Should I stay or should I go?

Case-loading midwives' perceptions of transfer of midwifery care for epidural

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Declaration concerning thesis presented for the Degree of Master of Midwifery

I, Bronwyn Marie Carpenter

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Abstract

New Zealand has a world-leading and unique maternity system. Case-loading midwives known as Lead Maternity Carer (LMC) midwives may care for a woman from pre-conception through to six weeks postnatally. The LMC midwife (or her backup) provides continuity of care in a partnership model throughout this period, sharing responsibility with the woman for maternity care. This service is funded by the government via The Primary Maternity Services Notice (Section 88) of the New Zealand Public Health and Disability Act, 2000, which outlines the responsibilities of the LMC along with the payment schedule for services provided.

The Ministry of Health (MOH) produces guidelines that outline levels of referral for different conditions in the childbearing year. A request for epidural anaesthesia during labour calls for an LMC to recommend a consultation with a specialist. This guideline, and the New Zealand College of Midwives Transfer Guideline, recommend that a conversation takes place between the LMC and specialist about ongoing responsibilities of the midwife in the event of such consultation. Lead Maternity Carers are required, within the terms of their access agreement, to inform the District Health Board (DHB) of their scope of practice with regard to their epidural certification status. The transfer guidelines suggest that the LMC can reasonably expect to continue providing care until the facility has a core (hospital-based) midwife available to take over. The LMC may also choose to stay with the woman in a support role following transfer of clinical responsibility. This statement infers a co-operative approach which may or may not be a reality.

This study used a qualitative descriptive approach in order to explore LMC midwives' perceptions and experiences in relation to transfer of midwifery care for women whose labour choices or needs include epidural anaesthesia. Two focus groups were conducted; one with a group practice who provide continual labour care for women with an epidural, and the other with a group practice

where the midwives transfer midwifery care for epidural to the core midwives at the facility.

The research question was “How do case-loading midwives feel about providing ongoing care when a woman has an epidural in labour?”

Five key themes were evident within the midwives’ discussions; midwifery philosophy, continuity vs. dependence, professional interactions, time for change, and “You can do it!” (the joy of normal). Midwives in both groups felt passionately about their well-considered philosophy and practice decisions. They clearly articulated their objectives for healthy inter-professional relationships in the facility setting.

The midwives who chose to provide epidural care, expressed a growing sense of disillusionment with the perceived inequity in payment for providing what they saw as secondary care as a primary-funded midwife, and therefore - in effect - subsiding the District Health Board (DHB) services by providing epidural care in the interests of continuity with the woman.

Midwives who had chosen not to provide epidural care articulated their joy in being with women having a normal childbirth experience and their ways of keeping a safe space for women to birth. Both groups intimated that payment issues and inequity have created disharmony and tensions regarding this aspect of midwifery care provision, by challenging the philosophy of continuity and questioning some basic concepts about what it means to be a case-loading midwife.

Key words: epidural, continuity of care, case-loading midwives, Lead Maternity Carer, transfer of care, midwifery philosophy, focus groups, qualitative descriptive.

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Table of Contents

Introduction

This research examines the perceptions and attitudes of self-employed case-loading midwives towards transfer of midwifery care in labour for women with epidural anaesthesia. This transfer of midwifery care tends to happen if the case-loading midwife is not epidural certified and opts to transfer the woman to the care of the hospital team (secondary care). This research also explores the impact on case-loading midwives of transfer to secondary care for epidural in relation to continuity and what self-employed case-loading midwives think about continuing their care of women with epidural.

For the purpose of this research, the self-employed case-loading midwife may also be defined by the Aotearoa New Zealand descriptor of Lead Maternity Carer (LMC) and these terms will be used interchangeably throughout this thesis.

The history of the Aotearoa New Zealand context is explored in Chapter 1 as well as a personal perspective of this practice dilemma. The interface of primary and secondary care at the local level is also considered in this section.

Chapter 2 sets out a comprehensive review of the literature regarding transfer of clinical responsibility in Aotearoa New Zealand and internationally. The literature is also examined from the point of view of women (consumers of maternity) and of case-loading midwives. This literature review sets the scene by for the justification for the way the data was collected.

The research methods used for this investigation are explained in Chapter 3, exploring the purpose for choosing the research approach and setting up the framework for the study. Ethical issues are discussed in this chapter as well as the Ethical Approval process. The details of the data collection are described, and the analysis of the data is presented. In the next chapter the findings are considered.

Chapter 4 sets out the findings from the research, and it is here that the voices of the participants are heard for the first time. Themes from the data collection are drawn out and discussed in this chapter.

The discussion section in Chapter 5 considers the implications of this study for midwifery practice. Strengths and limitations of the study are considered as well as opportunities for further research.

Finally the conclusion chapter gives a synopsis of this study.

Chapter 1: Background to the research

In the urban and semi-rural location in Aotearoa New Zealand where I live there are two choices for midwife LMCs working as self-employed case-loading midwives in providing care in relation to epidural anaesthesia. This may be different in other parts of the country due to the regional arrangements of various DHBs. One option is for the LMC midwife to be epidural-certified and to continue care of her client if epidural anaesthesia is requested by the woman. This has implications for midwives. There are potential problems including tiredness if the labour is long as well as possible financial compromise if payment (out of the birth module) is required for the backup midwife. The second option is for a midwife to opt not to be epidural-certified and to transfer clinical responsibility to secondary services at the hospital should the woman request an epidural. The LMC may either leave her client in the care of the hospital midwife with the option of returning for the birth or stay as 'support person' for the woman if she chooses. The first option offers continuity of care for the woman, the second may or may not include continuity. Geographical location of the case-loading midwife's practice can have an impact on the midwife's decision around this aspect of care. For this research, I studied how two practices of urban LMC midwives, one group epidural certified and one group non-epidural certified, feel about this issue of transfer of clinical responsibility for epidural.

This thesis came about because I could see the desire of midwives to do the best for their clients while also wanting to sustain their practice in the longer term. I observed from my perspective as an LMC and as a core midwife that LMC midwives were staying on for overly long labours, becoming exhausted and disillusioned with midwifery and in danger of professional and emotional burnout. I felt this way myself at times. I saw other midwives handing over care at a critical point in their client's experience, sometimes feeling upset that they were unable to continue care with that woman and feeling detached from the rest of that woman's birth experience. I began to wonder how we, as midwives, could do this better and the seeds of the idea for this research were

planted. My creativity was awakened, and my thoughts of frustration gave way to a drive to complete research that might make a difference for midwives and for women.

1.1 History of the Aotearoa New Zealand context

New Zealand's maternity system had become increasingly medicalised and birthing women moved almost exclusively to the hospital environment in the years between 1920 to 1990 and in much the same way as other westernised countries, came under the control of the medical profession. Midwives were almost overwhelmed by this system both from a political and educational perspective, and midwifery nearly became subsumed within nursing regulations (Grigg & Tracey 2013; Pairman, 2010; Pairman & McAra-Couper, 2015). Midwifery identity had almost become lost and midwives sought to have their professional status as the experts in normal maternity care (in line with international definitions) restored through legislative changes (Pairman, 2010; Pairman & McAra-Couper, 2015). This regaining of autonomy to set up a new regulatory body separate from nursing, govern education for midwives and have independence as a profession only came about because of the partnership with women politically (Pairman, 2010; Pairman & McAra-Couper, 2015).

After a lengthy campaign by midwives and maternity consumers, Aotearoa New Zealand's maternity system saw revolutionary changes in 1990. The law was amended to restore to midwives the right to care for women in the childbearing year under their own authority. Following the 1990 Amendment to The Nurses Act of 1977, midwives regained autonomy (Grigg & Tracy, 2013; Guilliland & Pairman, 1995; Pairman, 2010; Pairman & McAra-Couper, 2015) and were again able to take responsibility for the care of women experiencing a normal childbirth experience. The LMC midwife may care for a woman from pre-conception through to six weeks post-natally. The case-loading midwife (or her backup partner) provides continuity of care in a partnership model (Guilliland & Pairman, 1995) throughout this period, sharing responsibility with the woman for maternity care. This service is

funded by the government via The Primary Maternity Services Notice, initially via Section 51 of the Health and Disability Act, 1993 and more recently, Section 88 of the New Zealand Public Health and Disability Act, 2000, which outlines payments and responsibilities of the LMC (Ministry of Health [MOH], 2007). The Primary Maternity Services Notice (Section 88) is the contractual agreement for primary maternity care in Aotearoa New Zealand whereby all women can have the opportunity to have a fulfilling outcome centred on practice that is "safe, informed by evidence … based on partnership, information and choice" (Ministry of Health [MOH], 2007, p.1003).

Other midwives involved in maternity care provision are the valuable staff who provide care for women who are in hospital for part of their childbirth journey. The midwives working in an employed situation in hospitals and birthing units work rostered shifts, in full or part time capacities. They support the work of the self-employed case-loading midwives at various times during the antenatal, intrapartum and postpartum phases of care for the woman (Pairman & McAra-Couper, 2015). These midwives are known as 'core midwives'. Of the 3,023 midwives registered to practice in Aotearoa New Zealand in 2016, 36% identified as case-loading midwives, and 50.7% as employed midwives (Midwifery Council of New Zealand [MCNZ], 2016).

Continuity of care is the hallmark of the Aotearoa New Zealand maternity system (Grigg & Tracy, 2013). Section 88 states as its aim to "provide the woman with continuity of care through her LMC who is responsible for assessment of her needs, planning of her care with her and the care of her baby" (MOH, 2007, p.1033).

The Ministry of Health has published guidelines for referral to specialist services that outline levels of referral for different conditions in the childbearing year, some of which recommend the offer of referral to a specialist (MOH, 2012). These are commonly known as 'Referral Guidelines'. The New Zealand College of Midwives has also produced 'Transfer Guidelines' in 2008 recommending that a conversation takes place between the woman, the LMC and secondary care provider about responsibilities of

the midwife in the situation of epidural care transfer (New Zealand College of Midwives [NZCOM], 2008). Lead Maternity Carers are also required, within the terms of their access agreement, to inform the District Health Board (DHB) of their scope of practice with regard to their epidural certification status (NZCOM, 2008). The New Zealand College of Midwives further states that it is also reasonable, after timely notice is given of request to transfer care for epidural, to carry on with that woman's care until the DHB facility has a core midwife available to take over. There is provision for the LMC to continue in a support role for her client even when clinical responsibility has been transferred to (and funded by) secondary services. Transfer Guidelines further state,

> "It is ultimately the LMC's decision on her ability and willingness to continue or not to continue to provide care once clinical responsibility has been transferred to obstetric services. It is acceptable for an LMC to withdraw from care provision if it is her judgement that she has reached the level of her expertise, is tired or has other community midwifery obligations which take priority e.g. returning to rural practice" (NZCOM, 2008, p.9).

This statement infers a co-operative approach which may or may not happen.

1.2 Personal perspective

The reason I have chosen this area of research is because during my sixteen years as an LMC midwife and more recently for over two years as an employed core midwife in both a primary birthing unit and a tertiary facility, I have observed this practice dilemma regarding transfer of care for epidural and potential inequities in the system. The differing ways of practicing appear to create conflict and disagreement on all sides of the decision-making process around epidural certification. Anecdotally, some LMC midwives I have spoken with argue that primary care (as set out by Section 88) does not include epidural care, whilst those who do provide this level of care argue for the continuity philosophy for women. I wanted to find out from research how

midwives felt about this issue and whether this was the reality of practice. Wakelin and Skinner (2007) found that ninety percent of LMCs would work for twenty-four hours before calling in their back up midwife meaning that they may become exhausted and were therefore at risk of leaving the profession because of burnout.

Epidural-certified LMCs and/or their back-up colleagues provide continuity of care throughout potentially protracted labours for women who may have an epidural. The LMC may choose to pay her backup midwife out of the existing budget for this woman:

> "Funding is paid out on a modular basis, the bulk of which is paid out on the labour and birth module. It does not allow any extra funding if midwives need to call for back-up from their colleagues. Under this structure, midwives who call for back-up because they are tired, or miss a birth because they are having some time off, can be financially 'out of pocket'" (Wakelin & Skinner, 2007, p.13).

This implies that continuity of care for the woman is a priority for LMCs with an epidural certificate as they stay to care for the woman, whether she has an epidural or not.

Non-epidural certified LMCs: The LMC who chooses not to be epidural certified - perhaps because of philosophical or geographical reasons - opts to transfer the woman to secondary/tertiary services if the woman requests epidural anaesthesia. The midwife may feel that epidural care is not within her personal philosophy of primary birth or that her rural caseload may require her to be back home for other potentially labouring women. She will be paid the full birth fee as long as labour was established before handover of care occurred.

> "A maternity provider may claim the labour and birth fee if the LMC anticipates that clinical responsibility for the labour and birth is to remain with the LMC and circumstances change and clinical

responsibility transfers after established labour to secondary maternity" (MOH, 2007, p.44).

1.2 Primary/secondary interface at the local level

There may be significant delays in the transfer process from primary to secondary care, waiting for a core midwife to become available to take over care of the woman needing an epidural, especially if the hospital is busy or understaffed. A recent internal audit showed the average waiting time for a core midwife to be available for LMCs requesting epidural handover in one DHB was eighty-nine minutes (S. Matthews, personal communication, 2016). The midwife may choose to stay on as a support person (Ministry of Health [MOH], 2007) or she may go home for rest with the intention of returning for the birth; but in both these cases, the LMC who is transferring care is not required to stay for the standard minimum postpartum period[1] of two hours and the core midwife continues her care of the woman. After transfer of care for epidural, the other option is to leave the facility and not return at all.

In my years working as an LMC and as a core midwife, I have also observed negative attitudes and judgement from core staff towards LMC midwives who are not certified to provide epidural care. Some of this may be due to inadequate staffing levels or this could be a reflection of the values of the facility midwifery staff and/or midwifery shift coordinators or even the potential misunderstanding of the primary/secondary interface. Another cause for conflict may be the perceived unfairness in payment: the epidural-certified LMC midwife is, in effect, providing secondary care, and subsidising the DHB at her own cost both in terms of money and time.

[1] Initial postpartum care: During this busy initial postpartum period, the woman and baby are fed, the paperwork for the birth is completed, the woman's hygiene needs are attended to, the initial baby check is completed and documented by the LMC and the room is stripped ready for cleaning.

This research aimed to find out how midwives feel about this practice issue and why they have come to the decision about continuing or discontinuing care of labouring women needing epidural anaesthesia. Knowing there were potential conflicts in this area I sought to provide an environment that was safe for midwives to openly discuss this practice situation.

This section has presented the context of this enquiry and the practice guidelines specific to Aotearoa New Zealand midwives that help provide safe working parameters. The next chapter will consider the evidence in the current literature both from Aotearoa New Zealand and internationally.

Chapter 2: Literature review

A search of the literature reveals the diversity (or dearth) of studies already completed in an area, the style and type of research available in the world and how it can be related to this project. Extant knowledge can be evaluated to find out if any of it fits with my existing ideas or if there is something new to be applied to this topic. After critiquing the existing information on this topic, gaps in this area were identified; it then assisted development of the research question and the design for the study.

In searching the literature, using databases such as the Cochrane Database of Systematic Reviews, CINAHL, Google Scholar and exploring Aotearoa New Zealand publications, in particular the New Zealand College of Midwives Journal (which gave me national information/research), key search terms were used including epidural, transfer of care, consultation, continuity of care. These key search terms yielded twenty articles for review. After perusing the abstracts, fifteen of these were retrieved as full text once their relevance to my research had been established. Further hand searching of the reference lists of these useful articles led me to a further five articles. Some of the international literature did not translate well to our unique Aotearoa New Zealand setting and was difficult to draw parallels with my topic so were discarded. The New Zealand College of Midwives Journal was the most useful resource as my research is located in the same context and is produced in the same legal and practice framework as this study. As well as the journals, I have used several books on research techniques and texts exploring midwifery relationships and practice.

On discovering that very little previous work had been completed that specifically addressed transfer of care for epidural, the net was cast more widely to explore the bigger context of midwifery relationships with women and the role of continuity and partnership, as well as the primary/secondary

interface. Once this broader context was explored, I focussed more explicitly on what little evidence does in fact relate to my research question.

2.1 Aotearoa New Zealand research

2.1.1 Continuity of care

Existing literature relating to transfer of clinical responsibility in the Aotearoa New Zealand context was located. Skinner (2011) found that most midwives remained involved in the care of women after consultation with a specialist. She commented that no other primary health practitioners provide secondary services to their clients and that "this belief in continuing care, even when risk is identified, was based on the relational nature of midwifery" (Skinner, 2011, p.20). The next paragraph will consider how transfer of clinical responsibility works out in practice in relation to this belief in continuity of care, in light of the literature.

In the situation of transfer of clinical responsibility for epidural, midwives are caught in a dilemma: 'should I stay or should I go?' Does this clinical predicament challenge Aotearoa New Zealand's model of care, the Partnership Model (Guilliland & Pairman, 1995)? The relationship between a midwife and a woman is based on shared trust and respect *and* continuity of care from a known midwife or her back-up midwifery partner (Pairman & McAra-Couper, 2015). The challenge of transfer of care for epidural lies in maintaining a sense of continuity of care for the woman. Although midwives are likely to remain involved in complex scenarios, as asserted by Skinner (2011), it does not appear from the DHB audit undertaken in 2016 (S. Matthews, personal communication, 2016) that all midwives stay involved throughout labour for women who have a clinical situation that includes an epidural. The partnership model, based on the concept of continuity of care, is defined as 'one midwife (or her backup colleague) providing midwifery care throughout the entire childbirth experience' (Guilliland & Pairman, 1995, p.

39). Therefore, the transfer of care situation for epidural in labour challenges the heart of this model, because if transfer does occur, the woman experiences some level of disconnect and discontinuity. It is this that has impelled some of the research objectives for this thesis. How do midwives feel about this? Do midwives articulate their philosophy about this issue to women? How is our midwifery model of care communicated to women seeking a midwife?

Midwives in Aotearoa New Zealand are familiar with articulating their philosophy and explaining their way of working with women. Most case-loading midwives present a profile on the NZCOM 'Find Your Midwife' website that gives a succinct summary of their individual view of midwifery and maternity care. 'Find Your Midwife' is a public website, where pregnant women can search for an LMC who fits with their world view, or for a midwife who is at least available when their baby is due!

The New Zealand College of Midwives has articulated its midwifery philosophy in their publication on their website regarding the Code of Ethics for Midwives, 'The NZCOM has developed statements to explain the underlying philosophy of the profession in Aotearoa New Zealand. These statements are written for midwives, women and the general public to identify the values and beliefs that the profession holds' (NZCOM, n.d.a). These statements outline the functioning of the College's philosophy.

The philosophical position outlined by the College is underpinned by partnership and continuity in protecting normal birth outcomes for women (NZCOM, 2017). The continuity model as set up in Aotearoa New Zealand within the government funded system is unique in the world (Grigg & Tracey, 2013). However, fifteen studies in an international Cochrane review of the benefits of continuity of care, which included 17,674 mothers and babies, showed that for healthy women there were no adverse effects for mother or baby. Women who received midwife-led continuity of care were less likely to have regional anaesthesia such as epidural or spinal, instrumental birth or episiotomy. They also had a higher chance of a spontaneous vaginal birth

(Sandall, Soltani, Gates, Shennan, & Devane, 2016). This is useful evidence suggesting that continuity of care is not only safe but beneficial for women having babies, particularly for low risk women. Midwifery philosophy encompassing continuity has at its foundation a belief in normal physiological birth (Pairman & McAra-Couper, 2015) which is explored further in the next section.

2.1.2 Normal birth philosophy

Davis and Walker's (2010) study exploring the experiences of 48 case-loading midwives, reported several ways that these midwives prepared women for the challenge of giving birth. Having directed them to useful resources, the midwives assisted women to explore their feelings about their upcoming labour, and paid attention throughout pregnancy to enhancing the women's confidence about their ability to grow, give birth to and parent their babies. The midwives communicated belief in the normality of childbirth and women's ability, and strove to create birthing environments that provided an "oasis of calm, privacy and woman-centredness" (Davis & Walker, 2010, p. 606).

The hard work of midwives in creating a safe environment for women to birth may be invisible to outsiders. This philosophy of woman-centred care that midwives work so hard to live and breathe may be unseen by the world as well. This sacred space to birth may be undermined when transferring midwifery care for epidural as the LMC relinquishes her clinical responsibilities to the team at the hospital.

Are midwives abandoning the continuity philosophy espoused by NZCOM if women have complex needs? It would appear from Skinner's Aotearoa New Zealand research that most midwives remain involved with the woman's care even after obstetric consultation (Skinner, 2011). However there are no previous Aotearoa New Zealand studies that look specifically at what happens with a scenario of transfer of care for epidural and the inherent implication of a so-called 'long' labour.

2.1.3 Tiredness and burnout

So how long is a long labour? A 2017 survey (administered by NZCOM to inform the development of a new funding model for primary care, the provisionally-named 'Co-design Funding model') asked 1250-member midwives about their opinions regarding the future funding for LMC work. The midwives who responded were representative of the midwifery population in Aotearoa New Zealand. There was a 64% response rate from current LMC members, and 82% of all respondents were either currently practicing as or had practiced as an LMC (NZCOM, 2017). One of the questions in the survey related to caseload complexity and length of time spent with a woman through her labour and birth. This survey suggests that the majority of midwives deal with medical and social complexity (between 25-50% of caseload being in this category for 77% of respondents). With regard to length of labour, over 58% of LMC midwives stay for 8-12 hours with multiparous women and 54% of midwives spend more than 12 hours with a primigravid (first time) mother in labour (NZCOM, 2017).

Tiredness can lead to a sense of disillusionment and a feeling of being underappreciated for the work that midwives do, and the subsequent physical and mental exhaustion can be stepping stones to burnout. There has been extensive midwifery publication in Aotearoa New Zealand about the effects of burnout on midwives (Young, 2011; Young, Smythe & McAra-Couper 2015) and on the precursors of the loss of midwives to the profession. Warning signs can be picked up by colleagues and family but can be difficult to detect in oneself. A husband, Max, in a study focusing on burnout, said this of his wife,

> 'She has a huge commitment to her women; she goes that extra mile to make sure it is a positive experience for them. That is one of her problems, she cares too much." Max describes a passionate commitment that focuses on "other" to such an extent it becomes problematic for "self." External to the passion of the commitment,

> Max sees this as a “problem” unlike the midwife who is caught up in it, (Young et al., 2015, p.158).

Burnout was the devastating result for the midwives in Young’s study. The passion that sustained them had been snuffed out by exhaustion of being continually available and not having time off from the demands of LMC work, ‘They embraced the ideology of continuity of care wholeheartedly and with little sense of self and no awareness of the need to set boundaries around their care provision’ (Young et al., 2015, p.163).

Is continuity of care in itself to blame? How does an LMC midwife work safely and maintain her longevity in the profession? This question is examined next.

2.1.4 Sustainability and partnership

Should we revisit the nature of continuity and partnership to help midwives remain passionate about their chosen profession and in maintaining a healthy work/life balance? This is a real dilemma for midwives; getting that balance right, in providing continuity of care and yet somehow being able to be absent at times for the sake of their own professional endurance and personal health.

‘Although midwives are now advised to create firm client boundaries to keep their client’s demands in check, it seems the ideological model of “partnership” needs further consideration by women and midwives’, (Young et al., 2015, p.162).

Partnership is a fluid concept, in that women can also have a therapeutic relationship with their back-up midwife when their primary carer is unavailable because of planned time off or illness. Midwives setting out healthy boundaries for care organise this with their practice partners and communicate this clearly to the women in their caseload.

Recent Aotearoa New Zealand research in this area has recommended ways to keep practice sustainable. It is suggested that midwives need to consider ways of working in a practice; negotiating with each other about size of caseload, time off, practice meetings, and having financial arrangements that

are agreeable. Women need to be aware of these provisions before booking. Renegotiating these parameters regularly will help to set up a sustainable way of working (Gilkison et al., 2015).

In exploring the relationship dynamics between a woman and her midwife there is a fundamental need for trust and belief in each other. The woman trusts in the skill of the midwife to keep her and her unborn baby safe throughout labour and birth, and the midwife trusts the woman's ability to birth her baby. It is a reciprocal relationship. Continuity of care is at the heart of this relationship. Midwives practicing in a reflective manner may ask themselves the following questions about continuity. Does the extreme end of continuity mean that the woman becomes dependent on her midwife? Can she birth her baby without her own trusted midwife? Does this then lead to feelings of dependence and loss of confidence for the woman?

Job satisfaction in nurturing healthy relationships is critical to the midwife sustaining her passion for the profession. It is what keeps midwives going. It is what makes midwives leave. As Wakelin & Skinner found,

> 'Continuity of carer both supports the sustainability of practice and yet paradoxically also challenges its sustainability. Continuity leads to the rewards that come with developing trusting and fulfilling relationships with women. At the same time continuity, with the long hours and lack of time for family and friends, can also lead to exhaustion' (Wakelin & Skinner, 2007, p.12).

Aotearoa New Zealand midwives recently took part in a research project to identify what sustained them in LMC midwifery. The study participants declared the most important factor to keep them going in LMC practice was the joy of the continuity relationship with the woman and her family/whanau (McAra-Couper et al., 2014).

How can we set up healthy boundaries on our care as midwives? Clearly this is an issue: 'Although midwives are inspired and sustained by partnership and reciprocal relationships, they also need to negotiate boundaries and ensure

their professional and personal lives are integrated and balanced' (McAra-Couper et al., 2014, p. 30).

The importance of the discussion with women about midwifery philosophy and practice arrangements from the outset is borne out in other Aotearoa New Zealand research. 'Sharing of arrangements underpins the concept of partnership through dialogue that is clear about how the practice works', (Gilkison, et al., 2015, p.13). Setting up boundaries around care keeps the midwife safe, by negotiating time off and having some space in her life for being off call. Women appear to accept this if arrangements are explained from the start of care (McAra-Couper et al., 2014).

Setting healthy parameters are necessary for a work/life balance. In a 2014 in-depth action research study examining work/life balance for sixteen Auckland LMCs, the authors discussed these difficulties of continuity. The participants found that the pressure of personal and professional obligations was difficult to cope with, as well as feelings of guilt in not always being able to be present (Donald, Smythe & McAra-Couper, 2014). This burden of wanting to always be available for the woman but not wishing to promote co-dependency had led to the development of some innovative strategies to help midwives become healthier. Midwifery teamwork can be one of the ways to keep midwives safer in their work with women, to give a better work-life balance (Donald et al., 2014). These authors also developed a tool to help LMCs assess their own well-being (Donald, et al., 2014).

2.1.5 Inter-professional relationships

As well as being part of a supportive team of midwives within a group practice, self-employed midwives also navigate the situation of interacting with other health professionals at the secondary or tertiary setting where transfer of care occurs. In this section I have focused on inter-professional relationships between midwives, as this research is examining the specific issue of midwifery transfer of care.

In a 2010 study which explored the practice of midwife LMCs, Davis and Walker found that midwives negotiated the boundaries of the hospital carefully and the importance of strong collegial relationships was emphasised,

> 'Core midwifery and obstetric staff – those primarily employed by the obstetric hospitals – play a pivotal role in shaping the experience of the childbearing woman in the obstetric hospital. Case-loading midwives participating in this study understand the importance of these roles, and work at establishing relationships that will assist them in providing woman-centred care' (Davis & Walker, 2010, p. 607).

The interface between LMCs providing primary care and the hospital (core) midwives providing secondary care is a delicate meeting point at times. The boundary between the two is often clearly defined but sometimes the lines between them can become blurred. The person at the centre of this crossroad of care is the midwifery shift co-ordinator at the hospital.

An Aotearoa New Zealand phenomenological study published in 2010 investigated clinical co-ordinator's (CCO) experiences on delivery suite, a position also known as 'Charge Midwife' in some centres. Five CCOs from three North Island tertiary units took part in in-depth interviews about their role and the stresses of their job setting (Fergusson, Smythe & McAra-Couper, 2010). The midwife co-ordinators in this study were very aware of the pressures on LMCs as well as the impact of transfer of care scenarios on the workload of the shift. There are comments on the specific practice issue regarding epidural handover during an account of a particular shift by one of the study participants, Jane,

> 'An LMC [Lead Maternity Carer] wanted to hand over at around 4am for an epidural for her client. I didn't have anyone and had to say, "you are going to have to explore other choices for your client because an epidural is not a choice" *Jane* (Fergusson et al., 2010, p. 10).

The study authors comment,

> ‘The LMC has the right to hand over care just as her client has the right to an epidural but neither are realities on this shift. Jane knows this and has to manage this reality the best way she can in trying circumstances’ (Fergusson et al., 2010, p. 10).

Clinical Co-ordinators also see themselves as the ‘hub’ of the birthing suite. These midwife co-ordinators are pivotal in the smooth running of a hospital birthing suite. Additionally, Fergusson et al. noted that effective communication skills are essential for a CCO (Fergusson et al., 2010).

2.1.6 Funding

Current funding within Section 88 does not cover the provision of backup midwifery care in the prolonged labour situation (Skinner, 2011; Wakelin & Skinner, 2007; Young, 2015).

Payments for LMCs are set out under the Primary Maternity Services Notice. Lead Maternity Carers are funded in a modular system where a capped budget is attached to each woman in her care. It is not legal to charge the woman for care provided unless she is not eligible for publically-funded care (Pairman & McAra-Couper, 2015) or the LMC is a private obstetrician. Difficulties may occur if midwives having time off miss a birth, and with the unpredictable nature of birth (the fee for which is more than the other modules) with the result that they may potentially be significantly out of pocket. LMC midwives need to organise cover to attend study days, sick leave, annual leave and backup midwifery support in the event of a long labour or if two women are labouring at the same time; all from the same capped schedule of payments. Often this is achieved in a partnership relationship with another midwife but means that at times each midwife carries a double caseload in a reciprocal way. Some midwives split the fee, but this can leave both midwives financially compromised (Young, Smythe, & McAra-Couper, 2015).

The fee-splitting mentioned above also applies if the midwife who has epidural-certification calls in her back-up midwife to take over if she has been

working an extended period in the case of a long labour. ‘There is a potential lack of safety in extended hours of care which the single fee intimates should be provided by a single person’ (Young et al., 2015, p. 164).

Midwives, funded for primary care, can choose to continue with women’s care in a secondary or tertiary setting, which no other primary health providers do, (Grigg & Tracy, 2012; Skinner, 2011).

> ‘No other primary health providers in New Zealand, such as GPs or dentists, are able to go into the hospital setting (including operating theatre) and continue to work with the specialist team in order to provide continuity of care’ (Grigg & Tracy, 2012, p. e62).

Midwives do this because of the relationship of continuity with the woman that they believe is the foundation of their philosophy (Skinner, 2011). However, continuity at any cost can lead to exhaustion if regular time off and time-out from a busy caseload does not occur.

2.2. Transfer of care

2.2.1 The woman’s experience

Anticipating the possibility of transfer, and the effect on women of continuity (or discontinuity) of care following transfer have been two strong themes from articles exploring the impact of in-labour transfer (Cornally, Butler, Murphy & Canty, 2014; Grigg, Tracy, Schmied, Monk & Tracy, 2015; de Jonge, Stuijt, Eijke & Westerman, 2014; Kuliukas, Lewis, Hauck & Duggan, 2016; Rowe, Kurinczuk, Locock, & Fitzpatrick, 2012). These findings are consistent despite the models of care being quite different across the countries the studies were conducted in.

A recent Aotearoa New Zealand study examined women’s experience of antenatal or intrapartum change of birthplace or post-admission transfer from primary maternity unit to tertiary hospital (Grigg et al., 2015). Four hundred

and seven women were enrolled in this study which found that women who planned to birth in primary units understood the need for these plans to change antenatally or in in labour. Women who transferred from the primary unit to the tertiary hospital in labour found the *decision to transfer* more stressful than the transfer itself. Although the research does not specifically relate to epidural handover and as almost all the women had continuity of care, the findings suggest that if there had been good communication and the women were informed about possible scenarios for care, they can adapt when needed and they have some sense of control in the situation (Grigg, et al., 2013). It is clear that the key to a satisfactory outcome is based on good communication between the midwife and the woman about what might happen if secondary care (including epidural) becomes necessary. Understanding the limits of care that LMC midwives provide (or not) *before* the event appears critical.

While not specifically investigating epidural handover, a study from Australia discussed intrapartum transfer from a Birthing Unit to the Tertiary Hospital (Kuliukas et al., 2016). Although this research was from a midwifery point of view, it also highlights that if midwives are able to stay with their client in a complicated situation it benefits the *women*. 'Continuity of care is known to increase satisfaction for women and in cases of intrapartum transfer, women are known to experience a sense of abandonment in cases where their midwife is unable to stay with them' (Kuliukas et al., 2016, p. 23).

In the Netherlands, midwives providing primary care hand over to their secondary care colleagues if the woman transfers into hospital with any complications. The women are aware of this system in advance and while they would prefer their midwife to stay with them, they understand that if their midwife accompanies them to hospital handover will occur (de Jong et al., 2014). This lack of ambiguity is in sharp contrast to the Aotearoa New Zealand system.

A study from the United Kingdom highlights the stress involved for women who transfer in from a primary setting to secondary services. While not looking

directly at transfer of care for epidural, this study explored how women feel about the process of transfer of clinical responsibility. Semi-structured interviews took place with thirty women who had transferred from a free-standing birthing unit to hospital. Midwives working in a primary setting very rarely continue the care of the woman if transfer occurs. Whilst acknowledging the difference in care models between Aotearoa New Zealand and Britain, a theme that developed from the study was the discontinuity of the whole process for women. When women were handed over at the door of the hospital there was an obvious disconnect from her known midwife. Women gave little thought to this transfer process and it came as a shock to them when it happened (Rowe et al., 2012). On the other hand, if the primary care midwife remained to care for the woman after transfer it made a difference for the woman.

> ‘For a very small number of women continuity between the two settings was maintained because their midwife continued to care for them after transfer. This helped them feel safe in the care of someone with whom they had formed a trusting relationship and meant they had one fixed point of reference and an advocate in a potentially rapidly changing situation’ (Rowe, et al., 2012, p. 11).

The argument to provide continuity of care in labour is further strengthened in an Irish study examining women’s experiences in labour. One of the findings of this study of 360 women who completed a questionnaire within a few days of birth, showed that one of the factors that contributed to a positive experience was “based on a trusting and supportive relationship between the woman and her caregiver, in particular, her midwife” (Cornally et al., 2014, p. 89). Further they concluded that the women were appreciative of the relationship with the midwife caring for them, as well as the expertise and qualities of their midwives (Cornally, et al., 2014).

2.2.2 Transfer of care: The midwife's perception

Midwives across different parts of the world appear to feel a sense of responsibility that they would prefer to remain with the woman when transfer occurs, even if the model they work within does not necessarily support this (Bourgeault, 2000; Klomp, de Jonge, Hutton, Hers & Lagro-Johnson, 2016; Kuliukas et al., 2016).

Research from Australia mentioned in the previous section highlights the feelings of midwives transferring women in from a Birthing Centre to the Tertiary Unit (Kuliukas et al., 2016). Fourteen in-depth interviews were conducted with birthing centre midwives who were involved in intrapartum transfers. This study looked at the emotional aspects of an intrapartum transfer from the midwives' point of view. The transferring midwives felt anxious deciding when to transfer as well as uneasy about working in an unfamiliar facility. They also had concerns about trying to help the woman have the type of birth she had planned. Midwives in this study felt the need for debrief of events afterwards. Healthy communication with the other health professionals involved was seen as a key to 'enhance information sharing and prevent women from feeling alienated' (Kuliukas et al., 2016, p. 22). Midwives in the study felt a deep sense of responsibility for their clients.

The Ontario College of Midwives has a similar transfer/ consultation document to the Aotearoa New Zealand version, outlining clinical situations that warrant consultation with a specialist or transfer of care if more serious. However epidural anaesthesia is not mentioned in their criteria (College of Midwives of Ontario, 2015). Bourgeault (2000) describes the historic struggle for autonomy for midwives in Ontario, concluding that the situation there is similar to the Aotearoa New Zealand context, in that midwives retain the care of the woman who are admitted to hospital. 'Women now have the freedom to choose to have a midwife as their primary caregiver at home or in hospital. Midwives no longer have to transfer care to a physician as they cross the hospital threshold' (Bourgeault, 2000, p. 187).

In a 2016 qualitative research study from the Netherlands with 23 midwife participants within four focus groups, the midwife participants discussed their perceptions of pain relief for women in labour. The midwives felt that '"working with pain" was seen as preferable to providing pain medication or an epidural to women' (Klomp, de Jonge, Hutton, Hers, & Lagro-Janssen, 2016, p. 3). Further to this, the system in the Netherlands means that, 'Pain medication or use of epidural analgesia during labour are only provided in hospital maternity units following transfer to obstetrician-led care. Accordingly, requests for pain medication or an epidural results in a discontinuity of care' (Klomp et al., 2016, p. 6).

There was also a sense from the midwives that when women in their care transferred into a secondary setting for pain relief or epidural, the discontinuity inherent in this was very dissatisfying. They stated that they would like to provide the continuous care for women even in a different setting that included obstetric input (as may happen here in Aotearoa New Zealand for instance).

Midwives in this study also appreciated the participation of partners and support people and noted the value of antenatal education for women and their partner about pain relief and expectations in labour. The authors also comment about the importance shared decision making based on good relationships within the midwifery partnership (Klomp, et al., 2016).

Why this study?

What we know from the literature cited above is that transfer of care in labour is viewed as a difficult situation for midwives and for women. However, little is known about this particular circumstance of transfer of clinical responsibility for epidural care. The decision for women to choose an epidural in labour can be difficult and emotional. The choice that midwives make regarding provision of epidural care impacts on midwives *as well as* women. Given the economic and social implications for women and midwives, a clear gap has been identified that warrants further investigation.

This gap in research is possibly due to the way the maternity system is structured in Aotearoa New Zealand, where midwives have the discretionary

choice of staying involved or transferring the woman's midwifery care during epidural anaesthesia for labour. There is a need for an examination of this practice quandary for self-employed LMCs. This research proposed to record and analyse the attitudes of midwives who provide ongoing care when epidural is requested and those who do not, in order to understand the perspectives of midwives across a range of practice. This may add further knowledge to the midwifery community and contribute to a larger discussion about funding in this circumstance.

Research question:

How do case-loading midwives feel about providing ongoing care when a woman has an epidural in labour?

The aim of the research was to investigate opinions and attitudes of LMCs about transfer of midwifery care for epidural and get a sense of how midwives feel about this issue.

Objectives of the research

- to gain new knowledge about the intricacies and boundaries of being an LMC, particularly in relation to labour care involving epidural anaesthesia.
- to investigate interactions at the primary/secondary interface.
- to potentially inform policy and funding in the future.

With regard for the objectives of my research, I decided on the design for the study in order to meet my research goals. The next chapter will outline the steps I took to identify the most appropriate way to answer my research question.

Chapter 3: Methods

The study design selected gleans rich data from participants and transforms it into an interpretation of a phenomenon. The research method for this investigation sprang from the desire to know how midwives feel about this practice issue. It was important to get midwife participants together to mull over their individual and group philosophies and bounce ideas off one another about the topic. The focus group method is ideal for this type of data collection. Some aspects of the design may be modified as the research process unfolds, such as the option of offering a separate one-on-one interview for any midwife who felt unable to share her feelings in the larger group. This option could be discarded if not taken up by any of the participants.

In deciding the design for the study, it appeared that a quantitative research approach would not yield the type of data necessary to investigate in depth the way midwives work in relation to the phenomenon of epidural care of labouring women. Quantitative research methods might have examined how often midwives transferred responsibility for epidural care or produced descriptive outcomes for women who did or did not receive continuity rather than the meanings midwives attach to their decisions in this area. Because of this, a quantitative research approach would not be suitable for this project so this design was ruled out in favour of a qualitative design method.

The nature of the qualitative descriptive approach is to look at a phenomenon from the point of view of the participants. Milne and Oberle (2005) discuss this type of qualitative research taken from the participant's viewpoint as 'rich detailed data' (p. 413). They also describe purposeful selection of participants because of the participant's ability to inform the topic of interest.

3.1 Qualitative descriptive approach

A qualitative descriptive approach was chosen for this research project (Bowling & Ebrahim, 2005, Sandelowski, 2000; Willis, Sullivan-Bolyai, Knafl, & Cohen, 2016). This research design is a straight-forward way of looking at a phenomenon that has been identified, because there is an emphasis on letting the participant's words speak for themselves (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000). This research methodology was used to analyse dialogue by employing a thematic approach (Braun & Clarke, 2006), categorising ideas presented by participants. Common themes emerge, not just the words from individuals but 'clustering together common ideas from multiple individuals to re-present the data' (Willis et al., 2016, p. 1193).

Codes are developed to make sense of the recorded conversations (Bowling & Ebrahim, 2005, Graneheim & Lundman, 2003). While the qualitative descriptive method is straight-forward there is scope for interpreting the data collected (Sandelowski, 2010) and presenting the findings from the research. A qualitative descriptive approach stays close to the words of the participants, allowing their voices to be heard through the analysis. The final interpretation, if there is any, should be a true reflection of the discussion by the participants. (Neergaard et al., 2009).

3.2 Focus group method

A common method to collect data in a qualitative descriptive approach may be by interviews with individuals or by holding focus groups in order to examine attitudes and beliefs (Willis et al., 2006).

Focus groups are very useful for gaining insight into work cultures particularly in a health setting. "Group processes can help people to explore and clarify their views in ways that would be less easily accessible in a one to one interview" (Kitzinger, 1995, p. 299). Jayasekara further states "the focus group provides a means of listening to the perspective of key stakeholders

and learning from their experiences of the phenomenon" (Jayasekara, 2012, p. 412). It is an effective way of collecting data from a group when the researcher is exploring the opinions and beliefs of that group (Carter & Henderson, 2005; Jayasekara, 2012). This is why the focus group method fits with the type of enquiry for this project. In the first instance, focus groups were offered over one to one interviews as a method for this research, because of the rich discussion and interactions it might produce. One to one interviews were offered as a follow up for midwives whose participation in the focus group led them want to contribute additional insights once they had reflected on the conversation

The focus group method may generate interesting discussion amongst members, where the way they interact may be even more informative than their actual words. These interactions between group members may be valuable to observe and may be more rounded in a pre-existing group (Barbour, 2007) and may therefore promote frank or challenging dialogue. Differences of opinion are just as important as consensus (Carter & Henderson, 2005).

As a naturally occurring group, members will be familiar with the way they typically work, so any participant who says something out of the usual model of their practice will be detected by the other members (Bowling & Ephrahim, 2005; Kitzinger, 1995). Norms and social values may be identified from this method compared to other methods such as one-on-one interviews.

Story-telling may also emerge, more so than in other approaches (Carter & Henderson, 2005). Sharing narratives in midwifery is often undervalued in comparison to scientific ways of knowing (Gould, 2017) but it is arguably a very good fit for the way midwives make sense of their experiences and generate new knowledge. Gould reminds us that "oral traditions [are] at the heart of midwifery practice" (Gould, 2017, p. 44). Focus groups can allow examination of how people understand a phenomenon and why participants respond in certain ways, described by Carter & Henderson (2005) as "…a

powerful tool in the exploration of people's 'frameworks of understanding'" (p. 221).

To collect the data two focus group discussions were facilitated. This involved purposive sampling of two midwifery LMC practices; one practice being epidural-certified (Group A) and the other practice not epidural-certified (Group B). Purposive sampling is a deliberate sampling strategy in which the researcher recruits participants because of their specific knowledge about the phenomena in question (Rees, 2011).

Each focus group had between four and six midwives, depending on the size of the practice and availability of members. With the unpredictable nature of birth and therefore the work of LMC midwives, the numbers in each group could not be determined exactly until the day of the focus group. There was intentional bias in the sampling of the groups, because of the need to explore the views of two schools of thought on midwives' provision of epidural care. Using a qualitative design, it was appropriate to have small numbers. In order to examine the phenomenon being studied in detail (Rees, 2011), midwives from two practices in an urban setting were recruited.

This research was undertaken in one region in Aotearoa New Zealand only and is not necessarily applicable elsewhere, though where the context of midwifery care provision is similar, it could be that the ideas expressed will resonate with midwives in other areas, so a measure of transferability may be possible.

In the next section, the ethical aspects of this research are considered.

3.3: Ethical considerations

The ethical framework involved with creating this research needed to be robust to ensure the protection of both the participants and the data derived from their discussions.

The project was assessed and approved by the Otago Polytechnic Human Ethics Committee following consultation with the Kaitohutohu office (Otago Polytechnic Māori Research Office). This required submission of the research proposal application addressing the ethical considerations and paying particular attention to how the conduct of the research would be culturally appropriate (Otago Polytechnic, 2015; Otago Polytechnic, 2016)

Midwives are not considered a vulnerable population as they have autonomy over their decision to participate in research. Written informed consent (see Appendix 7) was gained from each participant and they were informed that they could withdraw their contribution immediately following the focus group if they changed their mind. Pseudonyms were chosen by the participants to protect their identity in any future academic publication or conference presentation. The transcript files remained confidential to myself as the researcher and my two research supervisors. All electronic data was stored in password-protected files, and hard copy was stored in a locked filing cabinet.

There was minimal risk to participants in taking part in this research. The focus group moderator (myself, as the researcher) was alert to the possibility of participants' over-disclosure in a group situation and the following strategies were in place to offer further support if any midwives become distressed by the discussion of sensitive issues. In the first instance, an offer to temporarily cease recording would be made and it could be restarted if the midwife felt able to continue. Had any midwife become unduly distressed contact details were available for counselling services with the local Employment Assistance Programme (EAP) or NZCOM if required.

Ground rules were negotiated by the researcher and participants at the beginning of the focus group so that members felt safe to discuss the issues freely within the group but not outside of it. Participants were free to decline to answer any question posed to them or to withdraw from the discussion, or request the recorder be turned off at any stage in the data collection process.

However, no participant became distressed during the focus group or asked for a separate interview.

In addressing the particular issues relating to Māori research office approval, I included in my Kaitohutohu application details about the impact this research may have on Māori women and on Māori midwives. While not aimed specifically at Māori, the midwives taking part in the focus groups may have identified as Māori. I was aware of the need to allow these midwives a safe environment to 'have their say'. Te Tiriti o Waitangi needs to be acknowledged in this process and in particular the impact this research may have on Tangata Whenua (Health Research Council of New Zealand, 2010). Whakawhanāungatanga, the establishment of good relationships, is one of the underpinning principles of midwifery practice (NZCOM, n.d.b).

I recognise the partnership of Māori women, both midwife and client, in the birthing process. If Māori midwives took part in focus groups they may have a reluctance to share in this way as there is the possibility they may feel whakamā (embarrassed or shy about offering a personal opinion potentially different to rest of the group) (L.W.Carpenter, personal communication, 2016), however kanohi ki te kanohi (face to face) interactions can usually help with this.

'The Māori ethics framework references four tikanga based principles (whakapapa (relationships), tika (research design), manaakitanga (cultural and social responsibility), and mana (justice and equity) as the primary ethical principles in relation to research ethics' (Health Research Council of New Zealand, 2010, p. 4.) and this research has taken these values into account. I hope that this research will widen our understanding of transfer of care, which may benefit all involved including Māori women, both midwives and wāhine who are giving birth.

With approval in place from the Ethics Committee (Appendix 1) and the Kaitohutohu office (Appendix 2), the next stage in the project involved the recruitment of participants. While the participants were known to the

researcher, there was no direct involvement with them and in particular, was no seniority or power over them or the way they work.

3.4: Planning and recruitment

The recruitment of participants had to be carefully considered, as it was important to be able to have two groups of midwives that were willing to articulate their experiences and feelings on the subject. The midwives were approached by a neutral intermediary, so they did not feel under pressure to take part. Once the contact had been made and the focus groups set up, there was no turning back! The research had begun in earnest.

A letter was sent to two midwife members representing two different practices, requesting that an intermediary person attend a practice meeting of their group, to present this project and request the involvement of the individual midwives in a focus group (See Appendix 3). The intermediary was a well-respected midwife who has worked in the study location as an LMC for many years and more latterly as a core midwife. The two midwifery practices were selected because of the way they work as either epidural-certified or non-epidural-certified midwives. It was important to have the groups meet separately so each participant felt safe to discuss freely the way that she worked. Freedom to talk openly is seen to be a significant part of the process (Milne & Oberle, 2005; Neergaard et al., 2009) as this promotes authenticity in the results.

Consideration was given to conducting a third focus group of midwives who were known to have divergent views on this practice issue, but this did not take place. Creating an environment which could be potentially challenging or adversarial was less preferable than enabling a safe environment for the midwives to express openly how they felt about this issue. This was more easily achieved in groups where midwives practice similarly. A third focus group of mixed views may have jeopardised the collection of rich data.

Both practices responded positively and the meetings for the intermediary to attend were duly organised. The intermediary was provided with a set of instructions about her role in offering the midwives an opportunity to participate (Appendix 4). At each meeting the practice members were given an invitation letter (Appendix 5), information sheet (Appendix 6) and consent forms (Appendix 7) by the intermediary.

The intermediary attended the regular midwifery practice meeting time; practice meeting A on a Thursday morning and practice meeting B on a Monday morning; to make it easy for members to be present to hear the project presented. The intermediary gave information about the research and outlined the midwives' involvement. She gave them some options for dates in the following few weeks for the researcher to attend (again at the regular meeting time) to implement the focus group discussion.

Group A had only two members of the group available to meet with the intermediary as the other two practice partners had been up all night at a birth. However, the whole practice had an opportunity to discuss whether to be involved in this research, and decided they were happy to be involved. A focus group with the entire practice (babies permitting!) was arranged.

Group B met for their regular meeting at one of the midwife's homes. Seven members were present at the meeting and they had unanimous agreement on joining the project. The date for Focus Group B was arranged also.

3.5 Implementation of the focus groups

The focus group session requires attentiveness, time and no disturbances. The long-awaited data collection began, and the project started to take shape. Richard Krueger's book 'Moderating Focus Groups' (1998) was invaluable as I prepared to moderate the two groups. He encourages researchers to be mindful of showing positive regard and respect for participants, moderating *not* participating, guiding and listening rather than joining in the discussion (Krueger, 1998). Further to this 'the researcher(s) should be mostly inconspicuous – often only needing to contribute to commence, prompt

occasionally, and finalise the session' (Schneider, Whitehead, LoBiondo Wood, & Haber (2014). To get the session underway there were some key questions for the Focus Groups. While anticipating the issues of funding and relationships would surface spontaneously during the discussions, the objective was to follow the midwives' conversations wherever that may have led. However, some extra prompt questions were ready if needed, but these were not used.

Key questions:

- What is your usual practice regarding the provision of midwifery care when a woman elects to have an epidural in labour?
- When do you feel it is appropriate to hand over care to core midwife colleagues? Where do you see continuity of midwifery care fitting into this situation?
- Have you always worked in this manner? Have you changed your approach? And if so, why?

The first focus group with Midwifery Practice A took place at a midwife's home with all four midwives in attendance. The room was arranged with seating around a table, refreshments provided, and the recording device set up. Group guidelines were explained, with confidentiality being the cornerstone of the meeting. Midwives are familiar with this concept of confidentiality in sharing clinical details with one another. Written consent was gained. Use of pseudonyms was discussed and the midwives each chose a pseudonym. Then followed a rich and animated discussion which was recorded over the next fifty minutes. It was important that I worked as the moderator of the group rather than a contributor, and I worked hard to actively listen and prompt gently rather than be involved directly with the conversation.

Transcription of the recorded focus group meeting was carried out by me over the following days, as I immersed myself in the dialogue. I felt it was important to transcribe this myself, so that I could become familiar with the flow of the discussion and intonations of the participant's voices, as well as maintaining confidentiality by not involving a third party in this process.

The second focus group was held about two weeks later in the home of one of the participants, the usual meeting place of the practice. The midwives were seated in a circle and refreshments provided. Confidentiality was discussed and they, too, signed consent forms and chose pseudonyms for themselves. The midwives responded with enthusiasm to the research questions, and the recording time was fifty-three minutes. Transcribing the audio recording into text myself over the following few weeks meant I was able to become familiar with the data from the outset (Braun & Clarke, 2006).

During both focus group sessions, I was mindful to not direct the flow of conversation and to be listening actively. I informed each group that I may be taking notes during the session. I did take written notes during the focus group, of non-verbal interactions, as well as any points in the discussion that I may have wanted to go back to if needed. I was only involved in the focus group as a prompt for the next question if talk lulled. Fortunately, all of the midwives were great conversationalists and I barely needed to encourage them to keep chatting. There was no request from either group for a follow-up individual interview.

3.6: Analysis

The data from each of the focus group data was examined separately and codes found throughout the text. Several ideas started to emerge through the spoken language and each of these codes were highlighted in different colours. Repeated listening to the recordings and reading the transcripts enabled familiarisation with the data, ensuring rigour by ‘dwelling’ in the echo of the participant’s words (Braun & Clarke, 2006; Milne & Oberle, 2005). Gradually recurring ideas surfaced as living with the words helped me ‘read between the lines’. The pattern was slowly revealed. Each time the transcript was read different ideas began to interweave together, pulling these codes into themes. This is the method of analysis described by the literature (Braun & Clarke, 2006; Neergaard et al., 2009).

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As well as this, once thematic analysis was underway, the codes and themes were discussed with my academic advisors. This helped me to confirm that the themes aligned with the data and that my process to reach conclusions about the findings was reasonable. This was another way to add credibility to the research.

As described in the literature, 'Analysis involves a constant moving back and forward between the entire data set, the coded extracts of data that you are analysing, and the analysis of the data that you are producing' (Braun & Clarke, 2006, p. 15). An example of how such analysis was undertaken can be shown in the way the theme running through the text regarding the interface with the hospital team was uncovered. Throughout both focus groups with the midwives, many of them spoke of this aspect of their work. The way they networked with the secondary facility staff appeared frequently in the discussions. As this started to emerge a highlighter pen was used to go through the many pages of dialogue that had been printed out and each phrase was highlighted in the same colour where individual midwives had conversed about the way they interact and relate in the hospital setting. Gradually this theme emerged as one of the main themes in both data sets.

A summary of these initial themes for each group was sent to the respective practices for feedback with covering letter outlining the timeframe for this to occur (see Appendices 7, 8.9).

Focus group A responded to feedback by commenting.

> '*I thought the feedback you have presented back to us was very reflective of the discussion held in the focus group meeting. You appear to have a good understanding of how we felt and worked as a practice as well as within the hospital environment in regard to epidural care/handover'* (Pat, Focus Group A).

Focus group B responded to this feedback process by saying, '*the only feedback I have had is that your summary reflects what the group felt they were saying, so that's great*' (Laura, Focus Group B).

3.7 Rigour and trustworthiness of this data

Can this research be trusted? In considering the thoroughness and reliability of this data and also the trustworthiness of my analysis, I have reflected on elements described in the literature that ensure rigour, namely: authenticity, credibility, criticality and integrity. I use these as headings to outline the trustworthiness of this thesis (Barbour, 2001; Colorafi & Evans, 2016; Graneheim & Lundman, 2003; Milne & Oberle, 2005; Neergaard, et al., 2009). The participants are described as fully as possible without compromising their anonymity.

Authenticity: this data was collected from participants who were purposively sampled (as described above) and had freedom to speak openly. It was a safe environment of their peers. The group led the direction of the focus group for the most part. There were only minor prompts after the initial research question, to continue the dialogue. It is a detail-rich project rather than a surface examination. The role of the researcher was reduced by using focus groups rather than one on one interviews where there would potentially have been more influence. An accurate transcription of the audio-recordings was made soon after each focus group, completed by the researcher. This choice to transcribe the audio-data was made so that the research would become familiar and the words would be absorbed. The coding and thematic analysis was driven by the data and the participant's voices and opinions.

> 'The authenticity of a qualitative descriptive study depends not only on the ability to capture participants' perceptions but also to accurately analyse and represent them as well. Accurate representation begins with transcription of each interview,

continues with coding and categorising, and involves on-going attention to context' (Milne & Oberle, 2005, p. 416).

Credibility: the perspective of this research is from that of an 'insider'. Having worked as an LMC, the experience enables an accurate understanding of the phenomenon studied. However, there was alertness to not make any assumptions and to be open to hearing what the midwives had to say, without imposing any previously held ideas. The findings will 'ring true' (Colorafi & Evans, 2016, p. 24) with other midwives who work in a similar way. The participants were chosen because of their involvement in dealing with the phenomenon from a 'variety of aspects' (Graneheim & Lundman, 2003, p. 109), which increases the likelihood of thoroughly engaging with the research question.

Criticality: reflection by the researcher on each stage of the process brings a critical lens to the thesis and this is evidenced by my discussion throughout this research. 'Criticality in a qualitative study is a reflection of the critical appraisal applied to every research decision and is a key aspect of a study's overall integrity' (Milne & Oberle 2005, p. 417).

Integrity: the role of the researcher is acknowledged, as interviewer and clinician in the focus group itself and as analyser during the analysis phase. There was also the process of member checking (Carlson, 2010), when the transcript summary was sent to the two participating midwifery practices for checking, further enhancing the veracity of this data, 'Respondent validation, or member checking, involves going back to participants to review the findings, generally when data collection and analysis have been completed' (Milne & Oberle, 2005, p. 418). The midwives involved in the project were invited to give feedback on the summary of themes from the focus group meeting, and both groups were satisfied that their opinions were recorded accurately.

This chapter has discussed the framework for the research, a qualitative descriptive design, using focus groups to collect the data. The ethics approval process has been outlined. The qualitative descriptive research method used to analyse the data was described in detail as well as the reasons why this research is robust and trustworthy. The next stage in the process is to strongly present the findings of the research as a way to honour the insights the midwives have given on this subject.

Chapter 4: Findings

Midwives in Focus Group A are a practice of four midwives. They predominantly work in pairs and all are epidural certified. One of the midwives (Trixie) carries a small caseload and works occasional casual shifts at the local DHB secondary hospital. Their practice works with women from across the socio-economic and cultural spectrum. All four midwives were present at the focus group session.

Midwives in Focus Group B are a group of midwives who share a caseload in pairs, have a communal funding system where each midwife gets paid equal amounts of money from the pooled funds. One of the midwives (Ruth) doesn't have a backup partner at the moment and coincidentally she is the only one certified to provide epidural care in the group. This practice works predominantly with young women, as well as lower socio-economic and Māori women. Six midwives from this practice were present at the focus group meeting, one was absent on leave.

4.1: Themes common to both focus groups

There were some common threads running through both group discussions. This is fascinating, considering the midwives worked at opposite ends of the spectrum in the specific practice area of provision of epidural care in labour. Midwives have strong feelings about their commitment to the women in their care, which cuts across philosophical diversity. Regardless of practice arrangements, midwifery culture is at its heart women-centred and this commitment to relationships with women permeated the discussions of both groups.

4.1.1: Articulating philosophy and ways of practicing

Both groups of midwives were able to articulate their philosophical viewpoints during the focus groups and how that philosophy would work in a practical

sense. They were also clear about explaining that philosophy and their ways of working to women in their care and also to women calling to potentially book with them for care in their pregnancy. Midwives in Aotearoa New Zealand develop the ability to do this, from experience with talking to women one-on-one about this on an almost daily basis and also when promoting themselves on the 'Find your midwife' website. Articulating philosophy and ways of practicing is perhaps a phenomenon peculiar to Aotearoa New Zealand due to the way that women can personally choose an LMC and the degree of variability within individual midwifery practices. Midwives have had to meet the challenge of being able to give a succinct explanation, often in an initial brief phone call, about their way of working with birthing women.

Within each practice, the participating midwives worked in a similar way to each other and appeared to present a united front to women. They had worked this philosophy out over the years and it was incorporated into how they practiced. Each group of midwives were strong in their beliefs,

'*As a practice we…worked out a whole lot of our philosophies and ideas and one of them was around epidurals for pain relief saying we don't offer it'* (Laura, Focus group B)

'We've had that discussion many times as a practice, because if one had a different opinion, it's hard to be a part of it, but we all seem to be on the same page' (Anna, Focus group A).

'We've got a very clear philosophy. And that we are prepared to do options[2] visits before we book women' (Ruth, Focus group B).

The midwives in both groups clearly defined their role and responsibilities to women in different situations. All of the midwives educated women antenatally on the possible boundaries of their midwifery care and felt that the way they worked was made clear to the women in their care from the outset of the relationship. Women knew their midwives' ways of working regarding epidural

[2] An 'options visit' is where the midwife has a one-off no obligation visit with a woman seeking midwifery care. The midwife explains her philosophy, practice arrangements and midwifery partners, and gives the woman an opportunity to ask questions about the care the midwife provides.

care from the beginning, so that this information was not sprung on them in labour,

'We all do options visits for women and particularly women who have never been with us before, we will talk about it at that point in time' (Laura, focus group B).

The study midwives prepared the women for what might happen if they had an epidural in labour and what their midwifery role would be in that situation. All of the midwives felt the women understood their role in complex births,

> *'In the pregnancy when you explain what the options are and what actually women may need. But I do see it [epidural] as part of the care, these days, we have too many women who have long labours and complications and when that happens, epidural is kind of a product of all those interventions'* (Anna, Focus Group A).

'We talk about what would happen if that [epidural] became something that they chose then we would no longer be able to be, that the care would have to be handed over to the hospital' (Mary, Focus Group B).

'We, as midwives who provide epidural care, need to talk with women about it, and try to prepare them for any outcome' (Trixie, Focus group A).

> *'In my experience when a woman has an epidural I've already been there for a really long time and I've invested so much into that already, that I couldn't afford to be there for another 12 hours or whatever, and the women know this and they are very accepting that we will hand over care and we will probably going to go home and sleep, just as she probably will, once she has got one, and then come back in a supportive role not making any of the calls or anything but still there'* (Susan, Focus Group B).

Both midwifery practices spoke of the *need* for an epidural in labour, as a clinical necessity in a birth complicated by its prolonged nature or baby's position, rather than as an option just for pain relief. Both groups of midwives

talked about being the one to recommend an epidural when it became obvious it was necessary,

'It becomes very clinical and secondary care…generally it's for complex reasons, not just pain relief, there's been something unexpected that's happened, the labours gone on a lot longer, or the baby's position', (Mary, Focus Group B).

> *'The woman is having an epidural because she has a clinical need to have one, it's not for any other reason, other than that. I don't find it that hard convincing anyone out of it, very often ever. It's more like, I find myself, although it's been awhile since I've had to do it, telling them that 'I'm really sorry but that this is something that actually we need to do now.''* (Susan, Focus Group B).

> *'She initially had wanted one [an epidural] when she first booked with me. She was a primip and then when through the course of our relationship and her antenatal classes she changed her mind and wanted to do it as naturally as possible, and I actually wound up being the one to convince her to have one 'cos I knew she needed it'* (Trixie, Focus Group A)

'There's normal labour and then there's not normal labour. If it's not normal labour then probably you would consider it' (Monique, Focus Group B).

> *'I just recently had that with the primip I had with the prolonged ruptured membranes, she, like, just wasn't dilating and she was getting more and more distressed, and I actually said to her I think you need to have an epidural, because you need to get some sleep, you have been up for 24 hours'* (Trixie, Focus Group A).

The midwives in this study were remarkably similar in the way they clearly explained the principles of their practice parameters to the women within their care and that they saw epidural anaesthesia as a necessity at times for dysfunctional labours.

4.1.2: Secondary interface

Both groups of midwives were also able to clearly define their role regarding epidural care in relation to their secondary core colleagues at the hospital,

> *'When I first started practicing, it created grey areas because the core midwife is there, and I'm there and I wasn't very good at defining roles I guess, because I want to help if they needed help and I kind of blurred lines a bit. So, I got better at defining my role, I'm just for support'* (Susan, Focus group B).

This intersection between the LMC and core midwives appeared to be a pivotal point in the discussions, and both sets of midwives spoke of the need to establish a good reputation with their core colleagues and maintain healthy relationships with the hospital staff. It was important to the midwives to have the respect of their core colleagues and to be known as midwives who would come in when called. They acknowledged the value of keeping relationships 'good' at the hospital.

'I think that there's also the long-term relationship that we have built up with them [core staff]' (Ruth, Focus Group B).

'You need to keep the relationships good [with core colleagues], (Megan, Focus group A).

> *'It is about the fact that the midwives at [secondary facility] generally know that we provide good care… I think it's not just about what you do in one particular minute with each woman, it's about how you build collegial relationships and provide care overall'* (Ruth, Focus group B).

Keeping core colleagues updated and aware of the situation was also important to both groups,

'It's just about communication and letting them know where I'm at with my woman' (Laura, Focus group B).

Both groups of midwives had a clear understanding on the enormous pressures on the core midwives, and an appreciation of ever increasing

workloads for their hospital colleagues. They also could see the importance of the person who was running the birthing suite, the Clinical Midwife Co-ordinator (CCO), having a lot of influence on their work,

'*Just depends who's on, sometimes they are good, sometimes there are definitely some nice CCO's*, *depends how stressed they are, sometimes I think it's just that balance, you know it's all about communication'* (Pat, Focus Group A).

> *'I think it also depends who's co-ordinating, … some are a bit more forward with actually saying, 'you need to call someone else from within your practice to come in and take over for the epidural cares', and where others, in my experience, they say 'no, that's fine, we will organise a staff member for you''* (Monique, Focus Group B).

All of the midwives understood the problem of staffing shortages,

> *'I do care and I feel for them when they are short staffed, and run off their feet, and to see how stressed they are. That's never going to change if they are never going to employ more midwives at the hospital'* (Anna, Focus Group A).

However, they blamed the system rather than individuals,

> *'I think it would be nice that in an ideal world, if the systemic stuff was not such an issue and like the institutional stuff and the relationship stuff, the staffing issues, yes, then we could work towards something that was a bit more seamless for the woman'* (Laura, Focus Group B).

The focus group A midwives felt that providing epidural care possibly masked the staffing shortage to a degree, *'We actually don't help the situation by doing it [epidural care] for them, as well, because it makes it seem like they are coping' (Pat, Focus Group A).*

Midwives sometimes carried on with care, even when they felt they *should* have handed over to their secondary colleagues. '*I would have handed over the other night except there was no space in birth suite, at all, and there was no staff*' (Ruth, Focus Group B).

'It's just a staffing problem is the real issue, there's just no staff, and you feel for them, because there is no-one, it's a huge hassle for a whole core person to have to take over' (Megan, Focus Group B). Both groups understood that the hospital system was in the process of change, and that over the years there had been a shift, in a positive sense, in the way they interacted with the core midwives.

'It is better, getting better, but there's a lot of things that need to happen to change that' (Laura, Focus Group B).

Generally, there was respect and reciprocity for one another and for midwives working for the DHB.

'A positive thing that's come out now is… that we can hand over care if it got really hard and we have been there too long' (Pat, Focus Group A).

The midwives from both groups acknowledged the expertise of their core colleagues, respected their position and for the most part trusted the quality of that care.

> *'I think that the change has been really recognising within the DHB that that's been really important and I know it puts a lot of pressure on the core midwives but it's also leaving the midwives to provide the care in the community that is actually needed out there as well. So I think there is a good shift there'* (Laura, Focus group B).

4.1.3: Midwifery sustainability

Midwives in both practices discussed the effects of longer labours on their ability to function safely and the results of that tiredness affecting their fellow colleagues within the practice, and also other clients who might potentially birth.

'It's my sustainability, actually and my ability to function as a midwife, to be aware that actually I have other women due, who might go into labour while I'm here or an hour after I get home' (Susan, Focus Group B).

Both groups were aware of the pressure that providing epidural care put upon the remaining practice midwives; if one of their partners was tired and needed to get some sleep, and be off call for a time,

'It's the fact that then we are further burdening the practice by taking another person out so you've got one person at home sleeping, and you've got another still tied up managing the … epidural' (Trixie, Focus Group A).

Both groups of midwives discussed the safety aspects of the scenario of the tired midwife with a woman having a long labour,

> *'It's quite hard to stay awake especially if you've already been up all night. It is hard to stay awake, because everybody goes to sleep including the woman, and you are the only one looking at that CTG and its knocking on your head'* (Anna, Focus Group A).

Fatigue from a prolonged time caring for a labouring woman can be a prompt to transfer care when safety is compromised. Keeping the woman safe was a priority,

> *'I'd been awake for about 24 hours at that point and I guess at the end of this, you want your midwife to be able to say well, actually I'm not fit to provide care, and you need to have the safest care that you can have'* (Trixie, Focus Group A).

Midwives in both focus groups described the tiredness that goes hand in hand with labour care at times in LMC work. There is the exhaustion of working too many hours and not having the ability to carry on safely with the woman's care. '*Once you get past that point of not being able to cope after 24 hours there's generally been some form of intervention* (Pat, Focus group A).

> *'If the woman is getting one [an epidural], there's some kind of complexity and if you've already been there for 24 hours plus and then they have an epidural and you've got all the stuff that comes with that and all the excess stuff, and to then to be there, yeah potentially another, however many hours, I just wouldn't be able to be safe practicing like*

that, I'm at my limits and I think women would appreciate that' (Maggie, Focus Group B).

Midwives from Focus Group B also mentioned the impact on their decision making when tired;

Mary*: 'So our decisions are based on our relationships with the women, and wanting to be there to support them'*

Maggie: *'and also on our own ability to actually be making good clinical decisions'*

Mary: *'yeah, safety*'.

(Excerpt from transcript Focus Group B).

Both focus groups also discussed their stamina during long labours, and both mentioned their ability to stay on longer had increased over the years.

'I think the longer you have been a midwife the easier it gets, apart from when you get a bit older, but I'm not sure that makes any difference to your stamina to be honest' (Ruth, Focus Group B).

'I remember when I first started I would kind of be like oh 'I've been awake for 24 hours and I'm calling the backup in', now I just keep pushing through' (Trixie, Focus Group A).

4.2 Themes unique to Focus Group A

Focus Group A are a midwifery practice who are all epidural certified midwives and who continue care with women in labour even if it means staying for an epidural. The members had all been practicing this way since they joined the practice and were clear to the woman, with each other and to the hospital facility that they believed this was part of their role as the woman's LMC to continue to provide this care. They appeared to have good working and inter-professional relationships within the practice and be extremely supportive of one another. Meeting with these midwives left the overall impression that they felt totally committed to the women in their care, possibly sometimes at the

expense of their own health and well-being. They appeared weary at times during the discussion, disillusioned with and underappreciated by 'the system', as well as a little cynical at times about the burdens placed on them because of the type of care they wanted to provide.

Non-verbal behaviours in the focus group meeting indicated a strong sense of collegiality and care for each other. They often murmured agreement while someone else was talking. For example, they appeared concerned and empathetic towards one of the midwives, Anna, when she expressed her feelings of frustration at one point in the dialogue. They were generally respectful of the midwife who was talking, although when the discussion became intense there was some talking over one another. No one personality appeared dominant in the group. There were some further codes and themes to emerge from this focus group in addition to the ones outlined in the previous section.

4.2.1 The paradox of continuity vs dependency

Focus Group A midwives felt strongly that their role of continuing with the woman's care was a priority. These midwives discussed a tension they perceived as existing between balancing their close continuity relationships with the women, with the potential for creating a sense of dependency. They expressed their fears that handing over the care of the woman for epidural in labour could lead to feelings of abandonment for women.

'We know its secondary care, but we do it because the woman comes first and it's the continuity of care that you do it for' (Pat, Focus Group A).

The midwives felt strongly that it was important to stay and be there for the woman at that time, that leaving wasn't an option,

'It feels like you are just abandoning that woman when they actually need you the most' (Pat, Focus Group A)

'I always come back to that, how I will feel leaving the woman, and I never felt right about that, I don't think I can do that' (Anna, Focus Group A).

The Focus Group A midwives declared their commitment to the relationship and to the woman,

> *'But I will still stay because of the woman, because you took her on, you are responsible for her, you want this to happen in the best possible way for her, you want everything to go as smoothly as possible and you are there to ensure that, pretty much, with epidural or without epidural, I stay for the woman'* (Anna, Focus group A)

They spoke of the research they tapped into regarding continuity,

> '*There have been quite a few studies that say though, that if you're there for the whole duration of the care….and not leave them at the most hardest bit, there's a better outcome, even if the outcome is whatever it is, it is the fact that they have that familiar presence, the whole way through, you'll never really know the impact you have on the woman'* (Pat, Focus Group A).

The midwives also spoke about their preference in handing over care to the known, trusted backup midwife as a preference to an unknown core midwife,

> '*If they get good care with whoever else, like that's why if we are off and the backup has to do the labour you know that they are going to be fine, because they are going to get good care'* (Megan, Focus Group A).

Although they wished to keep relationships healthy at the secondary facility, they were sometimes sceptical about handing over to an unknown midwife from the hospital system, '*I think with the backup it's a bit different to just handing over to anyone in the hospital, you know there are probably some midwives you wouldn't want'* (Pat, Focus Group A).

However, one of the midwives wondered if they overestimated the importance of this continuity relationship, perhaps creating dependency.

> *'Sometimes I wonder if we, as midwives are putting too much…emphasis on the importance of our presence in those final hours to the woman? Are we making ourselves under pressure because we feel they can't possibly get through without us?'* (Trixie, Focus Group A).

Another midwife also alluded to the attitude of some of the women who had unrealistic expectations of their midwife, reflecting some sense of dependence from the woman,

> *'It is hard for the woman though as she would end up with somebody she has never met before and she's more likely to have met one of the backup midwives so it's, you know, but again after 24 hours or however long it has been you can't really expect, you know sometimes they have unrealistic expectations for you to carry on and organise for someone that they know to come in* (Anna, Focus Group A).

4.2.2 Inequity / disillusionment: Time for change?

Midwives in Focus Group A became animated when discussing the unfairness inherent in a system where there are the same payment rates for different lengths and types of work. They felt a sense of injustice which gave rise to feelings of disappointment with the remuneration system. It seemed unfair that the non-epidural certified midwives could handover and leave while they continued with the care and got very little recognition (financially or otherwise) for this care,

'If you look at midwives who don't have their epidural certificates, and they just hand over to core so why should we be penalised because we all have epidural certificates…it's not just the financial implications of it' (Trixie focus Group A)

> *'You work all that time and you end up having to pay the back-up…[there] should be a separate payment if after X amount of time you got called as a backup and you are actually helping the staff out by doing that and the recognition [should be that] you can claim that as a separate fee'* (Pat, Focus Group A)

There was a sense of disillusionment with how other (non-epidural certified) midwives chose to hand over the woman's care when it is complex, leaving them almost feeling foolish for staying on in this scenario.

'Why should I have to do that if you've got non-epidural certified midwives handing over and leaving?' (Trixie, Focus Group A)

> *'In recent months because I have, I did feel quite, undervalued, it's stupid in many situations, you know, when you see people come and go because they are not epidural certified and you stay there, it's like why I am doing that? I really felt on a few occasions, like I'm completely, like I'm stupid, I shouldn't be doing that. How can other people, and we get the same pay, and they leave and I stay' (Anna, Focus Group A)*

Being unappreciated by the DHB for this work was also frustrating for these midwives, they felt the work they did was invisible, and they were undervalued,

> *'It's interesting because they [the facility] are quite happy to fire at you, the primary, you know, section 88 primary requirements of what you need to do in the community so if you haven't gone to see that woman then 'you need to come in with that woman', yet they are quite happy to accept our secondary care without the blink of an eye. It's not like you're complaining about not handing over a woman to secondary care, it's that you are not getting any appreciation or thank you for doing it'* (Pat, Focus Group A).

Participants felt something needed to change to address this inequality, and each felt there was a definite mood for change.

> *'So, you either get paid less, or you actually get paid more if you stay and do epidural cares and that could be something out maybe of their budget. I don't know. Something has to change, yeah. In fairness… I think overall it just needs to be fair; they just have to come up with a system that is fairer, fairer in the hospital as well as fair in the actual Ministry of Health payments, just has to be'* (Pat, Focus Group A).

'*I think they need to do it though, with the involvement of core staff, you know it should be a discussion that happens with the people who actually deal with it, like the core midwives, the LMC midwives, both sides of the provision of epidural care, 'cos I don't think otherwise it would be an adequate solution. You know, it needs to be involving the people that actually live it'* (Trixie, Focus Group A)

All hoped the current 2017-2018 re-negotiation of the funding contract with the Ministry of Health may make some difference to the way things had always been.

'Be interesting if section 88 changes and if the hospital itself changes, you know, that would be a start. But if you can see changes happening it would give you more faith to carry on. Possibly. But if section 88 changes come out and if nothing in that area changes at all then that would make you think 'well, what's the point?' (Pat, Focus Group A).

The midwives also considered other creative ways of working, and discussed having someone at the facility who would do just the epidural cares, while the LMC remained on for the labour cares,

'[overseas], the staff, they do the epidural but you are the midwife, you don't hand over care, and maybe there could be something where you are still the midwife and the staff just are popping in and out maintaining the epidural and it's not that hard…. Like and then no LMC would be epidural certified, like it [epidural cares] would just be taken out of our scope and it would all be handled by obstetric nurses or somebody, but you are still LMC', (Megan Focus Group A).

4.3 Themes unique to Focus Group B

All of the midwives belonging to Focus Group B seemed to have fully embraced the model of primary care they had set up in their practice and enjoyed good relationships with each other in providing a team approach to

the woman's care. They had maintained their passion for birth by having regular time off call. Tiredness did not seem as evident in this group compared to Group A because of this scheduled time away from being constantly on call. However, they did have a good understanding about the feelings of fatigue as described earlier.

As a group they interacted well, with a common sense of purpose. There were strong feelings during the focus group session with enthusiastic responses which meant they did occasionally talk over one other, making it difficult to transcribe the data, at times. There was no single dominant member in the group, but some members contributed more than others. One new graduate member of the practice was relatively quiet compared to her colleagues.

4.3.1 "You can do it!"

It appeared from the discussion that this group of midwives they felt their strength was providing women with primary care, using their learned midwifery skills to get women through labour without the need for an epidural. They brought women back to the plans they had set up in pregnancy,

> *'If I can't see that there's any clinical reason for her to need an epidural then I don't really offer it as an option, or if she asks for one, then I try and use other techniques to buy a bit of time, and tell her, like, 'you can do it', you know 'we've had discussions about it antenatally', you know 'you didn't want to have an epidural'* (Susan, Focus Group B).

> *'And most of the time they will still have their baby, most of the time they will, once you've done the positional techniques and all of that kind of stuff, you kind of work through, I find that they just have the baby. Because they don't want an epidural, they know I don't offer it so they come to book with us because they want a normal birth'* (Susan Focus Group B).

'You try to work through all the positional stuff and all the skills that we have and the head stuff and all that kind of stuff' (Mary, Focus Group B)

This is grounded in their philosophical position.

> *'I guess, when you really get back to the basics and really peel everything back, why is it that I became a midwife? What do I want to support? And that is, normal birth and the epidural to me, is not part of normal birth, in terms of my own philosophy and practice. But I've become clearer and clearer and clearer as I've gone further and further along that, to me, yeah it's just supporting women with their normal physiology'* (Mary, Focus Group B).

Getting women through labour without any pharmacological intervention was a strong theme throughout the dialogue in Focus Group B as well as seeing the results and sharing the joy of that normal experience.

The midwives talked about their journey in learning ways of working with pain.

> '*I guess that it's also about learning midwifery, a skill of how to work with women in pain. What do you do with that stuff, if you are there by yourself and feeling quite overwhelmed, it is what you do with that isn't it? And how do you work through that'* (Laura, Focus Group B).
>
> *'It is a skill, 'cos I remember in my first year, the first time someone started demanding it and her partner got really aggressive. I remember thinking 'I actually don't know what to do!' and so I've had to learn'* (Maggie, Focus Group B).

They also rejoiced in the beauty of normal births and their satisfaction with positive outcomes for the women. They spoke of their satisfaction with the way they worked,

> *Susan: but once they've had their baby without having pain relief, without an epidural*
>
> *Monique: well they can get up and have a shower*
>
> *Susan: they are just like, you know, feel so awesome*

Maggie: yeah it's rewarding for everyone

Mary: And they get that beautiful rush of hormones

Susan: They feel so great that they were able to do it and you say 'of course you can! Of course you can!'

Mary: It sets them up for motherhood, just you know, perfectly (Excerpt from Focus Group B)

Midwives in Group B said that they recognised the power that comes to the woman who has achieved a natural birth, and that they took huge satisfaction in her delight, not looking for any admiration from the woman,

> *'if they look at you with praise and adulation, think you are an amazing midwife, you haven't done a good job, but actually that if they don't really worry about what your role was and they just think 'I did it on my own' then actually you've done a good job'* (Ruth, Focus Group A).

For these midwives, sharing in the woman's experience of normal gives satisfaction and it would be diminished if the woman was having an epidural.

'If every woman who had a baby was numb from the waist down, just the rewarding-ness of the job, the job satisfaction would go way down' (Maggie, Focus Group B).

Midwives in Focus Group B spoke of their midwifery skills; helping women to achieve their goal of a drug-free birth.

The midwives spoke of ways of working with women and with pain to achieve positive outcomes. They talked of the power for women in a drug free birth.

Group B participant's Susan's words, '*I try and use other techniques to buy a bit of time, and tell her, like, 'you can do it','*

Sometimes the act of withdrawing from the labouring woman for a period can be the most appropriate response from the midwife, allowing the woman time to work with the pain herself,

> *'It's also about learning midwifery, a skill of how to work with women in pain and when they ask and I've got clear visions of someone who ended*

up having home births with us, who the first baby she had at (primary unit), seven times she asked for an epidural and I had to leave the room for about half an hour or three quarters of an hour or something like that. Her partner had to say to her, 'you are going to have to stop, you are not going to get it, especially not here' you know.' (Laura, Focus Group B).

These natural labours are celebrated by the midwives and women alike, '*She's absolutely chuffed with herself and has said heaps of times "and I didn't have any pain relief, not even the gas!*"', (Ruth Focus Group B*).*

'I had a sixteen year old that had her baby… and she's going round saying 'I did this, you can do this' you know, 'I did this without any pain relief', you know and 'it wasn't that hard!' (Mary, Focus Group B).

The role of birth support people alongside the labouring women (both good and bad) was also discussed,

'I think it's very important to make that clear with her support people as well antenatally yeah because, um, recently had a woman go into labour who was a VBAC, so three previous caesarean sections and was wanting a vaginal birth, um, so I went, I talked with her husband about the stages of labour and transition specifically and she reached transition and he looked at me and I'm like 'this is that moment' and he was there right with her 'cos she was like 'I want an epidural, I can't do this anymore', and so he actually got her through that last bit. So having them on board with our stance as well towards epidural and yeah, giving them that role in the labour and birth has helped me heaps, I don't actually have to do very much talking with women around epidural, when they are in labour, 'cos the family do it', (Susan, Focus Group B).

Conversely, unsupportive birth companions can have a detrimental effect, as described by Ruth,

'I think the support people have a huge impact on that. And actually that woman of mine that had an epidural the other day, I think, although I kind of think she probably would have ended up with one, OP baby and

whatever, he offered her no support all night, just lay on the couch and barely said a word, and played on his phone or gone to sleep, and so I, there's a bit in me that also thinks "actually I can't do this on my own", 'cos you need to have support' (Ruth, Focus Group B).

Incidentally, Focus Group A midwives also enjoyed these normal labours, without intervention, even though they are all epidural-certified,

Megan*: maybe it helps in our practice that we have a lot of homebirths and primary unit births so then you know maybe we are not having to do epidurals every day, or every birth... But I think if you have those nice homebirths and primary unit ones then that helps the practice,*

Trixie: *keeps the faith.*

(Excerpt from Focus Group A)

'Keeping the faith', a powerful statement that women can do it, can inspire women to have confidence in their own ability to birth their baby drug-free. But what about when the woman needs help to birth?

Midwives who were not epidural certified also commented on the way women feel when they have ended up with an epidural,

'But I also think the epidural thing is quite undermining, well any sort of pain relief, isn't it? It's a bit like, 'well, you can't do this'' (Ruth, Focus Group B).

They discuss how the woman's disappointment can be disempowering,

Ruth: *And so at the end of it, they come out a bit thinking well actually I couldn't do that either', as well as all the other crap'*

Susan: *'How many women have you had who get an epidural and they feel so stink about it, as well? They don't feel good about having to have one'*

Maggie: *Yeah like, postnatally they are like, 'well, I couldn't do it'*

Susan: *or 'I couldn't do it', or 'I failed'*

My prompt question: *How do you respond to that?*

Susan: *Tell them that they're not. That, 'actually, you've worked so hard to get to that point where you were, that actually you run out of any other options. But you still had a vaginal birth and how awesome is that? You know it doesn't mean you're a failure! You're a mother! That's awesome! You did amazing!'*

(Excerpt from Focus Group B)

Focus Group B participants celebrated their role and the woman's achievement in her birthing experience. These elements of their work appeared from their discussion to be important components in their overall professional practice satisfaction levels.

4.3.2: Nature of caseload: Abuse issues

Midwives in Focus Group B described the demographic of the women in their care as predominantly young women, who often achieve physiological birth,

'But I also think that 'cos we work with younger women makes a difference in a way as well, because actually a lot of them are still in that space of thinking they are indestructible…Physically they often birth really well…often especially a lot of the younger ones they actually are way more terrified of hospitals and epidurals, and somebody putting a needle in their backs, than they are of …labour' (Ruth, Focus Group B).

The midwives also defined the women in their caseload as vulnerable, who sometimes presented with a past history of abuse.

'I said to someone the other day actually, that 'you've had way worse things in your life, haven't you, than having a baby?' and she was like 'yeah'' (Ruth, Focus Group B).

The midwives felt that sometimes an epidural enhanced the feelings of being out of control, and seemed to perpetuate the previous abuse issues,

> *'She didn't feel a part of the process of any of it, she just felt like people were doing these things to her, and it just added to powerlessness, and the abuse that she previously had in her mind'* (Susan, Focus Group B).

> *'What abuse are we perpetuating sometimes for these women? We are not necessarily going to know, you know, when women have had abuse, actually the process in labour is very overwhelming sometimes because of the things that it can trigger. If we take that away and we put something else in place, what are we doing in that process as well?*' (Laura, Focus Group B).

Midwives in this group also linked the normal drug free birth experience of these vulnerable women to a sense of regaining power and a sense of achievement. This also links into the previous theme of empowering women. The midwives said that for them, physiological birth facilitates the women to seize back their own power,

> *'It [giving birth drug free] might be the only thing that they've ever done, …when you think about some of the situations the women we work with live in and how they live their lives. There are not necessarily a lot of positives and it might be the only thing they see as a positive.* (Laura, Focus Group B).

'Sometimes you see those women after, postnatally, they have just kind of got this whole different confidence about them and stuff. 'Cos they were able to do that' (Maggie, Focus Group B).

This fits with the stories of the midwives in this focus group who felt the women in their care were often part of a vulnerable population. The women had often suffered some trauma previously in their life. '*Particularly some of them that have had a hard life, that have been abused or whatever'* (Ruth, Focus Group B)

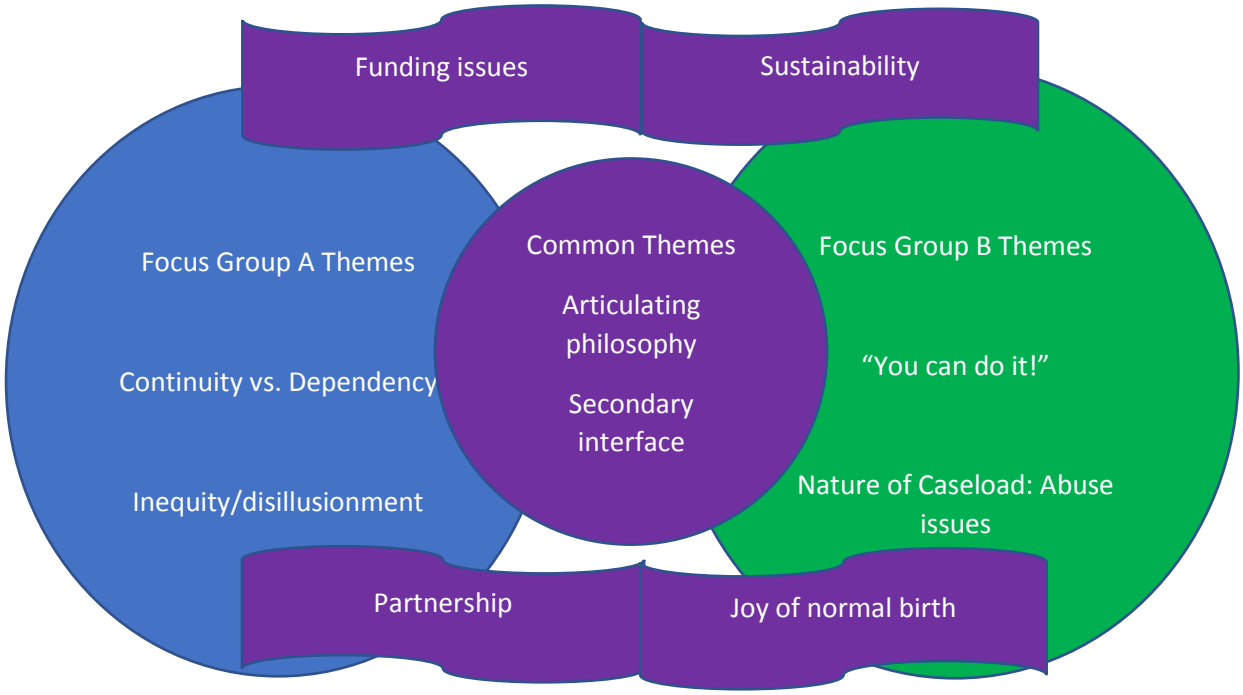
Midwives were careful to respect the woman's space to give birth and help her regain a sense of control over the process. This allowed women to be at the centre of the midwife's focus and to give back to the woman her sense of power.

'You know you want to provide support for the woman, you know and it's kind of yeah, it's giving it back to the woman and making them feel like they did it and they know that they did it, you know? (Mary, Focus group B)

Focus Group B showed insight and compassion towards their vulnerable clients and gave them positive feedback on their achievements.

4.4 Model illustrating research themes

Below is a graphical representation of the themes that arose from the participant's words showing commonalities and differences, and some perceptions that span both groups of midwives. Underpinning this diagrammatical illustration are the concepts of partnership and the joy of normal birth. Spanning across the themes from both focus groups are funding issues and sustainability of the profession.



The next phase of the research process is to move into examining the way midwives' experiences articulated in the focus groups have shaped the discussion section which follows. The discussion explores how the findings are now situated within a broader context of extant work, what others have found and whether these discoveries lend weight to the claims of others. Beyond this, it reveals how the focus group midwives have contributed some valuable insight to our understanding of this practice question, as well as implications for future practice.

Chapter 5: Discussion

This chapter reflects the content of the investigation and complements what has been revealed. In it the various themes are drawn together into a comprehensive picture. The findings are put into context alongside what else is known and provide some new insights. This has led to ideas for future research and exploration as well as recommendations for practice.

The aim of this research was to find out how midwives feel about this practice issue and why they have come to the decision about continuing or discontinuing care of labouring women needing epidural anaesthesia. “Should I stay or should I go?”

The Focus Group midwives very clearly voiced their feelings around their decision processes as well as how this worked out in a practical sense. As far as possible to discern, the midwives contributed to the discussions honestly and openly, which infers that the findings do provide an authentic reflection of how these midwives actually feel about this question.

A further objective was to consider interactions between the LMC and their hospital colleagues, as this appeared to be a crucial meeting point that was significant to the midwives. The interactions between the primary and secondary care practitioners were explored, exposing the midwives’ feelings about systemic difficulties with staffing levels in the DHB.

Both Focus Groups noted that support from colleagues who work in the hospital can be vital in helping LMCs maintaining the passion in their work. Conversely, the perceived lack of support from the tertiary system can also be very demoralising at times. The midwives in both focus groups said they were aware of the huge demands on the staff at the local secondary/tertiary facility and the pressures inherent in a busy unit. Both groups of midwives worked hard to establish healthy relationships with their colleagues at the hospital. Davis & Walker (2010) also found that midwives navigated the relationships within the hospital cautiously, and that it was important to have robust mutual respect with colleagues.

The perception of the role of the Clinical Co-ordinator (CCO) being pivotal in the culture of the birthing suite mentioned in the study by Fergusson et al., (2010) was also echoed by the participants in my research. Midwives felt that the attitude of the CCO on a shift could be crucial to their experience, good or bad, at the facility. Clinical Co-ordinators in Fergusson et al.'s study also reciprocated this understanding about the practice realities of LMC work (Fergusson et al., 2010).

The final objective was to investigate whether current funding discussions could be informed by this research. This study can potentially contribute to the wider discussion regarding funding, as these midwives discussed their valid feelings of disillusionment and frustration with the current model.

However, despite the negative aspects that this research has revealed, the passion that midwives feel about their work alongside women in childbirth cannot be underestimated. Both groups felt deeply committed to their relationships with the women yet chose to work in different ways to provide excellent care.

The tension of providing the 'gold standard' of continuity of care was particularly evident for Focus Group A. These midwives felt a heavy responsibility to remain with the woman throughout her labour, whatever that necessitated. The problem for these midwives was not about whether or not to stay; as they were clear about their absolute commitment to be there for the woman; but the inequity of the financial reward for this type work which was secondary care, especially when other midwives could leave and yet get paid the same. They recognised this was a personal choice in the interests of continuity for the woman. Could funding be developed to meet this need and the gap in service provision? Could case-loading midwives be paid a separate fee if remaining to provide secondary care?

Another dilemma for these midwives was also around whether they were creating a sense of dependency by providing this style of care. Nicky Leap has an interesting take on this in her chapter contribution to the book 'The Midwife-Mother Relationship', "We need to be mindful of the potential dangers

of creating mutual dependencies if continuity of care leads to exclusive, special relationships between individual women and their midwives" (Leap, 2010, p.27). It appears there may be a fine line between offering continuity and creating dependence.

The midwives in Group A eagerly anticipated modifications to the current system in the future with the reconfiguration of the funding model in 2018. They were ready for change and they saw change as not just necessary but also pressing. This group felt the consultation regarding any changes in epidural care funding needed to be across the board, including LMCs and core midwives. NZCOM initiated a consultation process in 2017 (which occurred coincidentally after the implementation of these focus groups) in relation to the potential changes in the funding model, 'Co-design Funding Model' (NZCOM, 2017). This consultation process did not appear to address epidural care and transfer of care for epidural anaesthesia. Midwives in this study felt this needed to be explored explicitly.

A sense of disillusionment came through the dialogue as midwives in both groups were feeling worn down by the way they worked, and not recognised, financially or otherwise, for this invisible side of their role. Midwives in Focus Group A were feeling weary from the demands on their time and their self-inflicted expectation to stay for the duration of the labour, whatever the length of time. There is a sense in these midwives that this prolonged time spent with the woman is a normal part of their working life. This is also found throughout the literature quoted earlier regarding burnout in the midwifery profession (Young, 2011; Young et al., 2015). There is the concern from the literature that midwives in this situation are on the verge of feeling so overwhelmed and fatigued with their work that they are in danger of burnout and leaving the profession altogether (Young, 2011; Young et al., 2015).

By contrast, throughout the course of the woman's pregnancy, the midwives from Focus Group B tried to instil confidence in the woman and in her ability to birth her baby drug-free. In her labour they used their learned midwifery skills to help each woman achieve her full potential. Leap describes "creative

patience" (Leap, 2010, p 25) for midwives working with women in labour. As well as this, Leap discusses avoiding the "pain relief menu" (Leap, 2010, p. 25). Focus Group B midwives described their process in learning to work with this situation, *'so I've had to learn, you know, to ignore it for as long as I can, how about the shower? How about this? How about that?* (Maggie, Focus Group B).

The exquisite joy in celebrating the achievement of women in having a normal birth is also found in other studies (Beech & Phipps, 2008; McAra-Couper et al., 2014). The passion of sharing this joyful experience with women and their families is what being a midwife is all about (McAra-Couper et al., 2014).

Leap considers the 'getting women through' aspects noted by Focus Group B even echoing the words used by participants in this research,

> 'Putting our faith in women gives them powerful messages, especially during labour where the quiet 'midwifery muttering' – 'You can do it!' – when a woman is saying words to the contrary is often all it takes to get women through the aptly named 'transition' phase of labour (Leap, 2010, p. 24).

Sometimes getting women through labour meant withdrawing for a time, a skill the Focus Group B midwives articulated. This withdrawal of the midwife is also described by Leap who sees this technique as a way to encourage women to withdraw within themselves, releasing endorphins and letting nature take its course (Leap, 2010).

These midwives considered the support people at a woman's labour an essential aspect of getting the woman through. Antenatal education for birth companions is essential to enhance their role and to ensure support for the woman's decisions (Royal College of Midwives, 2012). Partners can be seen as an essential part of the positive birth experience, (Howarth, Swain & Treharne, 2011; Karlström, Nystedt, & Hildingsson, 2015; Klomp, de Jonge, Hutton, Hers & Lagro-Janssen, 2016).

Focus Group B midwives reasoned that transferring the care of the woman to secondary services for epidural was logical given their focus on primary care and theoretically having reached the limits of their expertise in the event of the woman needing an epidural. The midwives also considered the subsequent implications of other potentially labouring women missing out on their care if they were exhausted (and recovering) from a possibly prolonged labour which included an epidural. As well as this, they were aware that the needed intervention of a consultation and epidural meant that the woman's plans for a normal birth had gone awry. 'The obstetric consultation presents a challenge to the case-loading midwife and her ability to maintain the oasis of calm, privacy and 'woman centeredness' within the room' (Davis & Walker, 2010, p. 607).

However, Leap comments on the notion of triumph, that even with interventions such as an operative birth, midwives expressing their admiration for the woman's courage and endurance may help these women feel empowered despite their experiences (Leap, 2010).

An unexpected finding of the research is presented next. Midwives in Focus Group B discussed their insights of how young vulnerable women with a history of abuse could, in theory, be re-traumatised during the process of labour, and in particular, during the course of an epidural anaesthetic. A study from Atlanta, USA, used questionnaires pre- and post-birth focussing on one hundred and three women's experiences during labour. The authors found that women were twelve times more likely to experience their birth experience as traumatic if they had a history of sexual abuse (Soet, Brack & Dilorio, 2003). Background events/life story for the likelihood of women suffering a post-traumatic stress reaction to childbirth are those who are 'more vulnerable in society (young, poor, unmarried, minority women) and …women with a past history of abuse' (Soet et al., 2003, p. 37). This is similar to the caseload described and care for by Focus Group B midwives.

The study by Soet et al. (2003) also considered the effect that the labour care may have in perpetuating abuse, as also mentioned by Focus Group B

midwives. Medical staff should take into account the psychological and physical effects of interventions prescribed for birthing women, such as continuous monitoring; leading to immobility which may mean women cannot use the techniques they may have learned to help with pain, therefore rendering them powerless (Soet et al., 2003).

On the other hand, the safe feeling of being cared for by someone caring and compassionate can avoid a feeling of being re-abused, or at least hasten recovery. Repič Slavič, & Gostečnik comment that the childbearing woman who is treated kindly and with respect by birth clinicians who are aware of her past history, can have a positive effect on her healing, especially if her feelings of trauma happen to be recalled during the process of giving birth (Repič Slavič, & Gostečnik, 2015).

Focus Group B midwives felt able to help women reclaim a sense of control through their positive birth experiences. The literature supports the concept of healing from traumatic experiences through the power of normal birth (Repič et al., 2015). Other scholars support this idea. Beech & Phipps (2008) also indicate in their research that a positive physiological birth with professional, respectful care may boost the woman's self-esteem as well as her mental and physical health.

Midwives work alongside a woman at a potentially vulnerable time in her life. Birth can have a profound effect on a woman. The midwife working with her can have a powerful sense of being the protector and upholder of her plans for a normal experience. Her professional identity as kaitiaki[3] of normal birth and working with the experience of labour present a challenge to this identity, especially when an intervention such as epidural anaesthesia is added as an option.

The nature of the qualitative descriptive approach I have presented means the findings are a close fit to the words and ideals of the midwives in the study.

[3] Kaitiaki: concept from Aotearoa New Zealand's indigenous culture (Māori) meaning guardianship or protection.

To place this discussion in an overall context of what it means to be a midwife working with women in labour, I refer to the work of Ruth Sanders who describes the pain of labour as 'functional discomfort' (Sanders, 2015, p. e87). Sanders suggests a shift from seeing contractions as pain to be relieved by clinicians employing pharmacological and anaesthetic means, to a positive experience that birthing women can achieve without intervention and without pain relief. This way of working with labouring women means helping women to see birth as a normal life event that nature intended to be celebrated. Pain is usually viewed with negative connotations of illness or injury whereas Sanders postulates that the sensations associated with childbearing are normal and not in any way pathological. Factors influencing positive attitudes towards labour 'discomforts' include avoiding the cycle of fear, therefore optimising the production of a woman's natural hormones and endorphins to flourish, as well as being in a low-tech birth environment (without access to epidurals). This is in essence what the midwives in my study describe when they talk about '*that beautiful rush of hormones'* (Mary, Focus Group B). They also understand that for women the un-medicated birth is '… *the only thing that they've ever done… that's so undervalued, that connection and that ability that comes from doing that [drug free birth]* (Laura, Focus Group B).

This section reviewed the outcomes of this research in light of other work in this area. Next the implications of the findings on practice realities will be considered.

5.1 Implications for midwifery practice

Many of the midwives in my study felt that there was a need for change. The time has now come to acknowledge the inequities in an obsolete system and consider ways to make it fairer for all parties going forward. The system has evolved to have some unanticipated outcomes. The request from women for epidural anaesthesia in labour may put midwives in a dilemma; should I stay or should I go? The individual midwife is obligated by the current system (and

by the DHB) to make a decision about where she sits in this debate. In discussing implications for practice, I hope that some of these ideas may come to fruition through the proposed funding restructure (the Co-design funding model).

Does she remain with the woman and provide continuous care by herself or from within her practice? Is she able to sustain this in the longer term (both physically and financially) and does this system of continuity hypothetically give rise to dependency from the woman?

By contrast, does the midwife sacrifice continuity and possibly safeguard her health and the future of her ability to practice by avoiding the protracted labours an epidural may possibly involve? Does she focus on being a *primary* midwife in *primary* settings only and avoid the secondary/tertiary facility altogether? What happens then to the women who need unexpected medical intervention and/or transfer? Would the midwife even accompany her in this situation?

This practice issue may be easier to solve if funding were able to be changed to make secondary funding (for epidural care, for instance) available for LMC midwives who choose to remain for this type of care. It would also help if there was separate funding available if a second midwife was called in to take over care in a prolonged labour or midwife fatigue situation. This may give continuity for the women and a sustainable practice option for the midwife; avoiding the fee splitting that is happening currently for epidural-certified midwives.

There is a much bigger question here too. What *is* the role of the midwife in self-employed practice? This is outside the scope of this enquiry but an important next step in understanding contemporary practice. However, the choice to provide different styles of care should remain with individual midwives rather than be imposed on them by any system. Midwives who excel in primary care settings should be free to continue to provide this valuable care to birthing women.

Do midwives provide continuity of care, establishing a relationship with women and following her journey regardless of complexity? If midwives wish to provide care across the spectrum, then funding models need to change to reflect the true nature of work undertaken and sustain the practice of midwives who provide this type of complex care.

Or do midwives wish to only provide primary care to healthy normal women? If midwifery is only about providing care in a primary setting, are current funding models adequate?

Neither practice philosophy is right or wrong; they are just different *and* valid ways of working. Each has value in different ways. A solution which fairly rewards midwives for the work that they do would enable midwives to pursue and sustain their midwifery practice in whichever way works for them, as long as women remain the focal point within the negotiated relationship.

5.2 Further research opportunities

Having investigated how LMC midwives feel about transfer of care for epidural, the next stage is to widen the discussion and consider how core midwives feel about this practice issue, being on the 'receiving' end, so to speak. What *do* core midwives feel about this? Do they see this care as part of their role?

Another aspect to consider is how do women feel about their care being transferred to secondary care core midwives should they require an epidural? A phenomenological study into how women experience having had their midwifery care transferred would give added insights into the feelings and experiences of birthing women affected by this scenario. Perhaps a quantitative study or practice audit looking at the extent of this issue and exploring the magnitude of the problem could potentially inform practice decisions further.

Understanding the perspectives of women who have experienced transfer of care for this particular circumstance, and core midwives who respond to a request for transfer of midwifery care, will be an important step in expanding our understanding of this area of practice complexity.

How could the funding frameworks be modified to better reflect the work midwives do in this area? The questionnaire from NZCOM regarding the 'Co-design Funding model' went some way in addressing the views of midwives about the future of primary care funding.

5.3 Strengths and limitations of this research

5.3.1 Strengths

This research is focussed on the experiences of LMC midwives and therefore the research reflects their ways of working with women and their professional interactions in the hospital setting. In this way the research accurately portrays the practice issues happening in this area of transfer of midwifery care for epidural. This is the first study of this kind within Aotearoa New Zealand to capture the explicit views of midwives on this specific topic. The methodology employed in this study enabled rich data collection and allowed the voices of midwives working as LMCs to be heard in a wider forum. Presentation of data as quotes gives authenticity to the findings. Participant numbers, although small, were appropriate for the study design.

5.3.2 Limitations

While the data collected is a rich and detailed assessment from a small number of midwives in one geographical area of Aotearoa New Zealand, it is not able to be generalised to a wider population. The midwife researcher was known to the focus group midwives, and this could have had the potential to have had an effect on their responses, however with the frank responses and

dialogue it does not appear to have been an influence. The findings have been generated within particular context and a time of politically driven change which may not translate to future midwifery practice in the future.

5.4 Summary

Midwives in this study generously gave of their time to explore their feelings and attitudes about transfer of clinical responsibility for labour care which includes epidural. What emerged was clearly a topic that midwives in both of the focus groups felt passionately about. The frankness of participants was, at times, brutal in its honesty. The joys and frustrations of being an LMC were plainly expressed by both midwife groups.

Both groups of midwives were able to strongly describe their care parameters in this specific area of practice. The midwives' explanation of work setting, boundaries and outlining their midwifery philosophy was a strong theme for both groups.

Midwives from both focus groups understood the pressures on their local hospital colleagues and valued their expertise and support. There was a sense of frustration from both sets of participants about the pressures on hospital staff and the trickle-down effect that this stress implied for LMCs, especially in a clinical handover situation such as epidural care. All midwives implied there needed to be changes to make the system work better, *'we could work towards something that was a bit more seamless for the woman',* (Laura, Focus Group B). There was a hope expressed that in a proposed new funding system (the Co-design funding model under consideration in 2018) that the current inequalities will be addressed, particularly for epidural-certified midwives.

Group A (epidural-certified) midwives gave voice to their ongoing commitment to the midwifery partnership and continuity with women. They were frustrated with the contradiction of providing continuity (and the inherent job satisfaction that provides) and yet feeling worn down by their self-imposed set of

standards for continuity of care, even throughout complexity. While they were understanding of the stressors on staff at the hospital facility, they were becoming disillusioned with the unfairness at providing secondary care with little professional or financial recognition. They felt it was time for change.

Group B (non-epidural certified) midwives showed commitment to assisting the women in their care to achieve a physiological birth and found enjoyment and satisfaction in being there for women through normal birth experiences even when their role, in a sense, became invisible. They declared their commitment to provide a safe space for the woman to birth. These midwives expressed their sensitivity to the needs of the vulnerable women in their care, recognising both the powerlessness and powerfulness of women in the realm of birthing.

For midwives, the values of continuity, relationships, philosophy, partnership and joy are key motivators for what they do. There are some tensions intrinsic to the current framework which are partly about compromising continuity and individual sustainability but are also about apparent economic inequity which can lead to disharmony, decreased work fulfilment and potential loss to the midwifery workforce through burnout. It is time to change how the system supports midwives to carry out the vital and rewarding work that they do.

Conclusion

Case-loading midwives in Aotearoa New Zealand are able to determine their own framework of working with women, within the confines of safe practice boundaries, legislation and current funding models. This autonomy is relished by midwives and by women, who have a choice regarding their LMC and the type of care they wish to pursue for their pregnancy journey. Midwives in this study acknowledged their commitment to providing high quality care by building strong, sustainable relationships with women, to give them and their babies the best possible outcomes. Midwives may assist women who may be in a vulnerable state to regain their self-determination. Midwives celebrate

their expertise in supporting women through the entire childbirth experience and in particular working skilfully with the discomforts of labour.

However, a funding system that was set up decades ago did not anticipate the choice midwives are faced with today regarding provision of epidural care. This system has created structural difficulties whereby midwives wishing to provide secondary care in the form of epidural in labour are effectively subsiding the DHB. This incongruity has potentially created an environment for disharmony. The inherent tensions when inequity is recognised has been borne out in my research. There are serious implications for sustainability for practice when midwives feel undervalued for the work they do.

The current system only works because dedicated midwives go above and beyond the call of duty to provide excellent care, bridging the structural inequalities created by an outdated funding system. Whatever the future holds in this arena, Aotearoa New Zealand's birthing women are fortunate to partner with a professional, passionate midwifery workforce that is dedicated to their best interests, whether they stay or whether they go.

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Appendices

Appendix 1: Ethics approval

Bronwyn Carpenter

[redacted]

Dear Bronwyn

Re: Application for Ethics Consent

Reference Number: 736

Application Title: Will I stay or will I go? LMC perceptions of handover of midwifery care for epidural

Thank you for your application for ethics approval for this project.

The review panel has considered your revised application including responses to questions and issues raised. We are pleased to inform you that we are satisfied with the revisions made and confirm ethical approval for the project.

Many thanks for your careful responses to our recommendations.

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 and/o conclusions to the Ethics Committee. All correspondence regarding this application should include the reference number assigned to it.

Regards

Richard Humphrey

Chair
Ethics Committee

Otago Polytechnic

Appendix 2: Kaitohutohu office approval

Kia ora Bronwyn, thanks for the effort and time you have put in considering implications for Māori within your research.

Your responses encourage the support from the Kaitohutohu Office for Ethics approval. The only tweak I suggest is that you take out the line “Tikanga Māori guides and informs all aspects of this kaupapa (methodology)” unless you have a supervisor or co-researcher who is Māori with reo and tikanga knowledge. This is not to say you will not do your best to work in this way, nor does it diminish or lessen your application in any way, just to acknowledge that concepts and tikanga sit within a cultural context of reo/cultural practice and without this one cannot be sure both are used correctly.
So in short the Office supports your application for Approval for ethics.
Regards
Richard Kerr-Bell
021427865

Appendix 3: Recruitment letter

[redacted]

4th July 2017

Dear …….. Midwives,

Your help is being sought to take part in my Master's Research project by being part of a small focus group with the other midwives in your practice. I would like to request that my intermediary …….be allowed to attend your regular practice meeting to briefly introduce the project and outline your potential involvement.

If you have any questions please don't hesitate to contact me, or my supervisor Suzanne Miller (Phone [redacted] or suzanne.miller@op.ac.nz)

Thank you for considering being part of this project,

Kind regards,

Bronwyn Carpenter

(Phone [redacted] or carpb1@student.op.ac.nz)

Appendix 4: Guideline for intermediary attending recruitment meeting

Present the invitation letter and information sheet about the project to the members of the practice. Ask permission for the researcher to attend at a mutually agreeable time and place to conduct a group session to audio-record their opinions and decision-making about epidural handover of care.

Outline that their participation is entirely voluntary and they can withdraw their contribution anytime up to the completion of the focus group. In particular note the process is entirely confidential and the members can elect a pseudonym or have one chosen for them. The identity of participants will be protected at all times.

The midwives can contact the researcher directly either by cell phone or email to ask any questions they may have about the project.

Appendix 5: Invitation letter

Dear Midwifery Colleagues,

Your help is being sought to take part in my Master's Research project by being part of a small focus group with the other midwives in your practice. I would like the opportunity to come along to a practice meeting and observe and record your interactions around the topic of Epidural Handover of care. This study has ethical approval from Otago Polytechnic. There is an information sheet and consent form outlining your involvement and rights. At all times your identity will be protected by the use of pseudonyms.

I am hoping to conduct the focus groups within the next 6 weeks at a mutually acceptable time and place. I will bring refreshments for the meeting.

If you have any questions please don't hesitate to contact me, or my supervisor Suzanne Miller (Phone 021705697 or suzanne.miller@op.ac.nz)

Thank you for considering being part of this project,
Kind regards,
Bronwyn Carpenter

Appendix 6: Participant information sheet

Project title: Will I stay or will I go?

Case-loading midwives perceptions of handover of midwifery care for epidural

Kia ora. My name is Bronwyn Carpenter and I am a Master of Midwifery student at Otago Polytechnic.

General Introduction

This research project is being undertaken to examine the opinions and attitudes of midwives in relation to transfer of clinical responsibility for epidural anaesthesia.

What is the aim of the project?

The aim of the study is to develop a greater understanding of secondary care handover for epidural, by exploring what happens, and midwives' experiences of the process.

The project has been reviewed and approved by the Otago Polytechnic Kaitohutohu Office and the Otago Polytechnic Research Ethics Committee (OPREC#736).

What will my participation involve?

You are invited to participate in a focus group discussion about this topic. The focus group will involve other midwives who are in your practice group. The focus group is anticipated to take no more than two hours of your time, and will be held at a mutually agreed time and place. The conversation will be recorded with the consent of those present, and will be transcribed at a later date by the researcher. A summary of the themes derived from the recording transcript will be returned to you for checking and review.

How will my confidentiality and/or anonymity be protected?

You will be allocated, or may choose a pseudonym. The transcript files will remain confidential to myself as the researcher and my two research supervisors. Only your pseudonym will be used in my thesis or any academic publications or presentations. You will be asked to sign a consent form prior to taking part (copy attached). You may withdraw at any time without giving any reason prior to the completion of the focus group discussion.

Data Storage.

All electronic data will be stored in password-protected files, and hard copy will be stored in a locked filing cabinet. Results will be reported in my thesis, and may also be used in peer-reviewed publications or conference presentations. You have the option to be provided with a link to the online version of the thesis when it is completed.

Thank you for considering being involved in this study. If you are interested in participating, please contact me using the details below, so we can arrange a suitable time to meet with all the participants. If you have any further questions about the project, please contact either myself or my research supervisor.

Researcher:	Research Supervisor
Bronwyn Carpenter Phone [redacted] carpb1@student.op.ac.nz	Suzanne Miller Phone [redacted] suzanne.miller@op.ac.nz

Appendix 7: Consent form

Project title: Will I stay or will I go?

Case-loading midwives perceptions of handover of midwifery care for epidural

Consent to Participate in a Focus Group Discussion

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 and I am free to decline to answer any particular question. I understand my identity will be confidential and pseudonyms will be used for participants.
- I am free to stop participating at any time, without giving reasons and without any disadvantage to myself. If I choose to withdraw, the withdrawal date is immediately after the focus group.
- I am aware I cannot withdraw my information once the focus group is complete.
- My data 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 five years after which it will be destroyed. If it is to be kept longer than five years my permission will be sought.
- The results of the project may be published or used at a presentation in an academic conference but my confidentiality will be preserved.
- I wish to receive a link to the online version of the final thesis held in Otago Polytechnic. yes / no (if yes, I have provided an email address below)
- I agree to maintain confidentiality following the focus group meeting by not discussing it outside of the group.

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

…… (signature of participant)

…… (date)

…… (signature of researcher)

…….. (email address if link to thesis requested)

Appendix 8: Letter requesting feedback from focus groups

carpb1@student.op.ac.nz

7 October 2017

Dear Focus Group Midwives,

Thanks you so much for your willingness to be involved in my thesis project. I have discovered some rich data within the recorded text. I attach a summary of the themes I have been researching and send them to you for feedback as discussed in the consent process. I would ask that you consider if my summary aligns with how you felt the practice discussed this issue of epidural handover during our meeting.

Please send me back your feedback by 10th November 2017 so I can proceed with my study. If I don't hear back from you by this date, I will assume you are happy and I will continue with my analysis.

Many thanks,

Kind Regards,

Bronwyn Carpenter

Appendix 9: Summary of themes for feedback Focus Group A

Midwives in Focus Group A are a practice of four midwives. They predominantly work in pairs and all are epidural certified. One of the midwives (Trixie) carries a small caseload and works occasional casual shifts at the local DHB secondary hospital. Their practice works with women from across the socio-economic and cultural spectrum. All four midwives were present at the focus group session.

1. Continuity of care - Abandonment vs Dependency

The midwives discussed a tension they perceived between balancing their close continuity relationships with the women, with the potential for creating a sense of dependency. This could lead to feelings of abandonment for women when handover occurs.

2. Inequity/ Injustice - Payment system Hours/ tiredness/ disillusionment

There was a feeling of disillusionment expressed with the system as it stands, and a perceived inequity in payments for epidural and non-epidural certified midwives. This aligned closely to the fatigue during long-haul labours, meaning that the backup midwife needed to be called in and paid from that woman's budget. They were also discouraged by the difficulties with handing over when they felt that they went the extra mile to provide epidural care.

3. Preparation/ articulating philosophy - Antenatal education of women

The midwives were very clear in their philosophy and in articulating that to women and to the hospital facility. They tried to discuss potential outcomes with women and their midwifery role in that.

4. Secondary care interface

a) Establishing reputation

It was important to the midwives to have the respect of their core colleagues and to be known as midwives who would come in when called. They realised the value of keeping relationships 'good' at the hospital.

b) Understanding busyness

The midwives were aware of the enormous pressure on the core staff and a clear perception of increasing workload for their hospital colleagues.

c) Considering other ways of working/change. There was a sense in the dialogue that change might be coming, for example in being able to hand over for tiredness. The midwives also talked about other ways of working that would mean they could continue care with the woman but not be responsible for the epidural care, as such.

5. Tiredness vs Stamina

The midwives discussed long hours, coping with long haul labours leading to safety issues, and not able to cope. They also discussed the pressure on remaining members of the practice and the impact on other women potentially birthing.

Appendix 10: Summary of themes for feedback Focus Group B

Midwives in Focus Group B are group of midwives who share a caseload in pairs and have a communal funding system where each midwife gets paid equal amounts of money from the pooled funds. One of the midwives (Ruth) doesn't have a backup partner at the moment, and coincidentally she is the only one certified to provide epidural care in the group. This practice works predominantly with young women, as well as women from lower socio-economic groups and Māori women. Six midwives from this practice were present at the focus group meeting, one was absent on leave.

1. Preparation

a) Articulating philosophy. Midwives were very clear in articulating their philosophy to women and to women seeking their care.

b) Antenatal education-women / support people. The midwives felt strongly that it was important to involve women and their families on being 'on board' with the plan for the birth.

2. Secondary interface

a) Defining role, again midwives were clear in letting the hospital know their philosophy and boundaries in providing primary care.

b) Establishing reputation with core colleagues. It was seen by the midwives as essential to have a good working relationship with core colleagues, to keep them informed of their woman's progress and the potential for assistance if this looked likely

c) Understanding busy-ness in hospital. The midwives were aware of the enormous pressure on the core staff and had a clear perception of increasing workload for their hospital colleagues.

d) Changes in system. The midwives were aware that there were definitely good changes that had taken place over recent years in relation to handing over for epidural care.

3. Empowering women – ‘you can do it!’

a) Primary care; beauty of normal. This was a strong theme throughout the dialogue; getting women through, seeing the results and sharing the joy of that normal experience.

b) Midwifery skills; empowering women. The midwives spoke of ways of working with women and with pain to achieve positive outcomes. They talked of the power for women in a drug free birth.

4. Abuse issues

a) Caseload type. Young ‘indestructible’ women. Birth was not the toughest thing they had faced in life.

b) Epidural perpetuating abuse, things ‘done’ to women could perpetuate that history of abuse.

5. Tiredness vs Stamina

The midwives discussed long hours, coping with long haul labours leading to safety issues, and not able to cope. They also discussed the pressure on remaining members of the practice and the impact on other women potentially birthing.