Keeping the Love Alive:

Factors Contributing to Increased Satisfaction for New Zealand Case Loading Midwives

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Declaration Concerning Thesis Presented for

The Degree of Master of Midwifery

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Solemnly and sincerely declare, in relation to this thesis entitled:

Factors increasing satisfaction for New Zealand case loading midwives

That the work was done by me, personally

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The material has not previously been accepted in whole, or in part, for any other degree or diploma

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Abstract

Working as a midwife can be very rewarding and satisfying but can also be very challenging at times. This study examines New Zealand case loading midwives and attempts to identify factors that contribute to maintaining and increasing satisfaction levels. Midwives in New Zealand regained their professional autonomy in 1990 with the passing of the Nurses Amendment Act (1990), and since that time have cared for women and their babies throughout their pregnancy, labour and up to six weeks postpartum. The style of practice is not prescribed, though most midwives work in small group practices of about 3-6 practitioners. While satisfaction levels, and in particular factors linked to burnout have been thoroughly researched, studies that identify practices that increase satisfaction, and that therefore could help contribute to a more stable work force, are rare.

Three midwives from one area in New Zealand were interviewed by telephone or videoconference video, the interviews were transcribed, coded and analysed using mind mapping with thematic analysis. This produced three tightly interwoven and interdependent themes based on satisfaction from client interaction, from professional interactions and the importance of looking after oneself and maintaining a satisfying lifestyle outside midwifery.

The areas described by these midwives which related to satisfaction were; relationships both with clients and other professionals, and personal needs, including time for family and friends. Midwives placed different importance on different areas, depending on their past experiences, their personal histories and their personalities. Allowing for this diversity strengthens the midwifery workforce, and promotes understanding between midwives.

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Introduction

Maintaining a workforce of experienced midwives increases quality of care and improves maternal and newborn outcomes. Factors that are linked to workforce longevity include increased levels of satisfaction and reduced risk of burnout. Much of the literature discusses burnout in relation to midwifery; however there appears to be gap regarding the factors that increase satisfaction levels. This study aims to present some factors which three New Zealand midwives found helpful to maintain or increase their satisfaction levels. This first chapter is an overview and summary of the study.

New Zealand maternity context

New Zealand midwifery is unique and often heralded as a world leader (New Zealand College of Midwives (NZCOM), 2011). Midwives in New Zealand provide autonomous maternity care for pregnant women following an amendment to the Nurses Act in 1990 (NZCOM, 2014). New Zealand women choose a Lead Maternity Carer (LMC) from among the practitioners available in their area; this LMC could be a midwife, general practitioner or obstetrician. Currently around 91% of New Zealand women choose a midwife as their LMC (Midwifery Council of New Zealand (MCNZ), 2013), a percentage which has been increasing since the introduction of the LMC model in 1996 (Guilliland, 1999). In order to provide this care midwives work in many different ways.

The New Zealand midwifery workforce currently comprises approximately 2940 midwives with practicing certificates (MCNZ, 2013). Over half that number have been in practice for 15 years or less, and 42% of that figure are working part time, defined as less than 32 hours per week (MCNZ, 2013). Just over 1100 midwives reported being in case loading practice, with the majority of them, 86%, describing themselves as self-employed midwives providing LMC services. These midwives report an average case load of 42 women per year (MCNZ, 2013). Midwives working as self employed case loading midwives spend time on call, attending labouring women whenever required and providing care from pre-pregnancy through until baby is six weeks old. To maintain this on call workload, midwives must decide on a style of practice that fits within their lifestyle. For some midwives this means working alone, some work in small groups of 3-4 midwives, and for others this means working in larger group practices.

An experienced midwifery workforce has been linked to increased quality of care, and improved outcomes (Curci, 2009; Grembowski et al., 2003) and it therefore is important to retain experienced midwives: one strategy to achieve this is to ensure they remain satisfied with the job, and their lifestyle. In order to examine long term satisfaction this research focused on midwives who have been in practice longer than five years.

Personal inspiration

This topic interested me specifically as I found myself struggling with my personal midwifery practice. I graduated with a Bachelor of Midwifery degree in 2001, and at the time I had no children. Even then I found the on-call lifestyle of a self employed midwife challenging at times. I stopped working as a midwife in order to become a stay at home mum when my own children were born. After more than five years I returned to midwifery work and I wondered how midwives with families manage to maintain an on - call lifestyle and a full family life.

This was compounded by observing the midwives around me and how they arranged their working life. During my break from midwifery I left New Zealand to be with my American husband, and began a new phase of my life in California. I now live in a small town that has just above 25,000 people, about 2.5 hours away from Los Angeles. I am the only self employed midwife in the town I live in. The closest midwife lives about 1.5 hours away, and there are another two midwives about 30 minutes further away again. I witness these midwives maintain their love of, and commitment to midwifery, even though they do not appear to take any time off, or have significant local professional support.

Both of these factors came together for me, when I started thinking about returning to midwifery. In the literature I found many articles discussing how burnout can affect midwives, the stress and demands of the job, but I was looking for information about what it is that keeps midwives in the profession. We work on call, sometimes for long hours, sometimes facing very emotionally demanding times, and not receiving abundant financial reward, so what is it that keeps us committed to our job? These are the reasons I am drawn to this topic, I love midwifery, I love working with mothers and babies, and I want to keep that love alive. Therefore I decided to focus my research on areas that might help increase satisfaction levels for midwives.

Aims of the research

The broad aim of this research was to uncover strategies that could lead to increased satisfaction in the New Zealand maternity workforce. More specifically the aims were to discern any common factors among midwives that lead to increased satisfaction with their working role, and to identify what was helping them maintain their satisfaction and remain fulfilled in their job.

Thesis overview

The *Literature Review* chapter outlines the research currently available around the topics of midwifery satisfaction, midwifery stress and burnout. It focuses on relationships with clients, other working relationships, managing workload and building resiliency.

In the *Methodology* chapter the design and method undertaken in this study is presented. This chapter also discusses interview techniques, recruitment of midwives, the data analysis and the ethical considerations of the study.

The *Findings* chapter details the data obtained from the interviews and collates the three themes found.

In the *Discussion* chapter the data is discussed in relation to the literature already available. This chapter highlights new insights uncovered by this research.

Summary

Context is a critical factor in all research. This chapter has discussed the New Zealand maternity system and contextualised the role of case-loading midwives within it. I have also explained my personal motivations for choosing this topic to study, which were factors of my environment. It is my hope that this research will benefit both my personal practice as a midwife, but also be helpful to other midwives, allowing them to maintain their satisfaction levels with midwifery over time. The next chapter aims to widen understanding by focusing on the research surrounding workplace satisfaction for midwives.

To begin, I will present what is currently known in the literature review, and identify the area not previously covered that this research attempts to address.

Literature Review

Introduction

This research endeavours to identify areas that help New Zealand case loading midwives maintain and increase fulfilment and satisfaction. Until recently the focus for research in the field of midwifery satisfaction has been on uncovering why midwives are leaving the profession, on midwives' burnout, or on discerning how satisfied midwives are. Though arguably different sides of the same coin, the research gaze has only recently shifted, to looking specifically at the factors which increase a midwife's satisfaction level or that encourage midwives to remain part of the workforce. Being able to identify these areas may allow midwives to maintain their satisfaction levels, to continue in case loading practice for longer, and therefore help to maintain the sustainability of the profession. An in depth literature review was conducted to identify and examine studies and surface what is currently known about the satisfaction midwives feel in their working lives.

This research was carried out over a two year period. Online databases searched included Cochrane, CINAHL, ProQuest, PubMed and Google Scholar. Search terms included 'midwives', 'maternity', 'satisfaction', 'balance', 'burnout', 'stress', 'coping', 'longevity' and 'life/work'. Additional material was obtained from the Robertston Library at the Otago Polytechnic and my local library at Cerro Coso Community College in California to broaden my understanding. Over 200 items were accessed for pertinent information. Articles were chosen for inclusion in this literature review based on their relevance, original information and currency. As this research is looking to midwives for ideas or thoughts regarding satisfaction, included are some articles written by midwives expressing opinions. These were included to support the research studies, by more fully exploring the New Zealand midwifery context.

The majority of relevant research comes from the United Kingdom (UK), though there are significant contributions from New Zealand and other countries. The UK Department of Health report titled Changing Childbirth dramatically altered the maternity system calling for a target of at least 75% of women to know their caregiver while in labour (Haith-Cooper, 1999). The report resulted in the emergence of many different styles of team midwifery throughout the UK, and it was followed by studies examining, amongst other things, how midwives felt about the changes to their manner of work (Sandall, 1999). The

experiences and feelings of these midwives highlight the different experiences of a case loading midwife to those of a midwife working hospital shifts.

These and other international studies have produced information that may be relevant to the New Zealand situation. It is important, however, to be aware that the way midwifery teams in other countries are arranged can be different to New Zealand midwifery arrangements and this may lead to different feelings and experiences from the midwives. There are many similarities though; being on call, working with women in a similar manner, and interacting with hospital shift work staff for example, that could lead to common experiences between midwives in different countries.

Satisfaction and working styles

Midwives appear to have a higher job satisfaction working with the team midwifery or case loading approach than working as hospital shift midwives (Haith-Cooper, 1999; Todd, Farquhar & Camilleri-Ferrante, 1998; Turnbull, Reid, McGinley & Sheilds, 1995). Case loading midwifery is where a midwife or a group of midwives takes responsibility for the care of a woman or women from conception planning and early pregnancy through labour and throughout the postpartum period (National Institute for Health and Care Excellence (NICE), 2007). In this thesis the terms 'core staff' or hospital based midwives are used to refer to midwives who work in shifts within a hospital setting. Positive attitudes were more commonly expressed by midwives working with case loading care. Caseloading midwives in Australia also reported lower burnout scores than their core staff counterparts when measured with the CopenhagenBurnout Inventory (Newton, Forster & McLachlan,2011). Other midwives identified factors such as being able to use the full range of their skills, to continue to learn through the job and to have increased autonomy as contributing to these positive attitudes (Haith-Cooper, 1999; Turnbull et al., 1995; Yoshida & Sandall, 2013). Midwives working in a case loading practice reported less workplace bullying, the incidence of which can lead to increased stress (Yoshida & Sandall, 2013). When asked, most midwives who had changed from shift work style midwifery to case loading midwifery stated they would not change back if given the choice (Todd et al., 1998).

Though satisfaction generally is seen to increase with case loading style practice, a decrease in job satisfaction at the beginning of learning to work with a full time caseload was examined in two Australian studies (Collins, Fereday, Pincombe, Oster & Turnbull, 2010; Turnbull et al., 1995). The midwives found managing the working hours and being

on call the biggest struggle and the authors attributed this initial drop in satisfaction to the midwives learning how to manage their case load and to work within the new system (Collins et al., 2010). This reduction in satisfaction levels recovered in a number of months, and it was suggested that this related to the midwives learning to express their own needs, and to set limits with their clients in order to have some personal time (Fereday & Oster, 2010). .

Relationships and their link to satisfaction

Midwifery relationships feature in many studies on job satisfaction. These include relationships with clients as a key feature, but also relationships with other colleagues including practice partners as well as medical and hospital based colleagues. The different ways midwives arrange their practice can impact the relationships they then create, and this in turn can affect their satisfaction levels.

Relationships with childbearing women

Much of a midwife's day is spent interacting with women. It is this relationship which appears to increase midwives satisfaction and yet to also create significant challenges in maintaining satisfaction levels. In a UK wide survey, case loading midwives expressed much of their job satisfaction coming from their relationships with women (Sandall, 1999). As the case loading or continuity style of providing midwifery care leads to more personal relationships, then consequently the authors suggested the relationships led to greater job satisfaction (Sandall, 1997, 1999). Sandall (1999) commented that this relationship accounted for some of the increased job satisfaction reported from case loading midwives in comparison with the hospital – shift working style of midwifery. Kirkham, Morgan and Davies (2006) conducted a large scale questionaire on retention issues with midwifery in the UK, asking why midwives stayed in their positions. This study included midwives working across all working styles of the field, including hospital midwives and case loading community midwives. They found that midwives enjoyed their jobs, and specifically that they received job satisfaction from the relationships they built – both with colleagues and with women. This was echoed by a New Zealand study with five midwives from one major metropoliton area (Engel, 2003) which discussed relationships leading to increased satisfaction, but they also identified the need for the midwives to keep a personal / professional balance and to set firm boundaries. Important to note is the other side of this situtation. Rouleau, Fournier, Philibert, Mbenque and Dumont (2012) interviewed midwives in Senegal and found the emotional connection the midwives created with the

women "experiencing distress, pain or anger" (Rouleau et al., 2012, p.10) led to increased emotion for the midwives which was identified as a risk factor for burnout.

The style of caseloading that midwives adopt also has an impact on satisfaction. A Dutch study which compared the experiences of 200 community midwives, 540 GPs and 1337 community nurses revealed that whilst midwives suffered less burnout than GPs, they reported higher levels of emotional exhaustion than community nurses (Bakker et al., 1996). Interestingly this study found a correlation between the number of home births a midwife attended, and a reduced risk of burnout. From this the authors concluded that attendance at home births increase a midwife's satisfaction level. As home birth has been shown to intensify the relationship between midwives and clients (Janssen, Henderson & Vedam, 2009), and strong relationships between midwife and client has also been shown to affect satisfaction levels (Curtis, Ball & Kirkham, 2006; Engel, 2003; Sandall, 1997). It is possible, therefore that this increase in satisfaction from attending homebirths could come at least in part from the increased intensity of that relationship. All these studies recognised the essential dichotomy that underpins midwifery; that it is the relationship with women that creates stress and struggles for the midwife, but it is also that same relationship that infuses the job with joy and satisfaction. Relationships with clients are a large part of a midwife's job, but midwives also have relationships with many others around them.

Relationships with colleagues and other health professionals

Similarly to relationships with clients, relationships with colleagues can affect work satisfaction, with the absence of teamwork and professional support linked to burnout (Sandall, 1997; Todd et al., 1998). In a study looking specifically at burnout, Banovcinova and Baskova (2014) found that conflict with a doctor was the second most common stressor reported by nurses and midwives in Slovakia. Yet even within the midwifery community support styles can differ between midwives and midwifery practices. Kirkham and Stapleton (2000) explored the collegial support structures of self employed UK midwives, and found that these midwives seemed to provide each other enough collaboration and encouragement, so that they did not feel the need for external support. The researchers suggested that this may be because these midwives have decided to work outside the regular system, and that this may intensify the bond between them. (Kirkham & Stapleton, 2000). A later study by Deery (2005) offered an alternative conclusion by suggesting that the concept of collegial support may be one that is difficult for midwives to fully embrace. Deery (2005) described a team of midwives that expressed feelings of being supported within the team, but in many other ways demonstrated strong feelings of

isolation. Deery (2005) called this “pseudo-cohesion” and found that it decreased levels of satisfaction, and increased stress levels for the midwives. This action research study offered external support to a group of hospital employed team midwives in the form of professional supervision, and found that the midwives, though stressed and having communication problems within their team, thought of the increased time requirments of attending supervision an unwanted additional demand. Deery (2005) concluded that it is critical that effective communication skills be taught to midwives, both for their collegial interactions, but also their interactions with women.Hildingsson, Westlund and Wiklund (2013) also found that conflicts with colleagues and managers created significant workplace stress which affected feelings of burnout in Swedish midwives working in a primary care role.

New Zealand studies have also looked at the effect of collegial relationships on satisfaction levels. Cox and Smythe (2011) interviewed five midwives who had recently ceased self-employed case loading practice. They reported that poor relationships with colleagues was one of the ‘burdens’ of practice the midwives identified as having contributed to their decisions to cease practice, along with the sense of responsibility they felt for the mother and baby and the stress of dealing with poor outcomes. This theme was reiterated by Scott (2012) who conducted informal discussions with New Zealand midwives where their thoughts about collegial interactions were discussed. These midwives saw their relationships with colleagues as being important for more than just emotional support. They suggested that working beside colleagues who shared their philosophy allowed them to take essential time off call while trusting that their clients would continue to receive quality care (Scott, 2012).

This was highlighted by the Chief Executive (CE) of the New Zealand College of Midwives (NZCOM) who recently published an article discussing midwifery relationships and the opinion that they are vital both to midwives and to midwifery care (Guilliland, 2013). She suggested that case loading midwives’ primary relationship was with their clients, however midwives who work in hospital settings would find relationships with their colleagues most important. This was similar to the recent report from the UK focusing on resilience in midwifery. The Royal College of Midwives funded a research study which identified enlisting the help of others as one of the four 'noble truths' of resilience (the other three being protective self-management; learning from others and also from past experiences and organisations facilitating empowerment) (Hunter & Warren, 2013). Guilliland also acknowledged the important role of relationships that case loading

midwives have with other health professionals around them, both with hospital based employees and with other self employed midwives. She commented that there are aspects of these relationships that increase satisfaction levels for midwives stating that "Group practices make it easier and sole practice makes it harder" (Guilliland, 2013, p. 6) recognising that the support that midwives receive from other midwives is crucial to well-being.

Managing workload

Why midwives leave practice

The breakdown of the ability to develop relationships, and dissatisfaction about the actual job are reasons cited by midwives when asked about why they choose to leave their positions. With a relatively limited body of literature exploring midwives' satisfaction levels, examining additional information from studies that focus on the dissatisfaction and struggles of midwifery practice can extend our understanding of the subject. The majority of midwives who were questioned in a study conducted by Curtis et al.,(2006) left their positions due to dissatisfaction about the job itself, rather than for any personal factors. Midwives across all work styles who decided not to renew their 'intent to practice' paperwork were invited to participate. The midwives discussed feelings of no longer being able to develop meaningful relationships with clients, not being able to practice the way they wanted to, and feeling like the women received sub standard care (Curtis et al., 2006). It is interesting to note that these things are almost the flip side of factors such as developing supportive relationships, having perceived control, and having pride in being a midwife, which were discussed in studies investigating why midwives remained in their positions.

These ideas seem to be consistent across countries. In response to Australia having a midwife shortage, Sullivan, Lock and Homer (2011) circulated a questionnaire to midwives from an area in New South Wales, looking at factors that contribute to midwives continuing in the workforce. They found three main factors that contributed to midwifery retention; midwifery relationships with their clients and colleagues, professional identity as a midwife and the practice of midwifery including the variety of the job. This study was designed to replicate Kirkham et al.'s (2006) English study, and found very comparable responses from the midwives specifically, relationships, professional identity and the actual work of midwifery. As well as the ability to develop relationships, it was also seen

as important for midwives to have strategies for maintaing a healthy personal life, which includes the freedom to be 'off call' from time to time.

Time off call

Case loading midwives provide an on call service 24 hours a day, 7 days a week unless they have arrangements for a colleague to be available for their clients. Making these arrangements can be complex, and as a result many midwives have difficultly in taking the time off they would like to. In 1999, just nine years after midwives regained the legal right to work as autonomous practitioners, the New Zealand College of Midwives Journal published an article by Lilian Rolston titled "The Issue of midwife self preservation" (Rolston, 1999). This article discussed burnout and asked five Auckland self-employed case loading midwives about their strategies for coping with being on call. These midwives identified taking time off call as being a very important part of maintaining a healthy working life. Taking time away from call was also identified by Cameron (2005) who examined midwifery in Ontario, Canada, which was included into the provincial health care system in 1994. She called for increased numbers of midwives, but also discussed the factors that were causing midwives to leave the profession – specifically issues around being on call, inadequate time off, and the lack of adequate remuneration (Cameron, 2005).

The relationship between satisfaction, job retention and time off call was examined in New Zealand by Wakelin and Skinner (2007). Their research found that less than a quarter of midwives took regular time off from being available for births and pager calls. Only 18% of the midwives questioned had regular formal back up arrangments and over a quarter of midwives said that their support felt inadequate (Wakelin & Skinner, 2007). These all contributed to a feeling of exhaustion, which the authors found was the number one reason given by the midwives for ceasing midwifery. As an outcome of their study of midwifery satisfaction levels Donald, Smythe and McAra-Couper (2014) created a work/life balance tool where midwives self assess their work-life balance to determine if it would be beneficial to make some changes in the way they practice, for example to take more time off. The hope for this tool is to reduce the number of midwives affected by burnout (Donald et al., 2014).

It seems that it is not so much the workload itself, but rather the amount of control that the midwife feels she has over that workload that affects midwives satisfaction levels. Looking specifically at burnout with hospital employed midwives from the UK, Sandall (1997,

1999) found a link between burnout and the lack of control, or perceived control a midwife has over her workload. Fereday and Oster's (2010) qualitative study of 17 hospital employed Australian midwives working in case loading practice reported findings congruent with the study by Sandall (1999), that perceived control over workload increased satisfaction levels. Loss of control over one's workload may occur due to multiple factors including rural location, illnesses or client numbers set by empolyers (Sandall, 1999).

While the total workload appears able to be regulated by the self employed case loading midwife in regards to how many clients she works with per month, the timing of that work is unpredictable. If all the women birth in a small window of time, both the workload from the births, and from the frequent schedule of postnatal visits can be significant (Engel, 2003). Midwives are paid per client in New Zealand, with the majority of the remuneration coming from the payment for labour and birth. Miscarriage, complications that result in caesarean section without labour, or extremely long labours can affect remuneration for New Zealand midwives. Some midwives book more clients to account for this potential loss of income, but then, if none of these circumstances come about, they can have more clients than desired (Engel, 2003; Rolston, 1999). This was examined further by Engel (2003) who investigated the loss of income component to the above unexpected outcomes and found that although this affected midwives' cashflow, it was not seen as significant in satisfaction, rather it was the access to good support and the ability to set boundaries that the midwives found more important.

Establishing boundaries

As well as having time off, it is seen as important for midwives to negotiate realistic expectations for 'between visit'contact between themselves and their clients, and to be mindful to book manageable caseloads (Brown & Dietsch, 2013; Dahlen, 2012; Engel, 2003; McLardy, 2002). Dahlen (2012) discussed some requirements for maintaining practice in the Australian context, which she summarised as being a need to create boundaries, both for client contact and on case load numbers, having the support of family, and loving what you do as a midwife. The 'boundary setting' idea was echoed by Brown and Dietsch (2013) who stated that "midwives initially expect that they will be responsible for each of the women in their caseload on a 24 hour, seven day a week basis, which is unsustainable" (p. e2). They went on to highlight the importance of professional boundaries as enabling balance between the needs of the woman with the needs of the midwife (Brown & Dietsch, 2013).

In the New Zealand setting, McLardy (2002), highlighted how managing these boundaries, as well as other specific challenges of midwifery practice (making business decisions and attending to financial affairs), is important to ensuring longevity of practice. The midwives Engel (2003) interviewed about practice sustainability agreed with these sentiments, identifying that effective communication regarding these boundaries, and specifying how and when clients could contact the midwives, were key strategies for fostering sustainable practice.

Lastly, and also from the New Zealand context, McAra-Couper et al. (2014) discussed the concept of sustainable midwifery practice and identified setting boundaries as one of the main themes to come from their interviews with midwives. Boundaries were seen as keeping the midwifery relationship safe, but they also allow the midwife to take time off in order to maintain other relationships with family and friends. Organising work schedules to suit the midwife, and keeping to those arrangements, were also noted as a significant factors in sustaining midwifery practice (McAra-Couper et al., 2014).

As well as the ability to set and adhere to boundaries, it is also important for midwives to feel control over their work.

Autonomy

Midwives practice across multiple settings and navigate multiple practice realities, therefore personal autonomy may be important for maintaining satisfaction. Though not directly employed by the hospital, self employed case loading midwives can be expected to follow the hospital protocols and systems even if the midwives personally do not agree with them (Hall, 2005). Casey, Saunders and O'Hara (2010) surveyed 306 UK hospital based midwives and nurses and noted a strong relationship between empowerment and job satisfaction, finding that if nurses or midwives do not feel empowered in multiple ways at work, job satisfaction decreases. The hospital protocols, if they are in opposition to the midwife's philosophy, could be seen as undermining to the midwife's sense of autonomy or empowerment and therefore contribute to a reduction in satisfaction. Way (2008) found that nurses with greater 'job control' had greater levels of satisfaction, than those with strict protocols to follow. This concept echoed a study by Kirkham, Morgan and Davis (2006) who also found that midwives discussed autonomy as important in maintaining their satisfaction levels, though the authors also recognised midwives as individuals and stated that different midwives found satisfaction in different areas.

Building resilience

While external factors such as boundaries and time off influence a midwife's feelings about her job, personal factors also play a part. A Dutch study by Bakker et al. (1996) concluded that it was partly workload or working arrangement, but also partly the internal qualities of the midwife that lead to situations of burnout. The authors commented on the importance of internal qualities that the midwife carries, and ones she creates, that affect how she deals with the inherent stresses of the job. Two different midwives can react very differently to the same situation and these differing reactions are driven by the midwives' internal qualities.

Increasing resilience is something which can be gained over time. This is an investment for the future made by the midwives, rather than a strategy to use as a response to a current situation. The most recent report from the UK which looks at resilience in midwifery (Hunter & Warren, 2013) used an online chat group to explore mostly hospital employed experienced midwives' ideas about resilience, looking at personal, professional and other factors that the midwives felt contributed. The study authors did not define resilience, allowing the midwives to use the definition that resonated for them. The authors concluded that acceptance, commitment, enlisting help, success with resolving past adversity and conserving anything good were the cornerstones that these midwives used to maintain their professional resilience (Hunter & Warren, 2013). It is important, however, to be aware that the way these midwives work is different to how New Zealand case loading midwives work, and this may affect the responses given by the midwives if the study were to be conducted in New Zealand.

McAra Couper et al. (2014) posited that the internal qualities of the midwife are what helps sustain her, specifically an optimistic approach by the midwife and an open heart both towards herself and towards others. That having good will and generosity affect all aspects of your life, including your working life – affecting your relationship with your clients, your partner midwives, other colleagues, and extends even to your friends and family (McAra Couper et al., 2014). The midwives they spoke to discussed the need to work at creating the type of community around you that supports your ability to work, and to take time for yourself when needed. The alternative is an unsupportive or fearful environment which makes midwifery neither satisfying nor sustainable.

Summary

When canvassing the literature surrounding midwives' satisfaction, common themes identified were the relationships formed with colleagues and clients and the need to contain these within boundaries to maintain a sustainable and satisfying personal life. The research suggests that higher satisfaction ratings among case loading midwifery is related to increased autonomy in the job, to the relationships built with women, and the ability to use a wider range of skills. However the midwives need to be aware of setting boundaries and maintaining necessary time off and of working to build professional relationships and develop networks of supportive colleagues. The internal qualities a midwife holds may also affect how she deals with job stress and challenging situations therefore influencing her feeling of job satisfaction. Thus good will and generosity from the midwife helps build supportive communities.

Much of our understanding to date has come from studies that focus on burnout or dissatisfaction of midwives. The possibility exists that factors relating to satisfaction could be the opposite of those linked with dissatisfaction, so it is important to test that assumption. This researcher is also aware that there may be something specific and unique that midwives who currently describe themselves as satisfied can contribute to the dialogue. This review has presented a background picture of the current literature relating to midwifery satisfaction levels. I will now go on to describe how I conducted my study in the Methodology chapter.

Methodology

The methodological framework of a study has to be carefully planned in order to produce data that is consistent with the study's aims. As this study focuses on the midwives' thoughts and feelings a qualitative method was chosen as most appropriate. This study was conducted using a qualitative descriptive study design. It aimed to produce results staying close to the original data with only limited interpretation. Midwives in one area of New Zealand were interviewed over telephone or Skype video conferencing using a semi-structured interview technique. The data was transcribed and coded, then analysed using thematic analysis. This next section lays out the way this research was carried out, including specific details about numbers of information packets sent out, number of packets returned, and timing of the study and data collection methods.

Midwives' perceptions of the factors they feel lead to increased work satisfaction and job fulfilment will form the data for this study. Of the two main types of research, qualitative and quantitative, it is qualitative that generates this type of data. Qualitative research has been well summarised by Neergaard, Olesen, Andersen, and Sondergaard (2009) as "an empirical method of investigation aiming to describe the informant's perception and experiences of the world and its phenomena" (p. 2). This means that rather than research using the numbers as the significant variable, qualitative research looks more at the peoples' ideas or thoughts. It surfaces the 'human experience' of an occurrence or a situation (Magilvy & Thomas, 2009). Qualitative data is usually in the form of transcripts and though it provides a description of the peoples' thoughts or feelings, the data itself doesn't provide any direct explanations or theories (Pope, Ziebland & Mays, 2000).

Qualitative methods have been criticised for having a lack of scientific rigour (Burgess-Allen & Owens-Smith, 2010). The smaller sample size, and the lack of ability to recreate the data has lead some researchers to question the validity of these methods (Mays & Pope, 2000), however with good quality analysis techniques and an understanding of the aims for the research, qualitative methods can examine peoples' thoughts and perspectives in a way not possible for quantitative research, and this in itself can lead to further understanding of the topic (Burgess-Allen & Owens-Smith, 2010).

Member checking is one way to increase the validity and reliability of qualitative data (Fade & Swift, 2010, Mays & Pope, 2000). This is where the transcripts are returned to the participants for their comments, and to allow the participants to add, change or edit

their comments. This ensures that data received from them is a true representation of their thoughts and feelings, and it reduces the chance of errors and incorrect interpretations.

Qualitative descriptive study design

Within qualitative research there are a variety of methodologies used to collect and analyse data. The four main methodologies are phenomenology, ethnography, grounded theory, and case study or field research (Trochim, 2006). While not a discreet category such as these, qualitative descriptive design is an often-used approach which has established its own credibility.

As the name suggests, the aim of qualitative descriptive research is to present a description of an occurrence. This comprehensive summary of the information gathered undergoes little interpretation by the researcher (Sandelowski, 2000) while still aiming to present the data in a way that adds to the general knowledge database (Sandelowski, 2010).

The level of analysis or interpretation of the data in this method has produced some controversy. Qualitative description has been used in the past as a default or a salvage method where other forms of interpretation have been seen as too difficult to do (Sandelowski, 2010). Sandelowski (2010) argues that this method is not one to use when further analysis seems to be tricky, but that it stands as a true method into itself. She states that qualitative descriptive is very useful with more general research questions and types of study.

Some qualitative research designs look at the data through the lens of a particular philosophical position, such as constructivism, which then shapes the methodology and design considerations. If, however, the research has no specific underlying philosophy, or is more limited in scope, then the qualitative descriptive style can be the appropriate method to use (Magilvy & Thomas, 2009). This is not to say that qualitative descriptive has no theoretical underpinnings, however it is suggested that it is aligned with naturalistic theory which tries to study things in as close to their natural state as possible (Sandelowski, 2000).

Findings within this methodology often depend of the type of data obtained and the style of analysis used. They are a summary of the data analysis, arranged in a way that ‘fits’ the data being presented (Sandelowski, 2000). The presentation of raw data (quotes) reassures the reader that the researcher's interpretation is accurate and enhances the trustworthiness of the findings (Drisko, 2005). The ideas that emerged from the midwives' discussions

coalesced into themes which were able to be presented as discrete data sections, thus keeping true to a naturalistic description of their sentiments.

This research focused on surfacing these midwives' ideas about their satisfaction levels, and as such some interpretation has occurred to the extent of 'arranging' congruent ideas in the presentation of the data. Qualitative descriptive design was therefore a valid and appropriate choice for this inquiry.

Method

Recruitment of midwives

An effort was made to contact all midwives within the target region. The pool of potential midwives was identified by contacting all midwives who had publically-available contact details, including those listed on the '0800mumtobe' Freephone number and the local telephone directory. In order to collect information from midwives regarding the long term fit of their midwifery practice with their personal life this study only included midwives with more than five years experience. The initial package was sent out to 80 midwives and included an information sheet (Appendix II) a confidentiality agreement (Appendix III) and a consent form (Appendix IV) to be returned by midwives interested in participating. A stamped envelope addressed to the midwifery school administrator at the Otago Polytechnic School of Midwifery was included. The envelopes were collected and forwarded to me, unopened.

Four midwives replied and were then contacted using their preferred method, either telephone or e-mail. Their criteria for inclusion were confirmed regarding length of time in practice, and a date and time for the internet interview was arranged. One midwife then declined to be any further part of the study for unknown reasons. Three midwives continued in the study and were asked about their preferred method of interview, Skype, Adobe Connect or telephone (using Skype client for recording purposes). If necessary an initial time was made to check that software was set up correctly, and that the midwife was comfortable with the process. One midwife requested Skype with video, and the remaining two midwives were interviewed using Skype client calls to their telephone. Interviews took place over a two month period and the interviews lasted between 40 and 60 minutes. These were recorded using Windows MP3 Skype Recorder, freeware downloaded from the internet, which saved the interviews using an MP3 digital format. For security reasons digital data files were stored on a computer without connection to the

internet and secured by a password. The interviews were then transcribed by the researcher and returned to the midwives for any comments or changes.

Interview as a method for data collection

Interviews are well suited to collecting personal data (Elmir, Schmied, Jackson & Wilkies, 2011). They are viewed as a way to obtain more in depth personal data than other forms of data gathering as they predominantly use more open ended questions (Sandelowski, 2011). Though there are different styles of interviews, based on the type of information sought, this project used semi-structured telephone or videoconference interviews. There were five main questions asked, but space and time were also available for the midwives to address any other issues they felt important. The geographical distance between interviewer and interviewees made either telephone or internet interviewing the only financially viable option. This type of data gathering technique allowed for the collection of in depth data, while working with the geographical limitations this study presented.

Interview format

The format of the interview can affect the type of data obtained. There are three recognised interview formats; structured, semi-structured and unstructured (Baumbusch, 2010; Doody & Noonan, 2013; Ryan, Coughlan & Cronin, 2009). The structured interview has a list of usually closed ended questions which the researcher asks in the same order and without deviating from or exploring further (Ryan et al., 2009). An example of this can be a questionnaire or street survey, where the respondent answers the questions, but no further information is requested. The unstructured interview works in the opposite way; it does not use a question structure, but rather just a topic for the researcher and the participant to discuss. The name is a bit misleading though, as these interviews do have a form of structure in order to ensure the data that is gathered is relevant to the study (Doody & Noonan, 2013). This style of interview technique is best used when there is little known about the topic area (Ryan et al., 2009). Both these styles combine to make the semi-structured interview, which uses aspects of each of them.

A combination of the two previous methods, the semi structured interview, was used in this study. This interview technique is the most common method used (Doody & Noonan, 2013) where the researcher has some open ended questions prepared, but also has the freedom to further explore into the information given by the participants. The questions are designed to be open ended to allow the participants to comment freely on what they

feel is significant (Ryan et al., 2009). Semi-structured interviews allow for in depth data gathering, while ensuring issues deemed important by the interviewer are covered. This combination was important for this study as it allowed the data to be specific to satisfaction levels, while at the same time allowing the participants to introduce topics they considered important.

The geographical distance between interviewer and interviewee made either telephone or internet interviewing the best options. Though more common in quantitative research, the use of telephone interviewing has advantages for this project over face to face interviews as it allowed midwives in remote areas access to participate (Elmir et al., 2011). Telephone interviewing also reduced the time requirements for the midwives, with no travel needed and minimal pre- or post-interview interactions. Though some literature argues telephone interviewing results in more superficial data as rapport can be more difficult to establish (Opdenakker, 2006), this claim does not appear to be backed up by research which shows similar depth of data obtained from either telephone or face to face interviews (Novick, 2008). While it is true that visual non-verbal cues are not seen during telephone interviews, this data from face to face interviews is interpreted by the interviewer, and may be perceived incorrectly, therefore producing misleading or incorrect data (Novick, 2008). As the interviewer I remained mindful of these potential limitations and also recognised that telephone interviewing can collect data as rich and detailed as other forms of interview technique.

In research designs where researchers form both the questions and determine the data to be analysed, preconceived ideas and premature conclusions can be of concern (Banner, 2010). This study used open ended questions which allowed the midwives the ability to discuss any point they found relevant as an effort to lessen this impact. Using many direct quotes in the results section increases the reliability of the data, allowing the reader to determine if the discussed interpretation is accurate (Drisko, 2005).

Interview questions

Five main interview questions were used to elicit the data. Elmir, et al., (2011) stated that "good interview questions are open-ended, clear and aimed at eliciting responses that reflect the participant's experiences" (p. 14). The order that the questions are asked is also important with less personal questions asked initially, for example demographic data, then building into more personal questions, followed by some concluding questions designed to give closure to the interview (Ryan et al., 2009). The questions were

1. How long have you been a midwife – How long a case-loading midwife?
2. Tell me about your practice - number of clients, support arrangements, rural/urban, major place of birth for women.
3. How satisfied are you in general with your midwifery practice?
    a. Can you identify any changes you have made in your practice to increase satisfaction, or changes you plan to make?
    b. When you think about your midwifery practice, what gives you the most satisfaction?
    c. (This may have come out previously) Have there been any times that have been difficult in your practice? (if no then skip next questions).
4. Think about one time that was difficult for you. Can you identify the things that helped you feel better about your work? (If there has been more than one time….)
    a. Are those things similar amongst other times you may have found difficult?
5. What tips would you give to a new midwife to help her remain satisfied as a midwife?

Three midwives returned the consent form and all three midwives were interviewed. A 'trial' interview was conducted with a non-midwife participant to practice with interview technique and to ensure the questions were clear and easy to understand. Data obtained from this interview was not included in the analysis. Practice interviews are seen as important for novice interviewers, like myself, to have an opportunity to look for leading questions or missed opportunities (Banner, 2010).

One of the final parts of the interview technique is going through the process of reflexivity. This concept acknowledges the effect of the researcher on the research process and makes space for the researcher to analyse personal aspects such as preconceived ideas, premature conclusions and missed opportunities during the research process (Banner, 2010). This occurred following each interview as the researcher transcribed the data and also during the analysis process. The researcher attempted to minimize the effect on future interviews of any assumptions uncovered during the process. Committing to steps such as this increases the trustworthiness of the data obtained (Banner, 2010).

Data analysis

The practice of transcribing can be one of the initial times where the researcher begins to interact with the data. There are various levels of data that can be included in the transcription from just including the specific words that are deemed relevant to the topic question, to writing down everything that was said, including the manner or style in which it was said (Fade & Swift, 2010). For this project I chose a middle ground of transcribing everything that was said, except explanations of the research process, but not including any specific mannerisms or vocal intonations. The transcripts in this study were returned to the midwives for member checking. The midwives examined their transcripts to make any changes, either in the wording, or in the intention of their comments. No changes were made to the data by the midwives during this process. To ensure anonymity the researcher changed the midwives' names and other identifying information.

There are two main styles of data coding, deductive or inductive (Pope et al., 2000). Deductive analysis usually means the categories used for coding are obtained from ideas gained either before the data was collected or while the data was being collected, whereas with inductive analysis the categories used to code the data come directly from the data itself. Inductive analysis is more often used in qualitative research (Pope et al., 2000) and is very useful when research is based on discovering new ideas from the data (Burnard, Gill, Steward, Treasure & Chadwish, 2008). The transcripts were read multiple times and the main ideas were recorded onto a mind map. The themes identified in this study arose from the data generated when completing the thematic analysis.

Drisko (2005) states that many researchers do not describe the method of data analysis in enough detail, relying on using terms such as 'thematic analysis' without explaining the way that the themes were produced. Description is important for readers to be able to evaluate the research and make decisions regarding reliability and trustworthiness (Braun & Clarke, 2006). Though thematic analysis has been called a "foundational method" of data analysis (Braun & Clarke, 2006, p.78) there are many variations to this approach. Thematic analysis as described by Braun and Clarke (2006) is used to identify codes and themes in the data. They described six steps in the analysis of data; "Familiarising yourself with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, producing the report" (Braun and Clarke, 2006, p87). Thematic analysis can sit within many theoretical underpinnings, one of which is the naturalistic

inquiry framework, in which qualitative descriptive research design also sits (Sandelowski, 2010). This makes it a good fit for this research project.

In keeping with the study design of qualitative description, themes were identified at a semantic level. This means that themes were analysed at the surface level of the data, not looking beyond what is said (Braun & Clarke, 2006). The spoken meaning of the data was discussed, collated and described without the lens of a particular theoretical framework, though in the development of the themes themselves there is already interpretation and theorising happening by the researcher (Burnard et al., 2008). This is important as it is necessary as a researcher to do more than just rephrase the original data, rather to obtain meaning and significance (Sandelowski, 2010). Themes were drawn from the data when all the main ideas were recorded on the mind map. The aim of the analysis is to add to the current understanding of the topic and thematic analysis aims to draw the important themes from the data. Thus, I have not just rephrased the data but rather looked for meaning in the results using thematic analysis.

Ethics and acknowledgement of the Treaty of Waitangi

In any research it is important to be aware of the impact that research can have on the participants and the wider community. Ethical considerations for this study included how the data would be collected, stored and disposed of. For the participants, issues including confidentiality, privacy, informed consent and potential harm were addressed. A research proposal was submitted for approval to the Otago Polytechnic Research Ethics Committee, and approval was granted on 3 December 2012 (approval number 528) (Appendix I).

As midwives in New Zealand were interviewed in this study, it was imperative that my responsibilities to the Treaty of Waitangi were taken into consideration. The Treaty of Waitangi is a foundational document signed between the indigenous peoples of Aotearoa New Zealand and the Crown in 1840, which sought to establish certain rights and protections afforded to both parties, and the nature of the ongoing relationships between the signatories. It embodies three main principles which are applied across all aspects of interactions, including with respect to research; these are partnership, participation and protection (Hudson & Russel, 2009). Partnership promotes respect for Māori traditional ways of knowing, and for Māori culture, the principle of participation sees consultation with tangata whenua as a critical underpinning of the research process to ensure mutual understanding about any aspects that affect the Māori community, (in research this would include data analysis, design and implementation), and protection refers to protecting

Māori rights, and ensuring that there are benefits for the Māori community (Hudson & Russel, 2009). Consultation with the Kaitohutohu office within Otago Polytechnic was carried out as part of gaining ethics approval.

Currently in New Zealand Māori women comprise 12% of the birthing population, but midwives that identify as Māori make up only 5.25% of the workforce (Ministry of Health, 2012). Though this study did not collect data from Māori midwives, it is hoped that the findings may resonate and have some impact on the long term retention of midwives, including Māori midwives, and that this may in turn allow more birthing women access to a midwife of their own ethnic identity.

All attempts were made to ensure the midwives' confidentiality. Midwives were not aware of the identity of other midwives involved in the study. All midwives names have been changed in the final document and any information sent to the midwives was sent to individual addresses, rather than group mailings. Any identifying information given by the midwives was not included in the data analysis.

Summary

The study used a qualitative descriptive design to produce data that described the current situation. Three New Zealand case loading midwives who had been in practice more than five years were interviewed via telephone or Skype videoconference. Data from semi - structured interviews was analysed with inductive coding to produce themes which were refined until the results emerged from the data itself.

The study method was designed to include little interpretation of the data, but rather to present the information gained, and to provide an introduction for further, more in depth research. The findings from the data will be presented in the next chapter.

Findings

Three New Zealand case loading midwives with a range of 8-15 years practice were interviewed. They were from the same geographical area and practiced mostly in urban settings. The midwives were satisfied with their jobs and all were expecting to stay as case loading midwives for the foreseeable future, as demonstrated by the following quotes

I do love it- Cathryn

I fluctuate at times, anywhere between the 'yes I really love this work' and 'this work is really good, at the moment I'm a bit overstretched, but it's still great'- Belinda.

Within the limitations of what the job is, it's fine.....I enjoy the community- Abby.

Three interlocking themes came from the data. The concept of satisfaction from working with the clients and their community was the idea discussed the most often. This was ideally felt to be a mutually satisfying relationship where midwives provide and receive nurturing from their clients and the community. Satisfaction from their professional relationships covers all other working relationships including practice partners but also other midwives both near geographically and those with strong emotional ties no matter whereabouts they are. The midwives also discussed the need to look after yourself and ensure satisfaction from sources outside work; to maintain your working boundaries, to take time off call and to have time to spend with family. These three ideas are interconnected, mutually dependent and flexible.

Relationships with women and the community

The most frequently mentioned source of satisfaction the midwives discussed was their interaction with clients. They discussed satisfaction coming from their relationship with their clients, from their interactions and connection and from seeing changes the clients make. The satisfaction was not just linked to the relationship with the pregnant woman, but also with her family, and at times included the community surrounding the woman.

Relationships with women

I've been some use to the world- Cathryn

It's the community that gives me more satisfaction, I catch babies in my sleep, that's what I do - Abby

Every midwife interviewed said that they got great satisfaction from their interactions with their clients. This thought was clearly described by Belinda who stated

I have a really authentic relationship with those people and feel fed by the work I do for them, hopefully in a similar way that they are nurtured by the work I do -Belinda.

Abby also stated

I've got a little niche in the community...and I love them dearly- Abby

The ideal discussed is a mutually satisfying relationship where the women and midwives feel that they have a good fit. These midwives felt that the relationship was important enough to refer clients on to a different care provider if either the practice style is not what the women are looking for, or if the relationship was feeling difficult.

I think for me at this stage in my life, I would probably encourage them to find someone else. Not because I don't feel safe in the relationship, or I don't feel competent working with them, but simply because if I don't get the same level of satisfaction working with them – it pulls my whole affect down a little bit- Belinda

Two midwives expressed satisfaction from seeing the clients do things, or make changes that affected the rest of the clients' lives. Abby worked with women who had increased risks due to social factors and she commented that when these women had normal births and breastfed their child, it would give them something to be proud of when the women are faced with other challenging life events. Cathryn discussed satisfaction from seeing the women gain confidence while in her care, and thought that perhaps she had contributed –

I've seen some of my tricky young mums do very good things with their life, and I like to think along the way I might have helped a wee bit - Cathryn

Both midwives were clear that it was the empowering of their clients that may contribute to the future, the act of helping the women to realise that they have the resources within

themselves, rather than the actions of the midwives themselves contributing in any unique way. This concept of the midwife not being indispensible will be discussed further when examining the importance of looking after oneself.

> *I've contributed to the well-being of my community, … That I've been some use to the world. Not that I've gone and caught the baby, but that I've been part of enriching their lives* - Abby.

Relationships with the community

At times the relationship discussed went further than just the midwife and her client. One midwife felt that a large part of the satisfaction from her job came from her interaction with the entire community surrounding the pregnant woman.

> *It's (the relationship) with the whānau. It's not just the relationship with the woman, it's with the children and her aunties and her mum, it's with the whole community* - Abby.

The job of midwifery allowed the midwives to be accepted into a community that otherwise may have been less open to them. The desire to be included may stem from multiple reasons, however this midwife expressed gratification from the community interactions themselves.

> *I enjoy the community a lot more than the job, but the job is the vehicle to the community really* - Abby.

Boundaries and sustainability

Having boundaries was seen as so important as it was discussed by all the midwives. These boundaries were set by the midwives around time off, having specific ways for being contacted and referring clients to other midwives if the relationship did not seem to be working well. The midwives discussed the idea that boundaries were developed over time and with experience

> *When you're new out it's really difficult to get your boundaries* - Cathryn.

The ability to prioritise workload into urgent and not so urgent was seen as necessary for when you were busy, or during late night phone calls/call outs. Developing systems for contact that helped women recognise this difference also reduced unnecessary interruptions for one midwife. She made a decision to carry a pager in order to remove the ability for her clients to contact her by text message.

My pager is another level of seriousness that the women only use it when they actually need me - Belinda.

She had a system for non urgent messages to go to her home phone and urgent messages to the pager. She had previously felt drained by the necessity of checking all her text messages, even in the middle of a client visit, and so implemented the system which was designed to allow her to remain accessible, while also placing boundaries on the amount of instant contact.

Within parameters set by the midwives, these relationships formed with clients and the communities surrounding the clients, was a main source of satisfaction. The midwives discussed seeing the clients make changes in their lives, and feeling like they made a contribution as very satisfying. Feeling accepted into community and valued and nurtured by the women was also valued by the midwives.

Professional relationships

A midwife interacts with many more people than just her clients. This category encompasses all relationships that the midwives have with people other than clients, in their professional life. Probably the closest of these relationships is between the midwife and her practice partner or partners. However, this also includes other midwives both in the local area, and throughout the country, obstetricians and hospital midwives, and also midwifery organizations and professional bodies.

Practice partnerships

One of the main professional relationships a self-employed case loading midwife has is with her practice partners or back-up midwives. Back-up relationships allow midwives to have time off by attending to clients' needs when the lead midwife is unavailable. All the midwives interviewed took time off, mostly taking long periods of several weeks or a month, during which they had no clients due. Some midwives also took weekends off call, either fortnightly or monthly. All of the midwives expressed much gratitude and appreciation to their back-up, while at the same time some admitting that the relationship was not their ideal

She's not ideal for me, but she's hard working and she's willing and she's got good people skills - Abby.

To avoid this situation one of the midwives had spent significant energy over the last six years creating her ideal back-up relationship with a collective group of midwives.

Now it's fabulous. You know you're never alone and that's just a big bonus in itself - Cathryn.

For Cathryn this situation grew out of an unsuccessful back-up relationship…

It got to the point where it wasn't working. And it stopped abruptly, so I was on my own - Cathryn.

She went on to create a group of midwives who support each other physically by taking on work commitments, for example where the midwife is at a birth for extended periods of time then others will visit her clients, but also by providing emotional support, for example by meeting for coffee during weekends on call. Cathryn discussed this as a vital part of her midwifery life, giving her the ability to coordinate her work so she can also look after her own emotional and physical needs.

While a great back-up relationship may provide both physical and emotional support, it is not necessary that these are both found in the same person. Though her back-up midwife supported her by being on call during her times off, Belinda had found great emotional support from another midwife in a completely different area of the country. She used this midwife to process issues coming up for her in her practice. Though she admitted that her ideal midwifery partnership would be to practice together with this midwife and moving to more shared ways of working together, she was happy with the arrangement she had.

I have that great collegial support, but far away, and excellent and serviceable collegial back up on the ground here - Belinda.

Though the midwives described working with colleagues as having many benefits, they also recognised areas which they found difficult. Practice partners called into a situation where the original midwife could not attend sometimes made different decisions than the ones the original midwife would have made. At times this resulted in uncomfortable feelings, though not usually open conflict.

She is a lot more medicalised than I am and she hasn't been practicing as long, but it enables me to get weekends off - Abby

She does a great job, but it's really a different style, so it doesn't always suit my clients. So it isn't always seamless and that makes it a bit trickier to go away, like when I'm on a shift and a woman calls then I'm a bit like 'oh damn, missing that'- Belinda.

Belinda supplements her income by working in a local hospital where she is unable to leave until the end of her shift. The issues she encounters in relation to this are applicable to any time a midwife cannot attend her own clients.

Though the midwives were aware of these issues, the overwhelming sentiment from the midwives was of gratitude for their practice partners.

Professional relationships also encompass more than just practice partners and back-up midwives. One of the midwives was very clear that being careful about what she decided to invest her emotional energy into helped her sustain her practice. She talked specifically about the midwifery professional organisations and said

... but they are only powerful if I give them that power…so that's one thing that helps me survive, it's just thinking well, you know, I'm not going to take on that - Abby.

She expressed feeling that her professional organisations were not supportive of her during difficult times, but rather had processes that she felt produced excessive stress for her. She therefore engaged more judiciously with the professional bodies and interacted with them solely to maintain her professional obligations.

In summary, relationships with other professionals was another source of satisfaction for the midwives. Back up midwives allowed the primary midwife to take time off call, but also created a place where discussions regarding clients, or midwifery situations could take place. Though the relationships could be tricky at times the midwives expressed a feeling of getting satisfaction from the professionals around them.

Family and personal life

Moving away from the concept of my essentialness - Belinda

Taking time away from being on call to spend with families and friends was an important factor in satisfaction. The impact of being on call affected not only the midwife herself,

but also her family and friends. The midwives also discussed how they survive when times get tough and what is needed in order to get through those times. Looking after yourself as a midwife, and getting through the struggles allows a better balance and greater overall feeling of satisfaction.

Family and friends were seen as a very important part of keeping work life satisfying. The need to take time to spend with people outside midwifery was noted more by its absence than its presence with the midwives, and also with their colleagues.

(there are) ongoing effects of the tiredness from the backup who didn't take her time off… - Cathryn.

Taking time off to spend with children was seen as especially important, though at times easier to justify. To take time off because your children needed you was seen as more legitimate than the need to take time off to spend time with your partner or just with yourself, and therefore an easy trap for a midwife without children to fall into.

unfortunately for me it's come almost too late, because my family has left home – it's just the two of us at home - Cathryn.

The impact on families was seen as very significant.

We've (all) missed something really important that we really should not have missed. And we all have big regrets about that. We had to be there for a woman in labour, we just had to be because she was so important, (but) those women wouldn't remember who we were - Belinda.

The midwives discussed the realisation that case loading midwifery can encompass your whole life if you allow it to. With time spent in practice all these midwives felt that family and time away were important.

There is more to life than being at the birth, it's caring for them before and after, and it's looking after yourself, and looking after your family, because they come second best so often, your family - Cathryn.

I am aware that I'm not only a midwife, I'm a woman as well, and there may be times in my life when being a midwife for other people is to the detriment of myself - Belinda.

Concern was expressed by one midwife regarding a new graduate in her practice. Cathryn commented that a colleague appeared to be finding most of her satisfaction from her client contact.

We have a new grad from last year, she just gives 150% to everyone and she is going to burn out - Cathryn

Cathryn expressed concern that the new graduate was not balancing time with her family well, and was having too much focus on her clients and working life. The ability to balance work with family life may be something that is developed over time.

All of the midwives interviewed used their time off to get "out of town". The necessity of being away from cell phone contact, or somewhere where they were not physically able to continue being involved in their clients' care was discussed by all three midwives. When they stayed in town some midwives felt a desire to just 'flick on the phone' and see what was happening even while off call, and this led to getting drawn into being more involved in situations than they wanted.

If I'm in town I find that I just stay on call for births - Abby.

Being off call may not mean that you are no longer thinking about your clients. Even when physically away from work these midwives commented that clinical issues can consume many hours of thought, even when they are not with the client.

sometimes a clinical problem sits with you mentally all the time, you know you're only seeing that woman once or twice a week, but you're thinking about them all the time - Belinda.

Though reflection and discussion about challenging clinical problems can help process them, sometimes it is only distance from the situation that helps, either by time, or by location.

only discharging that family was what resolved it for me - Belinda.

The professional relationships the midwives had built, allowed for time off, but with that can come the struggle that another midwife may be there for the clients' birth.

Experience helps you learn that you're not the be all and end all for your clients - Cathryn.

Even where the back-up relationship was described as not completely ideal, the midwives interviewed felt that their clients would be given appropriate care. They discussed the thought processes that led themselves into staying on call.

> *This idea that my clients have a great birth only because I'm there, I think is a real trap* - Belinda.

> *It came down to looking after ourselves, first because the women were always going to get well looked after, and it wasn't the end of the world if they didn't have us* - Cathryn.

One of the struggles discussed by the midwives that decreased satisfaction levels was the ability to manage their caseload effectively. Though the midwives had an ideal number of clients they worked with per month, in the location they were practicing this was difficult to regularly obtain. The midwives perceived the area to be well supplied with midwives to the point where maintaining a case load was becoming difficult.

> *the other (midwife) had decided to become a core* (hospital based) *midwife for personal and financial reasons* - Belinda

> *she was my practice partner and she felt she wasn't getting enough clients so she changed things around* - Abby

Sustaining a work load where you have enough clients to fulfil any financial obligations you have, but not exceeding your desired workload was seen as very tricky, especially in the area these midwives were.

> *So now sometimes I might take a bigger month than I normally would have because I might also have a smaller month. And I'm not the only one doing that, it's become a bit difficult. I know someone who would never…, but has taken nine (clients) in one month because she ended up with nobody for a month* - Cathryn

So in this area there were some midwives unable to feel control over their caseload size due to difficulty finding clients. This was affecting their satisfaction levels by increasing their stress levels, both from the workload demand during the busy months, but also from the increased stress due to financial worries.

When faced with struggles, the midwives interviewed relied on their practice relationship and family, but also discussed the idea of having inner strength that has been built up over

time in order to sustain practice. Though some of the midwives had specific things they did to relax, Abby found that when the job got really tough those kinds of things didn't do much to help. She had experienced loss of a client's baby and reflected on what helped her during that time. She commented that at the immediate time some knowledge of what helps you relax and unwind was not very helpful.

> *I love gardening and being outside and mowing the lawn, and little things boring like that, but if I have a baby that dies I don't think 'oh, I'll go and mow the lawn* - Abby.

She believed that having a strong spirit was important, and that came with life experiences.

> *I don't think that it's something that you do at the time, I think it's something that you learn with life, with the hard things that happen in life* - Abby.

There were many aspects to looking after themselves that the midwives discussed. Taking time off and needing to turn off from any client contact was seen as important by all the midwives interviewed. This included making time for friends and family, especially children, but also time for oneself. When discussing ways of dealing with struggles the midwives commented on the idea of inner strength, which may need to be cultivated, in order to survive the difficult times. Overall the sense from the midwives was one of needing to have a balance in your life; that it was easy to allow midwifery to take over your life, though with systems and safeguards in place it allows for a very satisfying lifestyle.

Summary

The midwives were satisfied with their jobs and discussed three main areas relating to this. They stated that much of their satisfaction came from their interactions with clients and their families. In particular, feeling that they had somehow made a difference in other peoples' lives was something that the midwives found rewarding. Ensuring a good client relationship was described as so important that some of the midwives would consider any relationship issues before committing to work with a client.

Practice partners and other colleagues give midwives physical support, including time off, but also contribute emotional support. The midwives felt that time off was very important, and therefore their relationship with their practice partners was seen as vital. However, different colleagues could fill different roles and even midwives at different ends of the

country were seen as part of a support network. Though one midwife had her ideal practice arrangement, the other two midwives felt that though not perfect, they had good working relationships with midwives around them, and this was more than satisfactory. It was not seen as necessary to have the perfect relationship with colleagues in order to feel support from them.

Life is not all about work, and all the midwives identified time away from work, with friends and family as a vital piece of their work-related satisfaction. All the midwives took some time off call, and they all took time out of town. This time to refresh and recharge was identified as vital to continuing to look after oneself and having the energy and desire for the job.

Discussion

This data supports and expands upon current literature. In this chapter the areas that affect satisfaction will be discussed and linked to the recent studies. Relationships were vital to these midwives' satisfaction, but there was also awareness that these needed to be contained to ensure the midwife also had time for personal needs. The findings suggest fluidity in areas identified by the midwives as important to satisfaction with changes over time and with differing experiences. In this chapter I will further address the concept of the inter-relationship between all the areas of satisfaction and the idea of midwives' individuality will also be discussed. The strengths of this study will be identified along with a reflection on aspects of the study which have led the researcher to make recommendations for further research. Overall the data presented by this research will be discussed within the context of the current literature.

Observation of the blurring of work and non-work

Initially this research project began by looking at the midwives' descriptions of their work life, and work satisfaction. On re-reading and further reflection it became apparent that, for these case loading midwives, it was very difficult to separate work satisfaction from overall life satisfaction. The important findings produced in this research showed that the line between work and non-work was blurred and unclear. For example when talking about how she arranged communication with her clients, Belinda discussed how different styles of contact she used affected her time with her family. For the midwives interviewed this distinction between work and non-work was not discrete and although work and non-work is described separately in this research, in reality they were interdependent.

Midwifery relationships

Relationships with clients and others

As found in other studies, much of the satisfaction for these midwives came from their relationships and connections with other people (Engel, 2003; Kirkham et al., 2006; McAra-Couper et al., 2014; Sandall, 1997; Sandall, 1999; Sullivan et al., 2011). The midwives discussed their relationships with their clients, their professional groups, and with others in their lives, rather than any of the components of midwifery care in itself, as being highly satisfying. As Abby stated, it was the community that was satisfying her, not the act of catching the babies.

Midwives are recognised as *agents of change*, for example by promoting breastfeeding and decreasing smoking in pregnant women (Fahy, Kable & Meedya, 2010; McLeod et al., 2003). The midwives in this study identified the role of supporting women as they make healthy changes as one which provided them with satisfaction. Empowering their clients to make positive changes allowed the midwives to feel helpful not just to the woman and her family, but also to the entire community.

While providing support for their clients it also imperative that midwives support, and feel supported by, their families. Similar to struggles in relationship with clients, relationships with family that did not meet expectations, or that faltered in some way decreased satisfaction. During the discussion the midwives raised issues around the conflict between relationship with clients and relationship with their family – especially midwives with children - and they commented that this was a source of concern. The midwives discussed how to balance this, noting that perhaps the balance was one of the things you developed with more time and experience. These midwives used strategies similar to those in the current literature, such as setting boundaries (McAra-Couper et al., 2014; Scott, 2012) and found them helpful to support a satisfying family life. The midwives felt that strong family and friend relationships helped with maintaining their satisfaction.

Boundaries

Paradoxically it was the relationships with women that both gave the most satisfaction, and produced the most stress; this accords with other studies (Engel, 2003; Wakelin & Skinner, 2007). These midwives discussed the idea that their clients nurtured them in the same way they hopefully nurtured their clients, but they also commented on the idea that if the availability for contact was not well contained within set boundaries the relationships with women could encroach onto their personal lifestyle at times when it was not urgent or necessarily welcome. The midwives decided how to manage this situation with techniques specific to each of them. For example Abby made sure she took significant time away, Belinda used a pager rather than a cell phone and Cathryn had built a strong practice of supportive midwives to share the work demands. These strategies ensured the midwives continued to feel satisfaction from their client relationships.

Like midwives in many previous studies, these midwives discussed having professional boundaries that work for both the midwife and the client (Brown & Dietsch, 2013, Engel, 2003). This was expanded on in this study by two midwives saying that once they set their boundaries if they encountered a client and found that she was looking for some other style

of care, that rather than change their boundaries for that client, the midwives would refer on and ask the woman to find another midwife. Boundaries set by midwives can increase longevity in practice and are associated with greater satisfaction levels (Brown & Dietsch, 2013). The area these midwives worked in was seen as having a number of excellent alternative care providers and therefore to refer the client on was not perceived as disadvantaging her in any way, rather it allowed the midwife to maintain her practice longevity and satisfaction levels by honouring her own boundaries.

Family and personal

Time off

Boundary-setting was one of the two practical points all of the midwives discussed in their interviews as being significant to their satisfaction levels. The other was taking time off. As mentioned in previous studies (Cameron, 2005;Wakelin & Skinner, 2007) time off was seen as vital to ensuring longevity in practice, and the ability to 'take a break' and spend time away also allowed these midwives to remember that they had other functions in their lives– a parent, a partner, and also a woman with personal needs. The midwives described taking this time in a way that inferred a type of midwifery recharge – where they could relax, let go of past concerns and then remember the reasons they did the job, and the joy they got from it. As in previous studies these midwives discussed the feelings of letting the client down if they weren't at the birth (Engel, 2003; McLardy, 2002), but they had realised that time away from work was more important to their continued ability to practice than being the attending midwife at all of their clients' births. Time off was also felt to reduce exhaustion levels, the main factor identified by Wakelin and Skinner (2007) as the reason to leave practice, and was specifically seen by Cathryn as contributing to the disintegration of an earlier practice partnership. Client expectations regarding issues such as time off were managed by discussions between the midwives and their clients in the initial visit.

Control and autonomy

Though autonomy was not mentioned directly by any midwife there were indirect comments made regarding midwives not being completely satisfied with the way their back-up midwives would deal with situations arising while they were off call. This concern may originate from the concept that the interviewed midwives had a particular practice style that they liked working within. Previous research highlighted the link between professional autonomy and job satisfaction (Casey at al, 2010; Curtis et al., 2006). The presence of individual style and the resulting conflict with other midwives who have different styles is an indication of the autonomy that these midwives experience. All of these midwives had been working as autonomous practitioners for over eight years, which may be why their autonomy was not specifically mentioned, but rather taken for granted. It was not until the midwives worked with another midwife with a different style that the conflict arising highlighted the different choices that midwives can make. This conflict of styles demonstrates the midwives individual autonomy that perhaps they have begun to take for granted.

Sandall (1997; 1999) demonstrated the link between having control over one's workload and a decreased risk for burnout. It is not a very big leap to suggest that if midwives have decreased burnout then this may be linked to increased satisfaction. Though some of the nature of the job as a case loading midwife is out of your control, (for example events such as miscarriage, pregnancy loss and the timing of labour happen unpredictably), these midwives raised another concern relating to control over workload. They saw their geographical area as being 'well supplied' with midwives which created a flow-on effect of difficulty in managing client numbers. Midwives discussed being in a place of 'taking what you could get', at times having what they described as very high numbers one month to make up for a shortfall of clients from other months. This need was financially driven as some midwives are sole providers and have to make enough money to support their family. This resulted in the midwives describing times of greater stress than normal, and a significant decrease in satisfaction levels. Though adequacy of remuneration was not specifically addressed in the interviews, it could be inferred from statements about caseload considerations as mentioned, because for case loading midwives in New Zealand remuneration is tied to client numbers.

Building resilience

Internal qualities for sustaining practice were suggested to be of prime importance by the midwives in this study. This belief was also found by McAra-Cooper et al. (in press). Klein (2009) stated that though there can be external factors affecting midwives' satisfaction, for example how the midwife arranges her time, it is always the way the midwife internalizes her job which allows for either job satisfaction or burnout. Though all the midwives identified specific actions they took, or things that helped when practice got tough, they also commented that it is an underlying strength that allows the midwife to keep on going. This strength was seen as something that can be enhanced and built over time, but when things get tough as a midwife you either have strength or you do not. Ensuring daily satisfaction even when it does not seem necessary allows this 'satisfaction bucket' to be filled in anticipation of a time when it may be needed. Just as midwives rehearse in order to manage a clinical emergency, it is important to have emotional reserves ready and waiting for times when they are needed.

In general the comments made by the midwives interviewed in this study reflected the current literature. Relationships, both with clients, the community and other professionals were seen to increase satisfaction. Maintaining healthy work and lifestyle parameters for example taking time off and having set boundaries with clients was also mentioned by the midwives as affecting satisfaction levels. Different personalities and/or differing experiences as a midwife and as a woman may be the reason why midwives placed different significance on the individual aspects that increased satisfaction. Understanding that factors that affect satisfaction can be different between midwives is important to allow individual midwives to find their satisfaction in their own personal manner.

Fluid, interdependent parameters

While these results have been presented as static parameters, they are interlocking and interdependent. The importance each midwife attributes to each aspect of satisfaction is also fluid and changeable between different midwives, with differing experience, with different life events and due to any number of other factors. For example, from the midwives interviewed it was possible to discern that Cathryn was finding significant satisfaction in her relationship with her practice partners, however Abby discussed more the wider community she was involved in as her source of satisfaction. The place where one midwife finds her balance can be very different from another midwife, and the

variation is important to recognise and accept. Further research to confirm differing areas of satisfaction could be carried out in the future.

It also important to recognise the likelihood that over a midwifery career the areas and the balance where midwives obtain satisfaction may significantly change. Cathryn discussed concerns regarding a new graduate in her practice that she perceived at risk of burnout from investing significant time into her client relationships. Yet it may be possible that when just beginning midwifery practice, the amount of satisfaction received from client interaction is extremely high, making up for deficits from other areas. This concept opens up the possibility that over time the satisfaction received from client relationships may decrease and then balance with different factors which allow midwives to maintain their satisfaction.

It is vital to be aware that there is no one correct or best place for midwives to draw from in order to fill their 'satisfaction bucket', however it is important that each midwife remains satisfied with the personal mix that works best for them.

Reflections

Strengths of the research

Qualitative research tends to create very detailed and rich data and this research was no exception. The qualitative descriptive methodology allowed the results to be presented as spoken, with little interpretation or adherence to a specific theory. These factors make this research a good starting point for further studies in the area of midwifery practice satisfaction. The reliability of the data was confirmed by returning the transcripts to the midwives for member checking, ensuring that the data received from the midwives was a true representation of their thoughts and feelings, thereby reducing the chance of errors and incorrect interpretations.

Limitations

As a small contribution of qualitative research this study was not designed to be generalisable to all midwives, however a sample size of greater than three may have produced additional insights. Whilst all midwives who responded to the initial information and subsequently consented to participate were included in the study, opening the study to other geographic areas, or to midwives with less working experience may have allowed further topics and increased detail to come to light. In particular it might have enabled further enquiry into changes over time in relation to what midwives find most satisfying.

Results containing different information might have been obtained if the interviews were conducted face to face, or in a focus group setting. While one type of information is in no way better or more accurate than another, it is necessary to be aware that the style of the interview could have affected the data obtained.

Further research

This study was focused on a specific style of midwifery, in a small geographic area and as such produced results linked to those midwives. Further studies could be conducted with a larger sample size, from differing locations, different working styles, midwifery autonomy and possibly different countries. Future research could be conducted exploring differences in where midwives find satisfaction over time in their working life, and could investigate in depth the relationships that midwives form with their clients, noting differences between urban and rural for example. In light of some comments from participants further research could also look at midwives' experiences of interactions with their professional organisations.

Recommendations for practice

The idea of job satisfaction and where this is obtained personally may not be something routinely considered in daily life as a midwife. The importance of this study is to help midwives identify the specific areas within both their work life and personal life that increases their satisfaction. As well as increasing daily satisfaction with their working life, adding to a 'satisfaction bucket' to be used if needed during the struggles that everyone faces in working life may help increase midwifery retention, and allow midwives a more enjoyable work/life balance.

The acceptance of the different ways midwives find satisfaction, and the thought that these ways may change over time is important to be aware of, especially when working in group practices, or in other areas where midwives interact. This research demonstrates that it is important to allow midwives to find their own balance point for satisfaction, and to remain open to accepting that changes that may occur over time and with differing experiences.

Summary

The findings of this study support current literature and present a new way of looking at the factors that increase satisfaction levels for case loading midwives. Client relationships, professional relationships, looking after oneself, boundaries, time away from work and control over work decisions as well as recognising inner strength and resilience were all identified by the midwives as significant factors.

As important as realising what specific things increase satisfaction for midwives, it is also necessary to recognize the interaction between the factors and the individual differences of the midwives. The amount of satisfaction each midwife gets from any one specific area will be different between midwives. One midwife may most highly value the interaction with her peers, while another finds most satisfaction from interaction with her clients. These areas where midwives find satisfaction may also change over time and with different experiences – and knowledge of that change and these differences may allow midwives increased understanding of themselves, their practice and others.

Conclusion

. The aims of this study were to find common factors among midwives that lead to increased satisfaction and identify what helps midwives maintain satisfaction and fulfilment in their jobs. Maintaining satisfaction levels of experienced midwives is one way to increase the chance of experienced midwives remaining in practice. This research shows that midwives discuss relationships with women and colleagues as an area where they received satisfaction, however boundaries need to be placed on these relationships in order for the midwife to also maintain time off and personal distance.

The three New Zealand case loading midwives interviewed in this study also identified relationships as both leading to satisfaction, and causing tension in their professional life. They discussed the need to develop close relationships with clients, but to contain these within firm boundaries. Time off was seen as important to remember that the midwives had more dimensions to their life than just work, as mothers, wives, and friends - and that these roles needed important time in order to be preserved.

Each midwife will find a personal balance of satisfaction areas, which may change with time, experience and personal factors. It is important that midwives be encouraged to recognise their personal satisfaction levels, and to be able to identify areas where they could look if they want to improve their satisfaction.

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Appendix I

Ethics Approval

3 December 2012

Megan Koontz
Midwifery
Otago Polytechnic
Private Bag 1910
Dunedin

Dear Megan,

Ethics 528: Factors linked to increased satisfaction for New Zealand Case Loading Midwives

Thank you very much for your communication with the changes made as requested by the Otago Polytechnic Ethics Committee, your reply was very helpful and thorough.

We agree that you have addressed all of the issues we had concerns around and have approval to proceed with your research.

Our only request is that you cross check your spelling and grammar on your information sheet:

> "The interview should take about 1hour and there will specific questions however here will also be ample time for your ideas and comments or to discuss any matters that you feel need further attention. The interviews will be audio taped. Information will be transcribed and then returned to you for comments and to check for accuracy before including in final results. You can withdraw from the study at any time until you have reviewed your transcript, and you may decline to answer any questions or make to any comment. The final results will be"

We wish you well with your work and remind you that at the conclusion of your research you should send a brief report with findings/conclusions to the Research Ethics Committee.

Sincerely,

Linda H Wilson
Chair - Ethics committee

Research Ethics Committee | Private Bag 1910, Dunedin 9054 | Freephone 0800 762 786, Phone +64 3 477 3014, Fax +64 3 471 6861 | info@tekotago.ac.nz, www.otagopolytechnic.ac.nz

Appendix II

Information Sheet for Midwives

Thank you for taking the time to read more about this research project. My name is Megan Koontz and I completed my Midwifery degree in Christchurch in 2001. This project is part of a Masters Dissertation through Otago Polytechnic, which I am hoping to complete by 2014. I currently live in California, USA and I do not have any specific ties to the Otago birthing community.

Aim

The aim of the research is to examine ways to improve the satisfaction levels for New Zealand case loading midwives. Recent research has focussed only on the challenges of maintaining a case load while also ensuring enough personal time, and energy for the midwife. This study will focus on the aspects in midwives work and home life that help maintain satisfaction levels. All participants will have more than 5 years case loading experience to ensure information is obtained from midwives who have longevity in their practice. The aim is to identify if there are consistent factors which will increase the working lifespan of midwives in New Zealand.

Data Gathering

The data for this study will be gathered in one-on-one interviews. Due to the overseas location of the researcher these will take place over the internet with either Adobe Connect or Skype, at your preference. The interview should take about 1hour and there will be specific questions, however there will also be ample time for your ideas and comments or to discuss any matters that you feel need further attention. The interviews will be audio taped. Information will be transcribed and then returned to you for comments and to check for accuracy before including in final results. You can withdraw from the study at any time until you have reviewed your transcript, and you may decline to answer any questions or to make any comment. The final results will be mailed to you and copies of the thesis will be available by request.

Confidentiality

This research project has been reviewed and approved by the Otago Polytechnic Ethics committee. All information gathered will be kept under password protection until destroyed, 7 years after completion of the project. Any names will be changed and other

identifying information (practice name or location) will be altered as much as possible to maintain anonymity, however as the Otago birthing community is small, it is possible that people may be identified from comments made. In order to reduce the chance of this happening, you will have opportunity to read and alter your transcript prior to any data analysis. Please use your discretion when choosing to share information.

Acknowledgement

In appreciation for your time a voucher will be given.

My supervisors for this project are Suzanne Miller (suzanne.miller@op.ac.nz) and Dr Jean Patterson (jean.patterson@op.ac.nz) and I welcome you to contact either myself of either of my supervisors if you have any questions about the project.

Megan Koontz (megankoontz@verizon.net)

1426 West Franklin

Ridgecrest, CA

93555, USA.

Appendix III

Confidentiality Agreement

As an aspect of the confidentiality of this entire project, and to enable you to feel open to share information all participants and researchers are asked to sign this confidentiality agreement. It is important that any specifics or identifying information that is discussed during the interview is not shared. Though it is recognised (and in fact, hoped) that information useful to your practice may be obtained from this process, it is important that sharing that information is done without mentioning any identifying data – for example, names, places and any other specific information. As we all know the Otago birthing community, and in fact, the New Zealand birthing community is a small place, and the importance of confidentiality cannot be stressed enough.

Please sign and return this form to the researcher.

I _____(name) recognise that the information shared in this interview is of a confidential nature and will not repeat any indentifying information. Though factual data may be repeated, stories, experiences, places or names and any other identifying information either from current participants, or people referred to will remain confidential.

Signed _____ Date_____

Appendix IV

Consent Form

Factors linked to increased satisfaction for New Zealand Case Loading Midwives

I have read the information sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

I know that:

- My participation in the project is entirely voluntary.
- I am free to withdraw at any time until I review my transcript without giving reasons and without any disadvantage.
- The data (including audio tapes) will be *destroyed* at the conclusion of the project but any raw data on which the results of the project depend will be retained in secure storage for seven years after which it will *be destroyed*. If it is to be kept longer than seven years my permission will be sought.
- Petrol vouchers will be offered as appreciation for my time
- The results of the project may be published and used at a presentation in an academic conference but my anonymity / confidentiality will be preserved.

Additional information given or conditions agreed to

I agree to take part in this project under the conditions set out in the Information Sheet.

..... *(signature of participant)*

..... *(date)*

..... *(signature of researcher)*

This project has been reviewed and approved by the Otago Polytechnic Research Ethics Committee.