81	3	7	4	9
	Case B	27	63	8	19	6	14
There is less autonomy for midwives	**Case A**	5	12	14	33	23	53
	Case B	8	19	16	37	18	42
Midwifery practice is less medicalised	**Case A**	17	40	12	28	13	30
	Case B	7	16	16	37	19	44
Midwife/ doctor relationships have deteriorated	**Case A**	11	26	17	40	14	33
	Case B	6	14	20	47	16	37
Midwife / midwife relationships have improved	**Case A**	14	33	19	44	9	21
	Case B	17	40	20	47	5	12
Midwives are more satisfied with work	**Case A**	10	23	4	9	27	63
	Case B	13	21	11	26	18	42
Continuing education opportunities have increased	**Case A**	17	40	14	32	11	26
	Case B	16	37	18	42	6	14
Clinical education support has decreased	**Case A**	17	40	13	30	12	28
	Case B	6	14	16	37	18	42
	Case A	16	37	18	42	8	19
	Case B	23	54	10	23	9	21
	Case A	3	7	12	28	34	79
	Case B	4	9	10	23	28	65

A							
	Case B						
Rosters are less flexible	**Case A**						
	Case B						
Working conditions have improved	**Case A**						
	Case B						

Table 24: Changes in work environment for midwives since 2000

7.5.1. Respondents Perceptions of Changes in Maternity Services for Women

Several questions related to how the midwife perceived changes in maternity services had affected women (Table 25). The majority of respondents agreed with the statements that the 'relationships between midwives and women had improved' and 'women were more involved in decision making'. They also agreed that 'more women were going home in less than 48 hours after birth'. However, more respondents at Case B (67%) compared to Case A (28%), agreed 'breastfeeding advice was more consistent'. A majority of respondents from Case B disagreed that 'most women had met the labour midwife before', compared with less than half from Case A who disagreed. More respondents from Case A (35%) perceived that 'women were less satisfied with their care', than from Case B (12%).

To what extent do you agree with the following statements?		**Agree**		**Neither agree nor disagree**		**Disagree**	
		n(43)	***%***	***n(43)***	***%***	***n(43)***	***%***
Midwife/client relationships have improved	**Case**	23	53	16	37	3	7
A		25	58	13	30	4	9
	Case B	24	56	10	23	7	16
Women more involved in decisions	**Case**	25	58	10	23	6	14
A		34	79	5	12	3	7
	Case B	37	86	3	7	2	5
More women go home < 48hrs	**Case A**	8	19	14	33	19	44
	Case B	2	5	7	16	32	74
Most women have met labour midwife	**Case**	12	28	12	28	19	44
A		30	67	4	9	8	19

	Case B	15	35	12	28	14	33
Breastfeeding advice is more consistent	**Case A**	5	12	15	35	22	51
		22	51	11	26	9	21
	Case B	19	44	12	28	11	26
Decreased client satisfaction	**Case A**	14	33	9	21	18	42
		17	40	12	28	13	30
	Case B						
Maternity services are women centred at this hospital	**Case A**						
	Case B						
Continuity of care for women has improved	**Case A**						
	Case B						

Table 25: Changes in Maternity Services for Women since 2000 views of respondents

7.6. Most Important Issues for Midwives

The midwives were asked to provide what they thought were the most important issues in midwifery today. They were also asked to describe any changes that had impacted on midwifery care. Responses related to change were mainly termed in the negative, with only a few positive comments from either case (Table 26). The main issues for Case A were staffing ratios, woman-centred care and the quality and safety of midwifery care. The responses from Case B related to staffing and enforced rotation.

	A		**B**	
	n(43)	***%***	***n(43)***	***%***
Current Issues				
- **staffing ratios / workload / shortage midwives**	15	35	7	16
- **woman-centred care**	12	28	9	21
- **quality / safety in maternity care / legal issues**	13	30	9	21
- **continuity of care**	10	23	2	5
- **midwife profile / professionalisation**	5	12	11	26
- **education of midwives / students**	4	9	4	9
- **breastfeeding / postnatal care**	3	7	2	5
- **midwife satisfaction / retention**	3	7	8	19

- **medicalisation of birth**	1	2	5	12
- **evidence based care**	1	2	1	2
Impact on midwifery care of changes in your workplace				
- **No response**	13	30	1	2
Positive				
- **Women more informed / community clinics**	4	9	1	2
- **Rotation between PN/labour**	0	0	2	5
Negative				
- **Increased workload /ratios – shortage of staff**	15	35	4	9
- **Care of women diminished**	7	16	4	9
- **Enforced rotation between PN /Birthing – loss staff / sick leave ↑**	0	0	11	26
- **Financial – Closure / loss experienced staff**	1	2	5	12
- **Litigation / paperwork**	0	0	5	12
- **Other**	3	7	3	7

Table 26: Current issues for midwives responding to the survey from Case A and Case B

7.7. Woman-centred Care

Australian midwifery philosophy (ACM, 2007b), the Competency Standards for the Midwife (ANMC, 2006) and the Victorian Maternity Care Policies (DHS, 2002a, 2004a) are underpinned by the concept of woman-centred care. The concept of woman-centred care was discussed in Chapter Three in relation to midwifery and is considered essential for midwives to understand. An open ended question on the survey sought to discover what midwives understood by the concept of woman-centred care. The data were then compared to the definition as used within the Australian Competency Standards for the Midwife (ANMC, 2006). For the purposes of analysis the definition was divided into five items (Table 27). I acknowledge that the definition of woman-centred care as developed by Leap (2000), encompasses ***all*** five items and should be viewed as a whole. However, the presentation in the ANMC Competency Standards for the Midwife of the definition as five items, provides a useful framework for comparing the responses to the survey used in this study. At the time of the study the ANMC Competency Standards for the Midwife had not been ratified and the definition used was not at that time one that conceivably would have been widely circulated in Victoria. Therefore there was no expectation by me that the items

would be described in the same words, only that the results would provide a starting point for identifying midwives' understanding of the concept.

No respondent provided a description of woman-centred care that included all five items. Nine respondents (10%) included three items and 23 (27%) mentioned two, while the remainder of those who responded (53%) only described aspects of one. The majority (58%) provided a response that recognised the need to focus on women's needs. Half of the respondents mentioned some form of informed choice and these responses were all coded into the second item of 'recognition of the woman's right to self-determination'. Two of these only described providing women with a choice of model of care. The time factor involved in completing the survey may have contributed to the brevity of some answers or to an apparent lack of a clear understanding of the concept.

Items of woman-centred care (ANMC, 2006, p.3)	Case A		Case B	
	n(43)	*%*	*n(43)*	*%*
• **is focused on the woman's individual, unique needs, expectations and aspirations, rather than the needs of institutions or professions**	23	54	27	63
• **recognises the woman's right to self-determination in terms of choice, control, and continuity of care**	20	47	23	54
• **encompasses the needs of the baby, the woman's family, significant others and community, as identified and negotiated by the woman herself**	5	12	5	12
• **follows the woman between institutions and the community, through all phases of pregnancy, birth and the postnatal period**	4	9	4	9
• **is 'holistic' – addresses the woman's social, emotional, physical, psychological, spiritual and cultural needs and expectations**	2	5	4	9
Non response	7	16	1	2

Table 27: Responses matching items from a definition of woman-centred care for midwives

7.8. Midwifery Continuity of Care

Team models of care had been developed at both cases in an effort to improve continuity of midwifery care for women. The survey asked midwives to describe what they understood by the concept of continuity of care. Four items identified by Hodnett (2004), discussed in Chapter Three, were used as a framework for comparison with the responses (Table 28). I acknowledge that there is a potential for overlap between the items however, only 10 (12%) of the respondents described more than one item. The majority (73%) described it as care by the same caregiver or team of caregivers. A few (6%) mentioned a shared philosophy or shared guidelines. Two respondents from each case only identified the care of women on consecutive shifts.

Items of continuity of care (Hodnett, 2004)	Case A		Case B	
	n(43)	*%*	*n(43)*	*%*
• **a stated commitment to a shared philosophy of care**	1	2	4	9
• **a strict adherence to a common protocol for care during pregnancy and/or childbirth,**	4	9	9	21
• **a system whereby those who are discharged from hospital are routinely referred to community services,**	0	0	3	7
• **actual provision of care by the same caregiver or small group of caregivers throughout pregnancy, during labour and birth, and in the postnatal period**	32	74	31	72
Non response	7	16	1	2

Table 28: Responses matching items from a definition of continuity of care

7.9. Conclusion

Midwives in Victoria have been experiencing change in the workplace related to the provision of maternity services. The midwives responding to the survey clearly value the interaction with women as an important factor in the satisfaction of their midwifery role. In

relation to changes that have occurred within the provision of midwifery services, the largest effect on midwives appears to be related to workload and staffing ratios. The Victorian state policies related to maternity care clearly support the development of woman-centred continuity of care models. While midwives responding to this survey indicate that maternity services provide woman-centred care there is little indication that continuity of care has improved. The implementation of models that restrict midwives from working in an area of choice might as identified lead to reduction of satisfaction within the profession.

The next section will explore the findings from the focus groups and individual interviews.

CHAPTER EIGHT

FOCUS GROUPS AND INDIVIDUAL INTERVIEWS

8. Introduction

This chapter presents the findings from the interviews and focus groups for both Case A and Case B. The findings from each case are presented separately. Three themes were identified for Case A and two for Case B. Only one theme was common to both. The findings for each case are presented separately, with discussion about the two cases in the next chapter.

8.1. Case A

Eight midwives participated in two focus groups and four midwives were interviewed individually. The midwives who participated in these interviews had similar demographics to the respondents of the survey (Table 29). There were six interviews with leaders, of whom one was no longer employed by the health authority.

	Survey respondents Case A		Interview participants Case A	
	n	%	*n*	%
Total participants	43	100	12	100
Employment status				
Part-time	33	77	11	92
Full time	10	23	1	8
Age group in years				
20-29	4	9	0	0
30-39	5	12	1	8
40-49	25	58	8	67
50-59	5	12	2	17
not answered	1	2	1	8
Age group of children in years				
0-4	3	7	0	0
5-9	8	19	2	17
10-14	11	26	2	17
15-19	5	12	2	17
20+	5	12	3	25
no children / not answered	13	30	3	25
Midwifery Education				
- Hospital certificate	26	61	6	50
- Postgraduate University course	16	37	6	50
- Undergraduate University	1	2	0	0
Years of Midwifery Experience				
- ≤ 10 years	16	37	6	50
- > 10 years	27	63	6	50

Table 29: Demographic characteristics of midwives participating in interviews compared with the survey response

Much of the data obtained was a description of the process and actual changes. This information has been used to inform the description of Case A in Chapter Six. From the interviews, several common threads were identified, many of which were inter-related. Of these, three themes were isolated; one relates to the midwives 'feeling unable to provide care', a second relates to midwives 'ability to practice as a midwife' and the third related to a 'loss of trust' in the management that was felt by some midwives. The first two themes

have several sub-themes, some of which might be perceived as relating to both themes. The themes and sub-themes will be outlined with examples of the data that informed the findings.

8.2. Theme One – Feeling Unable to Provide Care

There were many factors identified by the participants that contributed to their inability to provide optimum care for women. Frustration and dissatisfaction with the demands placed on them that restricted how they cared for women was seen, not only in what they were saying but also in their voices during the interviews. The sub-themes identified were 'workload and staffing', 'devaluing of postnatal care' and 'the physical environment' all contributing to an inability to provide care.

8.2.1. Workload and Staffing

Staffing levels related to the model of care were raised by the midwives who were interviewed, in particular in relation to how this impacted on their ability to care for women. One midwife stressed:

> *With one person allocated per shift for three LDRs or labour rooms, it's just ludicrous and sometimes you can have all three of them full, all three labouring and one person looking after all the other patients and that person still has to leave her postnates* [postnatal women] *to go in to receive a baby at the time. It's just not staffed at all well.*
> (Interview Midwife 3, Case A)

The increased workload may have been related to an increase in the birth rate the reduction of midwife:woman ratios and the difficulty in sourcing additional staff as identified in Chapter Six. These factors were related to staffing numbers, for example:

> *One extra person would be fantastic and I think you'd be able to actually give better care and give better quality care, because now some days I'm lucky if I ever get time to spend five or ten minutes with a woman before I have to go off and do the next thing* (Interview Midwife 1, Case A).

… another negative I have found about this model of care[41] *is that we have been stretched so far staff wise that it is a major, major issue and I think we are losing staff because they're burning out they're tired of working in this particular hospital because of the women:staff ratio and getting agency staff is a major problem because I heard someone quote the other day ' you've got to be kidding who would ever work here with this workload when compared to* [hospital D]'
(Interview Midwife 2, Case A)

The additional skills[42] taken on by midwives were perceived to contribute to a higher workload for the midwife, with no increase in staff levels. This increasing workload affected the ability of midwives to complete their work, and contributed to their dissatisfaction. The perception was that if midwives were unable to provide care to their own satisfaction, then they were more likely to leave:

We've increased our clinics, we've increased in every department they've just had enough. I've got senior midwives going home crying because they just can't complete their work. They'd love to move elsewhere but they can't. They have commitments.
(Interview Leader 3, Case A)

More than one midwife talked about leaving, for example:

I enjoyed being a midwife. I used to think this was the best area of nursing but now, if somebody offered me a job elsewhere I'd take it.
(Focus Group One, Midwife B, Case A)

[41] The midwives continually blamed the model for the difficulties when I felt that the factors impacting on the midwives were more complex. As they talked it seemed to me that the model of the integration – not necessarily the team model was the major contributor to the difficulties.
[42] Includes suturing, intravenous cannulation, antenatal care, baby discharge checks, while acknowledged as within the scope of midwifery practice were not widely practiced prior to changes at Case A.

> *It's made me think that I have to get out of the hospital system, it's encouraged me to go on and get further education* [to enable her to get another job out of clinical midwifery]. (Interview Midwife 4, Case A)

Despite the willingness of midwives to enhance their practice and increase their ability to provide continuity of care, the downside was that they perceived that it increased their workload. An increased workload regardless of the reason results in less time with individual women. Despite midwives trying to improve their ability to provide total care for women within the hospital setting by learning new skills such as suturing and intravenous cannulation, the less time she has to put these skills into practice. The effect of not being able to maintain continuity of care across a full shift was elucidated by one midwife who said:

> *I've done the* [suturing] *course, I just need to be supervised to continue, but that's a problem itself. The more things that I learn, the more stretched that I am. … Now, even though I've done the course and I've done two suturings, whenever the opportunity arises I'm too busy, so I say 'get the doctor' because I don't have time and there's a lack of continuity for the woman, but I just physically don't have time.*
> (Interview Midwife 2, Case A)

8.2.2. Devaluing Postnatal Care

All the participants mentioned the difficulties of providing care to postnatal women. The reasons provided for the inability to provide care included the rearrangement of the wards and the staffing levels of the new maternity model of care. In addition, the early discharge of women, usually within 72 hours, increased the perception that there was a need to provide women with parenting education, information and support within a short period of time while they were in hospital. All women at Case A were offered at least one home visit, an environment more conducive to provision of information that women want rather than what the midwife perceives they need. A continuity of care team midwifery model might be expected to enhance this care as midwives get to know the woman's needs throughout the pregnancy and can potentially anticipate some of the postnatal needs.

However, the team model at Case A did not appear to provide that level of continuity. Repeatedly the issue of insufficient staffing was raised as affecting women's care, especially postnatal care. When asked if care for women had improved one midwife said:

> *If we were staffed properly yes, but because we're not staffed properly, no* [women's care has not improved]. *A lot more* [women] *are going home with a lot more problems because we've not got time to help. People who are staying in for 3 days are going home without ever bathing their babies because no-one's had the time to show them or help them do it… they are going home earlier with more complications because we haven't got the staff to deal with it and we have had an increase in our numbers* [births] *as well…* (Interview Midwife 3, Case A)

The inability to care for women at times led to a reliance on women to care for themselves. The midwife quoted below identifies several issues that suggest postnatal care was not valued. These included the regular expectation by management that postnatal women would be left unattended, that women might not ask for assistance because the midwives were busy, with the implication that women in labour are more important. She said:

> *I leave my postnatal patients* [sic] *alone and have to go and receive a baby. So you take it on trust that the women* [will manage], *and the women know you're busy so they are very reluctant to ask you for help, and that's not the way it should be, they should have a level of communication that feels that they're not impinging on you* [that is, not feel guilty about calling for assistance]*; and they know you're busy and they know women are labouring as they can hear the women screaming, … and they won't ask you* [for help]. (Interview Midwife 4, Case A)

It was reiterated by many of the midwives that, because of the model and staffing levels, the focus of care was on birthing women, to the apparent detriment of the postnatal women, for example:

> *The women just do not get the care that they should, because if you've got an LDR* [birth] *issue the postnates just get left by themselves and it's just*

not good enough, if you've got two in labour that's two staff and who does the postnates – nobody. [murmurs of agreement]
(Focus Group One, Midwife A, Case A)

8.2.3. The Physical Working Environment

There was much discussion surrounding the changes to the physical environment and the impact that this had on the care provided for women. The birthing rooms were interspersed with the postnatal rooms (see Figure 5, Chapter Six) and the distance between these birthing rooms, in association with the development of the teams, reduced the midwives' ability to support each other. The implication was that if the birthing rooms were altogether they could support each other to care for women. This was discussed quite vociferously in one focus group:

If we were together, we could all support each other more and give these women the care that they need in labour. I mean they are expecting us because of the EBA [enterprise bargaining agreement] *as well, to cope with two midwives with three labouring ladies …* (Midwife B)

It shouldn't really happen (Midwife C)

[It] *makes me … angry because I'm here to look after my patients and they are my number one priority and the care you give them, and it doesn't happen and it's very frustrating, very frustrating. I feel very sad.*
(Midwife B)
(Focus Group One, Case A)

The physical environment of the renovated maternity unit at Case A was noisy and busy with access to some of the postnatal rooms necessitating visitors to pass outside of the birthing rooms. These factors were identified by the midwives and leaders as impacting on the ability to provide a suitable environment for women to give birth in, a space that is quiet

with sufficient room to move around in and where there is no risk of visitors walking uninvited into the room. As one midwife explained:

> *The way its set up at the moment is difficult some times, because just the physical fact that you have visitors walking past women's doors who are having babies. That in it, if it was me in labour would make me a little bit anxious. So I think that's got a fair amount to do with the physical environment that these women find themselves in,* [it] *is not closed comfortable, safe. I think that does create a problem for women.*
> (Interview Midwife 2, Case A)

Theme one demonstrates the importance for midwives of the role as caring for women and the difficulties faced in providing that care. The overall impression was that, despite the intention of the government to improve women's satisfaction (DHS, 2004a) with their care, there was a potential at this site to have the opposite affect. As outlined earlier, the idea of the new model was proposed as a way to enable midwives to work across the full scope of midwifery practice. The second theme to emerge out of the data provided a dichotomy of views about practising as a midwife.

8.3. Theme Two – Ability to Practice as a Midwife

The model of maternity care at Case A was introduced to the midwives as a vision of what could be achieved for women. The ideas of providing women with woman-centred care, choice of antenatal provider and continuity of care were the concepts underpinning the vision. The opportunity for midwives to work across the full scope of midwifery practice was also promoted as an essential part of being a midwife (Interview Leader 6, Case A). Several sub-themes were identified that relate to the 'ability to practice as a midwife'. These sub-themes were 'fear and anxiety', 'consolidating and maintaining competence', confidence to provide care', 'midwifery philosophy', 'valuing the midwifery role' and 'loss of trust'.

Within this framework, the education provided to the midwives in the forums about the model implied that they needed to change to fulfill the role of the midwife:

> [In the forums they were saying] '*We're going to do this' and you guys will be in teams and do everything, and if you don't like it you can't really be registered, because being a registered midwife means that you must be able to perform at all levels of midwifery…That's ok, but for the last 15 years or however long they* [some midwives] **haven't been doing that** [emphasis in voice]. (Interview Midwife 3, Case A)

Midwives who had accepted the changes embraced the ability to practice across the full scope of midwifery practice. They identified it as a positive concept. It had even led to one midwife travelling for over one hour to get to work, as she pointed out:

> *I know I could work somewhere closer to home, but I don't want to work just in one particular area. I think that's limiting yourself and your skills and its also limiting just the experience of being a midwife. I find it really rewarding to be able to do all areas. I think it would be boring just to do one area.* (Interview Midwife 1, Case A)

The introduction of antenatal clinics physically based in community settings was identified by one midwife manager as a positive development for both women and midwives. She had midwives who having developed the confidence to work in the community wanted to do more:

> …*women think that they* [midwives in community clinics] *are* ***their*** *midwife. The midwives really feel they own those women and they want the flexibility when they're on, if women call to say they are too sick to keep an appointment, the midwives want to go to see them at home. And they want to birth those women. They definitely are asking can they be there, an they be called in early and can they be paid. There is definitely this bond between community clinic midwives and women.*
> (Interview Leader 4, Case A)

These midwives were clearly willing to change to be able to provide continuity of carer for women. Unfortunately the model, colleagues and organisational needs posed barriers to implementing caseload practice.
Those participants who had embraced the model talked about the *rewarding* experience of having the ability to provide continuing care to women. As one midwife put it:

> *The people* [midwives] *who do clinics end up loving the clinics because they get to see the same women, you know week after week or month after month and that's a very rewarding way to know that everyone's getting everything done and being followed through properly.*
> (Interview Midwife 3, Case A)

The sub-themes that emerged for theme two demonstrate the different reactions of the midwives to change and their role as midwives.

8.3.1. Fear and Anxiety

The perception was that many of the midwives did not embrace the midwifery model. The participants believed that many of the midwives were anxious and stressed about becoming competent to provide care for women. Although, fear and anxiety about the future is a common occurrence for individuals involved in change (Antonacopoulou & Gabriel, 2001), participants felt that the lack of sufficient education and support provided prior to the change contributed to the stress. In particular, midwives who had worked primarily in the postnatal areas felt that their preparation was insufficient to enable them to feel comfortable and capable of providing care to women for birth. The effect was to cause distress for several midwives, although not for all (Interview Leader 3, Case A; Focus Group One, Case A).

While one midwife discussed how some midwives felt they had been 'thrown in' and left to cope, she herself had been pro-active and re-skilled herself through a program outside the hospital. Although she had commenced this before the changes had been announced, she

had recognised that to be able to feel confident and return to practice in an area where she had no recent experience, required substantial effort. She said:

> *…there was a little bit of anxiety from staff who had been working postnatal who had in their words 'been thrown back in to the birth area'. Whereas for me it was wonderful as I was keen to get back into an area where I wanted to work, so I found that it was a great opportunity for me. I went back and did a re-entry program because I hadn't been in the birthing unit for a long time … because I know there are gaps in my education because I hadn't been there for a long time. So that's how I got over the fact that I'd been lacking skills.* (Interview Midwife 2, Case A)

Everybody who participated in the focus groups agreed how difficult it was for those midwives and acknowledged the anxiety felt by many of them. One midwife explained:

> *I think that's another thing, with some of the midwives is that they were quite happy working in the area they were in. They were quite happy working in postnatal for 20 years. With this model they have been forced to work in areas like labour rooms that they haven't done in 20 years. They are absolutely petrified and I don't blame them it's scary stuff when you haven't done it* [for so long]. (Focus Group One, Midwife C, Case A)

It was raised several times by participants that midwives had been promised that they would not have to work anywhere unless they felt comfortable to do so. As soon as the move to the new model occurred however, midwives had no choice. At no time during the interviews was it ever suggested that midwives had refused to work in an area, although apparently sick leave increased and some midwives resigned (Interviews Leaders 1 & 2, Case A). There had been a suggestion by two of the leaders (Interviews 2 and 6, Case A) that midwives had been 'bullied' to conform with the changes but no explanation or suggestion of how it might have been managed differently. It was apparent that some midwives did feel forced to work in an area they were uncomfortable with. The use of power to overcome resistance during change is well described in organisational literature (Graetz et al., 2006). However, there were two driving forces in Case A, one was

organisational (to reduce beds), and the other was midwifery driven (an aim to improve woman-centred care).

One leader presented the lack of support as increasing the fear saying:

> *I think that a lot of people were really frightened you know, in relation to the change, because if you've worked in postnatal for 10 years and suddenly you have to go to labour ward and you didn't take up the opportunity to actually be up-skilled, or there wasn't a particular plan to actually address their issues then you can understand their fear, you know the fear factor.* (Interview Leader 5, Case A)

Everyone who participated in the interviews used the term 'up-skill' when in reality they were referring to basic skills of midwifery practice. Some of these skills such as suturing and intravenous cannulation, would not have been considered as the domain of the Australian midwife when the majority of the midwives participating graduated. It is the ongoing need to maintain all midwifery skills that provided the next sub-theme.

8.3.2. Consolidating and Maintaining Competency

One of the leaders and several of those interviewed discussed the apparent increasing numbers of critical incidents[43] (Interview Leaders 4 and 5; Focus Group One, Case A). Two of the eight midwives who attended the feedback focus group felt this was a false perception due to the increasing numbers of births. Unfortunately I was unable to gain access to statistics to be able to confirm or refute the view of the participants.

The participants of focus group one vehemently discussed the increasing number of critical incidents and provided several examples of poor practice. They enumerated several reasons for this perception including the loss of skills, lack of education, and the lack of opportunity to consult with each other. The midwives were particularly concerned about

[43] Critical incident is a term used when obstetric/medical emergencies or medication errors occur.

their colleagues failing to recognise that women with deviations from normal required different management of their care:

> *A lot of people are into 'treat the patients as normal', but you are getting people like diabetics etc. and they are all being treated as normal. Don't worry about the diabetes and the hypertension and the preeclampsia that's ok….* (Midwife B)
>
> *There doesn't seem to be a clear cut line between abnormal and normal, so once you get to being abnormal you're still treated as normal.*
> (Midwife A)
> (Focus Group One, Case A)

Further discussion in this focus group revolved around rostering and the difficulties for midwives to consolidate their learning:

> *One of the ways we learn is by repetition. So if you are working in an area,* [continuously] *you may do five VEs* [vaginal examinations in succession]*, and that's just what the girls are not getting because today they do LDR* [labour room], *tomorrow they do postnatal.*
> (Midwife D)
>
> *Then they go on dom* [postnatal homecare], *then clinic.*
> (Midwife C)
>
> *They might not get back to LDR for three weeks* [then] *they've just lost the skill that they learnt when working in that area* [previously].
> (Midwife D)
> (Focus Group One, Case A)

The apparent loss of skill after a time out of the area might be related to an overall lack of confidence within that area. Midwives who have been very confident in one area of practice may have the knowledge but lack confidence. While the rosters might have

contributed to a lack of consolidation of midwives' skills, there were also concerns about the availability of educators. In addition, it was pointed out that the previous birthing area had provided a more suitable environment for providing midwives with support to learn, for example:

> *You can have an educator come and assist with an epidural on a Thursday, then on Sunday we have to do it again - you've been shown so that's ticked off* [as done]. *That happens on the wards now. In delivery suite someone would show you, then someone would show you again and again if you need it, so there would be follow up support - now* [you are] *shown once* [and the educators are] *gone.* (Interview Leader 3, Case A)

Consolidation of skills was recognised as an issue for midwives having difficulty becoming confident to suture:

> *I've done the suturing course* [but] *I haven't got enough time to be supervised to actually feel like I can be independent. I've done it* [suture] *about six times but I still don't feel,* [opportunities are] *so few and far between, that I'm happy to do it independently.*
> (Interview Midwife 3, Case A)

The expectations were that at a minimum, all midwives would work across both the labour and postnatal areas (Interview Leader 3, Case A). Emerging from the data was the perception that some midwives continued to resist, endeavouring to only work with women in the specific area that they felt comfortable in. Midwives and leaders interviewed reported that midwives who were uncomfortable with an area made their preferences known at the beginning of a shift, in anticipation of getting allocated to women in their area of choice. The person in charge frequently assisted in these avoidance strategies by allocating according to the preferences of staff. Although the midwife in charge might feel more comfortable herself with an experienced midwife caring for birthing women (Focus Group One, Midwife C, Case A), continually allocating midwives to their comfort zone reduces their opportunities to gain valuable clinical experience. If midwives are not given

the opportunity to develop confidence to work in an area then potentially these midwives would not be competent to cope when there is no choice. One leader recognised the potential problem of this behaviour:

> *…you'll still hear at handover time 'oh you're a birthing person you go with that labouring lady, you prefer posties* [postnatal women] *you can go with the posties', which is narrow-sighted really because in the event of someone having to go into birthing and they haven't done it for a while, well then there's a pickle* [problem]. (Interview Leader 2, Case A)

This attitude of providing the staff with an apparent choice to work where they were comfortable came through the different interviews as occurring more consistently in one specific team. While providing midwives the opportunity to work where they felt comfortable might be seen as being supportive, it would not have promoted confidence to practice.

8.3.3. Confidence to Practice

While some midwives appeared to struggle to gain experience to feel confident to practice across the full spectrum of midwifery care, for others the opportunity improved their overall confidence. The introduction of midwifery-led antenatal care has provided midwives with a greater ability and confidence to care for women in the community. As one midwife said:

> *…getting to know the woman through the various levels of her pregnancy and afterwards… increases your skills, increases your confidence in yourself and also the rapport with the woman.*
> (Interview Midwife 1, Case A)

The midwives enjoyed the variety. They used the community clinics to have a break from the busy wards. Midwives developed the confidence to care for women in all the different areas providing them with a sense of achievement. This positive effect of the change was recognised more by the leaders, for example:

> *…a lot of midwives have really blossomed, have really taken on board the challenge and they're now making a conscious effort you know. They've been moved outside of their comfort zone and they really like it, they are doing lots of different things and they are happy to do it. …now I think with having that flexibility and now with dom and teams and that sort of stuff there's a greater satisfaction for the midwife in her practice.* (Interview Leader 6, Case A)

> *I think it's really interesting that a lot of the midwives have an enormous sense of achievement that they can now work across all levels of midwifery. I think that the people that have been here and embraced the model have had no problem getting a job elsewhere …I think it is really interesting that when people apply for jobs they come back to you and say 'they were really impressed because I can do all of this'* [full scope of practice] (Interview Leader 5, Case A)

Extension of practice was not defined either during the interviews and focus groups or on the survey. Throughout the term 'up-skilling' was used, but it could be argued that a more appropriate term would be 're-skilling'. As the terms 'up-skilling', 're-skilling' and 'extension of practice' all refer to a change in practice for midwives they are discussed together. Most participants discussed extension of practice in relation to midwives taking on more aspects of pregnancy care than they had been doing previously. For several participants, the model at Case A was seen as providing the opportunity to work as a midwife as defined by the ICM (2005a). For a few, this included aspects of the role that until recently have, in Australia, been considered a medical role. Skills such as suturing, insertion of intravenous cannulae and insertion of Prostin[44] are now widely accepted as the role of the midwife at many hospitals, but not as yet expected of the newly graduated midwife. At the present time in Victoria, these skills are not routinely taught as part of the basic education of midwives.

[44] Vaginal prostoglandins

As the midwives became more confident, they relied less on seeking out the medical officer for assistance with procedures. There was recognition by the leaders in particular that midwives were changing their practice and taking on a wider role in caring for women.

One said:

> *…that was another big component that I see of the actual change, that I see the change in their practice.* (Interview Leader 4, Case A)

There still remained a number of midwives who were uncomfortable working in some areas. As only a few of the midwives who had previously worked in the postnatal area agreed to be interviewed, it was unknown why most of the midwives who disliked working with birthing women disliked it. A lack of experience was the main suggestion but one midwife identified the bullying that had occurred when she was a student as the reason she continued to dislike working in the labour environment many years later:

> *Technically I work all areas but I avoid the birthing rooms like the plague…because I didn't have a good time when I was training in labour and delivery – when they used to call it that – I was bullied there and I hated it* – [having a] *no good experience doesn't lead to confidence in anything else… I don't like birthing, I can do birthing, I have enough skills to do it but I just don't like it.* (Interview Midwife 4, Case A)

It may be that the previous experiences of other midwives also contributed to their lack of confidence and reluctance to work with birthing women. The midwife quoted above did not see herself as any less of a midwife by only providing postnatal care and others were of the same opinion. There were also midwives who had worked only with birthing women who did not enjoy working with postnatal women. The new model provided midwives with the opportunity to gain a different perspective of the midwife role.

8.3.4. Collegiality and Support

There was an acknowledgement that working across all areas provided a clearer understanding of what everyone's midwifery role entails.

> *I enjoy it because I do have opportunity to work in all fields of midwifery. I think that makes me a much better midwife. It makes me a much more considerate midwife to my fellow midwives in different areas, because I think very often you can have a me and them mentality, them in SCN, them in birthing unit. That sort of thing can happen I think sometimes people forget the sort of things that can happen in those areas, they think their work is the toughest the worst…* (Interview Midwife 2, Case A)

Relationships within the teams were considered good. Prior to the renovation, communication barriers existed between the staff of the postnatal wards and the birthing area. Initially everybody was seen to work together. Over time those barriers had returned and there now existed a certain amount of rivalry between teams. That rivalry might contribute to a reluctance of midwives to move between teams to cover shortfalls in staffing:

> *I think we're really quite supportive, we're supportive in the teams, not necessarily across the teams.* W*e're still fragmented quite effectively…friends tend to stay with friends, sort of normal I think…but it is very fragmented like A and B* [teams] *get on very well together because they're on one side, but if I'm moved over to C or D, its like* [I was] *having a panic attack over there, because I didn't cope very well over there.* (Interview Midwife 4, Case A)

The midwives in one focus group discussed the way the night-duty midwives worked together. The allocation of midwives according to their previous experience was discussed in the context of providing women with midwives capable and willing to provide appropriate care and supporting each other:

> *We* [night staff] *also know the capabilities of our own staff a lot better, so you would know if you are on with someone who is not, like there is*

people who don't like to go in and receive a baby so [indicates one of the other midwives] *you would make sure that you know who else is on that you can call to receive your baby. So that you'll say '[name of midwife] my lady's nearly fully* [dilated] *when I buzz can you come?' so she knows that when 28* [call bell] *goes she'll come.*
(Focus Group One, Midwife A, Case A)

It was evident from this particular focus group that the night-staff of two of the teams worked together more closely than the other two teams. The midwives on the other two teams indicating that they had no choice because of the mix of experienced staff everyone had to do everything and did not share the workload across the teams. It was clear that the midwives in charge of the ward each shift were to some extent colluding with those who wished to avoid areas. Reasons for this action may be seen as supportive of colleagues, protective of self or to enable provision of quality care for women, most probably a combination of all three.

8.3.5. Differing Philosophies

During the interviews the differences between midwives who believed in midwifery models of care and those based in a medical model, was most pronounced with those who had previously worked in the birthing area. One of the leaders discussed the attitude of the labour staff compared to the postnatal staff and the more recently qualified midwives:

Surprising enough the postnatal girls moved across to the delivery much better than the delivery girls[moved to postnatal] …*but there was criticism from the delivery suite girls saying 'they are not doing it properly' but at least they'd* [postnatal midwives] *go across and they'd have a go. I suppose there's this difference, you know, a lot of the girls particularly the postnatal girls are a lot more midwifery orientated, they handle their women much more in that way. Whereas the old delivery suite staff tended to be much more dominant,* [previously] *they wanted the synt*[ocinon] *up, they just shove the pethidine in…and it still happens.*
(Interview Leader 4, Case A)

It was recognised that there was more to providing midwife-led care than setting up a specific model. That for midwife-led care to be successful at Case A, there needed to be a change in philosophy of care:

> …*but then again if it* [caseload] *runs from here and you're using the midwives from here, a lot of them are still in the model of medicalisation, so even with caseload you still could run into problems, midwives still of that philosophy.* (Interview Midwife 3, Case A)

The overwhelming impression was that the midwives were continually talking about continuity of carer that is where only one midwife provides care across pregnancy, birth and postnatal care (Hodnett, 2006). They did not discuss continuity of care from the perspective of the woman receiving care from a team of midwives, where continuity is an outcome because of consistency of information and management throughout the period of the childbearing experience including the development of an ongoing relationship (with one or more members of the team) (Guthrie et al., 2008; Saultz, 2003). Never was it mentioned that they were working guided by a similar philosophy and care practices that should underpin the care provided by a team. It was acknowledged by one of the leaders that to educate and change practice had been difficult, with midwives openly saying that they would continue to do things the way they had learnt them. This was reiterated in the focus groups. In one group, the participants could not understand why some midwives continued to insist on doing unnecessary tasks that were not based on evidence. In the other group, there was a stance for continuing practice as 'we learnt it' with one midwife actually stating that she wouldn't change her practice. Several acknowledged that the only model that could provide the type of continuity of care that they were talking about was with caseload practice.

8.3.6. Valuing the Role of the Midwife

Many of the midwives were satisfied with the acceptance of their role by the women that they were working with. There was discussion about the wider lack of recognition of the midwife role as the primary care giver for women in birth, by both the general public and

the medical profession. In particular, that there is a lack of understanding in Australia of exactly what a midwife's role is. It was felt that midwives are not valued for the work they do and until they receive commensurate pay for their role, their status as professionals will not improve, for example:

> *I think that until midwives get their own provider number*[45] *and midwives get their own rate of* [pay] *you know whether a woman chooses to deliver with an obstetrician, for a normal delivery he will get the same amount of money as a midwife who does a similar job. We will never get anywhere until this happens.*
> (Focus Group Two, Midwife B, Case A)

Recognition by others is not the only barrier to improving the status of midwives. The resistance of midwives themselves, to seize any opportunity to act autonomously hinders the development of the profession.

One theme that did not sit with either of the previous themes was directly related to the process of the implementation of changes, so is presented as a single theme.

8.4. Theme Three – Loss of Trust

Both the midwives and leaders highlighted the communication difficulties that occurred during the change process. The midwives felt 'let down' when forced to work in the areas they were not comfortable in:

> *The leader had the vision and she recruited people appropriately. I agree with the model, but the way it was done left a sour taste in everyone's mouth and my level of trust diminished greatly because staff would say 'you said',* [or]*' some other manager said we wouldn't have to go into labour ward if we didn't want to' and that's exactly what was said.*
> (Interview Leader 3, Case A)

[45] A provider number is an identification number used by medical practitioners to claim allowances for services provided through the government health insurance Medicare system.

It was not only the midwives who lost trust in the management, but the middle managers lost any trust that they would be supported by the senior management.

Information was provided in an effort to stimulate open discussion between the midwives and management. The extremely hostile response from many of the midwives right from the beginning, suggests trust never existed. One of the leaders felt quite challenged by the midwives response, saying:

> *They* [the midwives] *were quite threatening. I first remember feeling like a piece of meat with a lion charging towards me. They were angry. What we tried to do was get the change from the bottom up.* [That is] g*et the clinicians wanting the change, and even though we could never generate the passion at the time, we had to change. So it was seen as a management change.* (Interview Leader 1, Case A)

Although a vision was spoken about by the managers despite their best intentions they failed to effectively communicate this vision to the midwives other than as something that management wanted.

The midwives felt that they had not been listened to:

> *I did go to the forums and they got very heated…well basically everyone knew that the change was going to come,… you know they said they'd talk to us about it and we'd have our input, but really there was no staff input. They made all the right noises that you have to make, but management didn't really want to hear what we had to say.*
> (Interview Midwife 4, Case A)

The midwife quoted above was referring to the processes that would enable management to say they followed the correct procedure for implementing organisational change. Victorian guidelines clearly include the need for discussion with staff and the involvement of the ANF.

8.5. Summary Case A

Three themes were identified for Case A and were presented here; 'feeling unable to provide care'; 'ability to practice as a midwife'; and 'loss of trust'. There were several sub-themes that while mainly connected to their respective main theme might also impact on the alternative one. The themes for both cases are compared in Table 30 at the end of the chapter.

The findings from Case B are now presented.

CASE B

8.6. Case B Interviews and Focus Group Findings

Two focus groups were attended by seven midwives. In addition, three midwives were interviewed individually and one provided information by email. There were a few differences between the demographic characteristics of the midwives who participated in the interviews and the respondents of the survey (Table 30). Of the midwives interviewed, half had transferred from Hospital C when it had closed. Two of the others had joined Hospital B since the rotation model had commenced. One came for the opportunity to rotate. The other midwife accepted an associate manager's position that would enable her to become a core staff member and she would not be expected to rotate. This midwife had moved from an integrated unit where the midwives were expected to work across birth, postnatal and special care nursery areas.

There were three interviews with managers and leaders. During the change process, of these three, one was an off site senior manager, one was an educator and one was a unit manager. The other unit manager involved in the change process was no longer employed within the health service and no other leaders, educators or managers were identified. The lack of leaders compared to Case A might be a reflection of the size of the maternity unit and the lack of antenatal services on site. In contrast to Case A, only a few of the respondents to the Case B survey completed the question about who they recognised as the leaders in their workplace. The three leaders interviewed were chosen because of their roles. They were each mentioned by two or three of the survey respondents.

	Survey respondents Case B *n*	%	Interview participants Case B *n*	%
Total participants	43	100	10	100
Employment status				
Part-time	29	67	7	70
Full time	12	28	2	20
			1 missing	
Age group in years				
20-29	5	12	2	20
30-39	8	19	3	30
40-49	12	28	4	40
50-59	11	26	1	10
60+	2	5	0	0
not answered	5	12	0	0
Age group of children in years				
0-4	4	9	1	10
5-9	3	7	1	10
10-14	7	16	2	20
15-19	3	7	1	10
20+	13	30	0	0
no children / not answered	13	30	6	60
Midwifery Education				
- Hospital certificate	30	70	5	50
- Postgraduate University course	12	28	4	40
- Undergraduate University	1	2	1	10
Years of Midwifery Experience				
- ≤ 10 years	13	30	4	40
- > 10 years	30	70	5	50
			1 missing	

Table 30: Demographics of midwives participating in interviews compared to survey

From the interviews and focus groups, one theme 'ability to practice as a midwife' with five sub-themes was identified and matched the second theme of Case A. The second theme that was identified as the 'loss of self', pertained to only to those midwives who were integrated from the maternity unit that closed. As with Case A, much of the data was

descriptive and has been used to inform the description of Case B in Chapter Six. Data were analysed separately to Case A and then comparisons made of the identified themes. During analysis the coding of the data closely resembled that of Case A in relation to the second theme of 'ability to practice as a midwife'. While workload and staffing levels were mentioned they did not appear to be such an issue as for the midwives at Case A. Neither the physical environment nor valuing of postnatal care were mentioned. Nor was loss of trust mentioned, possibly because the management at Case B appeared to have listened to the midwives because variations were made to the proposed rotation model in response to midwives concerns.

8.7. Theme One – Ability to Practice as a Midwife

During the process of change the midwives at Case B were told during the discussion forums that the introduction of a rotating model would enable the midwives to extend their scope of practice (Interview Leader 1, Case B). The rotating model at Case B in contrast to Case A, was never presented as a continuity of care model with expectations of improving services for women. The community based continuity of care team model was implemented at a later stage and was different in that it was a voluntary process to participate and not the only option. The main theme for Case B is however, similar to the second theme and sub-themes, identified for Case A.

The implication was that by registering as a midwife, they should be able to work across postnatal and birth was made clear by a few participants. However, this requirement led to attrition from the profession.

> *I just feel it's a bit sad, like with the up-skilling, that we lost so many good midwives because they wouldn't rotate. So it's a bit of a quandary really because midwives sign their registration* [that they are capable of working as a midwife] *and they should be able to work in all areas. I just felt that it was sad that we did lose some, who were prepared to leave midwifery simply because they had no confidence to work in another area. … and that was despite me sitting down one on one talking to them, offering them support, working with them personally. They were just not prepared to do*

it, and I think that was quite sad that we lost them.
(Interview Leader 1, Case B)

Although the leaders and midwives discussed the need for midwives to work across the full scope of midwifery at Case B, except for the community team, there was no opportunity for these midwives to provide antenatal care. Further, there was little recognition that while the managers and educators discussed the full role of the midwife there was no acknowledgement that the managers themselves only worked in one area.

In contrast with Case A, few of the midwives interviewed at Case B mentioned the ability to be able to practise across the full scope of midwifery as an effect of the changes. One midwife however, did recognise the importance and positives of having the ability to practise in more than one area, saying:

> *As far as rotations though, as a midwife with under three and a half years experience it* [has] *been great to keep my skills. For someone like where I am at, personally I wouldn't work at a place that didn't rotate because I don't want to lose* [skills]. *They don't rotate to nursery here which is a bit of a shame .. but being able to do classes and home visits I think is a real positive.* (Focus Group One, Midwife C, Case B)

The ability to practise across a range, if not the full scope of midwifery practice was clearly more appreciated by more recently qualified midwives for both cases.

8.7.1. Fear and Anxiety

As with Case A, some midwives had been anxious and fearful about making the change to a rotating model. For Case B however, the model was redesigned to reduce the frequency of rotations and the length of time spent in the alternative area (Interview Leader 1, Case B). There remained several midwives who had not necessarily resisted working across both the labour and postnatal areas, but have had difficulties in making this transition:

Some of them it's not the lack of support. They even say 'I know I'm well supported there', some of them it's a psychological thing they don't want to be there no matter what. (Interview Midwife 1, Case B)

Many staff were progressing well but for others the thought of working within the birth unit is sufficient to cause fear and anxiety:

…but for other staff its just been a nightmare and I can see it, they've tried to do the up-skilling stuff doing the 'in-services', its nearly always this area here [birth unit] *and it just freaks them out they just don't know what to do,* [they] *just work themselves up.* (Interview Midwife 2, Case B)

It was recognised that, despite encouraging the midwives to extend into postnatal home care, some midwives remained reluctant to become involved. They were uncomfortable with the driving and provided excuses as described by the midwife who did the rostering:

We're now getting some of the girls saying 'I can't do EPC' [postnatal home care] *and I'll say why what's the problem …' I can't possibly I'll get lost'... they don't like coming out of that comfort zone.*
(Interview Midwife 2, Case B)

Midwives in Victoria until recently had no experience of community midwifery during their training. Most would have had a limited exposure to nursing in the community but for some it would be a long time ago. Although these midwives were initially well supported at Case B, a small proportion were apparently still having difficulties. As was pointed out by one participant at Case A, there may have been other underlying factors, such as 'bullying' or being involved in 'critical incidents' that continue to impact on midwives' ability to work across the full scope of midwifery. These midwives did not volunteer to participate and therefore the fear and anxiety identified here is the perception of colleagues, who are indirectly affected as their workload increases to compensate and support others.

8.7.2. Consolidating and Maintaining Competency

The workload and staffing levels were not such an issue at Case B as at Case A. There were still concerns about the shortage of staff but this was not related to the changes that had occurred. The changes to the model with the introduction of the rotation model had led to increased stress levels for some midwives, primarily in relation to their ability to cope with the workload. When midwives first rotated to the birthing suite they were given a relatively light workload with allocation to the less complicated women with support from the more experienced midwives. When many of those more experienced midwives left to go to hospital D, the expectation for the rotating midwives increased. That I felt might be expected after 12 months of working in this model. The result was increased stress levels and for some midwives an inability to function at the level expected, for example:

> *I know the girl I'm working with* [at present, it] *doesn't take much to fluster her. She was performing after 12 months at an acceptable level, nothing flash but acceptable. Then the expectations* [went up] *because it got busier and we had new associates* [in charge positions] *coming into the position. The expectation on these girls changed and instead of the associates getting these girls* [to] *do basics, they started to put pressure on them expecting more of them, giving them a higher workload and expecting them to manage. ..and of course what happened with this girl that I'm working with, she just folded…* (Interview Leader 1, Case B)

Two factors increased the difficulty some of these midwives had in coping with labouring women. The workload had increased and the midwives appeared to lose confidence between rotations to the birth suite. One of the complaints of the midwives at Case A was the lack of time spent in one area to enable consolidation of learning. At Case B, the longer rotation to each area would potentially have overcome that difficulty, but this did not appear to be the case. One said:

> *Having listened to a couple of staff who want to be doubled* [supernumerary] *again, when you sit down sometimes it looks like* [a long time since they were there] *and it may have been unavoidable they've had holiday or sick leave. You've got to look after those skills too because*

we're so worried about their competency, you just get them through, and you've got to go through it again [getting them up to a basic level] (Interview Leader 2, Case B).

The development of a competency learning tool should have identified midwives who required additional help but as mentioned earlier there had been difficulties with appropriate completion of the tool by the supervising midwives. The educator at Case B had more clearly documented evidence of the level of knowledge and skill competence than at Case A, where no apparent effort was made to ensure midwives had appropriate skills.

Development of new skills such as perineal suturing and intravenous cannulation was slow. It was not that the midwives did not want to extend their skills but that the workload and rotations reduced their opportunities to become competent, for example:

I did try [suturing] *about 10 years ago…I did get to practice once and it was another 12 months before got to do it again.*
(Focus Group Two, Midwife B, Case B)

Some midwives were unable to participate in other aspects of midwifery practice because of the social constraints on the hours they needed to work:

I've worked permanent night shift, so a lot of the other things …doing classes or antenatal clinics [I can't do]. *I do cannulation. Suturing I've tried to get done. I've gone and done a course and then there's never anyone around to follow through with that.*
(Focus Group One, Midwife A, Case B)

Discussions about competence highlighted the issues that some midwives who did not like an area put little effort in and therefore were at risk of losing skills gained previously.

…but those who don't want the change in the first place, and some of them have stayed pretty negative about it…because they haven't got the interest they try to do the least possible work when they get to the opposite

area, and because of that, their skills maybe aren't staying up as well as those who are interested. (Interview Midwife 1, Case B)

Participants recognised the difficulties that some midwives had in becoming competent in an area they, for whatever reason, disliked working in. The midwife quoted below was supported by others in the focus group and was reiterating what was said by several participants in Case A.

…it's good to up-skill [but] *a lot of midwives are not comfortable with that, and never will be and it's not always to the benefit of our clients. There are midwives that shouldn't work in a particular area and they are being forced to,* [both] *in rotation and in other integrated units,* [where] *labour and postnatal* [wards are] *together. Staff have to be proficient in all areas and unfortunately that's not the case. No matter how much you try and up-skill people if that's not what they want to do they are never going to be proficient in certain areas, so it may get to the stage where it forces them out of that particular workplace, just because having to work in areas they don't want to.* (Focus Group One, Midwife A, Case B)

8.7.3. Confidence to Practice

The rotating model was seen to have improved midwives confidence in themselves and their ability to practise as a midwife:

I've seen a lot of midwives who were lacking confidence in certain areas, those that were stuck in postnatal for many years were scared stiff of coming to labour ward. NOW their self-confidence and self-esteem has gone up a lot, now they know they can go around [to birth unit] *and do it so that's improved a lot. That would be the main* [positive of model change] *because they've been re-skilled and you can see their attitude towards everything, their self-confidence, showing that they can be a midwife like they were trained to do.* (Interview Midwife 1, Case B)

The main improvement in confidence was for the midwives who went from the postnatal area to the birth unit. For midwives going from labour to postnatal they may also have gained confidence but certainly changed their attitude:

> *Well there were midwives who hadn't been to a birth for years and now assist with normal birth. Now midwives from birth unit will go willingly to maternity, and appreciate the huge workload,* [the] *complexities of postnatal care and time management.* (Interview Leader 2, Case B)

There was recognition of self-development, of having the confidence to extend their practice and feeling satisfied:

> *Some I think are enjoying that change and I put myself as one because I came from a low risk* [unit, in an] *associate position on night duty. Now I'm associate unit manager on days on birthing unit. … it's very stimulating, I'm finding it very stimulating. I think I was that sort, that just came to work and it all went along quite smoothly. So it's been stimulating, in a way I feel quite revitalised.*
> (Interview Midwife 2, Case B)

The effect however, for some midwives was a lack of confidence impeding how they were seen to practice. Providing care for women depends greatly on the ability of midwives to instil confidence in women that all is well with their labour. If a midwife is unable to instil confidence then the question must be asked is that midwife providing optimum care as a midwife. These points were identified by both midwives and leaders:

> *…I do have the odd woman who would say to me 'oh that midwife looked very worried', or 'she didn't look like she knew what she was doing', which really doesn't instill a lot of confidence into women who are in labour…* (Interview Midwife 3, Case B)

I don't think in a way that it's [the rotation model] *as good for women because they are getting midwives coming round who are not familiar* [with labour ward] *not that up to date, so I don't think they support women ……. these other girls haven't got the confidence to reassure the woman because they don't really know themselves.*
(Interview Leader 1, Case B)

The midwives at Case B had in the same way as reported at Case A come to appreciate the fuller role of the midwife.

8.7.4. Collegiality and Support

One aim of the change to a rotation model had been achieved with midwives prepared to move between birthing and postnatal when assistance was required. The midwives were working together, recognising the importance of the other area:

Now midwives from birth unit will go willingly to maternity and appreciate the huge workload complexities of postnatal care and time management, not having one to one or one to two [care for only one or two women] *and then relaxing when finished. There's an appreciation of booking documentation, less finger pointing,* [complaining and blaming] *much more support* [without being] *asked to help in maternity…. There are staff talking to each other,*[where they were] *not talking before, asking assistance of each other, that's really positive whereas in the past they would have not bothered to ask each other.* (Interview Leader 2, Case B)

Collegiality extended into social functions and the identification of themselves as a team. Both leaders and midwives identified the improved social spirit for example:

I think with the changes the staff see each other more as a team and the staff mix much better, there's not so much segregation – you know between maternity postnatal staff and birthing...they see each other more as a team and friendships have increased… and more social outings. Not just postnatal staff, not just birthing unit, everybody seems to go to social functions now. (Interview Midwife 1, Case B)

While improvement was seen in the way midwives worked and socialised, barriers continued to exist for the acceptance of midwife-led care.

8.7.5. Differing Philosophies

The strong medicalisation of services at Case B (also recognised at Case A), provided a barrier to midwives' acceptance of midwife-led care. One of the concerns was that, it was not only the medical profession who maintained medicalisation of childbirth for women at Case B, but that the midwives were also deeply entrenched in a medicalised model of care:

> *For me a negative thing is it's obviously a medical model* [here]. *Its taken a lot of drumming into not just the medical people but the midwives too, that midwife care is OK. I found that quite difficult at first, a lot them* [midwives] *were really horrible and I was really surprised at that reaction from my own 'sheep' as it were the flock* [laughter]. *Yeh, I was really shocked, it was my colleagues…I still get some comments now* [such as] *'your patients drive me crazy'*. [midwife on Community team]
> (Focus Group Two, Midwife A, Case B)

It was recognised that some of the midwives persisted in calling on the doctors to assess women:

> *Here a lot of midwives here would automatically ask* [doctor] *to do an* [vaginal] *examination rather than do it themselves.*
> (Focus Group One, Midwife A, Case B)

She went on to identify that one of the issues that contributed to a lack of change, was the lack of consistent policies both obstetric and midwifery, expressing surprise at the existing system considering that Case B was part of a large health authority, saying:

> *I think here* [compared to previous place of employment] *is even more hierarchical, old fashioned system. In lots of ways, management are still quite backward. Antenatal care is still quite disjointed because every obstetrician out there are still doing their own thing rather than the*

network [health authority] *trying to have a few standards.*
(Focus Group One, Midwife A, Case B)

The lack of consistent protocols added to the confusion for some midwives, reduced continuity and increased the risk of midwives providing conflicting information.

8.8. Theme Two – Loss of Self

Half of the midwives interviewed at Case B had transferred from Hospital C and provided a view of needing to reinvent their perspective of themselves as midwives. The transitory period when individuals experience organisational change has been likened to the grief process (Wells et al., 1998). The management at Hospital C acknowledged this process and made counselling services available for any midwives who felt the need. Group sessions were held with a pastoral care worker who organised a candle ceremony to remember and say goodbye to the old workplace and colleagues, as they relocated to different sites.

On the whole, midwives from Hospital C felt that they had settled in, although there were times when a few of them described themselves as feeling lost. The social interaction they had at Hospital C made them feel they had lost friends and family. They acknowledged that they had been made welcome and had developed new friendships. A difficult loss for several of them was related to the loss and recognition of themselves as midwives:

My only personal thing is that I think and I'm probably still struggling with it a bit is that because I'd been at [Hospital C] *for so long I knew what the doctors' likes and dislikes were. …knew exactly who to call, when and how. I'm still finding out things* [here] *there's still a lot of things I'm not sure about and with the changing registrars, they seem to have slightly different ways of handling things. Then* [when] *I thought I knew what I was doing …then I'm told no do it this way. Like it's that interaction, like we were saying we were in our comfort zone… I feel lost sometimes.*
(Focus Group Two, Midwife C, Case B)

Feeling lost and confused because of the different protocols and rotating doctors can lead to a loss of confidence but not the ability to act as a midwife as it was about learning the process. These midwives had come from a unit where their experience and capabilities were known to all the doctors and midwife peers. They now had to demonstrate this capability.

> *I think the worse thing is you're the new person and everyone's trying to get to know your capability… sometimes they underestimate and you have to say' sorry but I have done that before.*
> (Focus Group Two, Midwife D, Case B)

The other part of the loss with the midwife role for some of these midwives was the loss of autonomy. At Hospital C they had participated in a birthing centre model of care with a degree of personal autonomy. At Case B they found themselves participating in a medical model with rules and regulations that removed much of their ability to be autonomous practitioners:

> *At* [Hospital C] *we did admissions ourselves. I find it difficult here, you have to get the resident*[46]. (Focus Group One, Midwife B, Case B)

A midwife who had come from a different hospital agreed, saying:

> *A lot of women that might come in and out overnight* [who] *are not in established labour, in the past I would have done a CTG and if normal, do an examination, send them home. Whereas here they have to be seen by a doctor.* (Focus Group One, Midwife A, Case B)

The midwives who had come from Hospital C who worked as members of the community midwife team did not feel this loss of independence to the same extent.

[46] Resident is the most junior doctor

8.9. Summary

The external factors such as the implementation of ratios do not appear to have as great an effect as for Case A. However, similar issues have been raised that will be explored further in the discussion. With the closure of the maternity unit at Hospital C the midwives from there were more likely to say that they no longer had the opportunity to practice autonomously. These midwives were also more likely to indicate that Case B continued to provide a medicalised model of care for women.

Table 31 below provides a comparison of the themes identified for each case.

Case A		**Case B**	
Themes	**Sub-themes**	**Themes**	**Sub-themes**
Feeling unable to provide care	Workload and staffing Devaluing postnatal care The physical working environment		
Ability to practice as a midwife	Fear and Anxiety Consolidating and maintaining competency Confidence to practice Collegiality and support Differing philosophies	Ability to practice as a midwife	Fear and Anxiety Consolidating and maintaining competency Confidence to practice Collegiality and support Differing philosophies
Loss of trust		Loss of self	

Table 31: Comparison themes for Case A and Case B

Discussion pertaining to the findings for both cases is presented in the next chapter.

CHAPTER NINE

THE ROOMS – DISCUSSION OF CASE STUDY FINDINGS

9. Introduction

The focus of this research project was to explore the effect of organisational change on midwives. The ramifications of the physical, social and political environments made linking the experience of the midwives to the actual changes complex. The use of a layered case study approach (see page 144) provided the means to examine the effect from the perspective of midwives as a case that was separate but connected to a broader picture of organisational changes.

Many of the organisational changes implemented in Victoria over the last ten years have been stimulated by state government policy and because of interest in the development of midwife-led care. One of the findings of the study was that the changes that occurred at both case sites between 2001 and 2003 were related to financial constraints and only indirectly associated with maternity policy or the development of midwife-led care. Despite recognition of the need to provide midwife-led, woman centred care, the changes appeared to be more about organisational needs than either the needs of the midwives or women. Drawing on the findings presented in the previous three chapters, the context of the case, the survey and the interview findings, this chapter explores the differences and similarities between the two case sites. Three factors are associated with the differences and similarities between the two cases and provide the basis of the following discussion. The first factor is the different physical environment at each case site, the second is the implementation of models of care that enabled greater use of midwifery skills and the third relates to management and leadership in implementing change.

9.1. Different Working Environments

Working environments, including both the physical and social factors, can affect the workplace satisfaction. While workload and relationships in the nursing and midwifery workplace have been studied in relation to workplace satisfaction (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Curtis, 2007; Oncel, Ozer, & Efe, 2007; Shader et al., 2001), little has emerged about the effect a physical layout can have on midwives (Symon, Paul, Butchart, Carr, & Dugard, 2008c). The physical environment was one change that occurred at one site and not the other. At that site the physical environment was one of the factors associated with the concerns that midwives had for the quality of care provided. Although this association may be incidental, it raises the potential impact that physical changes can produce when planning changes.

Research into the physical layout of hospitals has focused on safety and patients' needs and neglected the impact on staffing and the quality of nursing care (Hurst, 2008). Maternity units are increasingly being designed or redeveloped, to provide a more home-like atmosphere to reduce the clinical appearance of the labour rooms (Symon, Paul, Butchart, Carr, & Dugard, 2008a), with the focus being the appearance and not necessarily the physical practicalities. The development of combined labour, delivery, and recovery /postnatal rooms (LDRs) appears to have emerged from a woman-centred approach as the means to allow women and families to stay together for a longer period of time following a birth. The LDR model is similar to the birth centre model where women remain in the same room for up to 24 hours after birth (Queensland Department of Health, 1998). These design features might improve the experience of birth and postnatal care for some women, but in units where women stay in hospital for longer than 24 hours, or there are a large number of births, transfer into a separate postnatal area becomes necessary. It is not economically feasible to design large maternity units with only LDRs (Queensland Department of Health, 1998).

The working environment at Case A was described as noisy, busy and lacking space. At no time were these issues raised at Case B, although there is evidence of midwives working in postnatal care across Victoria presenting similar views (Rayner, Forster, McLachlan,

Yelland, & Davey, 2008). In research in the UK, Symon et al. (2008b) also found noise to be an issue within maternity environments, particularly in postnatal wards. The integration of the LDRs into the postnatal area appears to have exacerbated this view at Case A and suggests that such integration might be inappropriate in larger units. Midwives complained about the noise and lack of space on behalf of women in Case A. Symon et al. (2008b, 2008c) have recognised that noisy cramped work environments can impact on the health and work effectiveness of midwives and potentially contribute to attrition of staff.

The physical renovations at Case A matched the 'vision' of integrated care presented by the leaders, but were implemented without taking into account the limitations of renovating rooms that were built for a different purpose. There is some evidence that women want room to move, have comfortable surroundings and minimal distractions (Lepori, Foureur, & Hastie, 2008). Providing women with a less clinical environment alone is insufficient if due consideration is not also given to other environmental factors such as noise, space and safety from intrusion. The descriptions of the working environment at Case A may well have impacted in a negative manner on the provision of what Foureur (2008) describes as a safe birth space. If midwives are unable because of financial and organisational constraints, to optimise the environment to promote normal birth then the care provided cannot be deemed as being woman-centred.

Providing a physical environment that meant women stayed in the one area with the same team of midwives throughout their stay in hospital at Case A, was to enable greater continuity for women and encourage team cohesion and collegiality for midwives. The large numbers of midwives on each team, together with the constraints of part-time employment, reduced the likelihood of continuity of carer for women. While collegiality did improve it was also seen to improve at Case B, where separate wards continued to exist.

The integration of LDRs within an antenatal/postnatal ward may work well in small maternity units where small numbers of midwives work each shift and the majority of women coming through the service are deemed to be low risk. Where women with more complex needs are being cared for it is essential that midwives also feel well supported

(Hunter, 2004; Kirkham & Stapleton, 2000). Over time, as midwives gain skills and experience, support needs would potentially reduce. Integrating birth rooms throughout the postnatal ward had the effect of dispersing experienced labour ward staff across a larger physical area. The practicality of integrated wards (postnatal and labour rooms as one ward) in larger maternity units does not appear to have been rigorously evaluated from either the woman's or the midwives' perspective. The development of integrated units in larger hospitals where women of all levels of risk are cared for appears to me to be motivated by the need to use staff more efficiently. The rationale behind the integration at Case A was to reduce beds and develop team-based care. The need for refurbishment rather than a purpose-built unit, and the large number of midwives working in each team, suited the needs of the organisation rather than those of the women or staff. However, it can be argued that to wait for sufficient funding for a purpose-built unit might have precluded the introduction of innovative ways of working and midwife-led care.

The midwives at Case A perceived that, since the changes, there had been rising rates of clinical incidents. They implied that these were associated with the introduction of the team model. This was supported by concern over the lack of supervision for the less experienced midwives and the difficulty in achieving and maintaining skill competency because of the daily rotations to different areas. In contrast, Case B maintained separate birth and postnatal areas with core staff to support the rotating midwives. With the exception of small birth centre style-models, midwifery models in the literature are generally based in hospitals where experienced midwives were retained as core staff in the labour wards, particularly where a percentage of women were high risk (including Ashcroft, Elstein, Boreham, & Holm, 2003; Biro, 2000; Homer et al., 2001a; Walker et al., 2004). That did not mean that only core staff cared for high risk women, but they were available as a consistent resource. When planning re-organisation of models of care it is essential to assess the ability to provide appropriate support and education within the new model.

The workload, staff shortages and inappropriate staff skill mix have been found in maternity care to be associated with adverse events or near misses (Ashcroft et al., 2003;

Symon, McStea, & Murphy-Black, 2006). The increasing birth rate contributes to the increasing workload for midwives across the whole of Victoria. There also appears to be more women requiring complex care (Davey et al., 2008). Both of which may be factors that confound the perception of increasing clinical incidents or near misses at Case A. If the environment at Case A, or indeed at any maternity site, is not conducive to providing quality midwifery care, the ability to demonstrate that midwife-led care is safe and satisfying for women and midwives becomes more difficult.

Overall, the survey suggested that the midwives at Case A were less satisfied with their role than those at Case B. Satisfaction with the working environment can negatively impact on midwives' perception of their provision of quality care (Symon et al., 2008a). It may be that the quality of care for women at Case A was not lower but that midwives perceived it to be. At Case A, the complexities of the impact of the staffing ratios, the implementation of a team model of care, in addition to the physical environment refurbishment, made evaluating the impact of change on midwives complex.

9.2. Midwifery Practice

The one common theme across both sites was related to the ability of midwives to practise midwifery, both from a perspective that the changes had enhanced their role and the converse that there were concerns related to ability. The term 'team' was used for the models that were implemented at both sites, but neither of the main models could be fully described as providing continuity of care for women. Using terms that imply a certain type of model can be confusing for midwives seeking employment, particularly where midwives seek to work in a continuity of care model that matches their philosophy. The differences also make it difficult to compare outcomes between sites. The primary change at each site was the requirement for midwives to rotate between more than one area of maternity care. The need for working in all areas is justified by the profession as necessary to maintain skills across the full scope of midwifery practice (Ball et al., 2002). Yet many midwives in Australia, who are unable or prefer not to work across the full scope of the midwife, still consider themselves to be a midwife and not a nurse. The need for experienced midwives capable of taking an 'in charge' position remaining in one area may be a defence for

maintaining support for the less experienced midwives in the short term but reduces career progression options for expert midwives. Responses to the changes for both cases, raises questions about the need for the midwifery profession to develop the profession in a way that supports midwives who have differing interests and experience.

While many of the midwives were positive about the opportunity to work across a wider scope than previously, several negative issues related to the rotation of staff were identified. These included difficulties in maintaining and consolidating skills, and the fear and anxiety associated with working with labouring women. Factors that have been identified elsewhere as impeding the quality of care for women (Forster et al., 2005) and safe practice (Ashcroft et al., 2003). One of the reasons that midwives left clinical practice in the UK was due to the rotation of midwives through all areas, with the feeling by many that they were just being used because the organisations needed a flexible workforce (Ball et al., 2002). Certainly at Case B, the driving force behind the introduction of a rotating model was to provide a flexible workforce but the models were introduced in both cases in response to organisational needs. Flexibility without due consideration to midwives' needs may lead to greater attrition from the profession at a time when it can be least afforded. The model at Case B had been adapted in response to midwives concerns and was possibly therefore more flexible than that at Case A. This may have contributed to the greater level of midwifery dissatisfaction at Case A found in the survey.

An important factor that impacted on the way midwives practise was the predominant medical philosophy at both sites. The community team established at Case B was put into place to provide midwife-led care and midwives could apply for positions on that team. The other 'teams' implemented presented limited options for some midwives to provide midwife-led care within the framework of a 'team' but with little or no choice about participation. Midwives may be familiar with working in a multi-disciplinary team, although it might be argued that these teams are merely groups of individuals working together (Wilson, 2005). Teamwork requires shared goals, values and mutual respect along with good communication, to enable the provision of effective quality care (Freeman et al., 2000; Wilson, 2005). Continuity of care is enhanced where providers have a common

philosophy (Hodnett, 2006). Working with colleagues who have different philosophical beliefs not only reduces continuity of care for women but can lead to increased stress for midwives and may contribute to the attrition of midwives from the profession (Hunter, 2004). Hunter's (2004) study revealed the dichotomy between hospital and community-based midwives. The ideologies she wrote about related to a medicalised approach versus a 'with woman' approach, which resonates with the findings of my study. Although at both sites, there was evidence of improved collegiality and support for each other, there was also evidence of discordance in part due to differing philosophical perspectives. Further, no clear strategies demonstrated that any attempts had been made, other than initially at the open forums, to discuss common philosophies or aims.

Although the teams, with the exception of the Case B community team, were not continuity of care midwifery team models as described in the literature (Homer et al., 2008), some of the findings associated with midwives experience of 'team midwifery' were similar. Several studies (including Brodie, 1996; Stevens & McCourt, 2002b; Stock, 1994; Walker et al., 2004) found that team models provide midwives the opportunity to use more of their skills and gain professional satisfaction; opportunities mentioned by midwives at both Case A and B. Having the opportunity to use a wider range of skills does not correlate with maintaining competence in those skills. There is some evidence that midwives from teams struggle to maintain their skills and confidence, particularly where women's needs are complex (Ashcroft et al., 2003; Ball et al., 2002; Haith-Cooper, 1999; Shallow, 2001d). As many of Case A midwives also rotated to provide antenatal and postnatal community care, their time with labouring women was less than for those at Case B and more fragmented. This may have contributed to the greater concern at Case A about the ability of midwives to consolidate skills. Further, providing midwives with the skills to practice across all areas does not necessarily imbue them with the confidence to put their knowledge into practice. Education sessions were held at both sites but only the midwives at Case B were provided clear guidelines of what they needed to demonstrate competency in. The focus, other than breastfeeding skills, was on managing technological interventions and emergencies. This focus on risk and obstetric technological management of birth has been identified elsewhere (Shallow, 2001a) and may contribute to the fear and anxiety felt by some midwives in

labour ward. Midwives risk losing their skills in maintaining the normal contributing to the de-valuation of basic midwifery skills and leading to continuing increases in medical intervention.

The question has been raised in the literature about whether midwives want to be autonomous practitioners (Baird, 2007; Fleming, 1998a; Pollard, 2003; Watson et al., 2002; Watson et al., 1999). Although autonomy was identified as an important attribute of midwifery practice by most of the midwives in the survey, less than half wished to work in a midwife-led role. It was not mentioned by anyone responding to the survey as a current issue nor as being affected by the changes implemented, although it was identified by a small number (10/86) as the most satisfying aspect of their role. This was echoed in the interviews with only a couple of the midwives at each site who clearly wanted to participate in continuity of care, midwife-led models. The strong impact of a medical model of birth on the practice of midwives was identified at both sites. Not only may that have been due to a lack of exposure, either through education or observation, to midwife-led care but also due to the socialisation of midwives into the medical model. Considering the increasing complex needs of women giving birth, there may be an argument to maintain core midwifery staff in some areas to support midwives who lack experience. Caring for women with complex medical or obstetric conditions requires the midwife to work collaboratively, consulting and referring to with other health professionals when necessary. Recognising the individual expertise of each midwife whether that is in maintaining normal birth or specialising in one area is important. The provision of choice for women is important in providing woman-centred care, it is also important for midwives and may be one factor in reducing attrition from the profession.

The emergence of the models at each site were, from a management perspective, more to meet organisational needs than to improve the midwifery role. This included meeting government policy that all maternity service providers would establish a midwife-led model of care within their health area. The decision at Case A to place all staff onto a team regardless of ability or desire to participate in the model was a strategy to cross the wide chasm that existed between obstetric and midwife-led care in one leap. In contrast, Case B

had taken the option to make small changes with the maintenance of core staff and slowly developing midwives who were capable and comfortable with working towards the full scope of midwifery practice. While there might be some support for taking the first approach, the alternative might limit and slow the process but enable greater choice for midwives and improve retention rates. The importance of retaining midwives cannot be underestimated in Victoria, where there is an ageing workforce (Australian Health Workforce Advisory Committee, 2002) and increasing birth rates (Davey et al., 2008).

The different changes that occurred may purely reflect the specific needs for each site but are potentially related to different leadership.

9.3. Leadership and Management of Change

One of the aims of the research project was to identify the strategies used to introduce change. The change literature suggests that effective leadership is a major factor in successful implementation of organisational change (Bennis, 2003; Cook, 1999; O'Shea et al., 2007). More leaders were identified by survey respondents at Case A than Case B. This may have reflected the greater numbers of managers at that site or an indication of wider involvement of staff in implementing changes. The process that each site went through to implement change was similar with a couple of differences that relate to management or leadership. For example, there was an attempt at Case A to provide a vision, although there were indications that this vision may not have been adequately communicated to the midwives to enable full support of the changes. The use of a vision however, suggests a transformational leadership style (Grossman & Valiga, 2000; Lindholm et al., 2000; Pashley, 1998). In contrast, the management of change at Case B focused on tasks such as developing competency in particular skills. These strategies are suggestive of a transactional style of leadership (Grossman & Valiga, 2000).

In reality, a combination of leadership styles may have been more useful in successful implementation of change. Different approaches, drawing on change theory would include gaining support from midwives through the provision of a vision (Bamford & Daniel, 2005); focusing on tasks to support midwives in the transition; the use of mentoring (Wells

et al., 1998); two way communication (Stewart & Kringas, 2003); and, building trust (Ferlie et al., 2005). The midwives may have felt more connected to the process if there had been greater development and recognition of leadership skills in more of the midwives. Managing and leading in midwifery is complex, in part due to the need to provide cover for 24 hours a day, seven days a week. A model of leadership that enables the recognition and development of others, in conjunction with managing and leading as an individual is presented in the final chapter.

9.4. Summary

This chapter discussed the findings of the research project. The working environment was recognised as an important factor for both the midwife and the woman. There appears to be insufficient research into the development of LDRs and their impact on the provision of care in larger maternity units.

The introduction of models of care that emulate 'team' midwifery need to be viewed with caution as they cannot be directly compared to small teams that are able to provide continuity of care. Midwives who do not support the concepts and philosophical underpinnings of midwife-led care may compromise care through ineffective or inappropriate support for women. It is important therefore, that organisations fully evaluate the implementation of new models of maternity care from both the woman's and the midwives' perspectives.

The final factor discussed in relation to the findings was that of leadership. It has been widely recognised that effective leadership is essential for successful change. These findings suggest that this leadership should include a range of styles in order to meet the complexities found with implementing organisational change.

The next section brings together the different topics from the portfolio under the overarching roof of complexity science.

SECTION FOUR – THE ROOF

THE CONNECTIONS

CHAPTER TEN

MIDWIFERY THROUGH THE LENS OF COMPLEXITY

10. Introduction

The focus of my studies for this portfolio was underpinned by a desire to become more informed about midwives and their response to changes in the maternity services in the state of Victoria. The aims of the research were to identify the changes that had occurred and effects of those changes for midwives. During the research project (Chapters Five-Nine) it became difficult to view the midwife separately from the model of care. The case study approach was chosen to enable a wider view of the context. This led to the identification of the complexity of the factors impacting upon midwifery practice. Not only did the effect on midwives reflect locally driven changes but included the impact of complex external factors, which were often out of the control of the employing organisations. The similarities and differences between the two sites were discussed in the previous chapter.

Complexity science provides some insights as to why identical organisational and policy changes can have a different impact on midwives in different settings. Zimmerman, Lindberg, and Plsek (1998) explain complexity science as '… *the study of complex adaptive systems - the patterns of relationships within them, how they are sustained, how they self-organize and how outcomes emerge*' (paragraph 8). Complexity science and Complex Adaptive Systems (CAS) are discussed in more depth later in the chapter.

Stacey (1996) argues that it is the integrated, complex nature of the world that confounds the predictability of introducing new ways of thinking and acting in organisations.

Complexity science has led to new ways of studying dynamic forces in nature (Warren, Franklin, & Streeter, 1998) and has been identified as potentially useful in social science research (Gatrell, 2005). Organisations are complex systems with multiple lines of communication, formal and informal, internal and external, that can impact on how well it can function and evolve (Stacey, 1996). Diverse channels of information are important for normal functioning of organisations but might provide conflicting advice, differing opinions and images of practice for individuals. Differing values, practice beliefs, experiences and social needs can affect how individuals respond to information they have received. There are many examples in my findings and these are explored in this chapter. The reaction of one individual to proposed changes can affect the dynamics of a group, and the reaction and actual outcome of change, to a greater extent than might be expected.

Throughout this portfolio, complex factors have been identified, that impact on individual midwives, models of care, policy development, implementation of change and research that may confound the predictability of outcomes. Table 32 on pages 256-257 identifies some of the links to complexity science.

Chapter &Topic	Complexity link
Chapter Two Midwifery philosophy	The holistic paradigm for midwifery has emerged from quantum theory and the concept of connectivity to the whole universe (Davis-Floyd, 2001), encapsulating midwifery as a Complex Adaptive System (CAS).
Autonomy	The individual develops self-identity in response to interactions with environment, social group and work. To be an autonomous midwife includes being able to work independently as well as paradoxically, being interdependent with individual women and the health system. The midwife as a CAS may be inhibited from developing the ability to practise autonomously because of the interactions she has with others and/or because of her personal history within a medicalised midwifery culture.
Chapter Three Continuity of care	Continuity of care is an outcome of relationships within a CAS (Sturmberg, 2003). As a midwife interacts with a woman, each informs the other and they each adapt to the context. For example the midwife may change the way she communicates to meet the needs of a woman who is chemically dependant. The woman responds by attending antenatal appointments regularly as she has developed a relationship with the midwife.
Midwifery models of care	Midwifery models of care are CASs. Midwives in a caseload practice will interact and adapt individually and in concert with the women and their colleagues. For example, in response to one woman wanting an evening visit, discussion between the group may result in changes to the times they are available for home visits.
Chapter Four Health policy development	Governments are CASs. Interactions between agents of the government with agents of other CASs leads to adaptations in policies (Kingdon, 1995). For example feedback from the perinatal data collection system about rising caesarean section rates may prompt discussion that leads to a maternity review and further interactions with other CASs. The feedback may then lead to a policy that supports midwife-led care as a possible means of reducing caesarean rates through development of relationships.
Chapter Five Methodology	A case study approach to research enables a wider exploration of individual factors while reviewing the whole system, where the boundaries between phenomenon and

	context are blurred (Yin, 2003). This approach provides the researcher the opportunity to explore components of an organisation that together interact as a CAS.
Chapter Six Context, process and content of change	Each case study was a CAS embedded within a hospital, embedded within a health service, embedded within a health system. As such, interactions between agents of the CAS provide feedback within the system that lead to decisions to act and result in adaptations. The complexity of interactions, where external influences impacted on adaptations, was demonstrated when the introduction of the midwife to woman ratios resulted in reorganising the planned model at Case A.
Chapter Seven, Eight & Nine The findings Similarities and differences	As each case site was a CAS the changes were developed and implemented differently. The interactions between midwives within each case, or CAS, contributed to the reactions and perceptions of individuals and the effect on the whole. The interaction of several factors can affect the perception of the ability of midwives to provide care. These factors included workload, staff shortages, competence of staff and the physical environment. Similar interventions such as the introduction of midwife to woman ratios had a greater negative affect at one site demonstrating the different impact that one change can make. The effect for midwives and their ability to work across the full scope of midwifery practice is complex. It depends on a multitude of factors including personal capability and history (experience) of working in maternity care. These factors may lead to fear and anxiety and a lack of confidence when change occurs or conversely result in greater satisfaction. The changes at each case site affected individuals differently and the outcomes for midwives could not be accurately predicted.
Chapter 10 Connective leadership model	Although there are some clearly defined leadership styles including transactional and transformational most leaders actually use more than one style (Lipman-Blumen, 1996). The model presented next in this chapter brings together all styles demonstrating the need for connecting with others in a variety of ways as the most efficient way to support midwives according to the circumstance and enhance the development of new leaders. Leaders who use a 'connective' style would be more effective as CAS evolve and adapt in response to interactions and connections between members of the CAS.

Table 32: Links to complexity science throughout the portfolio

The next section provides a brief introduction to complexity science. This is followed by an outline of the attributes of CAS to provide an explanation for the different models that were implemented and the similarities and differences found. The final section presents a model for leadership that, in this connected world, is important for the future of midwifery.

10.1. Complexity Science[47]

Non-linear dynamics and chaos theory are well developed mathematical concepts that enable a fresh view of complex behaviour that previously had been difficult to understand (Halmi, 2003). Chaos theory and complexity science, while sharing similar concepts of non-linearity, are not synonymous. While complexity has been described by some as a subset of chaos (Halmi, 2003), others discuss chaos as a subset of complexity (Holden, 2005; McDaniel & Driebe, 2001). Mathematical views of chaos are that patterns are discernable within what appears to be chaotic behaviour but that they are unpredictable, whereas the term chaos in complexity science more closely aligns with common usage, that of totally unpredictable behaviour (Stacey, 1996). Chaos theory and complexity science might be more aptly described as opposites. Chaos theory explores the emergence of complexity from simplicity whereas complexity science explores the emergence of order from complex systems (Lewin 1992 cited McDaniel & Driebe, 2001). They both however have emerged with the development of quantum theory and the concept of the world as a web of connectivity.

Complexity science is not just one theory but encompasses more than one theoretical framework (Zimmerman et al., 1998). It may include the use of concepts from a range of other theories as it is the nature of complexity that several theories can be necessary to explain behaviour. As Gatrell (2005) purports, complexity science has moved away from prediction and control to explanation and understanding. Complexity science exists within a paradigm of connectivity and wholism instead of one based on reductionism, where the

[47] The terms complexity science and complexity theory are used in the literature by different authors to describe the same concepts of non-linear dynamics in the study of systems. The term complexity science is used throughout this chapter.

whole is reduced to its individual parts (Capra, 1996). Within the new paradigm, the language of complexity has moved away from the use of the machine as metaphor. The world view is instead '*characterised by words like organic, holistic and ecological*' (McDaniel, 1997, p.23). It is natural in everyday life to use metaphor (Capra, 2002) so it is only the metaphor that has changed not the ontological use of metaphor. There are arguments against transposing physical science models directly into social sciences and the use of metaphor to do this (Gatrell, 2005; Stewart, 2001) but Gatrell argues that the use of metaphor is appropriate for social sciences where visual representation of concepts are useful.

Gatrell (2005) presents complexity science as appropriate for use in the social sciences because it concentrates on the whole phenomenon. He argues that the scientific reductionist view, by focusing on individual risk factors, marginalises context and relationships and ignores the global effect. Stewart (2001) in contrast, views social processes as too complex for complexity science to clearly elucidate without improvement of existing social theories. He does not say that complexity science should not be used in social sciences, but that social theory development requires further development to complement complexity science.

Complexity science evolved from the study of systems. Systems that interact with their environment are known as open or living systems and may be simple or complex. From a systems perspective individual parts can only be understood as part of the whole. This is a reversal of the mechanistic view that the whole can be analysed by looking at the individual parts (Capra, 1996). Systems thinking evolved from the science of thermodynamics. In the second law of thermodynamics, it was recognised that in closed systems as energy was dissipated its ability to continue production was limited and ultimately led to entropy or death (Capra, 1996; Wheatley, 2006). Bertalanffy theorised that living organisms were open systems and that the second law of thermodynamics and therefore entropy did not apply. However, it was not until the 1970s that Prigogine was able to develop the mathematical techniques to support Bertalanffy's theories (Capra, 2002). Prigogine (1989) described open systems as being far from equilibrium but at the same time remaining

stable. Structure is maintained through the exchange of components leading to the description of them as dissipative structures (Capra, 2002; Prigogine, 1989). At times crises occur in systems that may lead to the emergence of new structures, self-organisation and creativity (Capra, 2002; Stacey, 1996). While Prigogine (1989) initially described systems within the context of science he went on to recognise that they also applied to systems within a social context. Health systems are therefore open to self-organisation with the emergence of new structures in response to a catalyst. Midwifery exists within health systems and may become involved in emerging structures and self-organisation. Science has further evolved taking concepts from systems theory to create a new speciality field of complexity science (Capra, 1996) that may also be applied to social systems (Prigogine, 1989; Wheatley, 2006).

Evolution in complex systems may be unpredictable thus they can be described as Complex Adaptive Systems (CAS) (Burns, 2001). Common patterns of behaviour in diverse systems provided insights for new ways of working (Zimmerman et al., 1998). The unpredictable, non-linear behaviour of these systems has been explored using complexity science resulting in the emergent theory of CAS (Zimmerman, 1999). Theories of non-linear behaviour provide the means to '*describe and classify the complex behaviour*' (Halmi, 2003, p.84) of many different types of systems. CAS as a relatively new theory, has already been used as a framework for exploring complexity across a variety of fields that include bioscience (Higginbotham, Albrecht, & Connor, 2001); social sciences; epidemiology (Gatrell, 2005; Halmi, 2003); economics (Lessard, 2007); career advice (Bloch, 2005; Pryor & Bright, 2003); change (Boyatzis, 2006; Pettigrew et al., 1992); management and organisations (Lichtenstein et al., 2006; Schreiber & Carley, 2006; Stacey, 1996); and nursing (Penprase & Norris, 2005). I suggest that it is an appropriate framework for exploring midwifery practice given the holistic paradigm that the midwifery profession encompasses (ACM, 2007b) whereby both chaos and systems theory have informed and underpin the connectivity of the mind, body and spirit of holistic practice beliefs (Davis-Floyd, 2001).

The research project sought to elucidate the effect on midwives of organisational change but although each midwife can be viewed as an individual she is also an employee

interacting with other staff in a maternity unit. As such, the way she acts and reacts to others can reflect on the way others react to her. It is these interactions both within a maternity unit and within the larger organisation that meet the attributes of a CAS and provide an explanation for differing outcomes to similar organisational change. The next section provides a brief outline of CAS followed by its application to midwifery and this portfolio.

10.1.1. Complex Adaptive Systems

The theory of Complex Adaptive Systems (CAS) has emerged from systems thinking where components are exchanged both within the system and across boundaries (Capra, 2002; Stacey, 1996). Adaptation occurs in systems where feedback provides a stimulus to change behaviour. The response may be based on previous knowledge and occur consciously or subconsciously (Halmi, 2003). It is this ability to adapt that stabilises complex systems although they may border on the edge of chaos[48] (Halmi, 2003).

Plsek and Greenhalgh (2001) define CAS as ' … *a collection of individual agents with freedom to act in ways that are not always totally predictable and whose actions are interconnected so that one agent's actions changes the context for other agents*' (p. 625). Stacey (1996) includes learning and co-evolving in order to survive through adaptation. Cilliers (2000) does not formally define CAS but instead provides a qualitative description that provides a useful framework to relate complex adaptive theory to social or organisational systems. These consist of seven attributes (Cilliers, 2000, p.24) that are described in the next section.

1. Complex systems consist of a large number of elements that in themselves can be simple. In quantum physics, everything is connected. In biology, living systems interact with each other from the smallest single cell, such as the amoeba to the highest multi-cellular system, the human being (Capra, 2002). Simple systems are embedded within larger systems making them complex, and complex systems are embedded or interact with other complex

[48] See Glossary for definitions of terms

systems (Zimmerman et al., 1998). The most important factor is that the elements interact, leading to learning and co-evolution (Holden, 2005; Stacey, 1996).

2. The elements interact dynamically by exchanging energy or information. These interactions are rich. Even if specific elements only interact with a few others, the effects are propagated throughout the system. The interactions are non-linear.

All systems have boundaries although those boundaries are permeable, allowing interactions across a network. Social systems are bounded by organisational structures such as employment contracts or cultural mores. Within organisations, formal legitimate networks are guided by rules that drive the flow of information and actions. While these are generally linear, the idiosyncratic behaviour of individual elements produces non-linear actions (Stacey, 1996). Informal or shadow networks develop spontaneously within organisations whereby the interaction is non-linear (Stacey, 1996). These boundaries can be described as fuzzy as they allow for the passage of information to the outside (Plsek & Greenhalgh, 2001). The interactions do not lead to a cause and effect but co-evolution or mutual shaping (Zimmerman et al., 1998).

3. There are many direct and indirect feedback loops.

In biological systems there are feedback loops. For example, the endocrine system in the human body provides both positive and negative information to the elements of the system (Capra, 2002). The feedback process includes discovery, choice of response from a set of rules leading to action. The choice may be to act on universally shared rules of the legitimate network or individual or shadow network rules (Stacey, 1996).

4. Complex systems are open systems – they exchange energy or information with their environment – and operate at conditions far from equilibrium.

Simple feedback loops in closed systems exist in order to maintain stability. Stability is equated with equilibrium but the reality is that a lack of disturbance leads to a lack of ability to continue producing and leads to entropy or death (Capra, 2002; Wheatley, 2006). In organisations or social systems, a lack of disturbance in the form of negative feedback can lead to the inability of the organisation to be creative. Sustainability depends on

diversity, reduction of diversity reduces future adaptability (Zimmerman et al., 1998). Competition and collaboration need to exist together to provide conditions that stimulate innovation to find the best strategy for survival (Stacey, 1996).

5. Complex systems have memory, not located at a specific place, but distributed throughout the system. Any complex system thus has a history and the history is of cardinal importance to the behaviour of the system.

History is passed on from one cell to another to enable reproduction of the element. Memory is an important facet of all systems. Implementation of identical programs in different organisations can produce vastly different outcomes because of history and context present at each site (Zimmerman et al., 1998). It is not possible therefore, to make accurate predictions of results for any planned program or intervention.

6. The behaviour of the system is determined by the nature of the interactions, not by what is contained in the components. Since the interactions are rich, dynamic, fed back and above all, nonlinear the behaviour of the system as a whole cannot be predicted from an inspection of its components. The notion of "emergence" is used to describe this aspect. The presence of emergent properties does not provide an argument against causality only against deterministic forms of prediction.

Although the history of an element in a complex system can affect the reaction, it is not possible to analyse each element to predict an outcome. Emergence is the product of self-organisation that is unexpected and cannot be planned (Stacey, 1996). The presence of attractors might influence the interactions and outcomes. An attractor is something that draws energy towards it (Zimmerman et al., 1998). These attractors act as catalysts for new behaviours to emerge (Chaffee & McNeill, 2007). However, the nature of emergence, history and context do not ensure that attractors in one organisation will act as attractors in another (Arndt & Bigelow, 2000).

7. Complex systems are adaptive. They can (re)organise their internal structure without the intervention of an external agent.

All open systems are self-organising. That is they reproduce, recreate or reorganise themselves. Adaptation is a consequence of interactions that is enhanced by diversity (Holden, 2005). Control is distributed amongst the whole system, change emerges from the interactions and relationships of the elements (Zimmerman et al., 1998). Control of a system to adapt depends upon the rate of information entering the system, the richness of the interconnectivity and the amount of diversity present (Stacey, 1996). Information is the energy that generates the ability of elements in a CAS to re-organise and adapt (Wheatley, 2006).

Examples from the case studies, reported in Chapters Six-Nine, are related to the seven attributes of CAS in Table 33.

CAS attributes (Cilliers, 2000, p.24)	**Case A and B as Complex Adaptive Systems**
Complex systems consist of a large number of elements that in themselves can be simple	Each midwife employed at Case A & B are as human beings, a CAS. Each midwife as an individual was an element in maternity unit A or B. Case A or B were an element of Hospital A or B, that was an element of Area Health X or Z.
The elements interact dynamically by exchanging energy or information… Even if specific elements only interact with a few others, the effects are propagated throughout the system and are non-linear.	Information was exchanged in the forums held at both sites. Information from the forums was indirectly passed on to others. Discussion occurred between midwives in meetings, informally at work and socially.
There are many direct and indirect feedback loops.	The feedback loops included open forums, informal discussion between midwives and managers and the ANF ballot.
Complex systems are open systems – they exchange energy or information with their environment – and operate at conditions far from equilibrium.	Negotiations for changing the model of care included the ANF. The project manager at Case A was guided by models established at other maternity units in Victoria. Different models of care were developed to meet economic constraints.
Complex systems have memory … distributed throughout the system. Any complex system thus has a history and the history is of cardinal importance to the behaviour of the system	The medicalised culture at both sites was identified as impeding acceptance of midwife-led care. At least one midwife was anxious about working in the labour ward because of previous difficulties in that area.
The behaviour of the system is determined by the nature of the interactions, not by what is contained in the components. Since the interactions are rich, dynamic, fed back and above all, nonlinear the behaviour of the system as a whole cannot be predicted from an inspection of its components.	Continuity of midwifery care is an outcome (see Chapter 3) and depends on the interactions of the team members as a group. Assessing continuity by evaluating the actions of one midwife cannot predict the perception by the woman that she received continuity of care.
Complex systems are adaptive. They can (re)organise their internal structure without the intervention of an external agent.	Midwives adjusted the daily workload allocations according to the knowledge, experience and preferences of those rostered each shift.

Table 33: Attributes of Complex Adaptive Systems related to the Case Study

While complexity science may be a useful adjunct for understanding health services management, Arndt and Bigelow (2000) caution against applying the concepts of CASs in a reductionist manner. Therefore although the attributes used in Table 32 above, appear as a list they are not hierarchical. Each attribute is clearly connected to other attributes. Although I am presenting CAS as a means to explain complex connections that can affect outcomes, within a CAS other explanations exist that can be incorporated into explanations for the whole. For example, psychological theories related to group dynamics may be useful for explaining team behaviour but may be used in conjunction with social theories that look at the development of social capital. Nor does the introduction of the theoretical components of a CAS mean that other direct linear components of life become discarded.

Using complex adaptive theory, leaders have the opportunity to move away from predictability and control towards one of building relationships that can ultimately improve outcomes (Penprase & Norris, 2005). It is acknowledged that the midwifery profession requires effective leadership to develop and guide midwifery-led practice (Brodie, 2002; Coggins, 2005). One of the findings from this portfolio is the importance of effective leadership. The role of a leader is to be able to interact both independently and interdependently within a CAS, in a way that promotes the best outcomes. Leadership should viewed as a process rather than as a person leading (Zimmerman, 1999). The connective leadership model (Lipman-Blumen, 1996) is suggested as an approach that fills these needs. The next section describes the model briefly and then connects the findings of the research project and midwifery in general to the connective leadership model.

10.2. Connective Leadership Model

Lipmann-Blumen (1996) developed her connective leadership model using theoretical perspectives, empirical evidence of leadership achieving styles and analysis of the behaviours of renowned leaders. Basing her model on the emerging paradigm of complexity, the aim of Lipmann-Blumen (1996) was to provide a template for evaluating leadership behaviour in different organisations and to provide a guide for learning. The model demonstrates the interconnectivity of diverse leadership styles and approaches to leading. Linking these behavioural and achieving styles, Lipmann-Blumen (1996)

demonstrates that it is important and valuable to utilise diverse leadership skills. The greater the diversity of leadership behaviours utilised, the greater likelihood that the leader will be effective (Denison et al., 1995). Although this model has evolved primarily from research conducted in the USA, there is evidence many of the concepts are universal (Bass, 1997). The three main leadership styles in the connective model, **Direct, Relational**, and **Instrumental** are each divided into three sub-groups [49]. The model is circular and interconnected with no specific behaviour taking precedence over another with an expectation that leaders would use a variety depending on the context (Lipman-Blumen, 1996).

The direct group of leadership styles reflects the actions of the individual, who acts independently to master their own tasks (Lipman-Blumen, 1996). The **direct approach** can be seen to be aligned to the masculine perspective where dominance, independent thinking and competitiveness are often equated with leadership skills (Grossman & Valiga, 2000; Hackman & Johnson, 2004; Korabik & Ayman, 2007; Lewin & Regine, 2000).

The **relational group** of leadership styles reflects the actions of those who gain satisfaction from being a team member and working with others. The ability to collaborate is vital within a new world paradigm of relationships and connectivity where the importance of shared leadership is becoming paramount (Bligh, Pearce, & Kohles, 2006; Malloch & Porter-O'Grady, 2005).

The third group of achieving styles are about maximising interactions through the use of self and others. The **instrumental approach** includes aspects of the person that have been explored in leadership theory related to 'charismatic' leadership. The qualities that are required for leaders using the instrumental approach focus on their character, that should be grounded in the core values of integrity, trust, truth and human dignity (Sankar, 2003).

10.2.1. The Connective Leadership Model and Midwifery

[49] See Appendix J for brief explanation of the individual components that make up each group of styles.

Lipman-Blumen (1996) describes her model as taking a feminine approach because of the incorporation of the relationship behaviours that she perceives are more readily performed by women. Her model also includes assertive behaviours that are associated with male dominated approaches. It is suitable for either male or female leaders to use as a framework to guide their activities. Androgynous models of leadership behaviour, that is, behaviours that include both male assertiveness and female relationship-building abilities ultimately provide a more effective leader of either gender (Denison et al., 1995; Korabik & Ayman, 2007; Regine & Lewin, 2003). As the majority of midwives are female it might be expected that they would more readily identify with the connective leadership model.

While the model for connective leadership comes from outside the healthcare industry, in many respects the way maternity services are managed require a mixed approach to leadership. There are occasions when midwifery leadership requires a **direct** approach, a **relational** approach or an **instrumental** approach but may also require a combination of all three. A **direct** approach is necessary when there is a need to act quickly or when the leader has the required expertise to make them the best person to take charge of a situation (Lipman-Blumen, 1996). In midwifery this might be necessary during an emergency such as a shoulder dystocia.[50] In this example, a midwife might take charge providing clear directions for others, expecting those orders to be followed implicitly. The midwife taking this leadership role may not be the person with the most legitimate authority but the one with the expertise at the time. Leaders are frequently seen to emerge during critical events, taking charge and doing their best until legitimate authority arrive to take over (Simpson, 2007; Wheatley, 2006).

Midwives work in a profession that is required to develop and maintain relationships with other health professionals as well as women and their families. In maternity services, midwives are not only a member of a 'midwifery team' but also members of the wider healthcare team. Therefore, from a **relational** leadership approach a midwife leader may establish an interdisciplinary team to develop maternity policies. In a maternity unit there

[50] A shoulder dystocia is an emergency situation where the anterior shoulder of the baby is impacted under the pubic bone preventing the birth of the baby.

may be one official unit manager but with the need for 24 hour, seven days a week care staff of a midwifery unit change each shift. Each shift requires a designated person to be 'in charge' at all times. A connective leader would assist midwives to develop skills to take on those duties. This may be through mentorship, contributing to their education and/or enabling a midwife to be 'in charge' when the leader is available to provide support.

An example of using all three approaches might occur when a midwifery leader becomes aware that there is a project to develop a new interdisciplinary antenatal service for women with complex needs. The midwifery leader might use the instrumental networking approach to get the midwifery team invited to participate in the project. Then she might use a direct approach to designate one midwife to work on the project. This would then be followed by the use of the contributory approach to provide assistance to the midwife so that she is able to participate successfully.

Table 34 relates the Connective Leadership Model to the study reported earlier in the portfolio.

Attributes of the Connective Leadership Model	**Relationship to Findings**
Relational **Contributes to others tasks** • Vicarious - mentors • Contributory - helps • Collaborative - joins forces	Mentorship was used in Case B but was not mentioned in Case A. At least one leader at Case A spoke about 'getting out and working in the new antenatal clinic' to help less experienced staff. Both sites employed a working party to develop the models.
Instrumental **Maximises interactions** • Entrusting - empowers • Social - networks • Personal - persuades	Maximising interactions appeared to be lacking at both sites. Midwives lost trust in their leadership at Case A, as the perception was that management had made decisions regardless of their concerns. The leader who provided the vision at Case A was not visible, therefore did not use her personal attributes to enable her vision to be accepted by everyone.

Direct **Masters own tasks** • Power - takes charge • Competitive - outperforms • Intrinsic - excels	Leaders at Case A made decisions to change regardless of feedback from staff.

Table 34: Connective leadership model related to findings

The concepts embedded in the connective leadership model are not new but by linking them together Lipman-Blumen acknowledges that they all have value as leadership skills. Looking at the model from a holistic point of view it is not the individual concepts that provide the strength but the model as a whole. Midwifery leaders who are able to adapt their style of leadership to suit the context of the situation will be stronger and more suited to working in times of change. In addition, midwifery leaders who are able to connect with peers, other professionals and stakeholders in maternity care are more likely to promote appropriate strategies for change. As change occurs and the workplace is disrupted, by being connected to the whole picture it is easier for midwifery leaders to see the patterns that are being created and thus seek the innovations that produce the final outcomes (Wheatley, 2006).

Change occurs only if it is seen as the means to preserve the self. Therefore it is essential for leaders to work from within a group to discover what issues are important for each member (Wheatley, 2006). Midwifery leaders who are connected to the whole are able to communicate the potential of the change outcomes in a more meaningful and acceptable way. Many of the strategies to lead in a connected world are already incorporated into organisational workplaces but, in many instances, have failed. Many were implemented because they were identified as the latest in management strategies without due consideration to the context and complexities faced (Wheatley, 2006).

Midwifery needs a model of leadership that encourages development of new leaders (Pashley, 1998), is flexible enough to meet the needs of a dynamic service (Welford, 2002b), and lends itself to the development of group power (Sieloff, 2004). Complexity science acknowledges the importance of relationships. Relationships are important for

building trust and creating social capital (Regine & Lewin, 2003). Within midwifery, Brodie (2003) promotes the need for professional capital. It would appear that the use of the connectivity leadership model could provide midwifery leaders a guide to developing their skills to enable the development of professional capital. Connective leaders can be seen as ones who are able to combine strategies, are not addicted to power, think about the well-being of the group, share the burdens of leadership and develop relationships both within and outside of the organisation. They lead from within a group but are capable in times of crisis to lead from the front (Lipman-Blumen, 2000a).

In this dynamic complex world, change can impact more widely than can be anticipated and planned for, therefore leaders need to be able to utilise a range of skills to support and guide midwives. Connective leadership is a holistic model that encompasses many aspects of leadership to enable the best to emerge from the whole organisation. Midwifery is a profession that has a philosophy embedded in holism, whereby communication, interactions and collaboration underpin our practice. There are times when midwives need to direct activities and times when they need to allow others to be in control. Each part of the connective leadership model has been recognised as useful as a leadership strategy for success but the use of all approaches in a connective way creates synergy and better outcomes than by using one strategy alone. I suggest that midwifery should look to the **connective leadership model** as a format that best supports midwifery leaders of the future.

10.3. Conclusion

This portfolio set out to explore the role of the midwife within the state of Victoria and to identify the effect that maternity service policy and organisational change had for midwives and their practice. This chapter concluded the portfolio by drawing together the earlier sections under an overarching roof of complexity and connectivity.

The recognition of individuals, maternity units, organisations and governments as Complex Adaptive Systems (CAS) acknowledges the dynamic non-linear interactions that occur within and between these elements in the provision of maternity care. Maternity units as

CAS may outwardly appear to have similar structures and face similar problems but evolve in response to local conditions. Different adaptations are due to the underlying attributes of CAS. That is dynamic interactions occur between the elements of CAS, each CAS has memory and thus history that affects responses, feedback and exchange of knowledge between other CAS shapes further adaptation. The cases presented in earlier chapters provided examples of the different models that evolved from a similar need to improve the utilisation of resources.

The review of the literature into the philosophy and autonomy of midwives and midwife-led models of care provided insights into the different approaches that individual midwives have to midwifery practice. Midwives' ability to be autonomous practitioners depends not only on their recognition and acceptance by others, such as regulatory boards and other health professionals, but also on the individual's desire, ability and willingness to take responsibility. The findings of the study suggest there was a dichotomy between those midwives desiring autonomous practice and wanting to work in midwife-led care and those wishing to remain in one specialised area. The continuing domination of the medicalisation of childbirth was identified as an influential factor that was, to some extent, being maintained by the midwives themselves. Midwives are the foundations of midwifery care. One strategy that is necessary for enhancement of these foundations is effective leadership that encompasses development and support of midwives. The connective leadership model was suggested as the means to provide leadership that is inclusive of providing direction, mentoring new leaders and providing support and opportunities for midwives to become empowered to practice autonomously. There is a need for midwifery role models, continuing education, support and leadership to ensure acceptance and integration of midwife-led care into practice. Without such leadership, midwife-led care is at risk of remaining on the periphery of options for women.

Section two of the portfolio reviewed the processes of recent maternity service policy development in Victoria. Policy provides a floor upon which to develop appropriate services for women and their families. The dynamic non-linear process of policy development in the development of maternity service policy was recognised by reviewing

the process using Kingdon's (1995) approach to policy analysis. The case studies revealed that despite the provision of forward thinking maternity service policy in Victoria, the changes that occurred in some maternity units were based on the needs of the organisation over any recognition of the needs for women and midwives. Organisations acting as CAS adapt according to their own agendas. The adoption of terminology and models that imply midwife-led care might meet policy directives but without changing the underpinning philosophy, without the provision of full support, education and leadership, midwives will resist the implementation of change that does not meet their needs.

The re-organisation and renovation of the physical environment at one site was a response not only to their particular need to reduce beds, but also to establish shared working spaces for their midwifery teams. This re-organisation of the physical layout highlighted the importance of the environment for maintaining normal birth for both midwives and women. The provision of an environment conducive to the provision of woman-centred care requires more than reducing the clinical appearance of labour rooms. This re-arrangement is limited by the assumption that a design from another site can be successfully repeated in a new context.

The key findings of the portfolio were that; not all midwives in Victoria want to work across the full scope of midwifery practice; the implementation of organisational change requires appropriate education, support and leadership; and the physical environment is an important factor in the provision of midwifery care for midwives as well as women.

Recommendations for the future of midwifery include:

- The need to establish sufficient education and professional support programs when instigating change.
- The need for research into the physical environment including the use of integrated maternity units and LDRs.
- Review of the terminology used to describe midwifery models of care to establish a common understanding to enables effective comparison of models.
- Leadership training that incorporates a mixture of styles as demonstrated in Lipman-Blumen's (1996) model.

- Recognition that organisations are Complex Adaptive Systems. This will assist in planning for future change through the acknowledgement of the complex factors that need to be considered and that outcomes may not be the same for similar changes introduced elsewhere.

Complexity science does not provide simple answers to problems. The recognition of the need for diversity in life acknowledges the value of many theoretical positions. Diversity includes recognition of the different roles midwives may play. Given the stress and anxiety that occurs for some midwives when expected to work in areas not of their choice perhaps it is time to review the interpretation of the role of the midwife and acknowledge that for some there is value in being an expert in one field. There is a need for a full and frank debate into midwifery in Australia. It is essential to establish ways that midwives can practise according to their full scope but also in ways that give them satisfaction in an ever changing complex environment if the future for midwifery is to be bright.

REFERENCES

ABC News. (2008). Birth rate too fast for new hospital. Retrieved December 2, 2008, from http://www.abc.net.au/news/stories/2008/06/25/2285710.htm

Achterberg, J. (1990). *Woman as Healer*. London: Rider.

ACM. (2006a). Position Statement - Prescribing Rights and Diagnostic Tests Retrieved April 21 2008, from http://www.acmi.org.au/AboutUs/ACMPositionStatements/PrescribingRightsandDiagnosticTests/tabid/267/Default.aspx

ACM. (2006b). Standards for the Accreditation of Three Year Bachelor of Midwifery Programs. Retrieved March 3, 2007, from www.midwives.org.au

ACM. (2007a, 11/01/07). About the College. Retrieved May 7, 2008, from http://www.midwives.org.au

ACM. (2007b). ACM Philosophy Statement for Midwifery. Retrieved February 6, 2007, from http://www.midwives.org.au/default.asp

ACM. (2007c). Midwifery Practice Review Retrieved May 16th 2008, from http://www.midwives.org.au/LinkClick.aspx?fileticket=TmzHfETI10s%3d&tabid=856

ACM. (2008). MidPlus The Australian College of Midwives Continuing Professional Development Program Retrieved October 11, 2008, from http://www.midwives.org.au/ForMidwives/MidPLUSContinuingProfessionalDevelopment/tabid/310/Default.aspx

Adams, A., & Bond, S. (2000). Hospital nurse' job satisfaction, individual and organizational characteristics. *Journal of Advanced Nursing, 32*(3), 536-543.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J., & Silber, J. H. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA, 288*(16), 1987-1993.

Allen, J., Jimmieson, N. L., Bordia, P., & Irmer, B. E. (2007). Uncertainty during Organisational Change: Managing Perceptions through Communication. *Journal of Change Management, 7*(2), 187-210.

Anderson, R. A., Crabtree, B. F., Steele, D. J., & McDaniel, R. R. J. (2005). Case Study Research: The View from Complexity Science. *Qualitative Health Research, 155*, 669-685.

Anderson, R. A., & McDaniel Jr., R. R. (2000). Managing health care organizations: Where professionalism meets complexity science. *Health Care Management Review, 25*(1), 83.

ANF Vic. (2007). *Nurses (Victorian Public Health Sector) Multiple Business Agreement 2007-2011*. Melbourne.

ANMC. (2006). National Competency Standards for the Midwife. Retrieved January 18, 2007, from www.midwives.org.au/Documents/Competency_standards_for_the_Midwife.pdf

ANMC. (2008a). Code of Ethics for Midwives in Australia. Retrieved October 11, 2008, from http://www.anmc.org.au/docs/Research%20and%20Policy/Codes%20Project/New%20Code%20of%20Ethics%20fo%20rMidwives%20August%202008.pdf

ANMC. (2008b). Code of Professional Conduct for Midwives in Victoria. Retrieved October 11, 2008, from http://www.anmc.org.au/docs/Research%20and%20Policy/Codes%20Project/New%20Code%20of%20Professional%20Conduct%20for%20Midwives%20August%202008.pdf

ANMC. (2008c). Project to Develop Standards and Criteria for the Accreditation of Nursing and Midwifery Courses. Retrieved October 11, 2008, from http://www.anmc.org.au/docs/Bulletins/Accreditation/Bulletin%202%20Aug%202008.pdf

ANMC. (n.d.-a). Australian Nursing and Midwifery Council Home Page. Retrieved October 10, 2008, from http://www.anmc.org.au/

ANMC. (n.d.-b). Regulatory Authorities. Retrieved December 23, 2009, from http://www.anmc.org.au/contacts/authorities.php

Antonacopoulou, E. P., & Gabriel, Y. (2001). Emotion, learning and organisational change. Towards an integration of psychoanalytic and other perspectives. *Journal of Organizational Change Management, 14*(5), 435-451.

Antrobus, S. (1997). An analysis of nursing in context: the effects of current health policy. *Journal of Advanced Nursing, 25*, 447-453.

Arndt, M., & Bigelow, B. (2000). Commentary: The Potential of Chaos Theory and Complexity Theory for Health Services Management. *Health Care Management Review, 25*(1), 35-38.

Ashcroft, B., Elstein, M., Boreham, N., & Holm, S. (2003). Prospective semistructured observational study to identify risk attributable to staff deployment, training, and updating opportunities for midwives. *British Medical Journal, 327*, 584-588.

Auditor General Victoria. (2002, 15th August 2002). Nurse work force planning. Retrieved January 18, 2007, from http://www.audit.vic.gov.au/reports_par/agp78brf.html

Australian Health Workforce Advisory Committee. (2002). *The Midwifery Workforce in Australia, 2002-2012*. North Sydney: Australian Health Workforce Advisory Committee.

Australian Health Workforce Ministerial Council (AHWMC). (2009). Communique - Design of new national registration and accreditation scheme. Retrieved 23/12/09, from http://www.nhwt.gov.au/natreg.asp

Australian Industrial Relations Commission. (2000). *Nurses (Victorian Public Sector) Multi-employer Agreement 2000-2004*. Melbourne.

Axinn, W. G., & Pearce, L. D. (2006). *Mixed Method Data Collection Strategies*. Cambridge: Cambridge University Press.

Baird, K. (2007). Exploring Autonomy in education: preparing student midwives. *British Journal of Midwifery, 15*(7), 400-405.

Bakir, C. (2003). Who Needs a Review of the Financial System in Australia? The Case of the Wallis Inquiry. *Australian Journal of Political Science, 38*(3), 511-534.

Ball, L., Curtis, P., & Kirkham, M. (2002). *Why do Midwives Leave?* London: Royal College of Midwives.

Bamford, D., & Daniel, S. (2005). A Case Study of Change Management Effectiveness within the NHS. *Journal of Change Management, 5*(4), 391-406.

Barbour, R. S. (1999). Are focus groups an appropriate tool for studying organizational change? In R. S. Barbour & J. Kitzinger (Eds.), *Developing Focus Group Research*. London: Sage Publications.

Barbour, R. S., & Schostak, J. (2004). Interviewing and Focus Groups. In B. Somekh & C. Lewin (Eds.), *Research Methods in the Social Sciences*. London: Sage Publications.

Bareil, C., Savoie, A., & Meunier, S. (2007). Patterns of Discomfort with Organisational Change. *Journal of Change Management, 7*(1), 13-24.

Barker, K. K. (1998). A ship upon a stormy sea: The medicalization of pregnancy. *Social Science & Medicine, 47*(8), 1067-1076.

Barlow, K. A., Marion, H., Conroy, C., & Lennan, M. (2004). An evaluation of the midwifery services at a New Zealand community maternity unit (birth centre). *New Zealand College of Midwives Journal, 31*, 7-12.

Barraclough, S., & Gardner, H. (2008). A problem-oriented approach to health policy analysis. In S. Barraclough & H. Gardner (Eds.), *Analysing Health Policy: a problem oriented approach*. Sydney: Churchill Livingstone.

Bass, B. M. (1990). From transactional to transformational leadership: learning to share the vision. *Organizational Dynamics, 18*(3), 19-31.

Bass, B. M. (1997). Does the Transactional-Transformational Leadership Paradigm Transcend Organisational Boundaries? *American Psychologist, 52*(2), 130-139.

Baulcomb, J. S. (2003). Management of change through force field analysis. *Journal of Nursing Management, 11*(4), 275-280.

Beanland, C., Schneider, Z., LoBiondo-Wood, G., & Haber, J. (Eds.). (1999). *Nursing Research Methods. Critical Appraisal and Utilisation* (1st Australasian ed.). Artarmon, Australia: Mosby.

Benjamin, Y., Walsh, D., & Taub, N. (2001). A comparison of partnership caseload midwifery care with conventional team midwifery care: labour and birth outcomes. *Midwifery, 17*, 234-240.
Bennett, S., & Newman, G. (2000). Victorian Election 1999. Retrieved November 3, 2003, from http://www.aph.gov.au/library/pubs/rp/1999-2000/2000rp19.htm
Bennis, W. (2003). *On Becoming a Leader* (2nd ed.). New York: Basic Books.
Bergen, A., & While, A. (2000). A case for case studies: exploring the use of case study design in community nursing research. *Journal of Advanced Nursing, 31*(4), 926-934.
Bernstein, D. (1993). *Female Identity Conflict in Clinical Practice*. Northvale: Jason Aronson.
Bernthal, P. R., & Insko, C. A. (1993). Cohesiveness Without Groupthink. The Interative Effects of Social and Task Cohesion. *Group & Organisation Management, 18*(1), 66-87.
BFHI. (n.d.). Assessing Code Compliance in BFHI Assessments: Why, and what BFHI Assessors will look for. Retrieved August 10, 2008, from http://www.bfhi.org.au/
Biro, M. A. (2000). Team midwifery care in a tertiary level obstetric service: a randomised controlled trial. *Birth, 27*(3), 168-173.
Biro, M. A., Waldenstrom, U., Brown, S., & Pannifex, J. (2003). Satisfaction with Team Midwifery Care for Low- and High-Risk Women: A Randomised Controlled Trial. *Birth, 30*(1), 1-10.
Bligh, M. C., Pearce, C. L., & Kohles, J. C. (2006). The importance of self- and shared leadership in team based knowledge work. A meso-level model of leadership dynamics. *Journal of Managerial Psychology, 21*(4), 296-318.
Bloch, D. (2005). Complexity, Chaos and Nonlinear Dynamics: A New Perspective on Career Development Theory. *The Career Development Quarterly, 53*, 194-207.
Boyatzis, R. E. (2006). An overview of intentional change from a complexity perspective. *Journal of Management Development, 25*(7), 607-623.
Bridges, W. (2003). *Managing Transitions Making the Most of Change* (2nd ed.). Cambridge, USA: De Capo Press.
Brockopp, D., Brockopp, G., Warden, S., Wilson, J., Carpenter, J., & Vandeveer, B. (1998). Barriers to change: a pain management project. *International Journal of Nursing Studies, 35*, 226-232.
Brodie, P. (1996). *Being with Women: The Experience of Australian Team Midwives.* Unpublished Masters of Nursing Thesis, University of Technology Sydney, Sydney.
Brodie, P. (2002). Addressing the Barriers to Midwifery - Australian Midwives Speak Out. *Australian Journal of Midwifery, 15*(3), 5-14.
Brodie, P. (2003). *The Invisibility of Midwifery – Will Developing Professional Capital Make a Difference?* Unpublished Doctoral Thesis, University of Technology, Sydney, Sydney.
Brodie, P., & Barclay, L. (2001). Contemporary issues in Australian midwifery regulation. *Australian Health Review, 24*(4), 103-118.
Brodsky, C. M. (1976). *The Harassed Worker*. Toronto: Lexington Books.
Brown, S., & Bruinsma, F. (2006). Future directions for Victoria's public maternity services: is this "what women want"? *Australian Health Review, 30*(1), 56-64.
Brown, S., Darcy, M.-A., & Bruinsma, F. (2002). Having a baby in Victoria 1989-2000: continuity and change in the decade following the Victorian Ministerial Review of

Birthing Services. *Australian and New Zealand Journal of Public Health, 26*(3), 242.
Brown, S., & Lumley, J. (1994). Satisfaction with care in labor and birth: a survey of 790 Australian women. *Birth, 21*(1), 4-13.
Brown, S., Lumley, J., Bruinsma, F., & Darcy, M.-A. (2001). *Victorian Survey of Recent Mothers 2000.* Paper presented at the Victorian Survey of Recent Mothers 2000 Seminar, Melbourne.
Bruinsma, F., Brown, S., & Darcy, M.-A. (2003). Having a baby in Victoria 1989-2000: women's views of public and private models of care. *Australian and New Zealand Journal of Public Health, 27*(1), 20.
Bryman, A., & Burgess, R. (Eds.). (1994). *Analyzing Qualitative Data*. London: Routledge.
Buchanan, J., Bretherton, Bearfield, T. S., & Jackson, S. (2004). Stable, but critical the working conditions of Victorian public sector nurses in 2003. Retrieved January 25, 2007, from http://www.anfvic.asn.au/download/mo_default.htm
Burnes, B. (2004). Kurt Lewin and the Planned Approach to Change: A Re-appraisal. *Journal of Management Studies, 41*(6), 977-1002.
Burns, J. P. (2001). Complexity science and leadership in healthcare. *Journal of Nursing Administration, 31*(10), 474-482.
Calman, K. (2002). Communication of risk: choice, consent, and trust. *The Lancet, 360*, 166-168.
Capra, F. (1992). *The Tao of Physics* (3rd ed.). London: Flamingo.
Capra, F. (1996). *The Web of Life a New Synthesis of Mind and Matter*. London: Flamingo.
Capra, F. (2002). *The Hidden Connections*. London: Flamingo.
Carney, M. (2000). The development of a model to manage change: reflection on a critical incident in a focus group setting. *Journal of Nursing Management, 8*, 265-272.
Carolan, M., & Hodnett, E. (2007). With woman philosophy: examining the evidence, answering the questions. *Nursing Inquiry, 14*(2), 140-152.
Chaffee, M., & McNeill, M. (2007). A model of nursing as a Complex Adaptive System. *Nursing Outlook, 55*(5), 232-241.
Cilliers, P. (2000). What Can We Learn From a Theory of Complexity? *Emergence, 2*(1), 23-33.
Clarke, R. (2004). Midwifery autonomy and the code of professional conduct: an unethical combination? In L. Frith & H. Draper (Eds.), *Ethics and Midwifery*. Edinburgh: Books for Midwives.
Coggins, J. (2005). Strengthening midwifery leadership. *Midwives, 8*(7), 310-313.
College of Midwives of British Columbia. (2006). Model of Midwifery Practice. Retrieved February 9, 2007, from http://www.cmbc.bc.ca/
Commonwealth of Australia. (2009). Maternity Services Review. Retrieved March 10, 2009, from http://www.health.gov.au/maternityservicesreview
Compact Oxford Dictionary (Ed.). (2006). *Thesaurus and Wordpower Guide* (2nd ed.). Oxford: Oxford University Press.
Cook, M. J. (1999). Improving care requires leadership in nursing. *Nurse Education Today., 19*(4), 306-312.
Cook, M. J. (2001). The renaissance of clinical leadership. *International Council of Nurses, International Nursing Review, 48*, 38-46.
Cook, M. J., & Leathard, H. L. (2004). Learning for clinical leadership. *Journal of Nursing Management, 12*(6), 436-444.

Cresswell, J. (1998). *Qualitative Inquiry and Research Design*. Thousand Oaks, California: Sage Publications.
Currie, S. M. (1999). Aspects of the preparation of student midwives for autonomous practice. *Midwifery, 15*, 283-292.
Curtis, E. (2007). Job satisfaction: a survey of nurses in the Republic of Ireland. *International Nursing Review, 54*(1), 92-99.
Curtis, E., & White, P. (2002). Resistance to change: Causes and Solutions. *Nursing Management 8*(10), 15-20.
Curtis, P., Ball, L., & Kirkham, M. (2006). Bullying and horizontal violence: cultural or individual phenomena? *British Journal of Midwifery, 14*(4), 218-221.
Cutts, D., David, P. M., McIntyre, M., Seibold, C., Hopkins, F., & Miller, M. (2003). Werna Naloo -- 'We Us Together': the birth of a midwifery education consortium. *Journal of Advanced Nursing, 41*(2), 179-186.
Davey, M.-A., Taylor, O., Oats, J., & Riley, M. (2008). *Births in Victoria 2005 and 2006*. Melbourne: Victorian Perinatal Data Collection Unit, Statewide Quality Branch, Department of Human Services.
Davis-Floyd, R. (1996). Autonomy in Midwifery: Definition, Education, Regulation. *Midwifery Today 46, (sourced author website).* Retrieved 11th October 2006, from http://www.davis-floyd.com/USERIMAGES/File/AUTONOMY%20in%20midwifery.pdf
Davis-Floyd, R. (2001). The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynecology & Obstetrics, 75*(S5-S23).
Davis-Floyd, R., & Davis, E. (1996). Intuition as Authoritative Knowledge in Midwifery and Homebirth. *Medical Anthropology Quarterly, 10*(2), 237-269.
Davis, A., & George, J. (1988). *States of Health Health and Illness in Australia*. Sydney: Harper and Row.
Dawson, W., Brown, S., Gunn, J., McNair, R., & Lumley, J. (2000). Sharing obstetric care: barriers to integrated systems of care. *Australian and New Zealand Journal of Public Health, 24*(4), 401-406.
Denison, D. R., Hooijberg, R., & Quinn, R. E. (1995). Paradox and Performance: Toward a Theory of Behavioral Complexity in Managerial Leadership. *Organization Science, 6*(5), 524-540.
Denmark, F. L. (2007). Feminist Leadership and Collaboration. In J. L. Chin, B. Lott, J. K. Rice & J. Sanchez-Hucles (Eds.), *Women and Leadership Transforming Visions and diverse Voices* (pp. 141-143). Malden: Blackwell Publishing.
Department of Health. (1993). *Changing Childbirth. Report of the Expert Maternity Group.* London: HMSO.
Department of Health. (2007). *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service*. London: NHS.
Department of Health W.A. (2007). Improving Maternity Choices - Working Together Across WA - A Draft Policy. Retrieved July 5, 2007, from http://www.healthnetworks.health.wa.gov.au/maternitycare/
Department of Human Services Victoria. (2004). Design Guidelines for Hospitals and Day Procedure Centres. Retrieved May 1, 2006, from www.healthdesign.com.au/vic.dghdp/

Deshpande, N., Publicover, M., Gee, H., & Khan, K. (2003). Incorporating the views of obstetric clinicians in implementing evidence-supported labour and delivery suite ward rounds: a case study. *Health Information and Libraries Journal, 20*, 86-94.
DHS. (1998). *Victorian Public Hospital Policy and Funding Guidelines 1998-1999*. Retrieved July 26, 2004. from www.dhs.vic.gov.au/ahs/archive/pfg9899/7.htm.
DHS. (1999). *Victoria- Public Hospitals Policy and Funding Guidelines 1999-2000 Section A - Policy*. Retrieved July 26, 2004. from www.dhs.vic.gov.au/ahs/archive/pfg9920/16app5.htm.
DHS. (2002a). About the Maternity Services Program. Retrieved July 26, 2004, from www.health.vic.gov.au/maternitycare/about.htm
DHS. (2002b). *Hospital Demand Management (HDM) Strategy Business Rules 2002-2003*. Retrieved August 11, 2008. from http://www.health.vic.gov.au/archive/archive2004/hospital-demand/busrule03/intro.pdf.
DHS. (2002c). *Victorian Women's Health and Wellbeing Strategy Policy Statement and Implementation Framework*. Retrieved April 5, 2006. from http://www.health.vic.gov.au/vwhp/downloads/whwb_policy-imp_frmwk_aug02.pdf.
DHS. (2004a). *Future Directions for Victoria's Maternity Services*. Retrieved February 5, 2005. from www.health.vic.gov.au/maternitycare/pubs.htm.
DHS. (2004b). *Rural Birthing Services: A capability based planning framework*. Melbourne: State Government of Victoria, Rural and Regional Health Services Branch, Rural and Regional Health and Aged care Services, Victorian Government Department of Human Services.
DHS. (2005). Emergency Birthing. Retrieved April 10, 2005, from www.dhs.vic.gov.au/regional/grampians/docs/emergency_%20birth_framework.pdf
DHS. (2007). Victorian Maternity Services Performance Indicators Complete set for 2006–07. Retrieved November 13, 2008, from http://www.health.vic.gov.au/maternitycare/matpeform-ind-0607.pdf
DHS. (2008). *Maternity Care VMR Summary*. Retrieved. from http://www.health.vic.gov.au/maternitycare/vmr_summary_brochure.pdf.
DHS. (n.d., October 21, 2008). Current Programs / Initiatives. Retrieved November 28, 2008, from http://www.health.vic.gov.au/maternitycare/progs.htm
Donnellan-Fernandez, R., & Eastaugh, M. (2003). *Midwifery Regulation in Australia: A Century of Invisibility.* Paper presented at the 6th International Conference on the Regulation of Nursing and Midwifery, Innovations in Regulation, Melbourne.
Donnison, J. (1988). *Midwives and Medical Men A History of the Struggle for the Control of Childbirth* (2nd ed.). London: Historical publications.
Draper, H. (2004a). Ethics and consent in midwifery. In L. Frith & H. Draper (Eds.), *Ethics and Midwifery* (pp. 19-39). Edinburgh: Books for Midwives.
Draper, H. (2004b). Introduction. In L. Frith & H. Draper (Eds.), *Ethics and Midwifery*. Edinburgh: Books for Midwives.
Duckett, S. (2007). *The Australian Health Care System*. Melbourne: Oxford University Press.
Dworkin, G. (1988). *The Theory and Practice of Autonomy*. Cambridge: Cambridge University Press.

Engel, C. (2003). Towards a sustainable model of midwifery practice in a continuity of carer setting: the experience of the New Zealand midwives. *New Zealand College of Midwives Journal,* (28), 12-15.
Eriksson, C. (2004). The effects of change programs on employees' emotions. *Personnel Review, 33*(1), 110-126.
Etherington, K. (2004). *Becoming a Reflexive Researcher Using Our Selves in Research*. London: Jessica Kingsley Publishers.
Farquhar, M., Camilleri-Ferrante, C., & Todd, C. (1998). Working with team midwifery: health visitors' views of one team midwifery scheme. *Journal of Advanced Nursing, 27*, 546-552.
Farquhar, M., Camilleri-Ferrante, C., & Todd, C. (2000). Continuity of care in maternity services: women's views of one team midwifery scheme. *Midwifery, 16*, 35-47.
Ferlie, E., Fitzgerald, L., Wood, M., & Hawkins, C. (2005). The nonspread of innovations: the mediating role of professionals. *Academy of Management Journal, 48*(1), 117-134.
Fielder, A., Kirkham, M., Baker, K., & Sherridan. (2004). Trapped by Thinking in Opposites? [Electronic version]. *Midwifery Matters, Autumn*(102).
Finlay, L. (2002). "Outing" the Researcher: The Provenance, Process, and Practice of Reflexivity. *Qualitative Health Research, 12*(4), 531-545.
Fisher, I., & Ziviani, J. (2004). Explanatory case studies: Implications and applications for clinical research. *Australian Occupational Therapy Journal, 51*, 185-191.
Fleming, V. (1998a). Autonomous or Automatons? An exploration through history of the concept of autonomy in midwifery in Scotland and New Zealand. *Nursing Ethics, 5*(1), 43-51.
Fleming, V. (1998b). Women-with-midwives-with-women: a model of interdependence. *Midwifery, 14*(3), 137-143.
Flint, C., Poulengeris, P., & Grant, A. (1989). The 'Know Your Midwife' scheme-a randomised trial of continuity of care by a team of midwives. *Midwifery, 5*(1), 11-16.
Foley, L., & Faircloth, C. (2003). Medicine as discursive resource: legitimation in the work narratives of midwives. *Sociology of Health & Illness, 25*(2), 165-184.
Forster, D., McLachlan, H., Yelland, J., Rayner, J., & Lumley, J. (2005). *A Review of In-Hospital Postnatal Care in Victoria*. Melbourne: La Trobe University.
Foureur, M. (2008). Creating birth space to enable undisturbed birth. In K. Fahy, M. Foureur & C. Hastie (Eds.), *Birth Territory and Midwifery Guardianship Theory for Practice, Education and Research*. Edinburgh: Elsevier.
Fraser, D., Watts, K., & Munir, F. (2003). Under the spotlight: Grantham's midwife-managed unit. In M. Kirkham (Ed.), *Birth Centres A Social Model for Maternity Care.* London: Books for Midwives.
Fredriksen, S. (2006). Tragedy, utopia and medical progress. *Journal of Medical Ethics, 32*(8), 450-453.
Freeman, L. M., Adair, V., Timperley, H., & West, S. H. (2006). The influence of the birthplace and models of care on midwifery practice for the management of women in labour. *Women and Birth, Journal of the Australian College of Midwives, 19*(4), 97-105.

Freeman, M., Miller, C., & Ross, N. (2000). The impact of individual philosophies of teamwork on multi-professional practice and the implications for education. *Journal of Interprofessional Care, 14*(3), 237-247.
Furlong, M. (2003). Observing the Rites of Autonomy, Distancing the Prospects for 'The Spiritual'. *Australian & New Zealand Journal of Family Therapy, 24*(4), 199-203.
Gardner, H. (2008). Population health, the health system and policy. In S. Barraclough & H. Gardner (Eds.), *Analysing health policy a problem-oriented approach* (pp. 41-54). Sydney: Churchill Livingstone.
Gardner, H., & Barraclough, S. (2008). Health policy as a process. In S. Barraclough & H. Gardner (Eds.), *Analysing health policy a problem-oriented approach*. Sydney: Churchill Livingstone.
Garside, P. (1998). Organisational context for quality: lessons from the fields of organisational development and change management. *Quality in Health Care, 7(suppl)*, S8-S15.
Gatrell, A. C. (2005). Complexity theory and geographies of health: a critical assessment. *Social Science and Medicine, 60*, 2661-2671.
Gillham, B. (2000). *Case Study Research Methods*. London: Continuum.
Gleick, J. (1988). *Chaos: making a new science*. London: Minerva.
Gosden, D., & Noble, C. (2001). Social mobilisation around the act of childbirth: subjectivity and politics. *Annual Review of Health Social Sciences, 10*, 69-79.
Graetz, F., Rimmer, M., Lawrence, A., & Smith, A. (2006). *Managing Organisational Change* (2nd Australasian ed.). Milton, Australia: Wiley.
Graham, J. W. (1988). Commentary: Transformational Leadership: Fostering Follower Autonomy, Not Automatic Followership. In *Emerging Leadership Vistas*: Lexington books.
Gray, G. (1999). Women's Health in a Restructuring State. In L. Hancock (Ed.), *Women, Public Policy and the State*. South Yarra: MacMillan Education.
Grbich, C. (2007). *Qualitative data analysis An introduction*. London: Sage Publications.
Green, J., Renfrew, M., & Curtis, P. (2000). Continuity of care: what matters to women? A review of the evidence. *Midwifery, 16*, 186-196.
Gregory, R., Slovic, P., & Flynn, J. (1996). Risk Perceptions, stigma, and health policy. *Health and Place, 2*(4), 213-220.
Griew, K. (2003). Birth centre midwifery down under. In M. Kirkham (Ed.), *Birth Centres A Social Model for Maternity Care*. London: Books for Midwives.
Grossman, S., & Valiga, T. (2000). *The New Leadership Challenge: Creating the Future of Nursing*. New York: F. A. Davis Company.
Guilliland, K. (1999). Midwifery in New Zealand. Retrieved February 27, 2007, from www.acegraphics.com.au/articles/guilliland01.html
Guilliland, K., & Pairman, S. (1995). *The Midwifery Partnership A model for practice*. Wellington: Victoria University of Wellington.
Guthrie, B., Saultz, J. W., Freeman, G. K., & Haggerty, J. L. (2008). Continuity of care matters. *British Medical Journal, 337*, a867.
Hackman, M. Z., & Johnson, C. E. (2004). *Leadership A Communication Perspective* (4th ed.). Longrove: Waveland Press.
Hadikin, R., & O'Driscoll, M. (2000). *The Bullying Culture - cause - effect - harm reduction*. Oxford: Books for Midwives.

Haggerty, J. L., Reid, R. J., Freeman, G. K., Starfield, B. H., Adair, C. E., & McKendry, R. (2003). Continuity of care: a multidisciplinary review. *British Medical Journal, 327*(7425), 1219-1221.

Haith-Cooper, M. (1999). Team midwives' views on team midwifery. *The Practising Midwife, 2*(6), 24-28.

Halliday, J., Ellis, I., & Stone, C. (1999). *WUDWAW "Who Usually Delivers Whom and Where"*. Melbourne: Victorian Perinatal Data Collection Unit.

Halliday, S. V. (2002). Barriers to customer-orientation: A case applied and explained. *European Journal of Marketing, 36*(1/2), 136-158.

Halliday, S. V. (2004). How "placed trust" works in a service encounter. *Journal of Services Marketing, 18*(1), 45-59.

Halliday, S. V., & Hogarth-Scott, S. (2000). 'New Customers to be Managed: Pregnant Women as Consumers of Maternity Care'. *Journal of Applied Management Studies, 9*(1), 55-69.

Halmi, A. (2003). Chaos and non-linear dynamics. *International Social Work, 46*(1), 83-101.

Hancock, L. (1999). Women's policy interests in the market state. In L. Hancock (Ed.), *Women, Public Policy and the State* (pp. 3-19). South Yarra: Macmillan Education.

Hart, A., Jones, A., Henwood, F., & Shiers, C. (2003). Public health. Use of client held records in the maternity services. *British Journal of Midwifery, 11*(11), 668.

Hastie, C. (2006). Exploring horizontal violence. *MIDIRS Midwifery Digest, 16*(1), 25-30.

Hatem, M., Sandall, J., Devane, D., Soltani, H., & Gates, S. (2008). Midwife-led versus other models of care for childbearing women (Review). *The Cochrane Library (Update software Oxford)*(4).

Hayhurst, C. (2007). Autonomous practice through staff empowerment. *PT: Magazine of Physical Therapy, 15*(4), 68-71.

Hazlehurst, D. (2001). *Networks and policy making: from theory to practice in Australian social policy* (Discussion paper No. ISBN 0 7315 3426 3). Canberra: Australian National University.

Health Department Victoria. (1990). *Having a Baby in Victoria*. Melbourne: Health Department Victoria.

Health Issues Centre. (2006). *Exploring Woman Centred Care in Maternity Care Project*. Melbourne: Health Issues Centre Inc.

Health Outcomes International. (2002). *Development of Options for Mainstreaming Maternity services Program Funding*. St Peters, South Australia: Victorian Government, Department of Human Services.

Higginbotham, N., Albrecht, G., & Connor, L. (Eds.). (2001). *Health Social Science A Transdisciplinary and Complexity Perspective*. Melbourne: Oxford University Press.

Hills, M., & Mullett, J. (2002). Women-centred Care: Working Collaboratively to Develop Gender Inclusive Health Policy. *Health Care for Women International, 23*, 84-97.

Hodnett, E. (2004). Continuity of caregivers for care during pregnancy and childbirth [Cochrane Review]. *The Cochrane Library (Update Software Oxford)*.

Hodnett, E. (2006). Continuity of caregivers for care during pregnancy and childbirth [Cochrane Review]. *The Cochrane Library (Update Software Oxford)*.

Holden, L. M. (2005). Complex adaptive systems: concept analysis. *Journal of Advanced Nursing, 52*(6), 651-657.

Holden, R. J. (1991). Responsibility and autonomous nursing practice. *Journal of Advanced Nursing, 16*(4), 398-403.
Hollins Martin, C. J., & Bull, P. (2004). Does status have more influence than education on the decisions midwives make? *Clinical Effectiveness in Nursing, 8*, 133-139.
Hollins Martin, C. J., & Bull, P. (2005). Measuring Social Influence of a Senior Midwife on Decision-making in Maternity Care: An Experimental Study. *Journal Community & Applied Social Psychology, 15*, 120-126.
Homer, C., Brodie, P., & Leap, N. (Eds.). (2008). *Midwifery Continuity of Care A Practical Guide*. Chatswood, NSW, Australia: Elsevier.
Homer, C., Davis, G., Brodie, P., Sheehan, A., Barclay, L., Wills, J., et al. (2001a). Collaboration in maternity care: a randomised controlled trial comparing community-based continuity of care with standard hospital care. *British Journal of Obstetrics and Gynaecology, 108*, 16-22.
Homer, C., Matha, D. V., Jordan, L. G., Wills, J., & Davis, G. K. (2001b). Community-based continuity of midwifery care versus standard hospital care: a cost analysis. *Australian Health Review, 24*(1), 85-93.
Hooijberg, R., Hunt, J. G., & Dodge, G. E. (1997). Leadership Complexity and Development of the Leaderplex Model. *Journal of Management, 23*(3), 375-408.
Hospital A Website. (2005). Hospital Website. Retrieved April 16, 2006
Houchin, K., & MacLean, D. (2005). Complexity Theory and Strategic Change: an Empirically Informed Critique. *British Journal of Management, 16*(2), 149-166.
Howlett, M., & Ramesh, M. (2003). *Studying Public Policy Policy Cycles and Policy Subsystems* (2nd ed.). Ontario: Oxford University Press.
Huber, G. P., & Van de Ven, A. H. (Eds.). (1995). *Longitudinal Field Research Methods*. Thousand Oaks: Sage Publications.
Hughes, D., Deery, R., & Lovatt, A. (2002). A critical ethnographic approach to facilitating cultural shift in midwifery. *Midwifery, 18*, 43-52.
Hundley, V., Cruickshank, F., Milne, J., Glazener, C., Lang, G., Turner, M., et al. (1995). Satisfaction and continuity of care: staff views of care in a midwife-managed delivery unit. *Midwifery, 11*, 163-173.
Hundley, V., Milne, J., Glazener, C., & Mollison, J. (1997). Satisfaction and the three C's: continuity, choice and control. Women's views from a randomised controlled trial of midwife-led care. *British Journal of Obstetrics and Gynaecology, 104*, 1273-1280.
Hundley, V., & Ryan, M. (2004). Are women's expectations and preferences for intrapartum care affected by the model of care on offer? *British Journal of Obstetrics and Gynaecology, 111*, 550-560.
Hunter, B. (2004). Conflicting ideologies as a source of emotion work in midwifery. *Midwifery, 20*(3), 261-272.
Hunter, B. (2005). Emotion work and boundary maintenance in hospital-based midwifery. *Midwifery, 21*(3), 253-266.
Hunter, B. (2006). The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery, 22*(4), 308-322.
Hurst, K. (2008). UK ward design: patient dependency, nursing workload, staffing and quality - an observational study. *International Journal of Nursing Studies, 45*(3), 370-381.

ICM. (2005a). Definition of the Midwife. Retrieved February 4, 2006, from www.internationalmidwives.org
ICM. (2005b). Midwifery: An Autonomous Profession. Retrieved August 2, 2007, from www.internationalmidwives.org
Iles, V., & Sutherland, K. (2001). *Managing Change in the NHS Organisational Change*. London: National Co-ordinating Centre for NHS Service Delivery and Organisation R & D.
Jaensch, D. (1988). *An Introduction to Australian Politics* (2nd ed.). Sydney: Longman Chesire.
Jenkins, S. R. (1994). Structural Power and Experienced Job Satisfactions: The Empowerment Paradox for Women. *Sex Roles, 30*(5/6), 347-369.
Johnston, J. (1998). *Options for provision of midwifery services in Victoria, 1998*. Melbourne: Australian College of Midwives Inc., Victorian Branch.
Jones, S. R. (2000). *Ethics in Midwifery*. London: Mosby.
Kakkib Li'Dthia Warrawee'a. (2004). Wisdom, Knowledge, and Information: Have We Lost Our Way in Our Understanding and Practice of Medicine? *The Journal of Alternative and Complementary Medicine, 10*(1), 9-11.
Keleher, H., Round, R., & Wilson, G. (2002). Report of the mid-term review of Victoria's Maternity Services Program. *Australian Health Review, 25*(4), 120-126.
Kelley, R. E. (1988). In Praise of Followers. *Harvard Business Review*, 142-148.
Kevern, J., & Webb, C. (2001). Focus Groups as a tool for critical social research in nurse education. *Nurse Education Today, 21*, 323-333.
Kingdon, J. W. (1995). *Agendas, Alternatives, and Public Policies* (2nd ed.). New York: Longman.
Kirkham, M. (1999). The culture of midwifery in the National Health Service in England. *Journal of Advanced Nursing, 30*(3), 732-739.
Kirkham, M. (2003a). Birth centres as an enabling culture. *MIDIRS Midwifery Digest, 13*(3), 401.
Kirkham, M. (Ed.). (2003b). *Birth Centres: A Social Model for Maternity Care*. London: Books for Midwives.
Kirkham, M., Morgan, R. K., & Davies, C. (2006). *Why Do Midwives Stay?* Sheffield: Women's Informed Childbearing and Health Research Group, Sheffield University.
Kirkham, M., & Stapleton, H. (2000). Midwives' support needs as childbirth changes. *Journal of Advanced Nursing, 32*(2), 465-472.
Kirkham, M., Stapleton, H., Curtis, P., & Thomas, G. (2002). The inverse care law in antenatal midwifery care. *British Journal of Midwifery, 10*(8), 509-513.
Kitzinger, J., & Barbour, R. S. (1999). Introduction: the challenge and promise of focus groups. In R. S. Barbour & J. Kitzinger (Eds.), *Developing Focus Group Research*. London: Sage Publications.
Kitzinger, S., Green, J. C., B, Keirse, M., Lindstrom, K., & Hemminki, E. (2006). Why do women go along with this stuff? *Birth, 33*(2), 154-158.
Knowles, R. (1999). Victoria Delivers on Birth Care Retrieved October 31, 2003, from hnb.dhs.vic.gov.au/web/pubaff/medrel.nsf/ab99dc10aa206bfa4a25681e0015cc4
Koch, T., & Harrington, A. (1998). Reconceptualizing rigour: the case for reflexivity. *Journal of Advanced Nursing, 28*(4), 882-890.
Kotter, J. P. (1990). What Leaders Really Do. *Harvard Business Review,* (May-June), pp. 103-111.

Kotter, J. P. (1995). Leading Change: Why Transformation Efforts Fail. *Harvard Business Review,* (March -April), 59-67.
Kouzes, J., & Posner, B. (1987). What followers expect of their leaders: knowing the other half of the story - strategic management and the public sector. In J. Kouzes & B. Posner (Eds.), *Leadership Challenge: how to get extraordinary things done in organisations* (pp. 15-27). San Francisco.
Kringeland, T., & Möller, A. (2006). Risk and security in childbirth. *Journal of Psychosomatic Obstetrics & Gynecology, 27*(4), 185-191.
Krippendorf, K. (2004). *Content Analysis: An introduction to its methodology*. Thousand Oaks: Sage Publications.
Kuhn, T. S. (1996). *The Structure of Scientific Revolutions* (3rd ed.). Chicago: The University of Chicago Press.
Kupfer, J. H. (1990). *Autonomy and Social Interaction*. Albany: State University of New York Press.
Kyburz-Graber, R. (2004). Does case-study methodology lack rigour? The need for quality criteria for sound case-study research, as illustrated by a recent case in secondary and higher education. *Environmental Education research, 10*(1), 53-65.
Lancaster, J. (Ed.). (1999). *Nursing Issues in Leading and Managing Change*. St Louis: Mosby.
Lane, K. (2002). Midwifery: A profession in transition. *Australian Journal of Midwifery, 15*(2), 26-31.
Lane, K. (2006). Understanding world views for midwifery. In S. Pairman, J. Pincombe, C. Thorogood & S. Tracy (Eds.), *Midwifery preparation for practice*. Sydney: Churchill Livingstone Elsevier.
Laschinger, H. K. S., Shamian, J., & Thomson, D. (2001). Characteristics on Nurses' Perceptions of Trust, Burnout, Quality of Care, and Work Satisfaction. *Nursing Economics, 19*(5), 209-219.
Laslett, A. M., Brown, S., & Lumley, J. (1997). Women's views of different models of antenatal care in Victoria, Australia. *Birth, 24*(2), 81-89.
Lavender, T., & Chapple, J. (2004). An exploration of midwives' views of the current system of maternity care in England. *Midwifery, 20*, 324-334.
Layne, L. (2003). Unhappy endings: a feminist reappraisal of the women's health movement from the vantage of pregnancy loss. *Social Science & Medicine, 56*(9), 1881-1891.
Leap, N. (2000). 'The Less We Do, the More We Give'. In M. Kirkham (Ed.), *The Midwife-Mother Relationship*. Basingstoke: Macmillan Press.
Leap, N. (2002). Identifying the Midwifery Practice Component of Australian Midwifery Education Programs. Results of the Australian Midwifery Action Project (AMAP) Education Survey. *Australian Journal of Midwifery, 15*(3), 15-23.
Leap, N., Sheehan, A., Barclay, L., Tracy, S., & Brodie, P. (2003). *Mapping Midwifery Education in Australia: Full Findings of the AMAP Education Survey, July 2002*. Sydney: University of Technology, Sydney.
Ledward, A. (2004). Retention and Autonomy in Midwifery Practice. In L. Frith & H. Draper (Eds.), *Ethics and Midwifery* (pp. 237-250). Edinburgh: Books for Midwives.

Lepori, B., Foureur, M., & Hastie, C. (2008). Mindbodyspirit architecture: Creating birth space. In K. Fahy, M. Foureur & C. Hastie (Eds.), *Birth Territory and Midwifery Guardianship -Theory for practice, education and research*. Edinburgh: Elsevier.
Lessard, C. (2007). Complexity and reflexivity: Two important issues for economic evaluation in health care. *Social Science and Medicine, 64*, 1754-1765.
Lewis, J. (2006). Being around and knowing the players: networks of influence in health policy. *Social Science & Medicine, 62*(9), 2125.
Lewis, J., & Considine, M. (1999). Medicine, economics and agenda setting. *Social Science & Medicine, 48*, 393-405.
Leyshon, S. (2002). Empowering practitioners: an unrealistic expectation of nurse education? *Journal of Advanced Nursing, 40*(4), 466-474.
Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic Inquiry*. Beverly Hills: Sage Publications.
Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed.). Thousand Oaks: Sage Publications.
Lindberg, I., Christensson, K., & Öhrling, K. (2005). Midwives' experience of organisational and professional change. *Midwifery, 21*, 355-364.
Lindholm, M., Sivberg, B., & Uden, G. (2000). Leadership styles among nurse managers in changing organizations. *Journal of Nursing Management, 8*(6), 327-335.
Lipman-Blumen, J. (1996). *The Connective Edge Leading in an Independent World*. San Francisco: Jossey-Bass.
Lipman-Blumen, J. (2000a). *Connective leadership : managing in a changing world*. New York: Oxford University Press.
Lipman-Blumen, J. (2000b). *Connective leadership: managing in a changing world*. New York: Oxford University Press.
Lipman-Blumen, J. (2007). Connective Leadership & Achieving Styles. Retrieved September 14, 2007, from http://www.achievingstyles.com/asi/connective_leadership.asp
Local Community A Website. (2006). Retrieved March 12, 2006, from Website not provided to maintain anonymity
Luck, L., Jackson, D., & Usher, K. (2006). Case study: a bridge across the paradigms. *Nursing Inquiry, 13*(2), 103-109.
Lumley, J., Brown, S., & Gunn, J. (2003). Getting Research Transfer into Policy and Practice in Maternity Care. In V. Lin & B. Gibson (Eds.), *Evidence-based Health Policy*. South Melbourne: Oxford University Press.
Lundgren, I., & Berg, M. (2007). Central concepts in the midwife-woman relationship. *Scandinavian Journal of Caring Sciences, 21*(2), 220-228.
Macklin, R. (2006). The Doctor-Patient Relationship in Different Cultures. In H. Kuhse & P. Singer (Eds.), *Bioethics An Anthology* (2nd ed.). Maldon: Blackwell Publishing.
Maher, J.-M. (2003). Rethinking women's birth experience: medical frameworks and personal narratives. [Electronic Version]. *Hecate, 29*(2), 140-152.
Mahmood, T. A. (2003). Evaluation of an experimental midwife-led unit in Scotland. *Journal of Obstetrics and Gynaecology, 23*(2), 121-129.
Malloch, K., & Porter-O'Grady, T. (2005). *The Quantum Leader Applications for the New World of Work*. Boston: Jones and Bartlett Publishers.

Manion, J. (2005). *From Management to Leadership Practical Strategies for Health Care Leaders* (2nd ed.). San Francisco: Jossey-Bass.
Marshall, J. E. (2005). Autonomy and the Midwife. In M. D. Raynor, J. E. Marshall & A. Sullivan (Eds.), *Decision Making in Midwifery Practice*. Edinburgh: Elsevier.
Martin, A., & Ernst, C. (2005). Leadership, learning and human resource management. Exploring leadership in times of paradox and complexity. *Corporate Governance, 5*(3), 82-94.
Maxwell, J. A. (1992). Understanding and Validity in Qualitative Research. *Harvard Educational Review, 62*(3), 279-300.
McCourt, C., Page, L., Hewison, J., & Vail, A. (1998). Evaluation of One-to-One Midwifery: Women's Responses to Care. *Birth: Issues in Perinatal Care, 25*(2), 73-80.
McDaniel, R. R. J. (1997). Strategic Leadership: A View from Quantum and Chaos Theories. *Health Care Management Review, 22*(1), 21-37.
McDaniel, R. R. J., & Driebe, D. J. (2001). Complexity Science and Health Care Management. In J. Blair, M. Fottler & G. Savage (Eds.), *Advances in Health Care Management*. Amsterdam: JAI Press.
McPhail, G. (1997). Management of change: an essential skill for nursing in the 1990s. *Journal of Nursing Management, 5*, 199-205.
Mickan, S., & Rodger, S. (2000). Characteristics of effective teams: a literature review. *Australian Health Review, 23*(3), 201-208.
Midwifery Academics (Victoria). (2008). *Securing Sustainable Staffing into the Future. Forum summary*. Melbourne: Midwifery Academics (Victoria).
Milan, M. (2005). Independent midwifery compared with other caseload practice. *MIDIRS Midwifery Digest, 15*(4), 439-449.
Milio, N. (2001). Glossary: healthy public policy. *Journal Epidemiology and Community Health, 55*, 622-623.
Morgan, D. L. (1997). *Focus Groups as Qualitative Research* (2nd ed.). Thousand Oaks: Sage.
Morgan, M., Fenwick, N., McKenzie, C., & Wolfe, C. (1998). Quality of midwifery led care: assessing the effects of different models of continuity for women's satisfaction. *Quality in Health Care, 7*, 77-82.
Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250-260.
Moss, C., Crisp, J., & Foureur, M. (2007). *Homing your Research - A practical framework for postgraduate students*. Paper presented at the University of Technology, Sydney Research Seminar Series.
Murphy, L. (2005). Transformational leadership: a cascading chain reaction. *Journal of Nursing Management, 13*, 128-136.
National Health and Medical Research Council, N. (1998). *Review of Services Offered by Midwives.* Canberra: Commonwealth of Australia.
National Health Workforce Taskforce. (2008). National Registration and Accreditation Scheme. Retrieved October 10, 2008, from http://www.nhwt.gov.au/natreg.asp
National Women's Health Program Evaluation Steering Committee. (1993). *National Women's Program: Evaluation and Future Directions*. Canberra: Australian Government Public Service.

New Zealand College of Midwives. (2002a). Midwifery Practice in New Zealand. Retrieved November 1, 2003, from http://www.midwife.org.nz/index.cfm/Practice
New Zealand College of Midwives. (2002b, 12th september 2002). Philosophy. Retrieved 9th February, 2007, from http://www.midwife.org.nz/index.cfm/Philosophy
New Zealand College of Midwives. (2005). Health Practitioners Competence Assurance Act. Retrieved August 16, 2006, from http://www.midwife.org.nz/index.cfm/HPCA
NMAP. (2002). National Maternity Action Plan for the introduction of community Midwifery services. Retrieved November 1, 2003, from http://www.maternitycoalition.org.au/THE%20FINAL%20NMAP%20Sepember%2024th%202002.pdf
NSW Health Department. (2003). *Models of Maternity Service. Provision across NSW: Progressing implementation of the NSW framework for maternity services*. Sydney: New South Wales Health Department.
Nurses and Midwives Board NSW. (n.d.). Nurses and Midwives Board The Registers and Roll. Retrieved October 10, 2008, from http://www.nmb.nsw.gov.au/Register-and-Roll/default.aspx
Nursing and Midwifery Board of Australia. (2009). Consultation paper on registration standards and related matters. Retrieved 23/12, 2009, from http://www.ahpra.gov.au/
Nursing Board of Tasmania. (2007). Nurse Registration. Retrieved August 21, 2007, from http://www.nursingboardtas.org.au/nbtonline.nsf/$LookupDocName/ANNUAL_RENEWAL#Audit%20Process
O'Shea, J. A., Mcauliffe, E., & Wyness, L. A. (2007). Successful Large System Change: At What Cost? *Journal of Change Management, 7*(2), 107-120.
Oncel, S., Ozer, Z. C., & Efe, E. (2007). Work-related Stress, Burnout and Job Satisfaction in Turkish Midwives. *Social Behavior & Personality: An International Journal, 35*(3), 317-328.
Orum, A. M., Feagin, J. R., & Sjoberg, G. (1991). Introduction: The Nature of the Case Study. In J. R. Feagin, A. M. Orum & G. Sjoberg (Eds.), *A Case for the Case Study*. Chapel Hill, North Carolina: University of North Carolina.
Osborn, R. N., Hunt, J. G., & Jauch, L. R. (2002). Toward a contextual theory of leadership. *Leadership Quarterly, 13*(6), 797.
Page, L. (2003). One-to-one Midwifery: Restoring the "with Woman" Relationship in Midwifery. *Journal of Midwifery & Women's Health, 48*(2), 119-125.
Page, L., & Drife, J. (2007). Do we have enough evidence to judge midwife led maternity units safe? YES. [Editorial]. *British Medical Journal, 335*(7621), 642.
Pairman, S. (2000). Woman-centred Midwifery: Partnerships or Professional Friendships? In M. Kirkham (Ed.), *The Midwife-Mother Relationship* (pp. 207-226). London: Macmillan Press.
Pairman, S., & Donnellan-Fernandez, R. (2006). Professional frameworks for practice in Australia and New Zealand. In S. Pairman, J. Pincombe, C. Thorogood & S. Tracy (Eds.), *Midwifery Preparation for Practice*. Sydney: Churchill Livingstone Elsevier.
Paley, J. (2005). Error and objectivity: cognitive illusions and qualitative research. *Nursing Philosophy, 6*(3), 196-209.

Palmer, G., & Short, S. (2000). *Health Care & Public Policy; An Australian Analysis* (3rd ed.). South Yarra: Macmillan.
Parker, J. M., & Gibbs, M. (1998). Truth, virtue and beauty: midwifery and philosophy. *Nursing inquiry, 5*(3), 146-153.
Parliament of Australia. (2006). The Blame Game Report on the Inquiry into Health Funding. Retrieved January 25, 2008, from http://www.aph.gov.au/house/committee/haa/healthfunding/report/fullreport.pdf
Pashley, G. (1998). Management and leadership in midwifery: part 1. *British Journal of Midwifery, 6*(7), 460-464.
Patterson, K., & Logan-Sinclair, P. (2003). Continuum of care and the antenatal record in rural New South Wales. *Australian Journal of Rural Health, 11*, 110-115.
Patton, M. Q. (2002). *Qualitative Research & Evaluation Methods* (3rd ed.). Thousand Oaks: Sage Publications.
Penprase, B., & Norris, D. (2005). What Nurse Leaders Should Know About Complex Adaptive Systems Theory. *Nursing Leadership Forum, 9*(3), 127-132.
Perkins, B. B. (2004). *The Medical Delivery Business*. New Brunswick: Rutgers University Press.
Perkins, E. R., & Unell, J. (1997). Continuity and choice in practice: a study of a community-based team midwifery scheme. In M. Kirkham & E. R. Perkins (Eds.), *Reflections on Midwifery*. London: Bailliere Tindall.
Pettigrew, A., Ferlie, E., & McKee, L. (1992). *Shaping Strategic Change*. London: Sage Publications.
Pettigrew, A., & Whipp, R. (1991). *Managing Change for Competitive Success*. Oxford: Blackwell.
Pettigrew, A., Woodman, R., & Cameron, K. (2001). Studying Organisational Change and Development: Challenges for Future Research. *Academy of Management Journal, 44*(4), 697-713.
Plsek, P. E. (2003). *Complexity and the Adoption of Innovation in Health Care.* Paper presented at the Accelerating Quality Improvement in Health Care Strategies to Speed the Diffusion of Evidence-Based Innovations, Washington, D.C.
Plsek, P. E., & Greenhalgh, T. (2001). The challenge of complexity in health care. *British Medical Journal, 323*(7313), 625 - 628.
Plsek, P. E., & Wilson, T. (2001). Complexity, leadership and management in healthcare organisations (Complexity Science part 3). *British Medical Journal, 323*(7315), 746.
Polit, D. F., & Beck, C. T. (2006). *Essentials of Nursing Research Methods, Appraisal, and Utilization* (6th ed.). Philadelphia: Lippincott Williams & Wilkins.
Pollard, K. (2003). Searching for autonomy. *Midwifery, 19*, 113-124.
Pope, R., Graham, L., & Patel, S. (2001). Woman-centred care. *International Journal of Nursing Studies, 38*, 227-238.
Popper, A. (2003). Leading Professionals: A science, a philosophy and a way of working. *Journal of Change Management, 3*(4), 349-360.
Popper, M., & Zakkai, E. (1994). Transactional, charismatic and transformational leadership: conditions conducive to their predominance. *Leadership & Organization Development Journal, 15*(6), 3-7.
Porter-O'Grady, T. (1996). The Seven Basic Rules for Successful Redesign. *Journal of Nursing Administration, 26*(1), 46-53.

Porter-O'Grady, T. (2003a). A different age for leadership, part 1: new context, new content. *Journal of Nursing Administration, 33*(2), 105-110.
Porter-O'Grady, T. (2003b). A different age for leadership, part 2: new rules, new roles. *Journal of Nursing Administration, 33*(3), 173-178.
Press Release. (1998). Knowles helps mums and babies make a good start. Retrieved October 31, 2003, from http://hnb.dhs.vic.gov.au/web/pubaff/medrel.nsf/0/f8e2bee9ac99811e4a256762001eecc7?OpenDocument
Press Release. (1999). Victoria Delivers on Birth Care - Knowles. Retrieved October 31, 2003, from htp://hnb.dhs.vic.gov.au/web/pubaff/medrel.nsf/ab99dc10aa206bfa4a25681e0015cc4...
Prigogine, I. (1989). The philosophy of instability. [Electronic Version]. *Futures, 21*(4), 396.
Pryor, R. G., & Bright, J. E. (2003). Order and Chaos: A Twenty-First Century Formulation of Careers. *Australian Journal of Psychology, 55*(2), 121-128.
Queensland Department of Health. (1998). Planning and Design Guidelines. Retrieved November 28, 2008, from http://www.health.qld.gov.au/cwamb/cwguide/section2.pdf
Queensland Department of Health. (2005). Government Response to: Rebirthing: report of the review of Maternity Services in Queensland. Retrieved July 5, 2007, from http://www.health.qld.gov.au/publications/corporate/maternity_report2005/maternity_response.pdf
Ralston, R. (2005). Transformational leadership: leading the way for midwives in the 21st century. *Midwives, 8*(1), 34-37.
Rayner, J., Forster, D., McLachlan, H., Yelland, J., & Davey, M.-A. (2008). A state-wide review of hospital postnatal care in Victoria, Australia: The views and experiences of midwives. *Midwifery, 24*(3), 310-320.
Raynor, M. D., & Bluff, R. (2005). Introduction. In M. D. Raynor, J. E. Marshall & A. Sullivan (Eds.), *Decision Making in Midwifery Practice* (pp. 1-7). Edinburgh: Elsevier.
Redfern, S., & Christian, S. (2003). Achieving change in health care practice. *Journal of Evaluation in Clinical Practice, 9*(2), 225-238.
Reed, J., & Roskell, V. (1997). Focus Groups: issues of analysis and interpretation. *Journal of Advanced Nursing, 26*, 765-771.
Regine, B., & Lewin, R. (2003). Third possibility leaders: the invisible edge women have in complex organizations. *Learning Organization, 10*(6), 347-352.
Reibel, T. (2005). Normal birth: a thing of the past or the new future for primary health care? *Primary Health Care Research and Development, 5*, 329-337.
Reid, R. J., Haggerty, J. L., & McKendry, R. (2002). *Defusing the confusion: concepts and measures of continuity of health care*. Ottawa, Ontario: Canadian Health Services Research Foundation.
Reiger, K. (1999). Birthing in the Postmodern Moment: Struggles over Defining Maternity Care Needs. *Australian Feminist Studies, 14*(30), 387-404.
Reiger, K. (2001). The politics of midwifery in Australia: tensions, debates and opportunities. *Annual Review of Health Social Sciences, 10*, 53-64.

Reiger, K. (2006). A neoliberal quickstep: contradictions in Australian maternity policy. *Health Sociology Review, 15*(4), 330 - 340.
Reiger, K. (2008). Domination or Mutual Recognition? Professional Subjectivity in Midwifery and Obstetrics. *Social Theory and Health, 6*(2), 132-147.
Riley, M., Davey, M.-A., & King, J. (2005). Births in Victoria 2003-2004. Retrieved November 3, 2008, from http://www.health.vic.gov.au/perinatal/
Riley, M., & Halliday, J. (2001). Births in Victoria 1999-2000. Retrieved November 3, 2008, from http://www.health.vic.gov.au/perinatal/
Roberts, C. L., Tracy, S., & Peat, B. (2000). Rates for obstetric intervention among private and public patients in Australia: population based descriptive study. *British Medical Journal, 321*, 137-141.
Rogers, C., Bloomfield, L., & Townsend, J. (2003). A qualitative study exploring midwives' perceptions and views of extending their role to the examination of the newborn baby. *Midwifery, 19*, 55-62.
Rogers, J. (2002). Guidelines for intrapartum midwifery-led care. *British Journal of Midwifery, 10*(1), 8-10.
Rolfe, G. (2006). Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing, 53*(3), 304-310.
Rolls, C., & Seibold, C. (2005). The challenge of implementing an undergraduate midwifery course within a three university consortium. *Contemporary Nurse, 18*(3), 273-278.
Rosser, J. (2003). How do the Albany midwives do it? Evaluation of the Albany Midwifery Practice. *MIDIRS Midwifery Digest, 13*(2), 251-257.
Rowland-Serdar, B., & Schwartz-Shea, P. (1991). Empowering women: Self, autonomy, and responsibility. *Western Political Quarterly, 44*(3), 605.
Sandall, J. (1995). Choice, continuity and control: changing midwifery, towards a sociological perspective. *Midwifery, 11*, 201-209.
Sandall, J. (1999). Team Midwifery and burnout in midwives in the UK: practical lessons from a national study. *MIDIRS Midwifery Digest, 9*(2), 147-152.
Sandelowski, M. (2000). Focus on research methods. Whatever happened to qualitative description? *Research in Nursing & Health, 23*(4), 334-340.
Sankar, Y. (2003). Character not charisma is the critical measure of leadership excellence. *Journal of Leadership & Organizational Studies, 9*(4), 45 -55.
Saultz, J. W. (2003). Defining and Measuring Interpersonal Continuity of Care. *Annals of Family Medicine, 1*(3), 134-143.
Sawer, M. (1999). The watchers within: Women and the Australian state. In L. Hancock (Ed.), *Women, Public Policy and the State* (pp. 36-53). South Yarra: Macmillan Education.
Schneider, Z., Elliott, D., Beanland, C., LoBiondo-Wood, G., & Haber, J. (Eds.). (2003). *Nursing Research Methods, Critical Appraisal and Utilisation* (2nd ed.). Sydney: Mosby.
Schruijer, S. G. L., & Vansina, L. S. (2002). Leader, leadership and leading: from individual characteristics to relating in context. *Journal of Organizational Behavior, 23*(7), 869.
Scoggin, J. (1996). How nurse-midwives define themselves in relation to nursing, medicine, and midwifery. *Journal of Nurse-Midwifery, 41*(1), 36-42.

Scott, P. A. (1998). Morally autonomous practice? *Advances in Nursing Science, 21*(2), 69-79.
Seale, C. (1999). Quality in qualitative research. *Qualitative Inquiry, 5*(4), 465(461).
Senate Community Affairs References Committee. (1999). *Rocking The Cradle*. Canberra: Commonwealth of Australia, Senate Community Affairs References Committee Secretariat.
Shader, K., Broome, M. E., Broome, C. D., West, M. E., & Nash, M. (2001). Factors influencing satisfaction and anticipated turnover for nurses in an academic medical center. *Journal of Nursing Administration, 31*(4), 210-216.
Shallow, H. (2001a). Competence and confidence: working in a climate of fear. *British Journal of Midwifery, 9*(4), 237.
Shallow, H. (2001b). Connection and disconnection: Experiences of integration. *British Journal of Midwifery, 9*(2), 115-121.
Shallow, H. (2001c). Part1 Integrating into teams: the midwife's experience. *British Journal of Midwifery, 9*(1), 53-57.
Shallow, H. (2001d). Teams and the marginalisation of midwifery knowledge. *British Journal of Midwifery, 9*(3), 167-172.
Shanley, C. (2007). Management of change for nurses: lessons from the discipline of organizational studies. *Journal of nursing management, 15*, 538-546.
Siddiqui, J. (2005). The Role of Knowledge in Midwifery Decision Making. In M. D. Raynor, J. E. Marshall & A. Sullivan (Eds.), *Decision Making in Midwifery Practice*. Edinburgh: Elsevier.
Sieloff, C. (2004). Leadership behaviours that foster nursing group power. *Journal of Nursing Management, 12*, 246-251.
Simpson, P. (2007). Organizing in the mist: a case study in leadership and complexity. *Leadership & Organization Development Journal, 28*(5), 465.
Stacey, R. D. (1996). *Complexity and Creativity in Organisations*. San Francisco: Berrett-Koehler publishers.
Stake, R. E. (1995). *The Art of Case Study*. Thousand Oaks: Sage Publications.
Stake, R. E. (2000). Case Studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed., pp. 435-454). Thousand Oaks: Sage Publications.
Stanton, P. (2001). Competitive health policies and community health. *Social Science & Medicine, 52*, 671-679.
Stapleton, S. R. (1998). Team building. Making collaborative practice work. *Journal of Nurse-Midwifery, 43*(1), 12-18.
Stark, S., & Torrance, H. (2004). Case study. In B. Somekh & C. Lewin (Eds.), *Research Methods in the Social Sciences*. London: Sage Publications.
Stevens, T., & McCourt, C. (2002a). One-to-one midwifery practice part 2: the transition period. *British Journal of Midwifery, 10*(1), 45-50.
Stevens, T., & McCourt, C. (2002b). One-to-one midwifery practice part 3: meaning for midwives. *British Journal of Midwifery, 10*(2), 111-115.
Stevens, T., & McCourt, C. (2002c). One-to-one midwifery practice part 4: sustaining the model. *British Journal of Midwifery, 10*(3), 174-179.
Stewart, D. W., Shamdasani, P. N., & Rook, D. W. (2007). *Focus Groups Theory and Practice* (2nd ed.). Thousand Oaks: Sage Publications.

Stewart, J., & Kringas, P. (2003). Change Management - Strategy and Values in Six Agencies from the Australian Public Service. *Public Administration Review, 63*(6), 675-688.
Stewart, J., & Wheeler, J. (2004). Maternal final holistic assessment by midwives. *Australian Midwifery: Journal of the Australian College of Midwives, 17*(2), 6-9.
Stewart, P. (2001). Complexity Theories, Social Theory, and the Question of Social Complexity. *Philosophy of the Social Sciences, 31*(3), 323.
Stock, J. (1994). Continuity of Care in Maternity services - the Implications for Midwives. *Health Manpower Management, 20*(3), 30-36.
Sturmberg, J. (2003). Continuity of care: A systems-based approach. *Asia Pacific Family Medicine, 2*(3), 136-142.
Symon, A., McStea, B., & Murphy-Black, T. (2006). An exploratory mixed-methods study of Scottish midwives' understandings and perceptions of clinical near misses in maternity care. *Midwifery, 22*, 125–136.
Symon, A., Paul, J., Butchart, M., Carr, V., & Dugard, P. (2008a). Maternity unit design study part 2: perceptions of space and layout. *British Journal of Midwifery, 16*(2), 110-114.
Symon, A., Paul, J., Butchart, M., Carr, V., & Dugard, P. (2008b). Maternity unit design study part 3: environmental comfort and control. *British Journal of Midwifery, 16*(3), 167-171.
Symon, A., Paul, J., Butchart, M., Carr, V., & Dugard, P. (2008c). Maternity unit design study part 4: midwives' perceptions of staff facilities. *British Journal of Midwifery, 16*(4), 228-231.
Symonds, A., & Hunt, S. (1996). *The Midwife and Society*. Basingstoke: Macmillan.
The North Staffordshire Changing Childbirth Team. (2000). A randomised study of midwifery caseload care and traditional 'shared-care'. *Midwifery, 16*, 295-302.
Thompson, F. E. (2003). The Practice Setting: Site of Ethical Conflict for Some Mothers and Midwives. [Article]. *Nursing Ethics, 10*(6), 588-601.
Thorogood, C., Thiele, B., & Hyde, K. (2003). Community Midwife Program (Western Australia) Evaluation November 1997 - December 2001. Retrieved February 16, 2006, from http://www.communitymidwifery.iinet.net.au/Eval97-01.PDF#search='evaluation%20midwifery%20services'
Thorstensen, K. A. (2000). Trusting women: essential to midwifery. *Journal of Midwifery & Women's Health, 45*(5), 405-407.
Timmins, F., & McCabe, C. (2005). Nurses' and midwives' assertive behaviour in the workplace. *Journal of Advanced Nursing, 51*(1), 38-45.
Tinkler, A., & Quinney, D. (1998). Team midwifery: the influence of the midwife-woman relationship on women's experiences and perceptions of maternity care. *Journal of Advanced Nursing, 28*(1), 30-35.
Tobin, G. A., & Begley, C. M. (2004). Methodological rigour within a qualitative framework. *Journal of Advanced Nursing, 48*(4), 388-396.
Todd, C., Farquhar, M., & Camilleri-Ferrante, C. (1998). Team midwifery: the views and job satisfaction of midwives. *Midwifery, 14*, 214-224.
Tracy, S., Hartz, D., Nicholl, M., McCann, Y., & Latta, D. (2005). An integrated service network in maternity - the implementation of a midwifery-led unit. *Australian Health Review, 29*(3), 332-339.

Travis, R., & Zahariadis, N. (2002). A Multiple Streams Model of U.S. Foreign Aid Policy. *Policy Studies Journal, 30*(4), 495-514.
Tucker, J. (2000). Team midwifery and continuity of care in hospital. *The Practising Midwife, 3*(7), 24-30.
Tuckett, A. G. (2005). Part II. Rigour in qualitative research: complexities and solutions. [Electronic Version]. *Nurse Researcher, 13*(1), 29(14).
Turnbull, D., Reid, M., McGinley, M., & Shields, N. (1995). Changes in midwives' attitudes to their professional role following the implementation of the midwifery development unit. *Midwifery, 11*(3), 110-119.
van Teijlingen, E. R., Hundley, V., Rennie, A., Graham, W., & Fitzmaurice, A. (2003). Maternity satisfaction studies and their limitations: "what is, must still be best". *Birth, 30*(2), 75-82.
Van Wagner, V. (2004). Why Legislation?: Using Regulation to Strengthen Midwifery. In I. Bourgeault, C. Benoit & R. Davis-Floyd (Eds.), *Reconceiving Midwifery*. Montreal: McGill-Queen's University Press.
Veatch, R. M. (2006). Abandoning Informed Consent. In H. Kuhse & P. Singer (Eds.), *Bioethics An Anthology* (2nd ed.). Maldon: Blackwell Publishing.
Veitch, V., Davey, M.-A., & King, J. (2007). *Victorian Maternity Services Performance Indicators Complete set for 2005–06*. Melbourne: Victorian Government Department of Human Services.
Vernon, B. (2002-3). A new national consumer voice pushes for reform of maternity services: The Maternity Coalition. [Electronic Version]. *The Australian Health Consumer*, (3), 21-24.
Victorian Government. (1993). *Post Acute Maternity Services A Discussion Paper*. Melbourne: Victorian Government Department of Health and Community Services.
Victorian State Government. (2002, 8/04/02). Industrial Relations Policy Framework. Retrieved July 26, 2003, from www.irv.vic.gov.au/web/IR/IRPolFrm.nsf/2dc22dba9e04cf95ca256b25007ef0b
Wagner, M. (1994). *Pursuing the Birth Machine The Search for Appropriate Birth Technology*. Camperdown: ACE Graphics.
Wagner, M. (2001). Fish can't see water: the need to humanize birth. *International Journal of Gynecology & Obstetrics, 75*, S25-S37.
Wakelin, K., & Skinner, J. (2007). Staying or leaving: A telephone survey of midwives, exploring the sustainability of practice as Lead Maternity Carers in one urban region of New Zealand. [Electronic Version]. *New Zealand College of Midwives Journal, 37*, 10-14.
Waldenstrom, U., Brown, S., McLachlan, H., Forster, D., & Brennecke, S. (2000). Does team midwife care increase satisfaction with antenatal, intrapartum, and postpartum care? A randomized controlled trial *Birth, 27*(3), 156-167.
Waldenstrom, U., McLachlan, H., Forster, D., Brennecke, S., & Brown, S. (2001). Team midwife care: maternal and infant outcomes. *Australian & New Zealand Journal of Obstetrics & Gynaecology, 41*(3), 257-264.
Walker, S., Moore, H., & Eaton, A. (2004). North Queensland midwives' experience with a team model of midwifery care. *Australian Midwifery Journal, 17*(1), 17-22.
Walsh, D. (1999). An ethnographic study of women's experience of partnership caseload midwifery practice: the professional as a friend. *Midwifery, 15*(3), 165-176.

Walsh, D., & Downe, S. M. (2004). Outcomes of Free-Standing, Midwife-Led Birth Centers: A Structured Review. *Birth, 31*(3), 222-229.
Walsh, D., & Newburn, M. (2002a). Towards a social model of childbirth: part one. *British Journal of Midwifery, 10*(8), 476-481.
Walsh, D., & Newburn, M. (2002b). Towards a social model of childbirth: part two. *British Journal of Midwifery, 10*(9), 540-544.
Wanberg, C. R., & Banas, J. T. (2000). Predicters and outcomes of Openness to Changes in a Reorganising Workplace. *Journal of Applied Psychology, 85*(1), 132-142.
Warren, K., Franklin, C., & Streeter, C. L. (1998). New Directions in Systems Theory: Chaos and Complexity. *Social Work, 43*(4), 357-372.
Warriner, S. (2003). Midwives: advocates or arbitors? *British Journal of Midwifery, 11*(9), 532-533.
Warriner, S., Pearce, L., Fraser, A., & Ullman, R. (1998). Experience of a Changing Childbirth Project. *British Journal of Midwifery, 6*(12), 797-800.
Watson, J., Turnbull, B., & Mills, A. (2002). Evaluation of the extended role of the midwife: the voices of midwives. *International Journal of Nursing Practice, 8*, 257-264.
Watson, L., Potter, A., & Donohue, L. (1999). Midwives in Victoria, Australia: a survey of current issues and job satisfaction. *Midwifery, 15*, 216-231.
Weaver, E., Clark, K., & Vernon, B. (2005). Obstetricians and midwives modus vivendi for current times. *The Medical Journal of Australia, 182*(9), 436-437.
Welford, C. (2002a). Transformational leadership in nursing: matching theory to practice. *Nursing Management (London), 9*(4), 7-11.
Welford, C. (2002b). Transformational leadership in nursing: matching theory to practice. *Nursing, Management*(London). 9(4), 7-11.
Wells, N., Barnard, T., Mason, L., Ames, A., & Minnen, T. (1998). Work Transitions. *Journal of Nursing Administration, 28*(2), 50-56.
Wheatley, M. J. (2006). *Leadership and the New Science Discovering Order in a Chaotic World* (3rd ed.). San Francisco: Berrett-Koehler Publishers.
Whiteley, A., & Whiteley, J. (2007). *Core Values and Organisational Change Theory and Practice*. New Jersey: World Scientific.
Whittemore, R., Chase, S. K., & Mandle, C. L. (2001). Validity in Qualitative Research. *Qualitative Health Research, 11*.
Wilkins, R. (2000). Poor Relations: The Paucity of the Professional Paradigm. In M. Kirkham (Ed.), *the midwife-woman relationship*. Basingstoke: Macmillan Press.
Willis, E. (1990). *Medical Dominance* (second ed.). Sydney: Allen & Unwin.
Wilson, S. M. (2000). An ethnography of midwifery work patterns during organisational redesign. *Australian Health Review, 23*(1), 22-33.
Wilson, V. (2005). Developing a vision for teamwork. *Practice Development in Health Care, 4*(1), 40-48.
Yin, R. K. (1999). Enhancing the Quality of Case Studies in Health services Research. *Health Services Research, 34*(5), 1209-1224.
Yin, R. K. (2003). *Case Study Research Design and Methods* (3rd ed. Vol. 5). Thousand Oaks, California: Sage.
Zimmerman, B. (1999). Complexity Science: A route through hard times and uncertainty. *Health Forum Journal*, 42-46,69.

Zimmerman, B., Lindberg, C., & Plsek, P. E. (1998). A Complexity Science Primer: What is Complexity Science and Why Should I Learn About It? Retrieved January 8, 2008, from http://www.plexusinstitute.org/ideas/show_elibrary.cfm?id=150

Glossary

Attractors A set of states of a dynamic physical system toward which that system tends to evolve, regardless of the starting conditions of the system. Strange attractors occur randomly and are not predictable (Gleick, 1988). They appear at the edge of chaos, can not be predicted or controlled and can have powerful effects (Penprase & Norris, 2005). Organisational change can be improved if leaders can recognise the attractors that are impeding change, that is, identify what issues are maintaining resistance and put into place a new attractor (Plsek & Wilson, 2001).

Complex Adaptive System Complex Adaptive Systems consist of a number of elements that through interaction with other elements learn and co-evolve. They adapt in order to survive building on previous experience (Stacey, 1996).

Continuity of midwifery care Consistent philosophy or organisational structure underpinning the care provided by midwives across the antenatal, intrapartum and postpartum periods. Continuity of care can be provided in a variety of ways (Homer et al., 2008).

Continuity of midwifery carer Care by a midwife whom the woman has previously met, feels she has developed a 'relationship' with and believes she 'knows' (Homer et al., 2008).

Edge of chaos This is where instability exists in a transition phase between order and total disorder in a Complex Adaptive System (Stacey, 1996). This is a concept where paradox exists and creativity might emerge. Spontaneous re-organisation can occur with creativity resulting from the disorder to form new order (Penprase & Norris, 2005). For this to occur in organisations there needs to be an environment that is trusting and comfortable, but also values risk taking and flexibility, the paradox of stability within a non-stable workplace (Penprase & Norris, 2005).

Emergence As systems move towards disorganisation at the edge of chaos order can emerge through self-organisation (Penprase & Norris, 2005). The natural emergence of order in complex systems can occur without the necessity of top down management (Plsek & Greenhalgh, 2001). Small errors can have a large impact. Recognition of this phenomenon may well have been recognised previously but did not fit the existing linear approach that depend on prediction and control of effect (Arndt & Bigelow, 2000).

Feedback Loops In thermodynamics closed systems use feedback loops to reduce instability, for example to prevent a machine overheating, ultimately this feedback leads to entropy (Wheatley, 2006). In open systems feedback loops can be both positive and negative and serve to communicate important information (Penprase & Norris, 2005) that both serves to identify disturbances but also to introduce new energy to maintain creativity and support change. The elements of a system can adapt in response to the feedback.

Non-linearity Non-linearity is demonstrated where small changes in one component or element of a network do not lead to correspondingly small changes in others. A change in one element is not directly proportional to change in another; therefore little changes can have big effects and large changes little effect (Gatrell, 2005).

Paradox A statement or idea that appears to contradict itself (Compact Oxford Dictionary, 2006).

Appendix A – ACM Philosophy Statement for Midwifery

Midwife means 'with woman'. This meaning shapes midwifery's philosophy, work and relationships.

Midwifery is founded on respect for women and on a strong belief in the value of women's work of bearing and rearing each generation.

Midwifery considers women in pregnancy, during childbirth and early parenting to be undertaking healthy processes that are profound and precious events in each woman's life. These events are also seen as inherently important to society as a whole.

Midwifery is emancipatory because it protects and enhances the health and social status of women, which in turn protects and enhances the health and wellbeing of society.

Midwifery is a woman centred, political, primary healthcare discipline founded on the relationships between women and their midwives. Midwifery:

- focuses on a woman's health needs, her expectations and aspirations
- encompasses the needs of the woman's baby, and includes the woman's family, her other important relationships and community, as identified and negotiated by the woman herself
- is holistic in its approach and recognises each woman's social, emotional, physical, spiritual and cultural needs, expectations and context as defined by the woman herself
- recognises every woman's right to self-determination in attaining choice, control and continuity of care from one or more known caregivers
- recognises every woman's responsibility to make informed decisions for herself, her baby and her family with assistance, when requested, from health professionals
- is informed by scientific evidence, by collective and individual experience and by intuition
- aims to follow each woman across the interface between institutions and the community, through pregnancy, labour and birth and the postnatal period so all women remain connected to their social support systems; the focus is on the woman, not on the institutions or the professionals involved
- includes collaboration and consultation between health professionals.

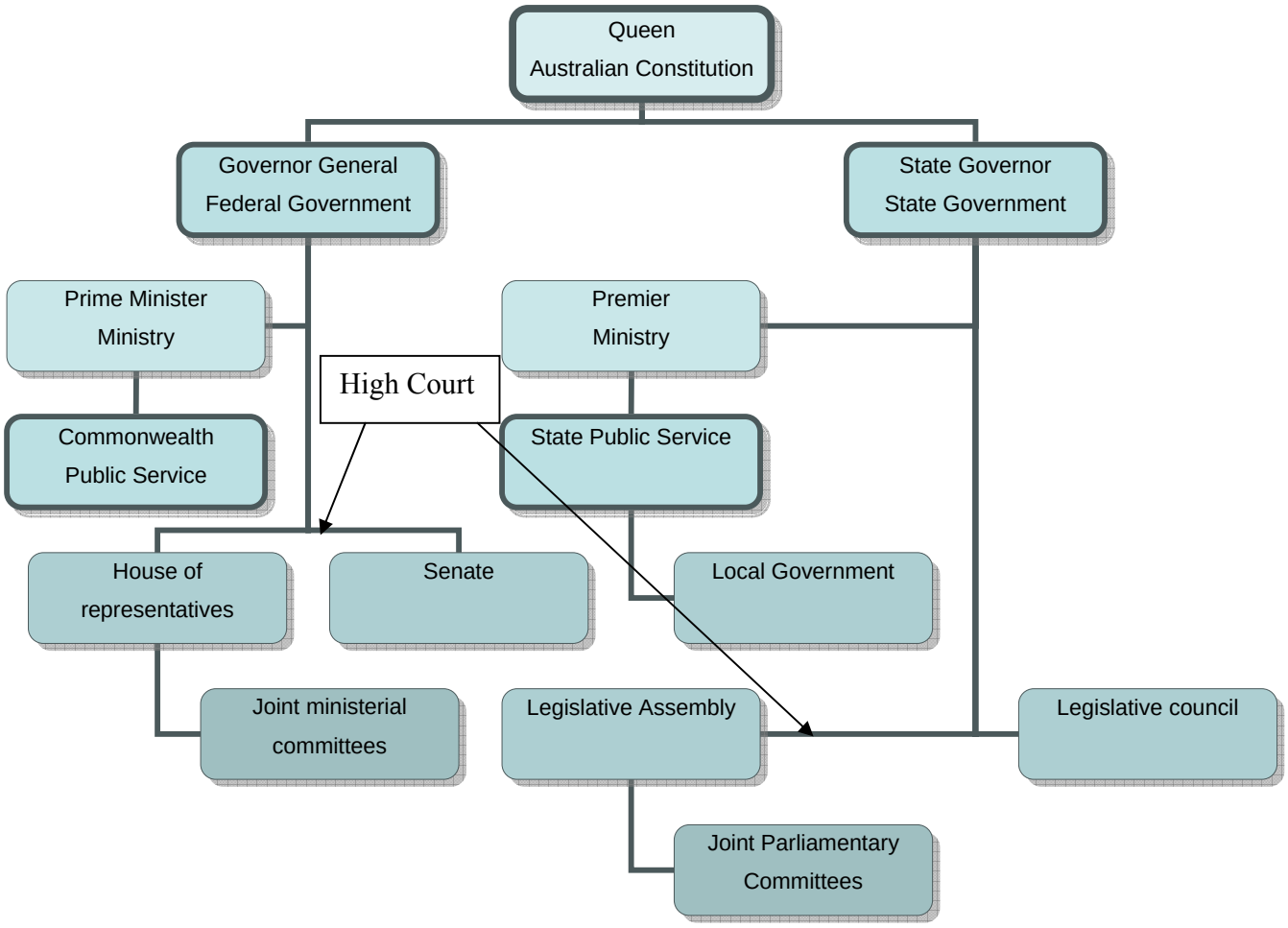
www.midwives.org.au

Appendix B – International Definition of the Midwife

A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery. The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care. A midwife may practise in any setting including the home, community, hospitals, clinics or health units. (ICM, 2005a)

Appendix C – The structure of Australian political institutions

(adapted from Jaensch, 1988, p.6)



Appendix D – UTS Ethics approval

15 March 2005

CB08.01.11D

Dear Caroline,

UTS HREC 2004-121A - "Continuity, control and choice for midwives within the changing face of midwifery."

At its meeting held on 08/02/2005, the UTS Human Research Ethics Committee considered the above application, and I am pleased to inform you that ethics clearance has been granted.

Your clearance number is UTS HREC 2004-121A.
Please note that the ethical conduct of research is an on-going process. The *National Statement on Ethical Conduct in Research Involving Humans* requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

I also refer you to the AVCC guidelines relating to the storage of data, which require that data be kept for a minimum of 5 years after publication of research. However, in NSW, longer retention requirements are required for research on human subjects with potential long-term effects, research with long-term environmental effects, or research considered of national or international significance, importance, or controversy. If the data from this research project falls into one of these categories, contact University Records for advice on long-term retention.

If you have any queries about your ethics clearance, or require any amendments to your research in the future, please do not hesitate to contact the Ethics Secretariat at the Research and Commercialisation Office, on 02 9514 9615.

Yours sincerely,

Professor Jane Stein-Parbury
Chairperson, UTS Human Research Ethics Committee

Appendix E – Explanatory Statement

Effects on midwives of changes in midwifery models of care

My name is Carole Gilmour and I am a Doctor of Midwifery student at UTS. My supervisors are Caroline Homer and Linette Lock.

This research is to find out how midwives have been affected by the changes implemented in maternity services that promote midwifery led care. To do this I wish to explore with midwives to what extent, if any, that midwifery models of care affect them professionally, socially, as individuals and as part of a team. To enable a broad range of issues and topics to be covered I will be collecting information in several ways.

Survey

All midwives at Dandenong hospital are being given the opportunity to participate in some way.

I would like to invite you to assist me in this project by answering the attached survey, which will take about 20 minutes. This will be entirely anonymous. A stamped addressed envelope is available for you to return it to me.

Focus Group

Midwives who are grade two or three and have been qualified for more than 12 months are invited to participate in **one** of several focus groups that will be audio-taped. This will take about 2 hours of your time. Alternatively **you** may choose to be interviewed individually which will take up to an hour of your time.

Individual Interviews - Leaders/Managers

If you are a leader/ manager involved in implementing change you are invited to be individually interviewed in a process that will be audio-taped and take about an hour.

The information gained from the focus groups and individual interviews will be confidential and if you participate you will be required to complete a consent form that acknowledges this.

As a midwife working in a changing environment, **your** knowledge of the effects of change on yourself and other midwives is **extremely important**, for future planning of changes for the midwifery profession and for women. If you are interested in participating in either a focus group or an individual interview please write your first name and phone number on the attached yellow form and indicate which of the options you prefer. These options include focus groups held on site at Dandenong hospital, a focus group held off site, or an interview to be arranged time and place to suit you. To keep your survey anonymous, please return this slip separately by placing it in the red sealed box provided in the midwifery staff room. You can change your mind at any time and you don't have to say why. I will thank you for your time and won't contact you about this research again.

All the information obtained during this research project will be de-identified and your confidentiality will be maintained. At the end of the project I will present my findings to all interested midwives at your hospital.

If you have concerns about the research that you think I or my supervisors can help you with, please feel free to contact me on 9787 0693, or Caroline Homer on 02 9514 2977

If you would like to talk to someone who is not connected with the research, you may contact the UTS Research Ethics Officer on 02 9514 9615, and quote this number *2004-121A*
Or
The Executive Officer, Southern Health HRECS, Ms Malar Thiagarajan Phone: (03) 9594 3025.

Appendix F – Consent forms for focus group and individual interview

I _____ agree to participate in the research project

Effects on midwives of changes in midwifery models of care

being conducted by Carole Gilmour,
of the University of Technology, Sydney for her degree Doctor of Midwifery.

I understand that the purpose of this study is to explore the effect that changes in maternity services that include the implementation of midwifery led care has had on midwives, both professionally and socially for them as an individual, and as part of a team.

I understand that my participation in this research will be as a member of a focus group that will require approximately two hours of my time. I understand that the focus group will be tape recorded as well as notes taken by an assistant. I understand that access to the information collected will be restricted to Carole Gilmour and her supervisors, Caroline Homer and Linette Lock.

I am aware that I can contact Carole Gilmour or her supervisor(s) Caroline Homer or Linette Lock if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish and without giving a reason.

I agree that Carole Gilmour has answered all my questions fully and clearly.

I agree that as a participant in a focus group that I will maintain confidentiality about information revealed by other members of the group unless otherwise agreed to at the time.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____

Signed by

_____ ____/____/____

Witnessed by

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer, Ms Louise Abrams (ph: 02 9514 9615, Louise.Abrams@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome. Or The Executive Officer, Southern Health HRECS, Ms Malar Thiagarajan Phone: (03) 9594 3025.

UNIVERSITY OF TECHNOLOGY SYDNEY

I _____ agree to participate in the research project

Effects on midwives of changes in midwifery models of care

being conducted by Carole Gilmour, of the University of Technology, Sydney for her degree Doctor of Midwifery. I understand that the purpose of this study is to explore the effect that changes in maternity services that include the implementation of midwifery led care has had on midwives, both professionally and socially for them as an individual, and as part of a team.

I understand that my participation in this research will involve an individual interview that will require approximately one hour of my time. I understand that the interview will be tape recorded.

I understand that access to the information collected will be restricted to Carole Gilmour and her supervisors, Caroline Homer and Linette Lock.

I am aware that I can contact Carole Gilmour or her supervisor(s) Caroline Homer or Linette Lock if I have any concerns about the research. I also understand that I am free to withdraw my participation from this research project at any time I wish and without giving a reason.

I agree that Carole Gilmour has answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ____/____/____

Signed by

_____ ____/____/____

Witnessed by

NOTE:

This study has been approved by the University of Technology, Sydney Human Research Ethics Committee. If you have any complaints or reservations about any aspect of your participation in this research which you cannot resolve with the researcher, you may contact the Ethics Committee through the Research Ethics Officer, Ms Louise Abrams (ph: 02 9514 9615, Louise.Abrams@uts.edu.au) and quote the UTS HREC reference number. Any complaint you make will be treated in confidence and investigated fully and you will be informed of the outcome. Or The Executive Officer, Southern Health HRECS, Ms Malar Thiagarajan Phone: (03) 9594 3025.

Appendix G – Expression of Interest

UNIVERSITY OF TECHNOLOGY, SYDNEY

RESEARCH PROJECT EXPRESSIONS OF INTEREST

CONTINUITY, CONTROL AND CHOICE FOR MIDWIVES WITHIN THE CHANGING FACE OF MIDWIFERY

If you are interested and willing to participate in a focus group or individual interview please can you indicate your preferences below.

Carole Gilmour will then contact you to discuss the best date, time and place for you. I am planning to run 3 or 4 focus groups though may run more with smaller groups or if there is a need to collect additional data.

Focus Group (6-10 participants) - on site at …….Hospital ☐

Individual interview - on site at ……Hospital ☐

- or to be arranged external to hospital ☐

Name ……. (first name sufficient)

Contact details ……
(phone number or email address if preferred)

Appendix H – Survey

MIDWIFERY SURVEY

Your views are valuable so **Many Thanks** for participating in this survey. It is anticipated that it should take about 20 -30 minutes of your time to complete.

Instructions: Please mark X in boxes provided. Additional information may be written on the back page of the survey.

PROFESSIONAL EXPERIENCE

1a. In which year were you first registered as a midwife ……

1b. In which year did you first register as a nurse …… not applicable ☐

2.What was your midwifery education: a hospital-based course ☐

a postgraduate tertiary course ☐

an undergraduate tertiary course ☐

3. Country in which you completed your midwifery education…….

4. Total number of years of post-registration midwifery experience ……

5. How many hours per week are you working? …….

6. Which of the following areas do you work in on a regular basis over a 12 month period? (mark all relevant)

antenatal midwives clinic	☐	antenatal ward	☐
labour ward/delivery suite	☐	neonatal nursery	☐
postnatal ward	☐	domiciliary care	☐
birth centre	☐	maternal and child health	☐
childbirth education	☐	midwifery education	☐

other (please specify) …….

7. How do you keep informed about what is happening in midwifery?

(mark all relevant)

continuing education courses at work ☐

continuing education offered by other institutions ☐

subscribing to nursing/midwifery journals ☐

using a nursing/medical library ☐

membership of professional organisations ☐

attending professional meetings by choice ☐

or as part of my work responsibilities ☐

other avenues (please specify) ☐

I am not really interested in doing so ☐

it is too difficult for me to do so ☐

SATISFACTION AS A MIDWIFE

8. Did basic midwifery education prepare you for your work as a midwife

thoroughly ☐ adequately in most areas ☐ not very well? ☐

9. How satisfied are you in your professional life at present? (Please mark one box.)

very satisfied ☐

somewhat satisfied ☐

somewhat dissatisfied ☐

very dissatisfied ☐

10. Listed are some attributes of your work as a midwife.

On a scale of 1 –5 where 1 equals very important and 5 equals not at all important please mark what these attributes mean to you

	very important				not important at all
professional status	1	2	3	4	5
interaction with women and their families	1	2	3	4	5
Collegiality (midwife/midwife relationships)	1	2	3	4	5
Collaboration (midwife/doctor relationships)	1	2	3	4	5
autonomy (ability to make your own decisions)	1	2	3	4	5
work activities	1	2	3	4	5
convenience (hours, location)	1	2	3	4	5

11. Over the last five years there have been changes in maternity services throughout Victoria.

On a scale of 1-5 where 1 equals improved greatly to 5 greatly deteriorated. Please indicate how these changes have affected you personally.

	Greatly improved		no change		greatly deteriorated
professional status	1	2	3	4	5
interaction with women and their families	1	2	3	4	5
Collegiality (midwife/midwife relationships)	1	2	3	4	5
Collaboration (midwife/doctor relationships)	1	2	3	4	5

autonomy (ability to make your own decisions) 1…….2…….3…….4…….5

work activities 1…….2…….3…….4…….5

convenience (hours, location) 1…….2…….3…….4…….5

12. What is the most satisfying aspect of your present midwifery position?

……

……

13. What is the least satisfying aspect of your present midwifery position?

……

……

14. How does your vision of ideal midwifery practice match with the way you are working now?

a very good match ☐

a good match in some ways, but not in others ☐

hardly at all a good match ☐

15. Please describe briefly how and where you would like to work as a midwife in an ideal world.

……

……

……

MIDWIFERY WORK ENVIRONMENT 2004

16. There have been changes in Maternity services over the last five years that may have impacted on your work environment. Please indicate on a scale of 1 – 5 to what extent you agree with the following statements where 1 equals totally agree to 5 totally disagree and 3 equals neither agree nor disagree

otally agree totally disagree

Government has made changes in maternity 1…….2…….3…….4…….5
services policies that support midwifery care

There has been greater utilisation of midwives 1…….2…….3…….4…….5
for providing maternity care

There is less autonomy for midwives 1…….2…….3…….4…….5

Midwives have extended their scope of practice1…….2…….3…….4…….5

	totally agree				totally disagree
There is decreased client satisfaction	1	2	3	4	5
Women are more involved in making decisions about the management of their pregnancy and birth	1	2	3	4	5
Midwifes are more satisfied with their work	1	2	3	4	5
There are more women going home in less than 48hrs	1	2	3	4	5
Continuing education opportunities have increased	1	2	3	4	5
Clinical education support has decreased	1	2	3	4	5
Rosters are less flexible	1	2	3	4	5
Working conditions have improved	1	2	3	4	5
There is more research occurring in midwifery areas	1	2	3	4	5
Midwifery practice is less medicalised	1	2	3	4	5
Midwives are more political aware	1	2	3	4	5
Midwife/doctor relationships have deteriorated	1	2	3	4	5
Midwife/client relationships have improved	1	2	3	4	5
Midwife / midwife relationships have improved	1	2	3	4	5
Most women have met the midwife with them in labour antenatally	1	2	3	4	5
Breastfeeding advice is more consistent	1	2	3	4	5
Maternity services at my hospital are women centred	1	2	3	4	5
Continuity of care for women has improved	1	2	3	4	5

17. Are there any other changes that you feel have impacted upon midwifery care/ Please describe……

……

……

……

18. What do you think are the most important issues in midwifery today?

……

……

19. Please describe what you understand as woman centred care

……

……

……

20. Please describe what you understand as continuity of care

……

……

……

21. Please name(full name) one or more of the midwives that **you** identify as leaders of the changes that have occurred / are occurring in your hospital (they may no longer be employed in your hospital)

……

PERSONAL INFORMATION

22. Residential postcode ……23. Gender Female ☐ Male ☐

24. Country of birth ……25. Is English your first language? Yes☐ No ☐

What other languages do you speak? …….....

26. Age at last birthday …….

27. Do you have children Yes ☐ No ☐

How old are they? 0-4 ☐ 5-9 ☐ 10 -14 ☐ 15–19 ☐ over 20 ☐

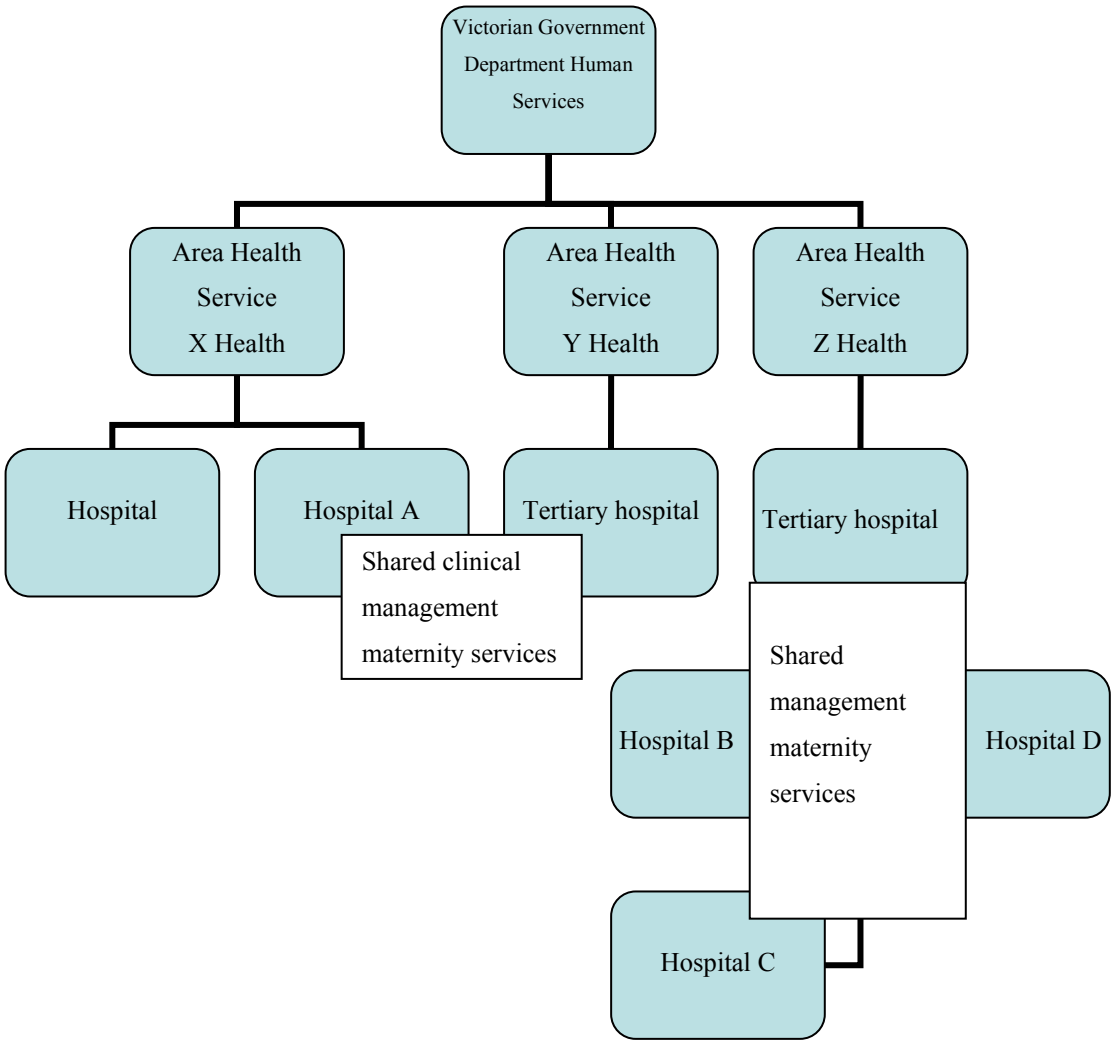
If you are interested in participating in a focus group to clarify some of the issues raised in this questionnaire, please complete the yellow expression of interest page included with this survey and place into the red sealed box in the midwifery staff room. The focus groups will be advertised around the midwifery unit so you will be able to decide to participate in one at a later stage.

If you would prefer to have an individual interview please complete your name and contact number on the attached sheet or phone Carole on xxxx xxxx.

Thank you again for completing this survey.

Please return in attached stamped addressed envelope.

Appendix I – Diagram of Health Services Structure Related to Case Studies



Appendix J – Connective Leadership Model

Direct approach

The direct group of leadership styles reflects the actions of the individual, who acts independently to master their own tasks. The three sub-styles are: 'intrinsic', 'competitiveness' and 'power' (Lipman-Blumen, 2007). The *Intrinsic Direct* approach is used by individuals who are self-motivated and gain reward from completing a task. They gain satisfaction from the sense of autonomy that comes with working independently (Lipman-Blumen, 2007). The *Competitive Direct* approach is preferred by those who enjoy performing a task better than others. They will keep trying until they achieve the best outcome but can become disinterested if the situation is non-competitive (Lipman-Blumen, 2007). The *Power Direct* approach is used by those who like to be in control. They are good at co-ordinating, organising and delegating and not so good at being a follower (Lipman-Blumen, 2007).

Relational approach

The relational group of leadership styles reflects the actions of those who gain satisfaction from being a team member. This includes 'collaboration', 'contributing' and 'vicarious'. The *Collaborative Relational* approach is preferred by those who enjoy completing tasks by joining forces with others. They may avoid working in isolation. They expect to be rewarded for their share of the work but also are prepared to take their share of the responsibility for failure (Lipman-Blumen, 2007). The *Contributory Relational* approach is used by those who gain satisfaction from assisting others to complete their task. Although they might view themselves as a partner, they acknowledge that the recognition for the achievement belongs to the other person (Lipman-Blumen, 2007). Individuals who use the *Vicarious Relational* approach gain satisfaction from the achievements of others. They act as mentors and provide support and encouragement but do not get actively involved (Lipman-Blumen, 2007)

Instrumental approach

The third group of achieving styles are about maximising interactions through the use of self and others. They encompass 'personal', 'social interactions' and 'entrusting' (Lipman-Blumen, 2007). The *Personal Instrumental* approach is used by those who rely on their personal attributes of personality, appearance, background and achievements to gain success. They have excellent negotiating skills, the ability to

communicate their message to persuade others to their point of view and to resolve conflict (Lipman-Blumen, 2007). The *Social Instrumental* approach is preferred by those who have well developed networking skills. They like to keep in touch with and use others for specific expertise or knowledge (Lipman-Blumen, 2007). Lastly the *Entrusting Instrumental* approach is used by those who demonstrate confidence and trust in the ability of others to complete a task. Their approach tends to provide minimalist directions that can be empowering for those entrusted with the task. They believe in people and expect them to meet their expectations (Lipman-Blumen, 2007).