MATERNITY CARE IN RURAL VICTORIA: MIDWIVES' PERSPECTIVES

Submitted by

Kathryn Felicity Brundell RM RN

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**School of Nursing, Midwifery & Paramedicine (Melbourne)
Faculty of Health Sciences
Australian Catholic University**

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Statement of sources

This thesis contains no material published elsewhere or extracted in whole or in part from a thesis by which I have qualified for or been awarded another degree or diploma.

No parts of this thesis have been submitted towards the award of any other degree or diploma in any other tertiary institution.

No other person's work has been used without due acknowledgement in the main text of the thesis.

All research procedures reported in the thesis received the approval of the relevant Ethics Committee or a relevant safety committee if the matter is referred to such a committee.

Candidate's name: Kathryn Brundell

Candidate's signature: _____: 28th October, 2015

Statement of appreciation

As a woman born to a large farming family in South West Victoria, my heart lies squarely with small hard-working communities who rely on each other to sustain and grow rural Australia. This thesis has been a labour of love for me, but with all things, rarely can we do it alone. There is a saying 'it takes a village to raise a child', which in the context of a developing thesis whilst mothering four children, working and living, is rather apt. My village is well populated, grass underfoot is green, the boundary fences are sturdy and the dams are full. I am lucky.

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Abstract

This modified Grounded Theory study explored the experiences of midwives working in a rural Victorian setting during a period of maternity service redesign. Changes to the local maternity service under study were block funded by the Rural Maternity Initiative, Victoria, Australia (Edwards & Gale, 2007). The Rural Maternity Initiative, along with the release of the maternity service review report (Commonwealth of Australia, 2009), incorporated women's requests for continuity of care provision, demedicalised care, choice in care, and accessibility of services across the pregnancy, birth and postnatal period.

Midwifery workforce shortages and maternity unit closures in rural Australia have been identified by the government, maternity service users and other stakeholders as factors reducing options, and increasing travel requirements, and social and emotional costs for women (Hoang, Le, & Ogden, 2014). Australian state and territory governments encouraged the redesign of maternity services with continuity models of care, more often caseload care or team midwifery, in an effort to combat workforce deficits and rural inequities (Commonwealth of Australia, 2009).

A review of literature was undertaken to frame key points associated with Australian health and maternity provision, recent policy developments, health workforce strategies, models of continuity care and rural maternity care accessibility. Significant gaps were noted, relating to the experience of the maternity service restructure in the rural setting, and the relationship between the health services undergoing maternity redesign and local communities.

A modified Grounded Theory methodological approach was undertaken, using symbolic interactionalism as the theoretical perspective to frame the study. The work of seminal theorists Glaser and Strauss (1967) informed the design methods employed, particularly that of constant comparative analysis, coding and memoing. A modified approach was taken, however, influenced by constructivist concepts. Charmaz asserts that rather than 'discovering' theory, data is socially constructed by study participants with reference to their individual circumstances (Charmaz, 2006). Developmental work by Blumer (1986) significantly influenced the theoretical perspective of this study, as an inquiry based on the lived experiences of a small group of midwives who were affected by maternity service redesign in one locality. In line with symbolic interactionism, this study seeks to understand the meaning these midwives placed on changes and the social interactions they attributed to their work environment.

The research setting was a small, rural maternity service, with a select sample population of fifteen. Participants were theoretically sampled and semi-structured interviews were the primary method of data collection. Constant comparative analysis was employed throughout the study, during which time the researcher became increasingly and thoroughly immersed in the data. Coding and categorisation was completed using *OneNote* Microsoft software to demonstrate thematic saturation and emerging theoretical concepts. It was during this rigorous analysis of data that a deep appreciation and understanding of Grounded Theory methodology was achieved. Constant comparative analysis enabled repeated interaction with data, comparative assessment of literature in conjunction with further data collection, and self-examination by the researcher.

Themes that emerged from the midwives' experiences of maternity service redesign in the rural Victorian context reflected known elements such as midwifery retention rates and burnout (Mollart, Skinner, Newing, & Foureur, 2013), and change planning, change leadership and interprofessional relationships associated with sustaining continuity models of maternity care (Monk, Tracy, Foureur, & Barclay, 2013). Two key themes related specifically to the rural context were communication of maternity service change, and change preparedness inclusive of women, families and interwoven rural communities.

Glossary and acronyms

Australian Health Practitioner Regulation Agency (AHPRA):
The organisation responsible for the implementation of the National Registration and Accreditation Scheme for health professions across Australia.

Block funding:
A federal or state periodic grant provided to health services or care providers otherwise unable to provide the necessary service provision, as judged by client activity and service use.

Caseload midwifery care:
Typically small group practices (n=4) with a primary/lead midwife and backup midwife providing continuity throughout the maternity episode; also known as midwifery group practices (MGPs).

Continuity of care midwifery models:
Models of care aimed to support women through pregnancy, labour, birth and the postnatal period by known midwives providing individualised care.

Director of Medical Services (DMS):
A senior medical officer and hospital board member who provides clinical governance, leadership and advice on medical services to a health organisation.

Eligible midwife:
A self-employed midwife with a Medicare provider number who works in a collaborative arrangement with a medical practitioner; eligible midwives are registered, and endorsed, by the Nursing and Midwifery Board of Australia (NMBA) and AHPRA.

Endorsed midwife:
An eligible midwife, who has also completed an approved prescribing course and is qualified to order certain diagnostic investigations and prescribe selected scheduled medicines.

Nursing and Midwifery Board of Australia (NMBA):
The organisation responsible for regulating the midwifery profession, supported by AHPRA; key functions include facilitation of registration, practitioner auditing and continuing professional development.

Rural Maternity Initiative (RMI):
A Victorian state government initiative designed to stimulate the implementation and/or restructure of rural maternity care providing continuity to women across the continuum of pregnancy, birth and the postnatal period (Edwards & Gale, 2007).

Chapter one: The study in context

Introduction

Maternity services within the Australian state of Victoria have undergone continual change. The federal government's focus on such services, and on the health needs of rural populations more broadly, has sought to improve health outcomes and enhance greater equity in access (Evans, Veitch, Hays, Clark, & Larkins, 2011). Maternity service inequalities in rural areas have been attributed to workforce shortages and the closure of small maternity units across Australia (Homer, Biggs, Vaughan, & Sullivan, 2011). Notably, women living in rural areas throughout Australia, including Victoria, are travelling further to access maternity care as a result of the increasing centralisation of services in metropolitan areas (Donnellan-Fernandez, 2011).

Due to escalating costs and workforce shortages, many rural maternity service providers have moved away from financially unsustainable, and increasingly unpopular, medical models of maternity care towards models endorsed by the Rural Maternity Initiative (see glossary) that provide midwifery continuity (Edwards & Gale, 2007). Primary care, typically delivered in a publicly funded hospital environment or community setting such as private practice midwifery (see glossary: eligible midwife), has provided a foundation for implementing midwifery-led models of care in rural locations for pregnant women defined as medically 'low risk'. These new arrangements, which have been driven by consumer requests and government requirements for low-cost, safe, maternity care, and facilitated by

state funding arrangements, help to ensure women enjoy continuity in midwifery care throughout the maternity episode (Department of Health and Ageing, 2011). There is minimal research, however, into models of primary maternity care with regard to the outcome of rural maternity care reforms. This is particularly so with respect to organisational changes and the possible impact on midwives' lives, including their relationships with colleagues and the childbearing women in their care. This project attempts to address a gap in the literature and the empirical research in this area.

The following section describes the researcher's background and place in the study project.

My place in the study

I began my research journey as a local woman, wife and mother to a young family, living in Victoria. I had borne four children, one in a tertiary maternity centre, the second in a private hospital after a normal pregnancy under obstetric care, the third at the local rural health service under caseload midwifery care. I again booked local caseload care with my fourth pregnancy, though I was transferred intrapartum with increased risk factors to a level two metropolitan centre. During the latter stages of my childbearing career, I also worked professionally as a caseload midwife at the same rural health service where I had received care. I consider this time as the best in my career to date. I embraced the independence offered by caseload midwifery and relished the increased responsibilities such

work required of me, though I was also acutely aware of the difficulties associated with accommodating my young family with my employment responsibilities.

This study was undertaken at the same rural health service where I had worked and been cared for during the pregnancy, birth and postnatal period for my own babies. I was, therefore, known to many of the participants who contributed to my study as a previous colleague and also as a woman for whom they either had personally cared, or knew the obstetric, social and emotional history. My time of employment occurred approximately eighteen months after caseload had commenced in the local health service. I noticed at this time that there appeared to be some disharmony among the midwives and hospital staff –particularly with the midwives. Other employees appeared to have differing understandings of the changed midwifery role and how the caseload model functioned. It struck me that the changes, supported by government and requested by women, had had a greater effect on staff than I had expected. This led me to question what caseload midwives understood about their own skills and capabilities, midwifery group practices and their perspective on the process of changing models of care from a traditional way of working to a more independent model.

The next section outlines the location and structure of the maternity service, and rural maternity funding arrangements as they applied to the health service under study.

The research setting

At the time of research, the rural maternity service under study had experienced significant changes in service provision, taking place from 2007. Previously

classified as a high-risk, medically-led model of care, the service was restructured to operate as a low-risk, midwifery-led, caseload model. Midwives became the lead professionals for low-risk pregnant women (that is, no known medical or obstetric complications). The hospital had served the surrounding community for approximately 170 years, and although midwives had conducted antenatal clinics, general practitioners (GPs) and a retiring obstetrician had previously provided maternity care to women. The obstetrician, known by generations of women within the community, gradually retired from the health service as the maternity redesign took place. With his retirement, the health service lost the capacity to perform caesarean sections (emergency or otherwise), due to a lack of other skilled personnel available. A replacement obstetrician was sought; however, at the time of research, none was in place. At this time the emergency department, previously staffed by on-call GPs, closed, maintaining emergency care and transfer referral delivered by nurse practitioners. Following the change, medical support was provided to the caseload midwives by a Director of Medical Services, who also ran a primary healthcare clinic, located on the grounds of the health service. The primary care clinic also accommodated the caseload midwives' antenatal clinic. Two other antenatal clinics were run by caseload midwives in neighbouring townships located within the district. These townships were located approximately 15–20 minutes away from the health service, thus reducing women's travel time.

Approximately six caseload midwives were employed in the new model of care, and women who booked into the service were allocated a primary midwife, based on their residential address and the location of the nearest antenatal clinic. The

allocation of bookings was determined by one midwife within the caseload group as an additional portfolio to her role.

Women identified as high risk and requiring specialised care, and so considered non-suitable for caseload care in this location, were referred to a metropolitan or larger regional maternity service prior to birth. During labour, caseload midwives accessed emergency obstetric advice by the then named Perinatal Emergency Transfer Service (PETS). If required, women were transferred via ambulance to receive appropriate emergency care. Caseload midwives would transfer and hand over care of women at the referred maternity service. Postnatal care was available for all women, regardless of final place of birth; caseload midwives provided a debriefing service as required. Under the caseload model of care, permanent night duty hospital staff provided essential midwifery cover, with one registered midwife rostered per night duty shift to care for women in labour until the primary midwife arrived; journeys would typically take up to an hour.

Publicly funded maternity care was provided to all women living in the health service catchment area, spanning approximately 1747 square kilometres (Australian Bureau of Statistics, 2011). Located in regional Victoria, the health service had a birth rate of approximately 184 per annum (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2010). Prior to the change of model, the health service was chosen to undertake the Rural Maternity Initiative evaluation. A report was produced outlining the types of continuity care models implemented in Victoria, women's and healthcare providers' levels of satisfaction,

costs associated with continuity care models and issues associated with implementation of continuity care models within the rural Victorian context.

It was after the evaluation had begun that the health service under study applied for Rural Maternity Initiative funding and began to implement changes to their maternity service. Several phases of change were evident, which are explained in the following section.

Phases of change

Several periods of change were identified (see Appendix A). These have been categorised into four phases that acknowledged the health service transitioning from an obstetric model of care in the initial phase to the final phase, which included transition to a caseload model of midwifery care. These phases will be referred to throughout the thesis as a chronological guide to the change-related activities discussed. The phases are categorised as follows:

- *Phase one:* This was identified by participants as the beginning of a shift from a combined obstetric 'all risk' model of care, with midwives employed in a community-based antenatal clinic. Women progressed to labour in hospital with an unknown, multi-tasking midwife who had responsibilities across both a general/surgical acute ward and a maternity ward.

- *Phase two:* This period of change involved a staged shift from the pre-existing (obstetric) model of care to a team (midwifery) continuity model of care. The initial stage involved booking 50% of women into the 'team' model with the remaining 50% booked to receive care as usual from midwives who remained working on the combined acute ward, and who

provided care for both general/surgical clients and maternity clientele. Gradually, 100% of women were booked into the maternity service under the team midwifery model, in which groups of three or four midwives collectively provided care for a group of women (Appendix A).

- *Phase three:* This was understood and described by participants as the move from a 'team' model to a 'modified caseload' continuity care model. The model of care was described by the health service under study as 'modified' for two main reasons. First, because night duty registered midwifery staff provided back up for the caseload midwives for women in labour until the caseload midwives could arrive at the hospital to provide care. Second, because a roster system remained in use whereby caseload midwives diverted their mobile phones to their colleagues on days off, although they were required to liaise among themselves to arrange any roster swaps or excessive work hours adjustments. Each midwife was allocated an individual caseload of women (n=36) per annum to provide care across the continuum of pregnancy, labour, birth and postnatal care.

- *Phase four:* This was the most recent transition, and involved caseload midwives providing care for their allocated clientele throughout the continuum of pregnancy, labour and birth. Caseload midwives were expected to be present for all births for the women allocated to them and provide their follow-up postnatal care, with responsibility for care altered only by annual leave requirements or unexpected coverage needs negotiated between the caseload group (for example, due to professional development or illness).

Conclusion

In response to issues pertaining to rural inequity, the Australian government has constructed health policy to address issues such as childbearing women needing to travel long distances for care, midwifery workforce shortages, maternity service closures due to a lack of financial viability, and women's desire for continuity of care by a known provider. Service remodelling throughout rural Australia has occurred in a variety of locations. The health service under study has been outlined, demonstrating also my role in the study setting prior to research involvement and how I related to study participants, some of whom were previous colleagues. Four distinct phases of change have been identified. These phases will be referred to further during the study findings and discussion chapters.

The following chapter provides a review of the literature concerning the Australian health system and health service workforce, and recent maternity reforms including midwifery continuity of care in the context of Australian service provision.

Chapter two: Literature review

Introduction

The Australian health system has continually developed and adapted as a model that has long provided private and public healthcare. The changing face of Medicare, the public healthcare scheme, and additional policy revisions have impacted on how maternity services are provided nationally. Australian health services have also moved to adjust maternity service delivery alongside funding incentives. The structure that Australian healthcare – and, more specifically, that of rural health and maternity services – has taken due to policy shifts has also been largely influenced by midwifery and nursing workforce pressures. The increasing deficit of midwives across Australia and lack of financial viability for services have been acknowledged as significant factors linked to rural maternity service closures (Pesce, 2008). These, along with known inequity issues, such as financial hardship and distance to services, are demonstrated in current literature. The redevelopment of maternity services and the institution of continuity of care midwifery models have been applied to rural localities in response to women's requests for a known and consistent care provider close to where they live. As suggested, alterations to health provision and midwifery practice have meant significant change and restructure for healthcare organisations.

A cumulative index to nursing and allied health literature (CINAHL) search strategy was used prior to data collection, and during research analysis. Key terms used to search literature were, maternity provision, Australian, Medicare, rural health, rural midwifery, birth inequity, maternity reform, continuity care and midwifery workforce, change communication, community inclusion, change management

and rural health policy. The following section examines the literature related to the Australian health system, workforce characteristics, midwifery care in the rural context, and change management theory.

The Australian healthcare system

The Australian healthcare system, including maternity care provision, is divided into two sectors: public and private. Taxpayer-funded, public healthcare, which is free or heavily subsidised, may be referred to as a 'welfare funding model', while private healthcare acts as a 'market-based system', allowing for consumer choice and business-driven profit for individual or collective healthcare providers (Willis, Reynolds, & Keleher, 2012). The consumer may choose to enlist either sector in the management of their healthcare at any time; however, variables such as accessibility to preferred healthcare providers or appropriate local resources are problematic in rural locations. As public health sector agendas and priority funding influences the availability and accessibility of maternity services within the public health system, differences in individual private insurance cover (or the lack of), together with place of residence (for example, rural location), largely dictate maternity care options for Australian women (Donnellan-Fernandez, 2011).

Health insurance covers most out-of-pocket costs charged for medical and other treatments in the private sector, inclusive of private obstetric and midwifery care (Willis et al., 2012). Private health insurers vary, however, in the annual fees they charge and the terms and extent of the cover offered. While both healthcare sectors are responsive to consumer demands, the public system is continually adjusting to meet the evolving needs of the total Australian (ageing) population

and, more specifically, maternity and rural health service sustainability. Furthermore, employees in the public sector are more obliged to provide evidence-based care, delivered in accordance with state and federal polices and guidelines.

Australia's original universal public healthcare scheme, Medibank, was introduced in 1975. It was a significant health reform, and one which was central to an equity-based political agenda, inclusive of women's rights and more equal access to educational and employment opportunities (Palmer & Short, 2010). In 1984, the then government instituted a revised public health insurance scheme, which was termed 'Medicare', and which remains in place today. Government funding, allocated to separate groups (hospitals and healthcare providers), aims to deliver accessible public healthcare free to all eligible recipients (Duckett & Willcox, 2011). The scheme includes inpatient, specialty and ambulatory care within the hospital environment, and payments to primary care providers for additional services, including consultations by medical, midwifery, optical, dental and allied health professionals. Funding and service agreements, relevant to Medicare, are shared between federal, state and territory governments, while hospital arrangements are managed by Local Hospital Networks as part of the current National Healthcare Agreement (Willis et al., 2012).

National Healthcare Agreements, policy reforms and maternity-related Medicare agreements were first introduced during the 1980s, in an effort to improve hospital efficiency and financial accountability (Duckett, 1995). These formal agreements outline national objectives, output requirements, expected outcomes, and

performance measures. Healthcare targets, including improvements to rural maternity services, have been driven by consumer demand and a need to curb excessive expenditure (Commonwealth of Australia, 2009). All health-related funding is increasingly performance related, with failure to meet targets resulting in financial penalties for the respective hospital or Local Hospital Network (Department of Health Victoria, 2013).

Local Hospital Networks, which link hospitals in geographical proximity, aim to ensure ongoing service collaboration and more efficient use of available resources. Each network operates under a Local Hospital Agreement, which is condensed and has a statutory authority, and as such is bound by the *Health Services Act 1988*, with a reporting line directly to the relevant state; compliance with the terms of agreements is required (Commonwealth of Australia, 1988). Co-ordinated reform in the primary care sector has seen the formation of 'Medicare Locals', regional organisations tasked with planning and coordinating improvements in primary healthcare for a designated population. As such, Medicare Locals enable care providers to tailor services to local community needs, thus refining provision and reducing duplication of resources, while improving multidisciplinary working among clinicians. It is anticipated that these changes will benefit rural populations by decreasing inequities in healthcare delivery (Australian Nursing Federation, 2012).

As discussed, healthcare reforms have been introduced to counter spiralling costs associated with the subsidised provision of healthcare and medicines in the public sector; however, these reforms have done little to remove pressure from the public

healthcare system (Martins, 2009). Consumers continue to increase their use of publicly funded facilities, such as emergency departments and inpatient care, which are free from out-of-pocket expenses (van Gool, Savage, Viney, Haas, & Anderson, 2009). While the rate of private health insurance cover in Australia has remained steady at approximately 45% of the population over the past decade (2000–2010), a 4.2% annual increase in emergency department presentations between 2007 and 2012 is indicative of the continued pressure on public sector resources (Australian Institute of Health and Welfare, 2012a). Some of the problems facing the Australian healthcare workforce that continue to compound service demands are on-going difficulties with staff recruitment and retention in rural locations.

The next section outlines health workforce demands within Australia, and those pertaining specifically to maternity services and midwifery practice in the rural sector.

Australian health services demand

Work force analyses indicate an ongoing, and escalating, demand for trained healthcare personnel. Additional pressures are generated by rising consumer expectations and an ageing population that is living longer and needing ever more complex services to meet the burden of chronic disease (National Health Workforce Taskforce, 2009). The healthcare workforce is also ageing and not being replaced, as young people (especially girls) are less constrained by the narrow range of professional occupations available to their predecessors. Nationally and internationally there is strong competition to recruit and retain well-

trained health professionals, while simultaneously fostering a locally sustainable workforce model (Health Workforce Australia, 2011). This is problematic, however, not least because of competing international labour markets, fluctuating employment needs across healthcare disciplines and localities, and significant disparities in health indices between rural and urban populations (Health Workforce Australia, 2012a).

While domestic training places within the healthcare industry have been increased as a long-term solution to workforce shortages, projected needs are nonetheless expected to outstrip supply, with a deficit of approximately 110,000 midwives and nurses Australia-wide by 2025 (Health Workforce Australia, 2012b). Although increasing student intakes is an important strategy for future planning, the benefits are likely to be limited in rural areas, in part due to the acknowledged difficulties in attracting and retaining staff with the requisite skills (Health Workforce Australia, 2011).

In keeping with international trends, the Australian healthcare industry has become an increasingly specialised workforce. This poses significant problems in rural areas where 'generalist' practitioners, possessing a broad range of clinical skills, are needed. Skill diversity and flexibility, including a willingness to be temporarily redeployed to neighbouring areas that may be inadequately served, are thus essential to ensure rural facilities continue to be well staffed (Health Workforce Australia, 2011). The emergence of discrete medical sub-specialties, often requiring specialist training, diagnostic and treatment facilities, has inadvertently exaggerated inequalities in healthcare provision for rural populations,

who are often dependent on the knowledge and skills of single-handed practitioners who lack access to sophisticated tests and amenities. These changes in skills and knowledge, and in clinical procedures, have increased staffing requirements as specialist practitioners replace previous generations of 'generalists' who were competent to undertake multiple roles simultaneously (National Health Workforce Taskforce, 2009). This 'specialist' model has been shown to be unproductive and unsuitable for rural healthcare provision as professional bodies such as the Australian College of Rural and Remote Medicine (2016) highlight a requirement dynamic, independent and adaptable practitioners.

The following discussion identifies the characteristics of and issues affecting the midwifery and nursing workforce.

Maternity and nursing workforce characteristics

Midwifery and nursing staff are the largest health-related workforce population in Australia, three times larger than medical staff (National Health Workforce Taskforce, 2009). Rural employment data indicates an ageing and part-time distribution of staff, with more than one third of nurses and midwives over 50 years of age (Australian Institute of Health and Welfare, 2012b). The average age is increasing: for midwives this was 50.2 in 2011, compared to 48.8 in 2007; the decrease in average weekly hours worked is also disproportionate to increasing age, with approximately 73% of under 25s working full-time compared to just 44% of those aged 55 years and above (Australian Institute of Health and Welfare, 2012b). The exit rate for midwifery staff is more than double that of medical staff, although a proportion of these 'exits' may be temporary due to maternity or study

leave; permanent exit is generally linked to retirement or to midwifery staff

retraining and changing professions (Health Workforce Australia, 2013). The

increasing age of Australian midwives and nurses (particularly those in rural

areas), alongside fluctuating retention and exit rates, is indicative of an overall

decline, with projected midwifery workforce demand exceeding supply by 2025

(Health Workforce Australia, 2012a). Midwifery workforce projections are

considered less reliable, however, with current workforce projections calculated

based on a births-by-population ratio, and not accurately reflecting or accounting

for all midwifery work-based activities. Midwifery workforce demand statistics are,

therefore, considered potentially greater than presently estimated (Health

Workforce Australia, 2012a). Innovative scholarships, with rural weighting and

increased practice-level support, have been identified as a means of attracting

potential staff and hence reducing these deficits (Health Workforce Australia,

2012c).

The majority of midwives and nurses are employed within hospital and acute

service settings, with approximately 6.6% in residential mental health services,

and 8.2% in community settings (Australian Institute of Health and Welfare,

2012b); 5.1% of midwifery and nursing personnel work within the private sector

(Health Workforce Australia, 2013). Although affecting only a small percentage of

the overall population, private practice employment demonstrates reduced exit

rates, perhaps suggesting better awareness of the need to actively engage in staff

retention practices and improved working conditions compared with the public

sector (Health Workforce Australia, 2012d). Australian midwives and nurses work

an average of 32.8 hours/week, with increased hours associated with

geographical distance from metropolitan areas. Midwives and nurses in rural areas are thus more likely to work longer hours (up to 39.5 hours/week) and are also more likely to be required to work split shifts, and cover for colleagues at short notice (Health Workforce Australia, 2013).

The next section briefly describes the maternity options available to childbearing women in the Australian context.

Australian maternity services

Statistical data demonstrates that general population growth has been maintained at a steady, to marginally increased, rate in Victoria, with the state retaining a significant percentage of the total Australian population (Australian Bureau of Statistics, 2013). The birth rate in Australia is approximately 300,000 per annum with Victorian state-registered births totalling 25% (Australian Bureau of Statistics, 2012). Victorian first-time mothers account for 43.3% of births, compared with the all-Australian rate of 41.6% (Li, McNally, Hilder, & Sullivan, 2010), while the median age of Australian mothers has increased from 28 years in 2010 to 30.8 years in 2013 (Australian Bureau of Statistics, 2013).

Maternity provision typically involves the delivery of antenatal, labour, birth and early postnatal care (to six weeks) for women and their infants. While the majority of care is delivered by midwives and/or obstetricians, actual models of care are likely to vary considerably between rural and urban areas, and between the private and public sectors (Commonwealth of Australia, 2011). Support from allied health professionals, including dieticians, physiotherapists and mental health specialists, is more likely in urban settings, although organisational workloads and hospital rostering requirements will also affect availability.

Midwifery-led services make provision for a lead midwife to deliver care, with appointment schedules largely negotiated directly between the midwife and her client(s) (Commonwealth of Australia, 2009); the continuity provided by midwifery-led models of care is highly valued by women (Homer et al., 2011). Midwifery-led care is generally suggested for women with low-risk pregnancies; as women are often referred to specialists if complications arise, though Tracy et al. (2013) have demonstrated the benefit of continuity care for women of all-risk.

Shared care arrangements provide flexibility in appointment schedules through most of the pregnancy, although women are still booked for birth at public hospitals where they are attended by rostered staff who they are unlikely to have met previously. Combined maternity care may include obstetricians and midwives, in addition to GPs (Commonwealth of Australia, 2009). Outreach maternity care, available within the Medical Specialist Outreach Assistance Program, provides multidisciplinary maternity care to rural and remote areas of Australia where access to services is otherwise limited (Willis et al., 2012).

Publicly funded maternity care models may thus include hospital and community-based clinics, outreach care, 'team' midwifery, caseload/midwifery group practices, and birth centres (Commonwealth of Australia, 2009). While publicly funded homebirth is technically an option, in reality the rates for Australian women are negligible (0.22%) compared with the United Kingdom (2.7%) and New Zealand (2.5%) (Commonwealth of Australia, 2009). The Australian homebirth rate starkly compares to the Netherlands, where 25% of all births are homebirths

(Statistics Netherlands, 2011). Australian maternity statistics reflect two key birth options: public hospital care (approximately 70%) and private hospital care (30%) (Commonwealth of Australia, 2008).

Private obstetric care is costly and is associated with high intervention rates, including caesarean section (Li et al., 2010). Although the caesarean rate in both public and private sectors in Australia almost doubled to 32% from 1991 to 2011, the private sector rate far exceeds that of the public sector: 43% compared to 30% (Li, Zeki, Hilder, & Sullivan, 2013). As previously mentioned, publicly funded maternity care options, including different models of maternity care, are largely determined by (hospital) location, workforce availability, demand and access to support services.

The next section discusses caseload midwifery as a primary model of care. It is supported by the Australian federal and state governments as a method of addressing resource demand, and improving maternal and neonatal outcomes.

Continuity of care: the caseload midwifery model

Caseload midwifery has been demonstrated as a safe and cost-efficient maternity model for Australian women that provides continuity of care provider, so care can be tailored to the individual woman's needs (Tracy et al., 2013). Midwives providing care take a primary caseload, this being three to four women per month pro rata, delivering antenatal, birth and postnatal care. Tracy et al. (2014) highlighted the relationship of continuity between the woman and midwife as a significant characteristic, specific to caseload, which is preferred by women.

Research suggests women's experiences of caseload to be satisfying, with less birth intervention and a greater sense of control during their period of care (Williams, Lago, Lainchbury, & Eagar, 2010).

Previous Australian literature identified caseload as an appropriate model of care for the low-risk woman, with research by McLachlan et al. (2012) demonstrating fewer caesarean sections. This view is supported in a recent Cochrane review by Sandall, Soltani, Gates, Shennan, and Devane (2013) who concluded that most women should be offered and encouraged to ask for a continuity model of care (that is, caseload). Sutcliffe et al. (2012) also provided a meta review confirming improved maternal outcomes and satisfaction as a result of midwifery led care. Sandall et al. (2013) advised caution on the part of care providers booking women with increased obstetric risks into midwifery-led continuity care. Tracy et al. (2013), however, demonstrated that the proportion of caesarean sections, irrespective of level of risk, did not differ in women provided with caseload care. They concluded that caseload care was appropriate for women of 'all risk' regardless of selected characteristics, such as parity and obstetric history.

The quality of ongoing communication provided by caseload midwives has been identified by women as an important factor that establishes a trusting partnership, including with women from minority ethnic groups (Kemp & Sandall, 2010). Beake, Acosta, Cooke, and McCourt (2013) indicated that the relationship that developed through caseload midwifery care facilitated conversations in which women felt more able to ask questions and air their concerns. While this study was undertaken in a metropolitan locality, Beake et al. (2013) acknowledge that the principles of continuous communication and relationship building, as they apply to

caseload, are applicable to all women, particularly those with problems of equity of access. Rural Australian women are a known population, limited by accessibility, choice and proximity to maternity services. Women in rural and remote areas in Australia have been highlighted by Kildea, Kruske, Barclay, and Tracy (2010) as a population in particular need of quality collaborative, local, caseload provision, and findings from their research has advised the restructuring of services in response to this need.

Recent literature from the Australian context, focused on midwives' experiences of caseload care, suggests midwives welcomed the increased autonomy, but also indicates a good work–life balance was necessary, along with support from family and a flexible work dynamic (Edmondson & Walker, 2014). Menke, Fenwick, Gamble, Brittain, and Creedy (2014) note similar findings, asserting that midwives who provided caseload care felt proud of their work and the positive impact they made when working with vulnerable women; however, they felt additionally frustrated by a lack of organisational support for the caseload model of care. Some research suggests that while caseload is a feasible model of care in the rural context, further research is required on how it is best implemented and sustained (Brown & Dietsch, 2013).

The next section describes rural maternity services in Australia, with a particular focus on Victoria, and the rural health service that was the site for my study.

Victorian rural maternity services

Maternity funding specific to rural locations is allocated using geographical parameters established by the Australian government. Demographic areas are

defined in accordance with the Rural, Remote and Metropolitan Areas classification, and the Accessibility/Remoteness Index of Australia (Commonwealth of Australia, 2007). Victoria (the capital of which is Melbourne) is categorised as having metropolitan, inner and outer regional and rural areas, with the health service under study serving a large rural area of Victoria (Australian Institute of Health and Welfare, 2004).

The Rural Maternity Initiative funded the implementation of nineteen continuity of maternity care models within rural Victoria between 2003 and 2011; the maternity health service under study was one such model. Funding was initially granted in 2006 to plan and introduce a 'modified' caseload midwifery service, so named due to the continued employment of permanent night duty midwifery staff (Edwards & Gale, 2007). Since 2007, low-risk pregnant women living within the catchment area have had access to local shared care arrangements, in addition to modified caseload midwifery services. At the time of writing, shared care required a referral to, and booking with, a metropolitan hospital in Melbourne or another regional Victorian city, potentially a three-hour round trip away. Private obstetric care was also available, although this similarly required women to travel to a metropolitan centre. Block-funded maternity services have allowed this area and surrounding districts to maintain low-cost and accessible maternity options within a primary care setting (Department of Health and Ageing, 2011).

Victorian state statistics report approximately 74% of infants are born within the Melbourne metropolitan region (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2010). Rural Victorian births, as identified by place of

residence, are approximately 24% of the total state population, with less than 2% of births identified as women residing interstate but birthing in Victoria. Regional and rural Victorian hospital data does not reflect these birthing numbers, however, with statistics showing lower numbers of births reported by rural hospitals than those registered within the local catchment area (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, 2010). This suggests that while rural Victorian women may be accessing antenatal care locally, they are travelling to larger, urban maternity care centres in Victoria for labour, birth and postnatal care.

The next section describes issues of particular concern to rural-dwelling childbearing woman, including unequal access to maternity care and reduced options for care.

The urban–rural divide: disparities in maternity care provision

Disparities in maternity care provision affect the options available to pregnant women; living in a rural location, for example, may severely limit, or even negate, choices with respect to models of maternity care, the availability of pharmacological analgesia in labour and other interventions including caesarean section (Donnellan-Fernandez, 2011). Pregnant women, especially those with complicated pregnancies, may also incur additional financial burdens and endure family distress as a result of mandatory relocation to metropolitan hospitals for investigations, treatments and/or birth (Evans et al., 2011).

Geographical isolation continues to hinder specialist service provision, despite the fact that 34% of the population live in rural, regional and remote areas of Australia (Commonwealth of Australia, 2007). As previously stated, many rural birthing services have closed, with 130 units across Australia disbanded since 1995 (Pesce, 2008); midwifery and nursing staff shortages, especially within Victoria, have substantially increased pressure on remaining rural health service providers (Australian Institute of Health and Welfare, 2012b). While the provision of rural Victorian maternity services has gradually reduced, the Australian population of childbearing women requiring maternity care has remained constant.

Future provision of rural maternity services thus appears dependent on optimising the capacity of the local workforce; for example, by offering training and skill-development opportunities, and innovative and more flexible approaches to practice (Pesce, 2008). Caseload maternity care is one such innovation delivering benefits to both staff and employer as it provides a flexible specialty career pathway for rural midwives, while also addressing the care preferences of rural-dwelling, childbearing Australian women (Francis & Mills, 2011).

The Maternity Services Review, which was informed by wide-ranging stakeholder opinions including those living in rural areas, laid the foundation for an Australia-wide maternity service reform to be disseminated through state and territory governments (Commonwealth of Australia, 2009). Women living in rural areas had expressed dissatisfaction with the maternity services they received and emphasised their rights to access care that was safe, while also exercising choice (McIntyre, Francis, & Chapman, 2011). Many also voiced strong preferences for a

move away from a medicalised model of care to other options such as primary midwifery-led care, homebirth and birth centre provision of care (McIntyre et al., 2011). A key conclusion of the review was that women's choices in maternity care could be improved if greater recognition was given to the role of midwives in service provision. Hence, the call to reform maternity care provision within organisations such as the rural service reported in this study.

The Australian government continues to encourage the effective use of midwives working in primary maternity services, requiring relative change management skills for organisations remodelling care provision (McIntyre et al., 2011). Professional lobby groups have also continued to apply pressure for the provision of equitable and sustainable rural maternity services, which has helped to engage the support of more diverse groups of maternity service stakeholders (National Consensus Framework for Rural Maternity Services, 2008). Ongoing support for rural Victorian maternity services was further evidenced by a 9% increase in funding between 2010 and 2011 (State Government of Victoria, 2011). For rural centres such as the health service under study, future challenges will be focused on increasing the provision of cost-effective continuity in care within the framework of primary care (caseload), with a midwifery-led service located within a hospital environment or community setting.

The next section provides an assessment of key change management theories, citing seminal theorists and selected change management approaches that have been referenced in the healthcare and midwifery literature.

Change management theories and approaches

Change management literature makes references to a number of pertinent theories, including Lewin's change theory. Kurt Lewin, a seminal researcher in the area of social psychology and group dynamics, applied a systematic approach to organisational change (Lewin, 1951). He led the development of field theory, in which he asserted that it is possible to understand and predict some behaviours by identifying the psychological pressures that influence those behaviours. Lewin's original model of change consisted of 'unfreezing', 'change making' and 'refreezing' (Mitchell, 2013, p. 33). This involves preparing staff accustomed to maintaining the status quo to understand the need for change, and then actioning change through effective communication and staff-empowerment strategies, and finally establishing change as routine throughout the organisation. Lewin later applied his understandings to organisational change theory (Burnes & Cooke, 2013).

More recently, Michie et al. (2014) suggested the Theoretical Domains Framework (TDF) as a possible change theory, based as it is on a collection of psychological theories used to implement evidence-based research findings into clinical practice. In short, TDF works to effect behavioural change in staff. Michie et al. (2014) noted several primary 'domains' when seeking to change individual behaviour. These included the identification of what needs to change, knowledge and skills required for change, and an understanding of the consequences resulting from change. The social and physical environments were also included – alterations to which often generate stress and emotional responses in those involved. Four steps for implementing TDF-informed change include: 1) identification of need, 2)

selection of appropriate theories to inform change, 3) use of selected domains (as noted above) to consider change techniques and modes of delivery, and 4) outcome measurement (French et al., 2012). While maternity service redesign involves complex behavioural changes, TDF can be applied as a framework for changes in work practices and service delivery. If carefully considered and appropriate to need and location, TDF may be an appropriate theory to inform change pathways.

Conclusion

This review of the salient literature has demonstrated an overview of the Australian health system and policies designed to enhance the provision of rural maternity care through continuity models; namely, caseload midwifery. Further to this, the Victorian state government Rural Maternity Initiative funding agreement has been described, alongside rural disparities and change management theories of relevance to health and midwifery research. The following chapter examines the study design, methodology and strategies applied in this study during the phases of data collection and analysis.

Chapter three: Study design and research methods

Introduction

Prior to undertaking this research project, I became aware that my midwifery colleagues, who had gained employment within the new modified caseload model, appeared unsure about how to adapt from a medical model of care to a more independent scope of practice. This was despite the fact that they were all very experienced practitioners and competent working in rural settings. I, therefore, chose a qualitative design for my study to explore possible reasons for their uncertainty, and to gain broader insight into the reforms that had occurred, and which had substantially affected their roles, collegial relationships and clinical practice. Hence, my research sought to describe broader changes in the midwives' working environments, including possible effects on their relationships with their midwifery and medical colleagues. In addition, my study sought to explore how midwives described their clients' use of the maternity service prior to, and following, the change in provision.

Research question

How do midwives describe the change in maternity care provision, in a discrete rural setting in Victoria, from a medicalised model of care to a continuity model of care?

Aim

The aim of the study was to investigate how midwives working in a rural Victorian location described recent and evolving changes in clinical practice, and their working environment, and the effect on their clients and colleagues.

Objectives

The study objectives were to:

1.   explore how midwives employed by the health service accounted for

       changes in their working and non-working environment by describing their

       individual understandings of the change processes

2.   examine how midwives described the new model of care, including any

       changes in clinical practices compared with how they had worked

       previously

3.   explore how midwives described their clients' current use of maternity

       services and how this compared with previous use.

Study design

Qualitative research

A qualitative research methodology was chosen to address the study aim and

objectives because the project sought to understand midwives' perspectives. This

was done by recruiting a small sample of midwives and asking them about their

clinical experiences and how they described recent organisational changes to the

model of midwifery care, including their working environment and the effects on

their clients. While significant literature addresses midwifery perspectives of

maternity care provision within the Australian context, this study aimed to

investigate the complex process of change, and the impact of rurality on clinical

practice, as perceived by the midwives living through the experience (Stewart,

2011).

Qualitative research is a type of methodological inquiry that examines a human

problem or social reality with participants in their 'natural' setting. A unique

situation is studied by typically involving small sample populations. How the researcher interprets the data informs study analysis, as both are entwined and not separate to the process (Holstein & Gubrium, 2003).The participant experience is appreciated as subjective, and individual perspectives are dependent on how each person interprets meaning and applies that to the way they see their world. Interview and observation methods are commonly used to collect data. The researcher enters into a relationship with participants and with their data, which gives 'voice' to their stories, as a specific picture of the place, culture and study context begins to form (Denzin & Lincoln, 2008).

This is in contrast to quantitative inquiry, arguably a more objective process, which begins with a hypothesis, and uses numerical data and mathematical analysis to prove or disprove theory. Quantitative studies aim to produce a result that is generalisable across large populations using methods, such as randomisation, to control variables. These broad methodological differences confirmed the appropriateness of a qualitative approach for this study.

The following section describes symbolic interactionism, as the theoretical perspective that framed the study inquiry, and its application to Grounded Theory.

Symbolic interactionism

Symbolic interactionism is attributed to the field of sociology and is understood to be a perspective of human conduct based on three main assumptions:

1.   humans relate with people and things depending on the meaning they attribute to them

2.   meaning is formed from the interaction that each person has with the other

3.   each person filters and modifies meaning as they individually interpret

encounters with others (Blumer, 1986).

George Herbert Mead, a pragmatist, Darwinist and behaviourist in the early 1900s,

significantly advanced symbolic interactionism while working for the University of

Chicago. He taught that pragmatism was an important element in symbolic

interactionism; that humans investigate their world to determine their own reality

and that they obtain knowledge and define their environment based on its level of

usefulness. In other words, perceived usefulness informs the level of value placed

on something or someone, which in turn influences the type of meaning placed on

these interactions in our world. Mead believed that to understand humans we must

focus on human behaviour. Herbert Blumer, a student of Mead, added to this

perspective, asserting that the concept of 'self', which is unique to humans, also

informs meaning and that this leads to self-directed behaviour. Blumer further

asserted that human behaviour is not just an individual action, but that we align

ourselves to groups of people who share meaning during the process of

socialisation (Charon, 2004).

The methodological framework for Grounded Theory is therefore underpinned by

symbolic interactionism. This is evident as the researcher must interact with

participants using qualitative methods in an attempt to make sense of the symbolic

meaning a participant places on a person, group, event or situation. In addition to

this, the researcher must be aware of their own subjective interpretations, and

personal biases, during data collection and analysis. Hence the need to reflect on

and construct the researcher's own impressions, through the notation of ideas

(memoing), of how they and the participants view their separate realities (Morse et

al., 2009). The following section clarifies the background to Grounded Theory methodology and the overarching methods used in data collection and analysis, concentrating on constant comparative analysis.

Grounded Theory key points

Grounded Theory was the chosen methodology and theoretical framework upon which this study was based. Grounded Theory was first introduced by Barney Glaser and Anselm Strauss with a seminal publication that asserted that theory should move beyond description of an event to explain how and why a situation has arisen. Glaser and Strauss (1967) argued that theory should be 'grounded' in the data and developed a systematic approach to theory construction. This was advocated through obtaining and analysing data derived from participants' social worlds using specific methods of sample selection, data collection and analysis (Glaser & Strauss, 1967). Strauss (1987) stressed two important processes: 1) coding and 2) analytical memoing, which must be incorporated into the study design. These two processes form the basis of constant comparative analysis – that is, constant comparison of codes and categories from data generated from the interview and memoing processes, and which are integral to the generation of theory. The development of systematic methods used to explain social process advocated by Grounded Theory were, at that time, unprecedented in qualitative research. Since its introduction, Grounded Theory has continued to evolve and has since become a popular qualitative methodology, particularly in the area of health science (Charmaz, 2006).

Glaser and Strauss advocated a method that 'distanced' the researcher from intensive participant interaction (Glaser & Strauss, 1967). They believed that this

provided a more uncontaminated or objective view from which the reality of a phenomenon may be better understood and interpreted. As Grounded Theory has developed, modifications have occurred to the strict methodological processes originally described. Over time, Glaser and Strauss identified differing perspectives on Grounded Theory that led to 'conflict' – though it is widely accepted that their personal and professional respect endured (Boychuk Duchscher & Morgan, 2004). Glaser referred to Grounded Theory as a method rather than a methodology, advocating the 'emergence' of key themes, rather than 'forced meaning' (Glaser, 1978). Glaser focused on the emergence of a core category while constant data collection and analysis took place. Strong emphasis was also placed on the analytical process of memoing, with Glaser arguing that coding done while advoiding or restricting memoing was not Grounded Theory (Glaser, 1978).

As mentioned, Grounded Theory has gone through several stages of change since its inception. Literature discusses these stages more broadly as 'generations' of Grounded Theory, as both researchers began to work separately. Strauss mentored a new wave of Grounded Theorists (Birks & Mills, 2011). Strauss and Corbin began a move away from Glaser's original view of Grounded Theory in the early 1990s, with Strauss, in particular, moving away from Glaser's post-positivist philosophical perspective, in which the researcher remained a detached and objective observer, towards a symbolic interactionism influence. Strauss and Corbin questioned where, if and how the researcher was positioned in the research; more recently, Charmaz has proposed Constructivist Grounded

Theory, which views data as socially constructed, rather than 'discovered', whether by participants or the researchers (Bryant & Charmaz, 2011).

Contemporary theorists such as Corbin, Charmaz and Clarke acknowledge that Grounded Theory evolves from realities constructed by those participating within each individual research study. Additionally, Constructivist Grounded Theory advocates flexibility and reduced rigidity surrounding methodological strategies (Thornberg & Charmaz, 2014). Clarke's contribution to Grounded Theory added situational analysis through a feminist lens. In essence, situational analysis moves beyond grounding theory in data and the construct of participant and researcher realities, and adds the mapping of social processes in the broader circumstance under study (Morse et al., 2009). Situational analysis proposes relational mapping, one of three main types of map analysis, as a strategy for linking codes and examining the nature of their relationship in the context of each circumstance (Clarke, 2005). Clarke's influence has been demonstrated (see the section on diagramming, later in this chapter) during constant comparative analysis as a means of articulating concepts and key themes emerging from the data. The researcher uses Grounded Theory methods such as observation, memoing, field notes, and 'diagramming', to reflect on, examine and evaluate their position and influence throughout the study (Morse et al., 2009).

Grounded Theory modification

The current study has been principally influenced by Corbin and Strauss (2008). Additional influence has been derived from Charmaz (2006), the Constructivist Grounded Theory viewpoint, and Clarke's situational mapping, referred to here as 'diagramming'. While fundamental procedures such as constant comparative

analysis (see 'Grounded Theory key points'), along with progressive memoing, have been adhered to (Glaser & Strauss, 1967), this research modified the Grounded Theory approach to align with the third generationalist constructivist standpoint (Bryant & Charmaz, 2011). Rather than distant analysis, the researcher 'partners' with participants, so that their voices and the integrity of their words remain, while theoretical analysis moves the research forward to a major theoretical concept (Birks & Mills, 2011). Further to this, purposive sampling was undertaken, largely due to the small research site, size and limited sample population. The use of purposive sampling is not unheard of in Grounded Theory research, however, as a precursor to theoretical sampling. Thornberg and Charmaz (2014) acknowledge that all Grounded Theory studies must, as a beginning point, utilise simple sampling strategies, such as purposive sampling. Once 'categories' have been generated, Charmaz asserts that theoretical sampling should then be employed. In this study, a select sample of midwives working in an exclusive rural location was identified as the sample population. While constant comparative analysis, memoing, coding and categorisation of data occurred, the sample population, pre-determined in the research planning stage, remained the same (Thornberg & Charmaz, 2014).

Glaser (1978) advocated a delayed approach to the review of literature during research. Rather than an initial literature search prior to data collection, a literature review was instead advised at the latter stages of analysis and study write-up. The intention was for the researcher to remain unincumbered by previous theories and influences. Constructivist Grounded Theory, however, suggests that literature can be used as a way of enhancing one's research by learning from other

perspectives, mistakes or findings (Thornberg & Charmaz, 2014). In this study, literature was repeatedly sought, reviewed and prioritised during the period of data collection, analysis and thesis construction. A detailed literature search and examination of the Australian health system, workforce constraints and maternity reform was, however, conducted prior to participant recruitment. Principle Grounded Theory methods have been used with some adjustment to the strict theoretical framework dictated by Glaser and Strauss (1967), thus the method used is described as modified Grounded Theory.

With these modifications in mind, a Grounded Theory approach allows the development of themes generated from the participants' perspectives, and is particularly useful to explain complex relationships in circumstances where knowledge is limited or there is no previous knowledge of the area under study. This notion is of particular relevance when considering the limited research in the context of Australian rural maternity service redesign and community involvement therein. The following section discusses the nexus between the position of the researcher and study participants, and Grounded Theory methods.

The researcher's position

My position, previously discussed, resonated with the principles of an emic, or 'insider' approach to qualitative research. The emic perspective differs from that of the etic, whereby the researcher studies the participant and their words from an 'outsider' perspective; that is, they do not actively participate in the culture (Gobo, 2008). As previously suggested, the use of Grounded Theory methods, such as memoing, provided a mechanism to explore my own assumptions and biases in a safe forum, reducing the opportunity to influence or misdirect analysis (Birks &

Mills, 2011). I was also mindful of the potential for power imbalances during the collection and analysis of data, as discussed within the ethical considerations section of this chapter (Damianakis & Woodford, 2012).

The following discussion describes in greater depth the methods of Grounded Theory. It also addresses how these methods have been incorporated into the study design.

Grounded Theory principles

Constant comparative analysis

Constant comparative analysis requires that data is continually collected and coded to identify emergent themes (Corbin & Strauss, 2008). Analytical labels, called 'codes', are generated by the researcher and are used to title emerging patterns in the data. These are constantly reviewed, and change and merge from one code to another. This process informs the development of larger themes, created or adapted throughout the comparative coding process. Grounded Theory uses the terms 'category' and 'theme' interchangeably. For the purpose of this study, I have used 'theme' to describe the linking of codes into a larger collective group. Some themes contained smaller clusters of codes – sub-themes, linked to a larger theme – yet they also contained different properties within the overall theme.

Themes and codes differ to properties. A 'property' is a type of conceptual characteristic that may be contained within a code and helps bind codes to themes (Glaser & Strauss, 1967). Progressively and repeatedly, coding of data continues until the emerging themes are completely saturated, which implies that

no new data is generated. Complete saturation must ensure that the conceptual properties within codes and themes are fully explored and explained. It is from this process that theoretical concepts emerge, which in turn form the basis of an emergent theory (Strauss & Corbin, 1990).

The process of constant comparative analysis is thus integral to the emergence of theoretical concepts. This process occurs simultaneously to (or in contradiction to) my reflective interpretations, which reflected an understanding of the participants' situational perspective and were used to generate more concepts that formed, saturated and connected themes (Bryant & Charmaz, 2011).

Constant comparative analysis is achieved through the process of both inductive and abductive reasoning (Bryant & Charmaz, 2011). Inductive reasoning was demonstrated as I progressively coded and reflected, attempting to interpret hypothetical understandings of what may be occurring in the data. Inductive reasoning was further undertaken as I returned to the 'field' to gather additional interview data, attempting to make sense of the emerging themes. It was during this process I aimed to identify a major theoretical concept. If this theoretical concept is of high quality (well saturated) it may evolve, through continued analysis, to an emergent theory. In other words, the research reaches a solution, or an explanation for an occurrence or state within the individual situation under study (Bryant & Charmaz, 2011). A major theoretical concept that evolved during the analysis focused on community inclusion during the maternity service change in the rural locality where this study was based. However, further saturation (see 'Strengths and limitations') was required to develop an 'emergent theory'.

Abductive reasoning, associated with Constructivist Grounded Theory, implies a type of reasoning that is used to explore possible explanations for the data, and to answer the research question. Ultimately, the most reasonable and applicable explanation is selected from which, as previously suggested, an emergent theory may be produced (Morse et al., 2009).

The next section elaborates further on the method of coding and categorisation in a Grounded Theory approach. It will also consolidate for the reader how these processes are interwoven in the process of constant comparative analysis.

Coding and categorisation of data

Coding, an essential element in qualitative analysis, is a continual comparative process in Grounded Theory research and is separated into initial and intermediate coding stages. Initial coding represents the beginning of a complex and methodical analysis process that involves identifying codes within data. A code is typically a repeating event or reference to interactions, people or places highlighted in the data. Primarily, coding occurs at the level of paragraph or sentences, which are highlighted and set aside for repeated comparison and investigation, potentially forming part of a theme (Chenitz & Swanson, 1986). Coding is seen as a process of breaking apart or disrupting data, and involves the researcher re-working and challenging their own interpretations as they examine the concepts created as code. During the initial coding phase, the principal and co-supervisor independently coded selected participant transcripts for comparison and further analysis, further ensuring research analysis quality and reliability.

It is essential that codes are named using developed terminology understood by researcher(s) and participants, rather than simply paraphrasing information, thereby embodying an inductive analytical process (Strauss & Corbin, 1990). While coding, I provided a working definition for each code along with its connection to any emerging theme. Each code was given a description, one which changed over time in response to additional data. The description was understood by myself and those participating in the study (that is, supervisor and co-supervisor). The researcher must evaluate how coded data impacts the study process; for example, by continually questioning the data during coding and analysis, thus deepening the researcher's understanding and the ability to accept and trust their own interpretations. It also sets in place a credible relationship between data and research interpretation (Bryant & Charmaz, 2011). For this reason and because I had a relatively small and manageable dataset (n=11), I chose to undertake coding by hand rather than employ a qualitative software package (such as NVivo). Hand-coding allowed an immersion in the data that enhanced the depth required for constant comparative analysis. Interviews were repeatedly listened to, and ideas for codes and themes were noted during the process. These ideas, along with my hand-coded transcripts, were compared and reviewed as themes became clearer, subthemes developed, and connections were identified.

This ongoing refinement of research codes and themes occurs in the second phase of coding known as 'intermediate' coding. This stage uses codes to direct the analysis, acknowledging the existence and use of researcher subjectivity during data analysis while recognising the participant's construction of their own

reality. My understanding of clinical and employment circumstances enabled me to interpret participant (caseload midwives) discussions and perspectives in comparison to the alternative realities as experienced by others (midwifery managers) who had differing agendas and expectations about maternity care provision.

Theoretical sensitivity

Theoretical sensitivity is required to move the research through all stages of data analysis and, most importantly, during the stage of intermediate coding. It requires an ability to generate abstract thought about the data, moving from a conceptual to theoretical level. In essence, theory is created from concepts of what the research analysis considers might be happening (Morse et al., 2009). The application of and a maturity in theoretical sensitivity is required in both the initial stages of data collection and later phases of comparative analysis leading to theoretical integration and emergent theory (Corbin & Strauss, 2008).

The next section explains memoing and its practical application in the context of this research study.

Memos and memoing

Memoing is a form of discussion or theoretical notation between the researcher and data. It is intended as a mechanism to generate internal dialogue, in the researcher's mind, and help to resolve conflicting ideas. As mentioned previously, it provides an opportunity for reflective interpretation; a way for the researcher to explore their own position within the analytical process. It also enables the researcher to understand how they perceive and attribute meaning to the data,

and to their own reactions, and the way in which participants attribute value and meaning (Glaser & Strauss, 1967). Typically, memos take a written form, and have done so for the purposes of this study. Memoing is an additional activity, separate from coding, yet closely related to it and, indeed, often occurring in tandem. A major benefit of memoing is that it provides an 'audit trail' by tracing the researcher's understandings of conceptual links between individual codes and categories. To this end, there is no exact way in which to write a memo, because they are the researcher's individual responses to the research process and hence must be flexible in style rather than prescriptive (Chenitz & Swanson, 1986). For the purpose of this study, I initially handwrote memos and, as I grew in confidence, typed them into a Word document, which I uploaded onto OneNote. Rather than type out handwritten memos, I photographed them and uploaded them in the same way, thereby resisting the urge to alter them and thus preserving the integrity of the analysis process.

What must be included in the memo is the researcher's own expression of ideas, and analytical thought processes, demonstrating progress to a logical conclusion that is grounded in data, rather than speculation (Morse et al., 2009). It is most important that the researcher is sensitive to the relationship between themselves and their participants, and not allow their own values to dominate the direction of the study.

In the next section, triangulation is described as another important feature of qualitative methods generally, and in Grounded Theory in particular.

Triangulation

This study applied triangulation as a means of ensuring validity. In its simplest form, triangulation is a way of comparing two or more data sources. For the purpose of my study, triangulation was performed by independently engaging my supervisor and co-supervisor in the coding and analysis of select verbatim interviews and conceptual diagramming. I also provided verbatim interview sheets to consenting participants for feedback. Engagement with my supervisors in triangulation showed a similarity of coded meaning interpreted from the data; however, the labels attributed to codes differed. This was addressed during this process, as coded language was discussed in comparison to the code or theme description, and code labels were adjusted accordingly to reflect the mutual meaning. Researcher bias, such as my defence of caseload midwives along the shifting power dynamic within the health service, was also pointed out during supervisory discussions, which forced a re-analysis of some data and helped to lessen a 'tunnel vision' effect during this important analysis period. In this way, I was able to identify the multiple ways in which both I and study participants viewed particular issues.

Diagramming, more recently used and developed as an additional analytical tool, is explained in the following section.

Diagramming

Diagramming is an extension of the analytical process of coding and categorising. It is a visual tool or conceptual map providing a picture of the links between codes and themes, possibly also highlighting deficits in saturation and theory development (Birks & Mills, 2011). It acts to highlight visual cues and visibly depict

relationships between codes and categories, and conceptual understandings. Diagramming (also referred to as 'situational mapping') has progressed as a method used in Grounded Theory, in conjunction with coding and memoing, to deepen analysis and progress theoretical development (Clarke, 2005). When used appropriately, diagramming helps the researcher to think in very concise terms, while providing a graphic depiction to explain the connection between themes. The primary function is to 'open up' the data so that the researcher is stimulated to constantly re-examine it afresh and to allow their ideas to evolve while memoing continues. In this way, the researcher may simultaneously examine relationships between emerging themes.

I initially undertook diagramming freehand (see Figure 1) as I marked up a depiction of key codes and links to emerging sub-themes, which in turn helped me cement my code labels. I continually moved between the visual diagram and written analysis, comparing what I had drawn and the description I had written for each code. As I gained confidence, I moved beyond freehand drawing to entering my diagram into Visio, a dedicated Microsoft tool (Figure 2) This computerised form of diagramming evolved through several versions, each requiring constant review of themes as data collection proceeded and the collapsing or merging of sub-themes occurred. As constant comparative analysis and data collection continued, my use of diagramming moved beyond a visual depiction of emerging themes, to become more of an analytical method (Figure 3)
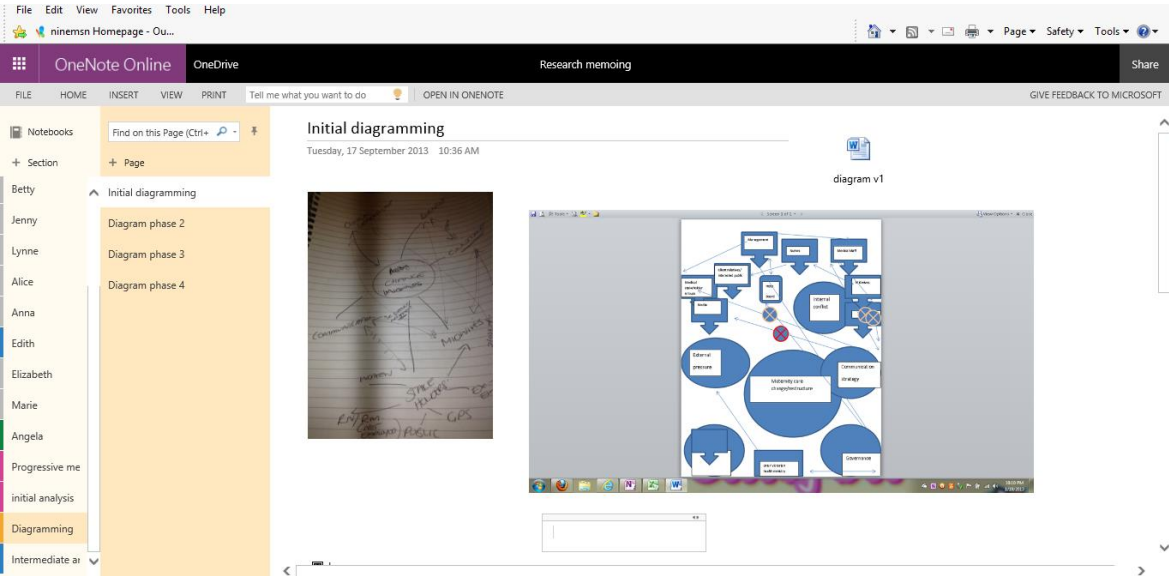
Figure 1: Initial diagramming
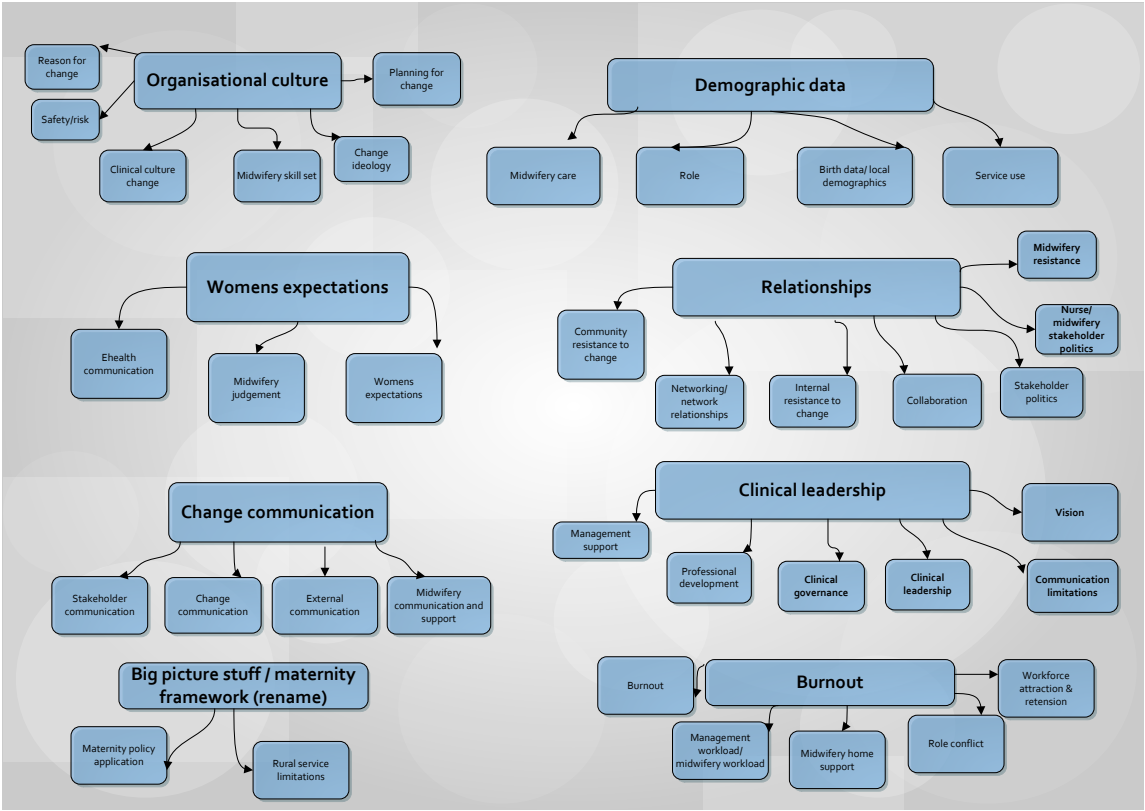
Figure 2: Interim diagramming
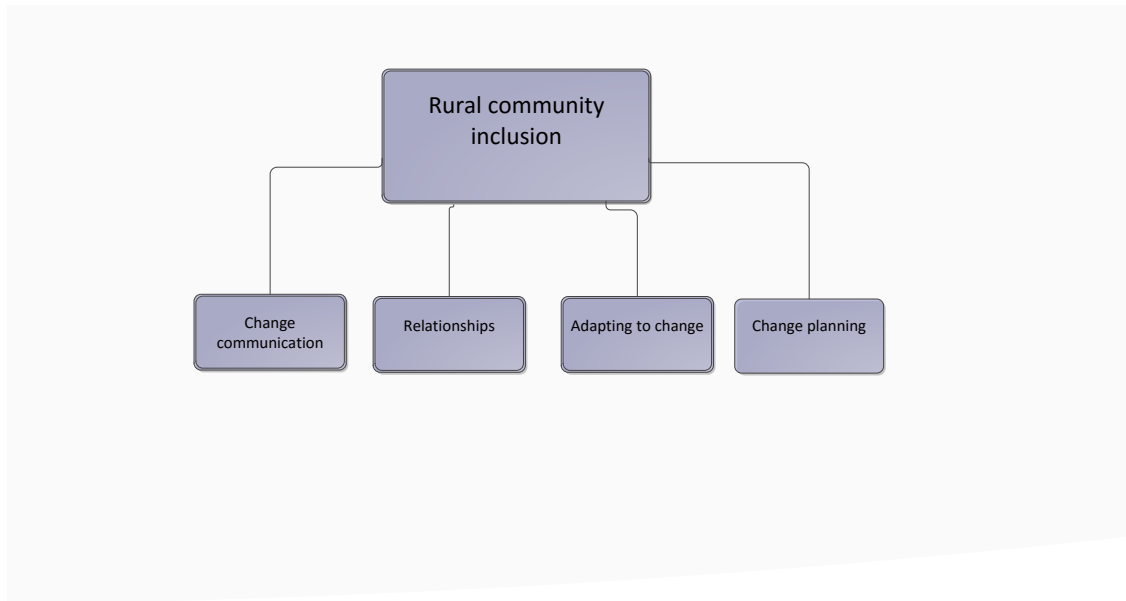
Figure 3: Final stage diagramming

The next section discusses the principles of purposive sampling, indicators and rationale for use.

Sample

The inclusion criteria required participants to be employed or have been previously employed in the researched health service, and to consent to participating in the study. All participants were midwives and midwifery managers, fulfilling a variety of roles within the organisation, and eleven of these consented to join the study. The final sample included five caseload midwives, two midwifery managers, two permanent night duty midwives, and two previously employed caseload midwives. Only one eligible participant who attended the information session declined participation, citing discomfort with the topic of research. A second, initially interested, withdrew prior to consenting due to personal, health-related concerns unrelated to the study. A further two eligible participants, no longer employed by the health service under study, did not respond to an email invitation to participate.

Due to the small size of the health service under study, a maximum sample population of fifteen potential participants was possible using the principle of *purposive sampling*. Recruitment of a select participant population occurred, chosen for their individual characteristics, and in response to the specific aims and objectives of the study. Comparatively, *theoretical sampling* in Grounded Theory is also in response to progressive data collection and analysis (Glaser & Strauss, 1967). Sampling is complete when participant interviews provide no new information (Corbin & Strauss, 2008). The potential maximum sample (n=15) for this study exceeded this requirement because the study topic was well focused and because prospective participants were experienced and well-established employees who were well informed about the issues under discussion.

The following section provides a detailed description of recruitment strategies and the process of consent for participants who participated in the study.

Recruitment and consent

An invitation to attend an information session was sent via employee email by administration staff to all eligible participants (n=15). An information sheet and consent form were included as email attachments (Appendices B and C). The information session was held in conjunction with a routinely scheduled midwifery group practice meeting, attended by caseload midwives and the Maternity Service Unit Manager.

The information session outlined the purpose of the study, and included a brief overview of the methods, the timeline and ethical considerations, and confirmation that university ethics approval had been granted. An open-ended question time

provided midwives with an opportunity to clarify the information they had received (Rees, 2003). Immediately following the information session, I invited participants to indicate their interest in the study and offered them the opportunity to book a preliminary interview at a mutually convenient future time and date. Four caseload midwives and the manager accepted the offer at the time of the information session. A further three participants later volunteered to be interviewed, indicating that although they had been unable to attend the face-to-face information session, they would like to be involved in the research. Three other participants volunteered via a 'snowballing' effect, responding to the initial invitational email after enthusiasm for the study had been shown by other participants. No evidence of coercion was noted; however, one participant expressed that she '*didn't want to be left out*'.

Interview details, including preferred location and a mutually acceptable time, were subsequently confirmed by all participants and any outstanding questions related to the research study were answered. Immediately prior to their interview, participants were asked to complete a brief demographic questionnaire, which included details about their employment and training history (Appendix D). The consent form (Appendix C) was then signed and witnessed.

Data collection and analysis

Several types of data (for example, memos, field notes and demographic details) were collected and analysed; however, interviews were the primary data collection method. Participants were individually interviewed following the completion of the aforementioned questionnaire. Each interview lasted approximately one hour and

was conducted onsite at the health service. Interviews occurred face to face, because this method allowed me to note non-verbal cues and promote a two-way dialogue (Offredy & Vickers, 2010). Interview questions were developed prior to data collection, however were adapted as the study progressed to explore emerging themes. Interviews were digitally recorded, transcribed verbatim to ensure accuracy of information and de-identified. Repeated listening to digital recordings increased researcher immersion and understanding of the lived experience of participants (Van Manen, 1990). Feedback was also collected from participants who elected to comment on their interview transcript. Field notes were documented immediately after each interview and memos were written progressively throughout data analysis.

As previously discussed, I had a professional relationship with all of the participants, which helped me to establish a rapport and ease the interview process. However, I am also aware that 'insider' research may be problematic, with colleagues feeling pressured to participate, and my own views biased by my pre-existing collegiate relationships and my clinical role as a midwife (Hoare, Buetow, Mills, & Francis, 2013). Every effort was made to minimise the impact of these influences (see the following section). At the conclusion of each interview, I spent time clarifying (with the participant) any information they had provided that was unclear (Kvale & Brinkmann, 2009).

Interviews were transcribed by a professional transcriber, known to me and previously employed by my enrolling university. Terms of confidentiality were agreed upon before transcribing commenced and transfer of audio files and

transcribed documents occurred using an online, password-protected hard drive. Instructions were provided to the transcriber, emphasising the need for full and accurate transcription. I then read the transcript while simultaneously listening to the digital recording in order to correct any transcription errors and to de-identify the transcript by inserting pseudonyms and disguising any other personal details which could identify the participant.

Data analysis was then conducted using the previously described constant comparative method. Participants who indicated their willingness to provide feedback on their transcript (Appendix C) were emailed a copy for email reply. Eleven participants requested their transcription, although only three participants responded to the email and provided feedback. All three confirmed their individual transcript authenticity, choice of pseudonym, and provided some additional comments related to ongoing caseload arrangements and team dynamics. No participant requested that their interview be amended or retracted or removed from the study. Any comments made were incorporated into the analysis, thus providing an important means of data triangulation and increasing research validity, depth and reliability (Rees, 2003).

Ethical considerations

The project was a low-risk study with minimal potential for harm to the participants. Ethical approval was sought and granted by the Australian Catholic University, Human Research Ethics Committee (HREC). Although I am a professional colleague of participants, at no time was a participant coerced or otherwise pressured into consenting to join the study. I believe that while my professional

relationship with some participants had the potential to create a power imbalance, participants also had knowledge about my personal circumstances (as a past client of the maternity service), which I believe played a key role in helping to facilitate mutual trust, particularly during the process of recruitment and data collection.

As previously outlined, information about the study purpose and aims was provided in the form of a participant information sheet (Appendix B), and an information session. In the unlikely event that a participant felt overwhelmed or distressed by the interview process, I was prepared to stop the interview, allow time for the participant to recover, and ascertain whether they wished to continue or withdraw. This did not occur, with eleven interviews completed without incident.

Confidentiality and anonymity was stringently maintained throughout all aspects of the study. All research data were held within a locked filing cabinet within my lockable office; the computer and USB were password-protected and all data was regularly and automatically backed up by ACU. All original data will continue to be held in accordance with Australian Catholic University requirements for a minimum of five years from the conclusion of the research study, or from the time of publication, following which it will be disposed of in accordance with ACU regulations. Data copies are kept by ACU to ensure protection from possible future claims of falsification. The copied data are kept securely in hard copy (that is, typed transcripts). This statement is held on my student file with a copy held separately by ACU, School of Nursing, Midwifery and Paramedicine, Ballarat Campus (Australian Catholic University, 2012).

Conclusion

This chapter has defined the study question, aim and objectives. Insight to

qualitative research principles has been demonstrated with particular reference to

the theoretical perspective of symbolic interactionism. Further to this, the

application of Grounded Theory, and the influence of seminal Grounded Theorists

Glaser and Strauss (1967) and subsequent contemporaries, particularly Charmaz

and Clarke, have been addressed. This chapter has also clarified specific methods

used during data collection and analysis, sample size, population and

characteristics, along with ethical considerations relevant to the study.

Chapter four: Study findings

Introduction

This chapter discusses the study findings generated from data collection and constant comparative analysis. The findings have been divided into key themes. An overview of participant profiles is provided, with insight into the participants' views of their roles within the organisation they are employed by and the community in which the live. Key themes discussed are change planning, communication and cultural change in the context of the clinical setting. Staff retention in this small healthcare setting and the inter/intraprofessional relationships during the period of maternity restructure are also discussed.

The participants' work setting and their profiles

The study participants, who included senior managers, were a distinct rural population of professional women, each with individual philosophies and responsibilities, and different degrees of clinical and managerial autonomy. At the time of interview, nine (of the eleven) participants were employed within the health service and two had resigned to pursue further career opportunities. The caseload model comprised midwives who only practised midwifery, rather than occupying dual (midwife/nurse) roles. Prior to change, the employment model required midwifery staff to care for acute clients and labouring women concurrently. While the majority of participants worked in the same healthcare setting prior to the changes being introduced, newer employees reported that it was the new model of caseload care that drew them to respond to recruitment advertisements.

All participants were offered, and accepted, the opportunity to comment on their profile information and preference their pseudonym. Only one participant chose an alternative pseudonym, opting to be named after historical Australian feminist Edith Cowan. Participant pseudonyms used were as follows:

Jenny, Elizabeth, Lynne, Betty, Edith, Samantha, Anna, Mary, Angela, Marie and Alice.

Participant comments on profiles and transcripts were sought via the email address they provided at the time they consented for the interview. Of the eleven participants, the first seven were employed as caseload midwives. The latter four participants fulfilled a variety of night duty and midwifery management roles.

The participant group comprised women aged between 35 and 65 years. Most midwives (including the night duty midwives) had worked consistently within the health service under study for more than 10 years, with the longest serving participant having provided upwards of 30 years' service. Those participants with less than 10 years' experience in the health service either were recently employed caseload midwives or held management positions. The majority of participants had upwards of 25 years' midwifery and/or nursing experience. Only one participant had less than 15 years' midwifery experience at the time of research.

Participants' sense of belonging to the local community
In addition to interview data, participants' demographic details revealed the degree to which they felt connected to the local area. The types of activities and community participation that helped form a sense of belonging to the district, and

the healthcare organisation, were also articulated through their responses the following question:

Researcher: *Would you consider yourself a local to the district? Why/Why not?*

While over 80% of participants considered themselves '*locals*', 54% did not live within the immediate area, but lived instead within the bordering municipality. Participants cited experience of living in the region, well-established social networks and the rural health service employment as factors contributing to a sense of 'local' identity.

> '*I do because I work locally and I know the area so well!*' [Mary, manager]

Samantha stated that although she did not live locally, she nonetheless considered herself a local, because of the enduring nature of her social and professional interactions that stemmed from local employment.

> '*While I don't live within the (geographical location), I feel I am local to the area, having lived and worked within it for many years.*' [Samantha, caseload midwife]

Betty cited the feat of having 'midwifed' generations of women, as well as knowing and being known by local people, as a contributing factor to her sense of belonging. She attributed knowledge of local government members, family networks, and personal connections to women and their children over time as justification for claiming both a sense of local identity and a strong sense of belonging.

> *'Yes, I know my neighbours very well and also numerous other local people. When I walk down my shopping strip I see **my** women who have birthed and their children.'* [Betty, caseload midwife; emphasis added]

Elizabeth suggested three key criteria that defined local identity: longevity of residency, investment in local industry, and emotional attachment to community.

> *'Yes,* [I have] *lived in the area 13 years, and 12 years in* [home town]. *I shop in the area, work and socialise in the area.'* [Elizabeth, caseload midwife]

Edith explained her sense of local identity not only by her residential history, but also by an emotional connection, linked to childhood memories and her formative educational years. Edith indicated this sense of ownership of the local area, generated in childhood, was an important element in her choice to later return and raise her family.

> *'Yes; lived in the region since early childhood; educated in the region; returned in adulthood and settled.'* [Edith, caseload midwife]

While Anna did not consider herself a local, she nonetheless felt at home in the area where she now lived and worked as a (caseload) midwife. She related to the area's geographical features, which were similar to the area of her childhood home. Anna also contended that length of residency was a determining factor in developing a local identity; five years was the minimum period required to define oneself, and be considered by others, as becoming '*more local*'. This suggested that residency over many years, perhaps even generations, was required before 'true local' status might be acquired. Alice offered a different viewpoint, suggesting

that being born outside the state (or indeed outside the region), seriously limited her claim to a local identity.

> *'No, I do not live in the (geographical location) and I am not a Victorian local.'* [Alice, manager]

As participants' narratives have suggested, the strength of connection to the local area was determined by the social and emotional relationships they created through their private and professional interactions. The following section presents information about participants' roles and responsibilities, and how these changed with the introduction of a caseload midwifery service into the rural setting.

Participants' roles and responsibilities

At the time of interview, all study participants had previous experience of working within the rural healthcare service under study, and specifically within the caseload model of maternity care. Of the three managers who participated, one was a registered nurse and midwife with significant experience in neonatal care, and the other two had considerable experience managing acute services, including maternity (see Figure 4 for a breakdown).

While some participants held additional management roles, when asked to list their roles and responsibilities, a discrepancy was evident between their actual employment title and the language they used to describe their role. For example, some midwives employed under the title of 'caseload', nonetheless described their employment role as 'team' midwives. When asked to explain this discrepancy, it became apparent that the term 'team' was used to refer to a collegial grouping, rather than as a reference to distinguish a model of care.
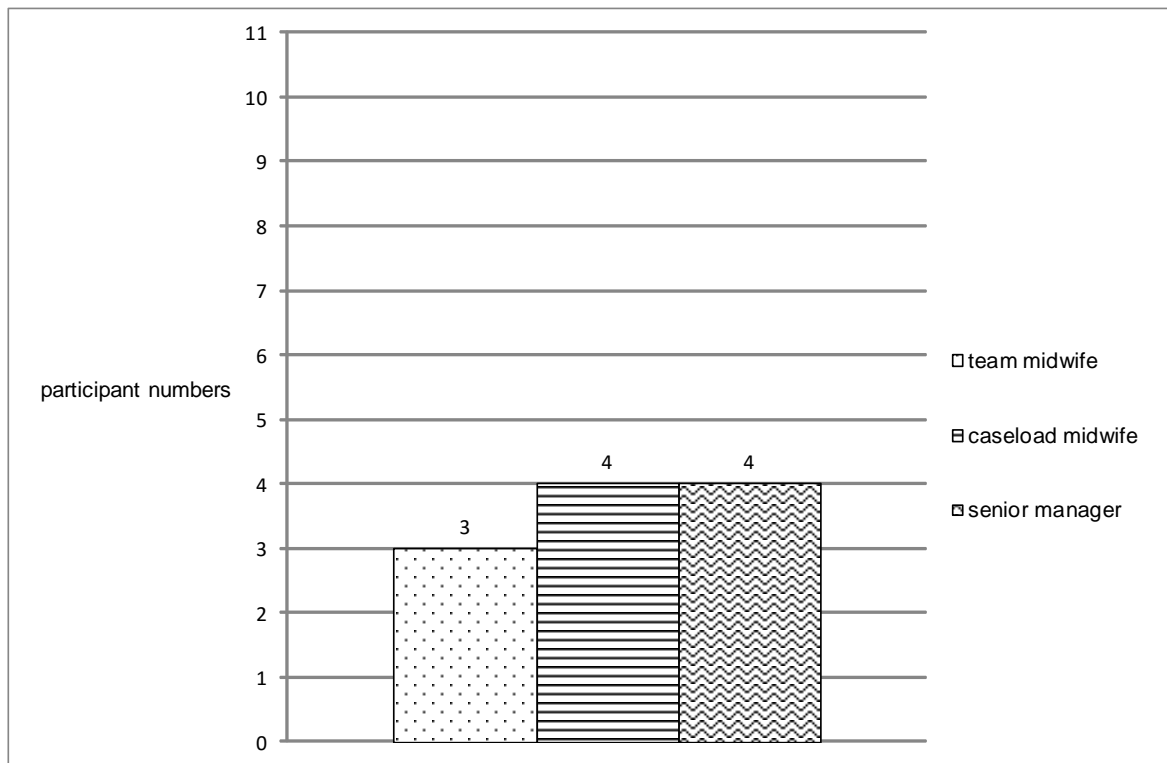
Please note: reading the columns left to right matches the descriptors top to bottom.

Figure 4: Participants' reported roles

Three quarters of the participants considered their roles and responsibilities directly contributed to women's care:

> *'I'm employed at the hospital, to be a midwife and look after my women.'*
>
> [Lynne, caseload midwife]

Responsibilities included the usual documentation and maintenance of paper and electronic records. Additionally, Lynne identified antenatal education as an important aspect of her midwifery role:

> *'I do feel our role as a midwife is to educate the woman every visit.'* [Lynne,
>
> caseload midwife]

Edith contended that she used antenatal education as an opportunity to empower women, encouraging them to seek out information. Edith highlighted the importance of partner education, suggesting that the events of pregnancy and childbirth were evidence that both individuals were entering into a new, and potentially challenging, life role. While her comments emphasised partner education, they also suggested this as an element of her workload that was not always accounted for by management. Later in her interview, Edith suggested that women may be disempowered by antenatal education programs. In the following quotation, Edith describes programmed '*task-orientated'* education during antenatal visits as a means by which the organisation fulfils the obligation to provide informed choice to maternity clients.

> *'… so providing enough education for people to make informed choices … I suppose there's still a task-orientated component to maternity care, you still have to tick however many boxes, that you've provided information.'* [Edith, caseload midwife]

She suggested task-based care evolved out of a necessity for midwives and organisations to reduce legal liabilities. Furthermore, a 'checklist' of antenatal and birth-related information may work to absolve an organisation of responsibility, because women have been informed and the box 'ticked'. Finlay and Sandall (2009) discuss the tendency for midwives to 'process' women as a factor that may also work to limit their ability to promote independence and self-empowerment. Process-driven care does not allow for a change of mind, women's choice, caregiver bias and a woman's ability to absorb or understand the information given.

In addition to providing antenatal education, some participants identified a number of other responsibilities pertaining to their senior roles, including that of unit manager. Anna, a caseload midwife, reported that she had been tasked with the job of promoting the new service in addition to her routine work. While Anna accepted this additional responsibility and workload, she also acknowledged that she had no marketing experience. She claimed that hospital management had failed to undertake a needs assessment, which might have identified her skill deficits, especially in the areas of media communications and marketing. As a result, not only was the new service not well publicised, but Anna's workload was also disproportionately greater than that of her colleagues. Anna was unprepared for the amount of time she would need for networking, collaborating, organising and hosting promotional activities, over and above her clinical responsibilities. She described her additional workload as regularly requiring:

> '*Collaboration between doctors and other service providers. Portfolio-service promotion, information nights, developing paperwork.*' [Anna, caseload midwife]

Jenny, another caseload midwife, confirmed that her role included an expectation that she would '*contribute to policy development',* despite the fact that she had no skills in this area. Meanwhile, Angela elaborated on her responsibilities as an after-hours supervisor, suggesting safety and clinical risk management, and supporting colleagues were key aspects of her role, but they received little recognition from management.

> *'Managing clinical risk for both staff and patients, occupational health and*
>
> *safety management. Providing clinical support to staff in various areas …*
>
> *Initiating transfers as required.'* [Angela, caseload midwife]

Participants reported that they were thus expected to assume a wide variety of additional responsibilities, often in the absence of training, support and recognition. Narratives suggested that many lacked appropriate, and on-going, mentorship, while limited expertise in key areas also meant that tasks often took much longer to accomplish, having a negative impact on morale and other aspects of service provision.

Participants' educational qualifications and clinical experience

Over 80% of midwifery participants indicated they had undertaken hospital-based training in nursing before gaining an additional qualification in midwifery. Approximately 37% of all participants had graduated through a university-based program, including postgraduate degrees in midwifery science or bachelors of midwifery science (see Figure 5 for education breakdowns). Hospital-based training may be understood as an indicator of (or proxy for) age (45+), because this was the only option open to those who trained in Australia prior to the 1990s. Since then, nursing and midwifery training has moved to university settings, following a recognition that the workforce needed to acquire academic skills. The age-related data from this study aligns closely with current Australian maternity workforce trends, in that the significant population of older employees nearing retirement will seriously affect health service sustainability in the years ahead, especially in rural and regional areas (Health Workforce Australia, 2013).

A number of participants reported having acquired extended qualifications, with 64% educated to masters level (in nursing studies). More limited midwifery specialist skills were reported, with only one participant holding a qualification as a lactation consultant (see Figure 5).
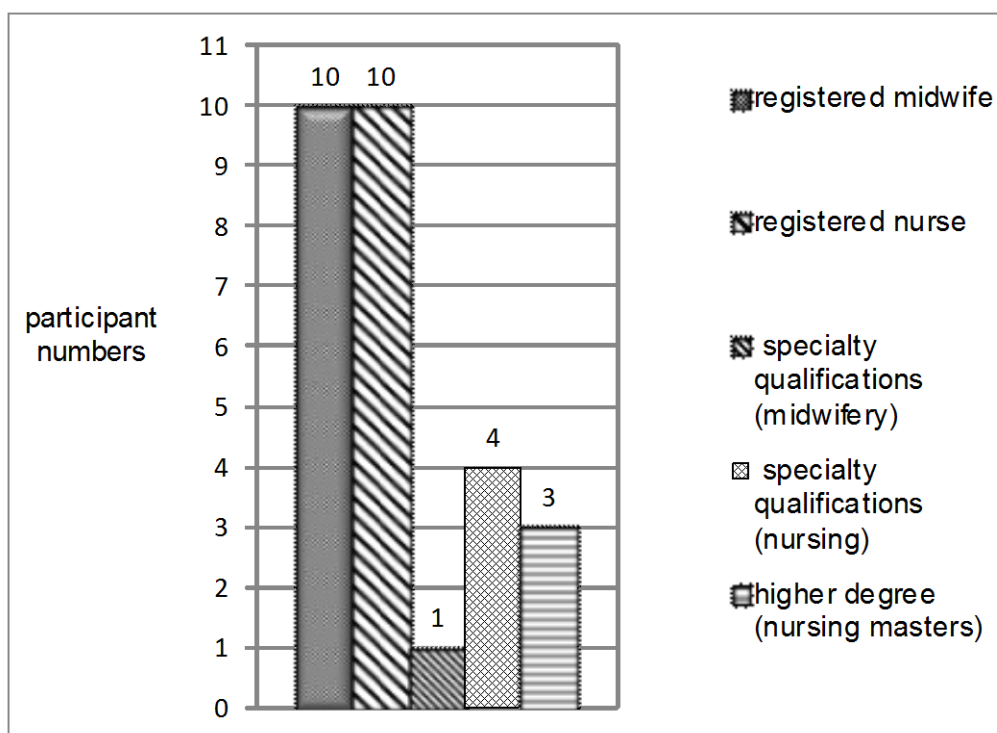
Please note: reading the columns left to right matches the descriptors top to bottom.

Figure 5: Participants' educational qualifications

Demographic data revealed that approximately 91% of participants had rural midwifery and nursing experience, with approximately 82% also having metropolitan nursing experience, and 73% having metropolitan midwifery experience. One participant reported previous experience in a birth centre that was linked with a tertiary maternity unit. Almost 45% of the caseload midwives had

experience in private practice, with one having had experience of homebirth (Figure 6).
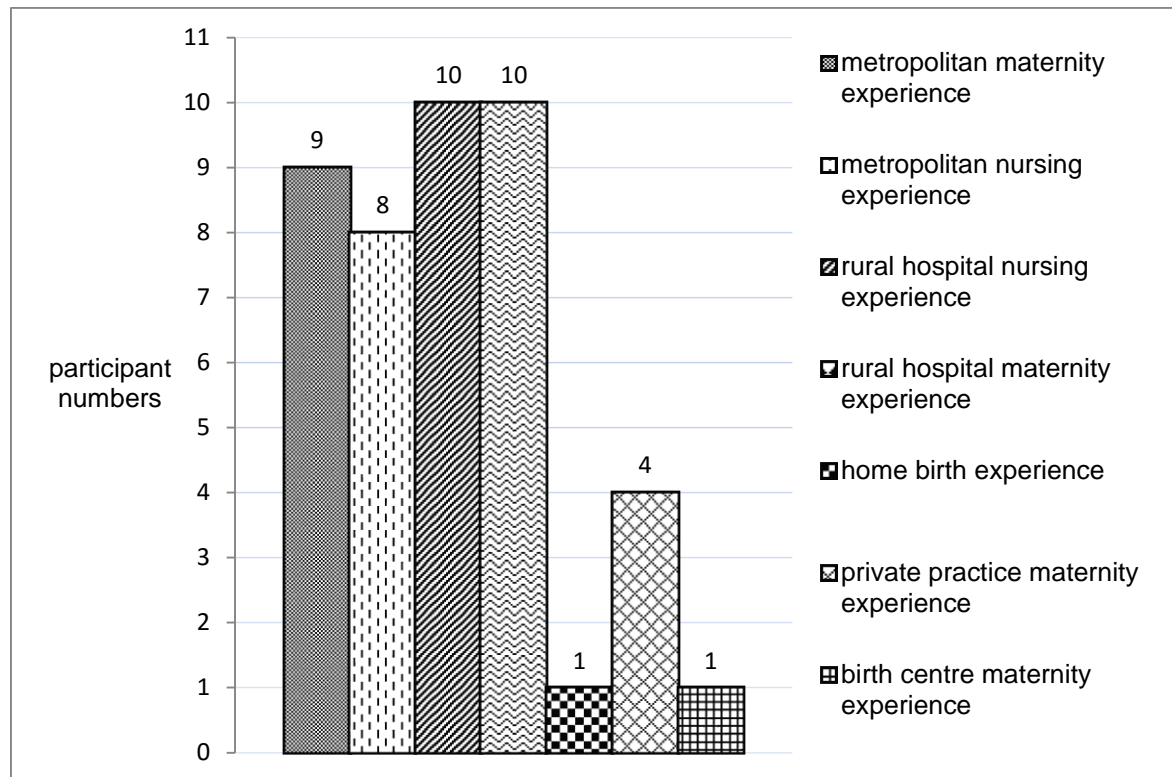
Please note: reading the columns left to right matches the descriptors top to bottom.

Figure 6: Participants' midwifery and nursing clinical experience

Nursing and midwifery qualifications were obtained in Australia by 82% and 73% of participants respectively. While approximately 20% of participants had worked overseas (in the United Kingdom and New Zealand) as midwives, only one participant had overseas nursing experience (see Figure 7).
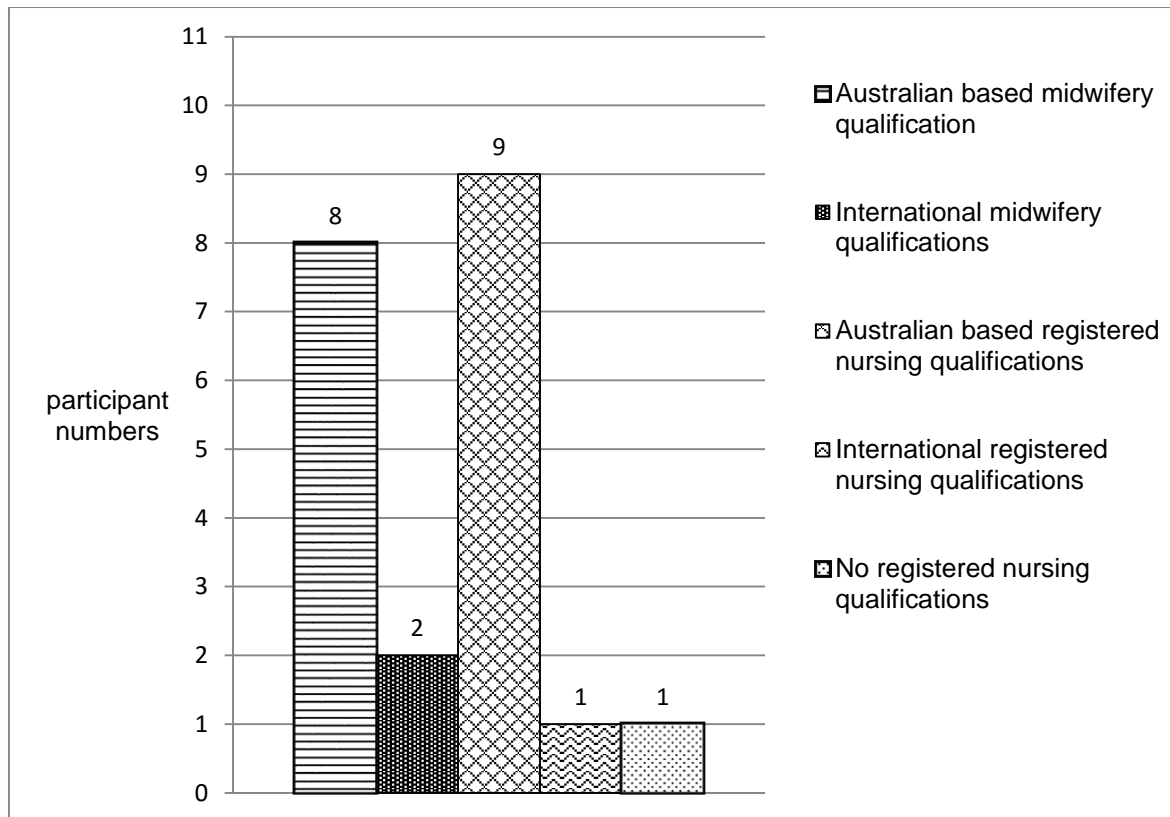
Please note: reading the columns left to right matches the descriptors top to bottom.

Figure 7: The location for participants' education

Of the eleven participants, 27% had been employed in the local health service for between one and four years, 36% for between five and ten years, 20% for between eleven and 20 years, and 20% for between 21 and 34 years. Hence, the majority of participants had considerable experience of working within the locality, with some having worked in the area most of their professional lives (see Figure 8).
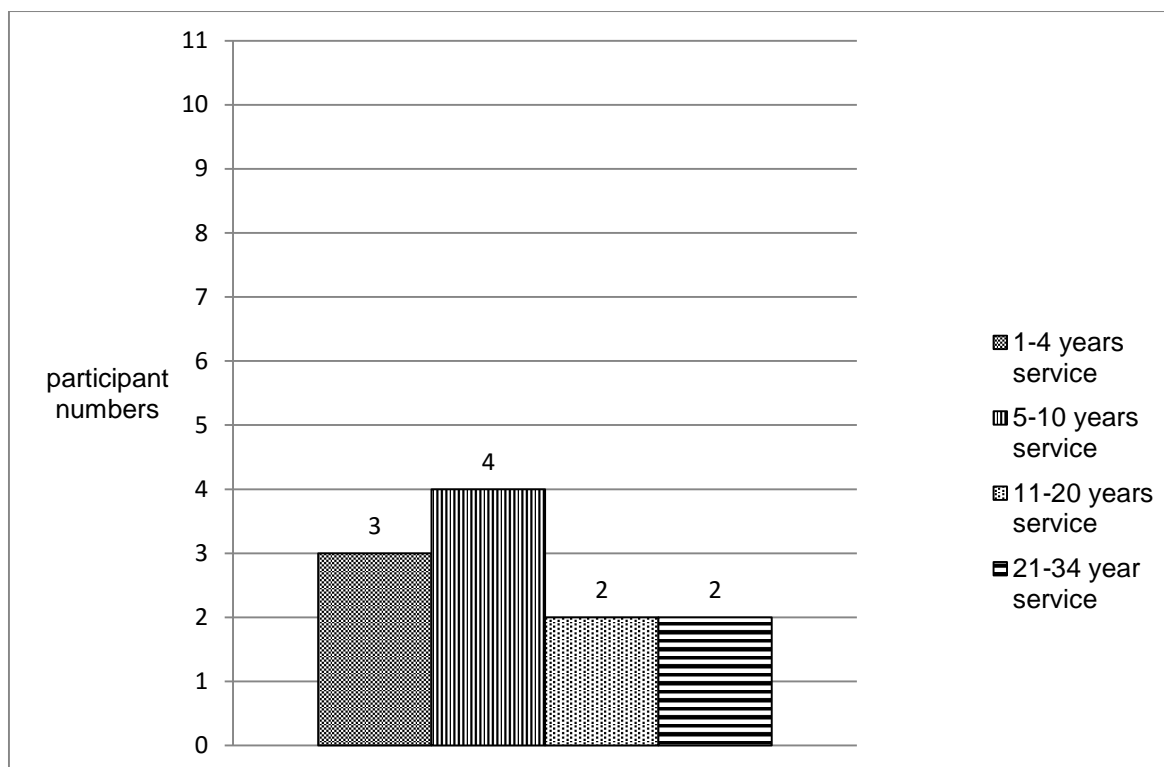
Please note: reading the columns left to right matches the descriptors top to bottom.

Figure 8: Participants' length of organisational service

To summarise, the participant sample comprised predominantly older women, with an average employment length in the local health service of eleven years. While some participants had obtained higher degrees or specialist nursing qualifications, there was little evidence that midwifery specialist skills had been acquired. Participants reported a spread of metropolitan and rural midwifery experience; however, few demonstrated previous experience of working outside of hospital environments, such as within birth centres and/or domestic settings (facilitating home birth).

The next section discusses the change planning, leadership and communication strategies undertaken throughout an ongoing, and intense, process of change and upheaval as the service moved from a medical to caseload model of maternity care.

Change planning and change preparedness

Forward planning is widely understood as an important element in the successful and sustainable implementation of organisational change (Kerridge, 2012). In this section, I refer to change planning as the way in which the caseload midwives and management perceived, and approached, the implementation of the caseload model.

Managers described their engagement in the change planning processes within the context of the Rural Maternity Initiative evaluation (Edwards & Gale, 2007), which outlined the maternity framework and the different continuity of care models operating in Victoria. This information was then used to plan the local health service model of care, taking note of factors impacting upon rural sustainability (Commonwealth of Australia, 2011). The maternity service managers were of the opinion that the executive team had a firm grasp on the maternity services framework and what was required for effective change.

Alice reported feeling confident that some aspects of the change would go more smoothly than in other rural areas, because local midwives were already providing essential elements of care. As part of the Rural Maternity Initiative evaluation, Alice had travelled to different sites in Victoria to review continuity care models that were well established, and to gather information about any adjustments that

had been made, and which might be required in the local context. In this way, the health service was able to shape the caseload model in line with local needs.

> *'I got to see into a lot of rural maternity services that were making these adjustments to continuative care models … we could see from all of the other sites across Victoria, rural sites, what worked, what didn't work … we were able to really craft something and learn off the others.'* [Alice, manager]

This comprehensive acquisition of knowledge, however, did not marry with some participants' sense of unpreparedness when the caseload model commenced.

> *'… we knew the basics but we were making the model up as we went along … only now that I reflect back on that do I think how poor that was.'*
> [Samantha, caseload midwife]

Caseload midwives felt confident about the principles of care provided; however, they generally felt unsupported in the logistics, set-up and daily application of the model. Angela explained that, as a night duty midwife, she was informed of the structural changes, stating that '*the process was easily available*'. This was not the consensus of all participants. Samantha, a caseload midwife, felt they '*were blind going into it*' needing '*someone with experience to sort of help us along*'. Mary described the midwives' desire for clear instructions on how the continuity of care model would function. Mary's reluctance to provide the requisite information, saying *'… I don't think I could* [be prescriptive]', indicates a desire for improved midwifery group decision-making. This may have contributed to the midwives' sense of confusion and apprehension. While the caseload midwives understood

that a different philosophy of care was needed in the new model, most felt
overwhelmed by what they perceived as a 'no-rules' approach to clinical practice.

> *'I remember a few years ago the midwife group wanting me to put it all
> down on paper, put the model of care down on paper and to really spell it
> out in black and white. I've never done it. I don't think I can, not even now,
> because* [what] *the model has to have is flexibility.'* [Mary, manager]

Betty described her initial expectations of midwifery management – namely, to
give clear guidance and direction to the caseload midwives. However, in the
absence of this being provided, the midwives self-directed the way the group
functioned. Betty further explained that it was only with experience and the benefit
of hindsight that management learnt how the model should function, and were
able to help staff plan logistically for the future.

> *'I guess we evolved as a group, but the direction that we needed I don't
> think they could offer because they didn't know where we were heading
> either; it was new to them. Whereas now, they have an understanding, it is
> a lot better; they know how it's working now and how to improve it.'* [Betty,
> caseload midwife]

Betty also described the excitement she felt with operating more independently, as
the caseload midwives were required to manage their own rosters and be
responsible for the decisions they made.

> '*We were left to set up our own rosters; it was pretty exciting but we were
> left to our own devices. We evolved, working out what worked and what
> didn't work.'* [Betty, caseload midwife]

Change was seen as an unexpectedly evolutionary process of trial and error, requiring group discussion and consensus on functional '*work issues*'. Caseload midwives indicated that they had greatly underestimated the workload required to operationalise the new model of care. In the following quote, Samantha suggested that the amount of work required was unfair and that expectations were unreasonable:

> '*We had to do a lot of the work and I don't think that we should have had to have done all that work because we didn't know what we were doing … working out the issues, the hours of work, where the clinic was gonna be and how the on-call roster was going to work.*' [Samantha, caseload midwife]

Samantha levelled criticism at management, describing the support available for the initial set-up of the model as '*absolutely minimal*'; indeed, she did not fully comprehend the '*poor*' level of support until after she had resigned from the health service. She was of the opinion that the situation improved only when the caseload midwives began to proactively contact metropolitan maternity organisations running similar models of care to gather information about how they were operating. These insights gave them clarity and a greater understanding of how their local model could function more smoothly.

> '*There was this expectation that we were professionals in our field and we should be able to do this. But truly, we hadn't worked in that model; we had to ring other hospitals and talk to other girls about how they were doing and what they were up to, and that was left to us.*' [Samantha, caseload midwife]

Edith elaborated on the difficulties she felt in planning and instituting a continuity model of care, while lacking the necessary experience and support in this rural setting. A lack of multidisciplinary support services, especially acute neonatal and obstetric services (for example, perinatal mental health), and a negative reception from the local press, GPs, consumers and other community representatives, affected midwives' self-confidence and sense of professional identity. Edith described the development of the caseload model as being based on trial and error, and having no '*footprints to follow*'.

> '*There's not a lot of models out there to be role models … it's an area that's unfathomed yet so there's not a lot of footprints to follow, so there's gonna be some mistakes we make along the way and no doubt we did!*' [Edith, caseload midwife]

Feelings of loneliness and uncertainty were also articulated by the night duty midwives, who felt especially isolated. Marie described feeling '*in limbo*', unsure of how she would fit into the changing organisational structure and wondering '*what my role was going to be*'.

> '*I would ask them, "Where do I play in this?" I didn't know where I slotted in to the organisation with midwifery.*' [Marie, night duty midwife]

Lynne, an experienced midwife, described the unexpected strain she felt in taking a leadership role in updating, or creating, many of the clinical guidelines after the health service had restructured to provide a low-risk model of maternity care. While Lynne expected, and welcomed, the responsibilities associated with caseload practice, she described her discomfort with the senior administrative

responsibilities she was also asked to undertake, and with which she felt overwhelmed and unpractised.

> *'I had base computer skills. I didn't know what I was doing … I felt like a right dick a lot of the time, because I was fudging my way through.'* [Lynne, caseload midwife]

Caseload midwives felt largely unprepared for the demands placed on them during phases one and two of the change (see Appendix A). On reflection, Samantha suggested the whole process of change had forced her to be more self-sufficient, and to articulate her views more clearly and confidently.

> *'I never thought that it* [work pressure] *was right, and I did sort of voice it on an occasion but probably not in the right way. I think I've learnt and grown over the years, and I think that perhaps we should have stood up for ourselves a lot more in the early days.'* [Samantha, caseload midwife]

Samantha suggested that extra support was required from a clinical midwifery specialist who had the expertise to support the installation of maternity service change, and that caseload midwives should have challenged the change process earlier. As caseload midwives felt unprepared for the initial change, they also underestimated the difficulties with managing complex group dynamics and maintaining group harmony while building and moulding a new model of care.

The next section discusses the midwives' interpersonal communication and support needs.

Midwives' interpersonal communication and support needs

The study participants described themselves as a mixture of dominant and passive personalities, making for an interesting and, at times difficult, group dynamic. Caseload midwives with lengthy employment experience in the health service appeared most secure and confident, with newcomers tending to be more reserved about expressing their opinions. This resulted in a small number of staff making decisions for the whole group, reflecting a power imbalance, and producing an uneven representation of ideas. Samantha, a long-serving staff member, identified herself as a dominant personality who tended to self-appoint as the spokesperson. She suggested that midwives who disagreed with 'group' decisions felt they were left with few options other than confrontation. On reflection during interview, Samantha showed insight and awareness into the downsides of her self-styled leadership, and an appreciation that it may not have been '*best practice*' and that at times it hampered group progress and decision-making.

> *'I spoke louder than others and was quite dominant. We didn't have a team leader; we were all on equal footing, but self-appointed ourselves as team leaders and spokespersons I s'pose. And we were allowed to get away with it, and I don't know that that was always good practice.'* [Samantha, caseload midwife]

Samantha's quotes show a transference in language as she slipped between speaking on behalf of herself ('*I*') and suggesting she was voicing the sentiments of herself and a few others ('*we were…self-appointed ourselves*'). As each caseload midwife was employed at an Associate Nurse Unit Manager level, no single individual should have been able to dictate authority over the group.

Samantha's comments, however, reveal that this was not the case, and that the issue was unresolved. She spoke of her frustration with some of their colleagues, who she viewed as unable to prioritise their time, which meant others were regularly called upon to provide extra assistance. Samantha suggested that when the issue of time management was first raised in the midwifery group, the caseload midwives concerned refused to speak up. Although they appeared to agree with the decision to modify their behaviour and work to agreed deadlines and complete the tasks they were allocated, in practice they continued to work as they had always done. Samantha also expressed her frustration with the lack of verbal contribution to group decision-making and the individualist mentality displayed by some of her colleagues, rather than a team approach to the work. She was also of the opinion that behaviour that she deemed as obstructive should have been challenged by management.

> *'I was becoming extremely frustrated with the other members of the team and their work practices, which ultimately affected me. I think that there are certain members of that team that sit back and say nothing at a team meeting…And then there is an assumption that they've agreed to something but in actual fact never ever in their wildest dreams would they do that. And I think that needs to be tackled.'* [Samantha, caseload midwife]

While Samantha suggested that the lack of contribution at team meetings was an issue that needed to be tackled, she also admitted that '*I don't know who's gonna do that*'. She was of the opinion that without effective leadership, resolution was unlikely, and that decision-making processes would continue to be ineffective.

'I think somebody needs to step in and say, "We have to all agree to this and if you've got an opinion then you have to say it and if you don't say it then it's taken that you've agreed to it."' [Samantha, caseload midwife]

Edith suggested that her reserved nature made it difficult for her to be an effective communicator. She viewed her newcomer status and recent entry to the team, and her anxiety about causing disharmony, as further reasons to withhold her opinions on clinical or logistical issues.

'I don't consider myself to be a particularly good communicator. I'm very reserved, and probably a little bit, what would you say, malleable? Rather than create any disharmony, I will just flow along with whatever is going at the time. So I potentially wasn't as vocal as I could have or should have been … I think also being a later-comer to the team, there's already established processes and pathways.' [Edith, caseload midwife]

Power imbalances between the caseload group members were identified as a rationale for inconsistent decision-making, planning and follow-through. Edith also took ownership for her lack of contribution to group discussions:

'I potentially wasn't as vocal as I could have or should have been. It's easy to talk about other people. When it comes to your own housekeeping, that's where it's a bit harder to, I guess, give and accept constructive criticism of the way you do things.' [Edith, caseload midwife]

Communication appeared to have improved as caseload midwives became more comfortable with the model of care, and with working and communicating with one another. Night duty staff indicated, however, that good communication practices,

including clinical updates (via email and verbal handovers), were very individual and dependent on the willingness of each caseload midwife, and whether she viewed this as an important facet of her work. Some did not appear to prioritise routine communication with night duty staff, which was a source of ongoing tension.

> *'Well it's good at the moment because they* [caseload midwives] *send me emails of where the women are up to; once they get near term or if anyone gets transferred out antenatally, I know now.'* [Marie, night duty midwife]

Marie further explained that as one of two staff often caring for the acute ward overnight, her role was to provide backup for the primary caseload midwife during the intrapartum period. Organising postnatal cover by other available caseload midwives was the primary midwife's responsibility, although some of them assumed that Marie or her colleague would step in to provide this care without being asked. Such assumptions were an ongoing source of irritation:

> *'They would just assume that I would look after a postnatal* [woman]. *But they wouldn't communicate with me or the afternoon supervisor.'* [Marie, night duty midwife]

Angela described how frustrated she felt with her colleagues who did not prioritise informing night duty staff about women's care plans and pregnancy/labour status, although she also suggested that this had improved over time. At the time the interviews for this study were undertaken, an established communication pathway between night duty and caseload midwives was in place. However, effectiveness was still largely dependent on individual midwives:

> *'Initially there were some problems, a lack of communication, not involving us in what was happening. Now we get the emails so we know who* [caseload midwife] *they've seen antenatally, who might be of concern. So we are formally informed on emails and a midwifery book that they update … sometimes.* [Angela, night duty midwife]

While night duty midwives were considered '*part of the team*', fulfilling an important supportive role, they were excluded from meetings. An invitation to attend caseload midwifery meetings was extended once Marie, a long-term night duty midwife, requested inclusion. Marie considered that her insistence on attending caseload meetings was threatening for some of her caseload colleagues. She attributed this to their sense of ownership over '*their*' women, which was at odds with Marie's need for involvement in the model of care. This need was not least because she would often be called upon to provide intrapartum and postnatal care when women were in labour.

> *'Because some of them didn't see myself as a team midwife. I still didn't feel like I had any ownership. I think it* [presence at meetings] *benefited me,* [but] *some of the midwives felt threatened by it … They would be saying, "You don't have to come to this meeting because we're talking about where we're up to with our ladies." And I'd say, "Oh no, I need to know too." So you had to have a bit of a thick skin, like a rhino, to cope with it.'* [Marie, caseload midwife]

Strategic planning, goal- and priority-setting activities were discussed as successful interventions, implemented in the later phases of change (Appendix A), which encouraged newer caseload midwives to have input into maternity service

decisions. It was suggested by participants that strategic planning had provided an opportunity for newer and less vocal midwives to voice concerns or question decisions. Samantha welcomed the increased level of questioning and critical thinking as new staff were recruited to the caseload team.

> '… new people are coming in and they are now questioning the practice and saying, "Well, why are you doing that, why do you think that this is how the roster is, and why do you think that that's how you do the on-call?"' [Samantha, caseload midwife]

Jenny, one such newly employed midwife, described the novelty of being asked her opinion when participating in strategic-planning activities:

> 'It's quite new for me to be working in a place that's always asking me what I think.' [Jenny, caseload midwife]

Caseload midwives were generally of the opinion that the group was increasingly able to offer the necessary emotional, practical, and clinical support to all members. When asked how the midwives supported each other, Anna suggested that colleagues were given support as the demands of their personal lives required. However, there was also an expectation of reciprocation at a future unspecified date.

> 'We all have our turn of just needing to step out a little bit – whether it's personal, family commitment or something. And we all move to support that and just know that that's what needs to happen, and know and trust that our turn will come for that when it does.' [Anna, caseload midwife]

While Anna's comment suggested that she had been a receiver of support, Lynne demonstrated annoyance with '*nobody to help*', indicating that she gave, but nobody was there to help her. The earlier uneven depiction of group support appeared to create small resentments that threatened group harmony. A gradual understanding that reciprocated support was something '*all needed*' was suggested by Lynne as an important factor for group cohesion and progress. Lynne indicated that solidarity among group members had been something of a work in progress, occurring over a number of years:

> '*I think the midwives together have helped each other. We work well as a group to accommodate the changes to the model. I think, it's taken a while – well, it's taken a couple of years – but I think we've all got a better idea of what our role is here and how we help women, how we can help each other, supporting each other.*' [Lynne, caseload midwife]

Samantha suggested that closeness and collegial friendships were built from hard times and difficult interactions, as well as positive experiences.

> '*There were times when we wanted to throttle each other but, for the most part, we made great friendships that will carry on for some time.*'
> [Samantha, caseload midwife]

When asked about the type of actions that best emotionally supported the small group of caseload midwives, responses indicated that designated group debriefings and peer meetings to establish group support for the medical reviews of difficult cases were of greatest benefit.

> *'A debrief is really important … immediately, and as a group within the*
> *week, if we can get people together and also to review whatever happened*
> *at the monthly obstetric review, so you've got peer support initially, and that*
> *is so important.'* [Betty, caseload midwife]

Edith commented on the importance of meetings as a specifically allocated time for the midwives to discuss issues and gain peer support. This was in addition to examining perceived deficits or considering ideas for improvements that might be made to the service, and the care delivered to local women.

> *'… those meeting times were a good opportunity to actually put some time*
> *together and not only talk about the women but talk about the service.'*
> [Edith, caseload midwife]

Group communication and discussion was at times dominated by a few opinionated and dominant caseload midwives with clear and strongly held opinions. While this was criticised by some participants, suggesting this limited others' contributions, these same midwives were held up as possessing qualities considered essential for clinical leadership.

The next section discusses participants' views on engagement with health service stakeholders and change communication.

Communication and information provision

'Stakeholder communication' is a term applied to the processes, including marketing and branding strategies, used to convey information about the maternity service restructure to everyone who had an interest in the sustainability of the

maternity service. In the context of this study, dialogues between nursing and midwifery employees and other clinicians, administrative staff and hospital management, and consumer groups and other community representative groups focused on the anticipated changes to the maternity service, especially the proposed new model of midwifery care. I refer to these dialogues as 'change communications', because they informed the initial transition from the pre-existing, medical, model of care to a team midwifery model. In the following quote, Mary emphasises the ongoing nature of the transition between the various phases of the organisational change and the introduction of the new model of care:

> '*It's been in a constant state of transition. We can pick our points very clearly where we've moved from half-team ward to full team, and then to caseload.'* [Mary, manager]

During the various phases of change, participants used different modes of communication – although face-to-face contact was used most frequently by all concerned. Information about the service change and development was also communicated internally through written correspondence and emails. Some external publicity was reported by participants in the form of a pamphlet, which outlined the continuity of care model to be introduced. Several local newspaper articles featured women and babies born at the health service, along with details for the hospital website as the primary online presence. Consultation was reported to have occurred mainly through surveys of women who were booked with, or had previously used, the maternity service, in association with the Rural Maternity Initiative. Caseload midwives were unsure if the survey results had been disseminated back to the community.

General staff meetings were used to disperse information and to provide opportunities for staff to be involved in decisions, most commonly by voting on a particular issue. In addition, these meetings also enabled health service managers and union delegates to address staff about any concerns they had – for example, regarding their workloads and staff–client ratios, which would be adjusted with the change in the model of care. Midwifery group meetings were used to plan long-term care objectives, discuss the various phases of change and the implications, and plan how best to collaborate and contribute during routine obstetric reviews. Midwives' educational needs with respect to their new roles and responsibilities were also identified as a topic for discussion.

Alice indicated some concerns with the repetition and persuasive tactics required to progress the necessary changes:

> *'It was a lot of talking, a lot of meetings, a lot of talking people through it, a lot of trying to get people to understand the picture … trying to teach a workforce about midwifery … we have got a newer way, a better way, a more interesting way of doing it, that will bring us more longevity … We went through the midwifery competency standards ad nauseam, we talked about them, we read them together. It was quite a mammoth task actually now that I am thinking about it!'* [Alice, manager]

Alice went on to comment on the importance of support from the medical fraternity. The (female) gender of the senior obstetrician was important to Alice, particularly in the early phases during change when delicate negotiations were needed with key stakeholders, including board members. Alice's statement below suggested her obstetric colleague was respected by board members on two

levels: as an obstetrician and as a woman. She also considered herself lucky to have such a colleague, implying that this was something of a rarity in a rural health service.

> *'When we started our Director of Medical Services was* [doctor's name] *who was an obstetrician herself, a female obstetrician, and was terrific. She succinctly outlined the risks within our maternity service to our Board within the first month of being here as our Director of Medical Services. That was terrific, but not every small rural health service has that.'* [Alice, manager]

Mary suggested that during the consultative phase, relationships with all stakeholders were generally positive, which enabled consensus to be achieved on the proposed changes. Involving hospital staff early in the process helped expedite decision-making processes:

> *'I think the consultative process was a positive thing in helping that transition, in that the hospital-based stakeholders essentially were involved in the decision-making process; in coming up with the decision to move towards a team model of care. So involving them sort of got them onboard perhaps a little bit quicker.'* [Mary, manager]

By contrast, community-based stakeholders were seen as not properly included in the change dialogue, with consumer surveys and data collated as part of the Rural Maternity Initiative the main sources by which consumer opinions were solicited. The Rural Maternity Initiative evaluation included nineteen, of a possible 27, funded health services. Consumer satisfaction was evaluated using several methods of data collection, as follows:

1. consumer questionnaires distributed from all sites, and given to women cared for under the Rural Maternity Initiative–funded continuity models of care

2. consumer (midwives and medical staff) feedback forums, conducted on four sites

3. consumer (women) feedback forums, conducted on each site

4. staff-satisfaction surveys, conducted prior to and six months post implementation of Rural Maternity Initiative–funded continuity models of care

5. A statewide forum in which all Rural Maternity Initiative sites (n=19) were invited to discuss common issues associated with implementation

6. interviews with health service management across Rural Maternity Initiative sites (n=19)

7. progress reports completed by Rural Maternity Initiative sites (unspecified completion rate), with four site summaries provided.

Caseload midwives felt greater community consultation and dissemination of information about the impending changes was required, especially with respect to GPs and local people most likely to be affected. Midwives were of the opinion that this could have improved the community's response to the introduction of caseload care. Several caseload midwives noted that this particular rural community held a sense of ownership toward the health service and, though not necessarily of childbearing age, many nonetheless felt very connected to the changes that were occurring. This was possibly because they had female relatives who were themselves of childbearing age or they were parents of young girls, and

hence considered the maternity service important to their futures. Alice described local grandmothers' questioning about the change as particularly demanding. This specific population of women was seeking more information than was provided to them, exposing a need to directly communicate with stakeholders who were well positioned to influence a younger childbearing generation (Reid, Schmied, & Beale, 2010).

> *'I remember the worst problem that we had with community perceptions was actually with the grandmothers. The mothers of the mothers. The grandmothers were often the ones asking a lot of questions.'* [Alice, manager]

In the following quote, Elizabeth expressed her concern with the falling off in maternity bookings since the introduction of the changes. She was unsure whether the community were consulted appropriately about their preferences and the impending changes, including what they thought about the loss of an epidural service and access to an operating theatre in the case of an emergency, and other obstetric interventions that had previously been available.

> *'Perhaps a bit more consultation. You've got to make sure it's what the community want as well…You see, there were some surveys* [Rural Maternity Initiative] *done of what women wanted, but I can't quite remember whether we asked the community first. What it seems like, because of the lower numbers, they really want somewhere with epidural backup and theatre.'* [Elizabeth, caseload midwife]

Edith was also critical of how the changing model of maternity care was publicised, suggesting that limited information may have fuelled misunderstandings. She implied that this resulted in a poorly informed public who believed the changes represented a reduction, rather than an enhancement, in service provision. Edith suggested that ill-directed and poorly constructed publicity encouraged negative views by emphasising what the service would no longer provide, rather than the positive aspects, such as continuity of care, which were likely to increase women's satisfaction with their maternity experience.

> *'I don't remember there being broad publications, it didn't go into the local paper. I don't recall* [reading] *that there was a change of service provision. It was brought about that the range of services would be reduced, that emergency caesareans wouldn't be available anymore. So it was probably perceived in community more as a reduction of services, not as an enhanced service for woman-centred care.'* [Edith, caseload midwife]

Samantha voiced her frustration that the local community did not appear to have a clear understanding about the limited obstetric capacity available to care for high-risk obstetric clientele. The lack of open dialogue was perceived to fuel misunderstandings.

> *'I don't think there was enough information made known that we didn't have obstetric cover. It wasn't that we didn't want the women, it was that we just couldn't provide that service at that particular time.'* [Samantha, caseload midwife]

Other caseload midwives suggested that communication with the community was simplistic and limited. The implication was that management underestimated community interest, particularly regarding the type and the depth of information required. Samantha suggested that not only was communication limited, but also the volume and the mode were inadequate for the scale and impact of the proposed change.

> *'We [pause] got one of the local papers to come and do a story but I think that it was not explained enough; I don't know that getting something in the post really made the community understand.'* [Samantha, caseload midwife]

The failure by health service management to take advantage of contemporary technologies such as social media was seen as particularly unfortunate; Alice also recognised the importance of social media:

> '*Well, the risk is that they* [women] *don't connect … because we're not out there on Facebook or on Twitter … we're not connecting with the younger generation.'* [Alice, manager]

While Alice signified that e-communication was an important tool for connecting to the public who has an interest in maternity provision and reform, she was reluctant to 'own' the responsibility, suggesting instead that it was a larger issue that the Department of Health should address.

> *'I think it's not only an individual hospital responsibility, but the Department of Health.'* [Alice, manager].

Betty was of the opinion that clearer and more consistent change communication strategies were needed as the service attempted to navigate an acute service

delivery model with two distinct, and operationally different, services: an acute nursing ward and a midwifery continuity of care model.

> *'I think there could have been better communication from the start. They (management) did say that it wouldn't matter if you were part-time or whatever, everybody could be involved. But it actually didn't work out like that. There was the three of us and then the rest of the midwives stayed on the ward'* [Betty, caseload midwife]

Midwifery participants felt that internal communication and information provision by health service management about the model of care was not competently conveyed.

> *'She* [acute services manager] *didn't seem to have any understanding of what we were trying to achieve and how to communicate that to the rest of the staff.'* [Samantha, caseload midwife]

Samantha expressed further frustration with the methods of internal communication used, stating that registered nursing staff and other employees were left unsure of what the new model of care entailed, and how midwives would work within it.

> *'The others* [hospital-based midwives and nurses] *felt that it was a good idea but would never work. That it was something we could never offer because of the work practices, because of the structured shift patterns and people didn't have an understanding of the change that was needed.'*
> [Samantha, caseload midwife]

Elizabeth was of the opinion that staff '*never really knew what was going on'*; Edith elaborated on her impression that hospital-based nursing staff, in particular, did not understand the new model of care, nor was it described to them as a fluid model that would be adapted to suit the needs of the maternity service. Poor communication was seen as the precursor to the establishment of negative feelings by hospital-based nursing staff towards the maternity service and the case-loading midwives.

> *'I don't think that even the general nurses had a concept of what this different model offered and what was required to provide those services to women, and I don't know that it was put out as a transition process to all of the staff. So I think probably what filtered out to the rest of the staff was predominantly the negative or the mixed feelings rather than the positive messages.'* [Edith, caseload midwife]

Betty described significant upheaval and renegotiated roles at senior management level as factors that related to poor communication with caseload midwives about employment application processes in the early phases of the change.

> *'I think better communication when setting up. It was all a learning issue, because there was a change of Director of Nursing and a change of Nurse Business Manager around that same time, so there was huge change for the ward.'* [Betty, caseload midwife]

Management considered verbal communication an effective tool for internal change communication; however, general staff, in particular, lacked the information they needed to fully understand the change and the transition process.

While responses to maternity surveys (by the Rural Maternity Initiative) provided some local consumer opinion, service adjustments that aimed to improve consumer satisfaction were mostly derived from complaints. Seeking to improve consumer relations and experiences using this type of feedback was a relatively new mechanism that Mary described as a learning process for all concerned.

> *'Patient satisfaction is something that we're learning … we do get our fair share of maternity complaints and that's not unusual and we're very happy to receive them … It's good to talk to women about their experience and then build improvement from that.'* [Mary, manager]

The caseload midwives expressed a desire for increased consumer input, which they perceived would lead to service enhancements, tailored to the individual needs of women in the local rural community. Betty understood that questioning the current provision (that is, the caseload model), was an important element in the process of refining and improving the service.

> *'We need to stop, get feedback from the women, make sure that what we are offering is really what the women want. Is the continuity of care the best we can do? ... getting women involved in meetings as well to get that consumer perspective and feedback.* [Betty, caseload midwife]

While collaborative discussion with various stakeholders was indicated in the early phases of the maternity service review, interview data indicated the need for increased communication during and beyond the initial (phase one) transition period. Specifically, participants suggested a disconnect with external GP stakeholders – medical practitioners who were not directly linked to hospital

governance, yet provided service referrals through private practice. Mary (manager) commented on consumer representation during the hospital's facilitated review of the maternity service, undertaken prior to the introduction of the change to the model of care. She suggested that *'They pulled the service apart and tried to come up with some recommendations that would improve outcomes.'* Alice also referred to the initial consultation, suggesting it demonstrated a collaborative and multidisciplinary discussion.

> *'We had a whole review of the maternity services. We had a multi-*
> *disciplinary group/working party. We had all various stakeholders involved,*
> *internal/external, colleges, obstetricians, GPs – you name it, they were on*
> *it!* [Alice, manager]

Samantha revealed her impressions of the limited understandings about the model of maternity care and service capacity expressed by local GPs. She suggested that this particular stakeholder group needed more information than was provided to them, and that this should have occurred before the new model of care began, to avoid a 'messy' start.

> *'I don't think it was communicated enough so that the GPs in the area didn't*
> *have an understanding … I don't think that there was ever information sent*
> *out to them* [phase one] *so that they understood what the changes would*
> *be and how really the service was changing, that there would be an*
> *improvement in care … You know, because in those first few months there*
> *were lots of phone calls: "Are you closing? Have you stopped doing*
> *maternity?" We sort of jumped the gun a little bit … it was sort of all very*
> *messy!'* [Samantha, caseload midwife]

Caseload midwives were generally agreed that improved communication, which targeted consumers, may have helped to reduce negative reactions.

To summarise, communication with GPs and community stakeholders about the anticipated changes was identified as limited in form and content, compounding local confusion and negative impressions. Maternity service consumers were initially consulted, with additional surveys during phase two of the change; however, the internal complaints process was the primary means of consumer feedback by which women's opinions were routinely sought. Thus, it was only staff at a higher level of management and the caseload midwives who seemed to be sufficiently well informed about how the model was functioning in day-to-day practice. Additionally, those at an executive level were reported as lacking sufficient understanding of the complexity and the impact of the changes, and the additional skills needed by the caseload midwives.

The next section provides an overview of leadership concerns articulated by participants. These concerns endured throughout the period of change, which saw a new model of care introduced by the hospital managers.

Leadership during the change process

In the context of this study, clinical leadership was considered as the continued influence of local clinical experts for the purpose of improving the delivery of maternity care (Garrubba, Harris, & Melder, 2011). Hospital management were generally considered as the main agents of change, portraying leadership skills and qualities by installing a progressive maternity service. Some clinical leadership in midwifery was demonstrated by a small number of caseload

midwives. They met the expectations of the clinical leaders in that they possessed, or were able to develop, necessary skills and confidence to work as autonomous practitioners from the outset. They were confident clinicians who provided high-quality care and consistently demonstrated their critical decision-making abilities. The then DMS (see glossary), who replaced the female obstetrician and subsequently became the onsite GP working in the primary clinic, was seen as knowledgeable, supportive and encouraging of midwives working more autonomously. For their part, the caseload midwives felt confident with their onsite GP colleague, who they considered to be respectful of their status and professional competence.

While most caseload midwives have levelled some criticism at the inadequacies regarding planning and communication during the transition processes, narratives nonetheless revealed that many were appreciative of the leadership provided by senior personnel, which actively encouraged caseload midwives to become more autonomous practitioners. Participants described the high level of executive support they received for the caseload model from the Chief Executive Officer, the Director of Nursing and managers throughout a period of substantial change to maternity service provision. However, they also reported that clinical role modelling on a practical skills level was insufficient, especially in the early stages of change. Caseload midwives reported that they wanted a clinical specialist midwife who had worked in a caseload model, and ideally in a rural setting, to teach them the skills they lacked and to set 'ground rules' for caseload practice. Betty described how management supported the model of care, and how she also thought management had a good understanding of women's needs.

> *'…they* [management] *felt they support women holistically* [caseload restructure] *and that this is what they want and this is what we're going to provide.'* [Betty, caseload midwife]

Lynne reported that the executive team saw local maternity provision as an expensive, but nonetheless positive, and viable contribution that supported the health needs of the local community.

> *'I think that the hospital administration have their boundaries but they are really positive about maternity at* [study location]. *They want the service to be here; as they said, 'We could slash $300,000 off our budget and close it, but we don't want to do that.' … I think that's a high for the township, for the hospital, that you've got the administration backing you, backing the service, wanting the service to flourish.'* [Lynne, caseload midwife]

Samantha agreed with this perspective, emphasising that without executive support the community faced a very serious threat of maternity service closure. Cost was a significant factor affecting sustainability in this rural setting.

> *'I guess the biggest help was the fact that the CEO and the DMS were supportive. They were extremely positive of the changes, they were all for whatever model to keep the service. There was no way the CEO wanted to lose the maternity services and, at one stage, thought they would have to close the service.'* [Samantha, caseload midwife]

Hence, participant consensus was that the executive team demonstrated support for the changing model of maternity care. Several caseload midwives were of the opinion, however, that clinical midwifery leadership was very limited and that this

negatively impacted on the caseload midwives' ability to function as independent practitioners. While this was most evident during phase one, this research data for this study consistently indicated that the caseload midwives considered that the clinical knowledge deficit was problematic throughout the entire period of change. Samantha voiced her frustration, stating that the executive team '*could have been more supportive*' with providing clinical guidance:

> '*At the time, the Acute Manager had no idea about maternity and was not helpful at all so she was no help to us. I think, in fact, lots of times she thought she was helping us but she wasn't really, she was hindering us! She would often come down and be asking clinical things because she didn't know and was expected to know.*' [Samantha, caseload midwife]

Edith described the effects this had on the caseload midwives, especially regarding their ability to practise using a full range of skills. While most management staff had midwifery qualifications, Edith was of the opinion that they were nonetheless primarily concerned about aspects of hospital administration rather than upskilling the caseload midwives and promoting their practice. Edith suggested that having a clinical midwife as an '*overseer*' – as the '*go-to person in the hierarchy of the hospital*' – would have been the best way of supporting caseload midwifery practice. She further suggested that this '*practice perspective*' was essential at management level, and that clinical leadership would have provided a '*smoother way to go*'.

> '*I guess in her role* [clinical leader] *she could be knowledgeable from reading, but not necessarily in a practice perspective. There's a lot of things that she would bounce back to us as a team … there's a perception that we*

> *should all be equals … we can soundboard off one other but I think at times*
>
> *it would be really beneficial to have somebody that says, "No, this is where*
>
> *it will go."'* [Edith, caseload midwife]

While clinical support was available for caseload midwives from after-hours administrators (evening clinical managers with midwifery qualifications), this was viewed as limited. Some caseload midwives described it as hindering midwifery practice. This was on account of different philosophies of maternity care held by the administrators, which were not necessarily aligned with the ethos of caseload midwifery. Edith suggests that while these staff members were 'passionate', they did not necessarily agree with the change to caseload midwifery and the more independent way of working espoused by the caseload midwives in their care of low-risk childbearing women.

> *'… the after-hour's administrator, who was a midwife, and quite a*
>
> *passionate midwife, but not necessarily in line with the philosophies of the*
>
> *service.'* [Edith, caseload midwife]

Edith further suggested that the evening administrators tended to regard their midwifery roles and responsibilities as secondary to their administrative/nursing tasks and identities:

> *'I would put the administrator first, she liked that! Nurse second and then*
>
> *midwife, as a third component to lesser degree.'* [Edith, caseload midwife]

Night duty midwives such as Marie emphasised the importance of practitioners working competently and safely when undertaking assessments of women in

labour. Having the experience and confidence to make decisions, and act on them in a timely manner, were considered important markers of leadership.

> *'She works safely. She knows when things are not going to work out well and she calls in help earlier … She's very confident in what she says and when she makes a decision, she stands by it.'* [Marie, night duty midwife]

Angela, another night duty midwife, concurred with Marie's perception of colleagues with good clinical leadership skills, defining them as:

> *'People who can work independently, who can make the decisions and not be uncertain about when things are going wrong.'* [Angela, night duty midwife]

As previously mentioned, the onsite GP was seen as a supportive practitioner, who role modelled the autonomy he expected his midwifery colleagues to display. Lynne described the professional respect he offered, and which was reciprocated by the caseload midwives.

> *'I'm confident with the GP that we have; he makes himself very available, and I think that, as independent practitioners in an autonomous role, that's where our clinical skills need to be spot-on! We need to be able to assess a woman in labour and, you know, have that frank conversation with the GP and say, "I'm here with her, it's not working, I need to call PERS [Perinatal Emergency Retrieval Service]. We need to move on."'* [Lynne, caseload midwife]

Marie concurred with the opinion of her colleagues, who described a positive working relationship between the caseload midwives and the onsite GP. She cited

good communication between the two parties as essential, particularly during night-time hours.

> '*Yeah, I see there's good communication with them and the GP.*' [Marie, night duty midwife]

In summary, it was felt that while a few caseload midwives eventually demonstrated leadership skills, employment of a clinical midwifery specialist by the health service, practised in caseload care, would have provided a more decisive voice for midwives negotiating the day-to-day running of the caseload model. This leadership strategy may have acted as a buffer for caseload staff and clarified issues more quickly through providing a primary voice of clinical authority for hospital nursing staff to liaise with, in an effort to diffuse concerns.

The importance of strategic leadership is discussed in the following section. Participants viewed this as crucial ensuring the vision they held for the future of the service were realised, and that on-going provision was dynamic and responsive to local needs.

The maternity service progress to date and future vision

A difference of opinion about the future of the maternity service was apparent between caseload midwives and management. While numbers of women booking into the service had reduced since the caseload model was introduced, Alice was of the opinion that this was a temporary setback and that the refashioned service would flourish due to its location in a population '*corridor*' with good projected future growth.

> *'I firmly believe this, it will only be a temporary thing. I reckon we will grow*
>
> *fairly substantially over the next couple of years.'* [Alice, manager]

Other participants, however, described a more conservative projection with a fairly stable number of low-risk bookings continuing at the current rate. Betty suggested that the health service might wish to consider marketing a '*boutique*' maternity service, which emphasised the normality of pregnancy and birth. She suggested remodelling the labour/birth rooms so that '*women would stay in those rooms until they went home.'* Introducing more facilities and a policy for water birth were also suggested:

> *'I'd love to see a water birth policy developed here … I'd like people to birth*
>
> *in the room and stay for their 24 hours if that's what they want to do, not*
>
> *moving them around. I think that's very old fashioned.'* [Anna, caseload
>
> midwife]

Anna preferred the greater flexibility provided by the caseload model, which enabled her to provide the majority of antenatal care to women in the comfort of their own homes. Anna described meeting women in their own environment as '*stepping into community … and we use the facilities here to birth.'* The same was true for postnatal care as many women returned home within 24 hours after birth. Anna clearly spelt out her wish for midwifery accreditation, which would enable her and her colleagues to become 'eligible' midwives (see glossary) with Medicare provider numbers, endorsed to prescribe a select range of pharmaceutical products, and request certain screening procedures such as ultrasound scans and blood tests. Accessing training to assess infant health and wellbeing prior to hospital discharge (baby check) was also wanted by some of the midwives.

While caseload midwives wished for support, almost seeking permission to proceed, they were not prohibited by the health service. Participants were able to enact and commence this midwifery eligibility education themselves. Anna's comment suggested a lack of self-empowerment – that she should instead wait for management to 'sanction' her practice potential:

> *'I would love us to be supported towards becoming accredited midwives, like private practice midwives. I think that we should be writing our own request slips, baby checks; that is in our scope of practice.' [Anna, caseload midwife]*

At the time this study was undertaken, caseload midwives required medical authorisation for all routine pathology and radiology requests, although they were permitted to action a small number of standing orders for pharmaceutical products that may be required during birth and the immediate neonatal period – for example, Syntocinon and vitamin K. The education that would qualify practitioners to prescribe other scheduled medicines may be undertaken independently, through Australian universities, with endorsement approved by the Nursing and Midwifery Board of Australia.

Participant views on the altered clinical culture during change are discussed in the following section, as philosophies of maternity care were seen as distinct between nursing, administration and midwifery staff.

Cultural change in the clinical arena

Over the past decade (2005–2015), this rural health service had undergone a significant adjustment, with major alterations in maternity services and associated clinical practices. Caseload midwives reported that they often felt uncertain about these changes, which had not always been welcomed by their hospital-based colleagues or community representatives. The caseload midwives generally considered the changes introduced into the maternity service had effected a substantial shift in perceptions of care, clinical processes and ideologies. In the context of this study, cultural change in the clinical arena reflected the altered or challenged beliefs, values and accepted practices health service employees held about the way care should be delivered before, during and after the implementation of maternity service change. While the literature in this area discusses organisational change in these terms, there is a significant gap in research into the changing culture of maternity services, particular those changes reflecting the rural and remote location (Jacobs et al., 2013).

The shift in power relations and service priorities challenged hierarchical structures and the elevated status of medical professionals, and contributed to redefining ideas about how rural maternity care might be delivered. In the following quote, Alice explained how this shift helped her to prioritise women's needs, rather than privilege the needs of care providers:

> *'It was actually about, and it has taken us a long time to break this down too, it was actually about the doctor, the midwife and then the woman. So now it's about the woman.'* [Alice, manager]

Cultural change in the health service under study was described as a dramatic upheaval in traditional maternity and nursing working practice. It required midwives to move from '*sheltered*' employment to the demands of a new and rather more challenging model of care, which emphasised practitioner accountability. Alice described how she '*ripped out*' medical support, forcing her staff to work as '*professional midwives*'. Alice empathised as she elaborated on the shock caseload midwives felt during the change process and the heightened anxiety, when staff found themselves in situations that demanded more of them than even she had originally expected.

> *'I took a bunch of midwives that are as old as me, or maybe up to 10 years younger, who'd worked in a particular way, mostly in the one particular hospital or maybe two since their whole training. I ripped out their doctor's support. I ripped out all sorts of stuff, and told them, "Oh, guess what? You're professional midwives now and you have to work that way."'* [Alice, manager]

The level of difficulty experienced in creating a new model of care, including identifying and rectifying educational needs, upskilling staff and helping them to adjust to their new role expectations, was largely underestimated by management. Alice suggested that, seven years following the first phase of the changes, the caseload midwives still had some way to go before they were practising according to what Alice understood as their standard for the local context. Alice's comments identified '*full scope of practice*' as the midwives being endorsed to prescribe selected medications and diagnostic investigations, and perform extended skills such as perineal suturing:

> *'Within the midwifery group that started off, to move those girls from being obstetric nurses into being true, full scope of practice midwives, I reckon we're only still about 85% there.'* [Alice, manager]

The challenges to bring about cultural change in the clinical environment were repeatedly emphasised by Lynne, who had previously worked as a general midwife before moving to a caseload position. Lynne referred to the '*big change*' for all staff employed at the health service, suggesting the change not only reduced midwives' dependency on medical staff, but also separated caseload midwives from other departments and personnel, including other midwives. This was a significant shift for a small service where many staff had been employed long term and were well known to one another, both inside and outside the hospital setting. Lynne suggested caseload midwives had previously been '*cushioned*' by the larger numbers of GP staff, who had assumed greater responsibility for labour and birth progress and outcomes.

> *'I've been working here for a long time. We always seem(ed) to have a core group of midwives and doctors around us, and we're always being cushioned by them because they're always there.'* [Lynne, caseload midwife]

It appeared that the new responsibilities and accountabilities associated with caseload practice were a daunting prospect for some of the participants. Data suggested that, along with the closer relationship caseload midwives assumed with '*their*' women, came an increased responsibility to achieve perfect outcomes. Samantha suggested this was unrealistic, saying, '*It doesn't always end up happy at the end';* although this did little to reduce the fear for midwives who were often

well known in communities, with no place to hide. By extension, Samantha described the greater reliance of women on the caseload midwives, and the unrealistic expectations midwives had of themselves:

> *'They rely on you and you have an expectation on yourself to, you know, get them through the experience all happy at the end.'* [Samantha, caseload midwife]

Anna described her ease of working in a caseload model, perhaps as a result of her earlier exposure to variety of midwifery (rather than nursing) experience in different settings, including private practice. Anna explained that her home birth experience provided her with access to care for low-risk '*normal'* women, external to hospital intervention, which enabled her to trust in her own knowledge and practice. She was of the opinion that institutionalisation was an inevitable consequence of hospital-based employment, and that her lack of experience in this respect helped to minimise the decision-making anxiety reported by her caseload colleagues.

> *'I just haven't been institutionalised! I haven't spent enough time* [in a hospital]. *I've never worked full-time as a nurse. I think that home birth was a really huge component in that, working on that level … well, you make decisions when you need to make decisions. I really learnt what normal is; therefore, I can identify what abnormal is, and I trust that.'* [Anna, caseload midwife]

In reflecting on the consequences of institutionalised midwifery practice, Lynne contended that the ageing population of midwives within the health service,

together with the fact that many had spent all their working lives in the local hospital environment, made cultural change extremely difficult to achieve. While she was aware of this issue, she was also surprised by the intractable nature of the problem.

> *'I didn't think that it* [achieving cultural change] *would take this long. But …* *we're an ageing population, you know, the average age that we have here* *is 40-plus. A couple of them* [midwives] *are heading towards 60. So those* *women have been ensconced into a model that's pretty hospital-bound for* *a long time. So making those changes has been difficult.'* [Lynne, caseload midwife]

Cultural change required the health service to redefine their ideas and expectations about midwifery roles and the professional scope of practice. It affected organisational staff differently, as discussed in the following section.

Responses to change

A change in the maternity model came at a personal cost for some caseload midwives, who described resistance from nursing staff and the development of an 'us and them' mentality. As I have previously explained, some nursing staff did not understand the proposed new model of care. They showed their disapproval by aligning themselves with the midwives who applied for, but who failed to gain, caseload employment. For their part, the caseload midwives described varying degrees of hostility directed at them, which they felt alone in managing. Samantha described how this affected her, especially when overt comments were made that signalled the extent of staff divisions. Where midwives and nursing staff had once

worked harmoniously, sharing the workload together, an emotional divide along persona, professional and employment lines became ever more visible.

> *'At the time of change, it was the worst place I've ever worked, ever! There was hostility for months and months and months between the acute staff and the midwives of the team, and the midwives who weren't part of the team.'* [Samantha, caseload midwife]

Samantha discussed how behaviour from colleagues alienated her from the acute ward. Witz (1990) describes these actions as 'exclusionary tactics', a term originally applied to male dominance against the female gender in professional occupations. More recently, Bevan and Learmonth (2013) brought this concept into the healthcare environment. While health-related occupied roles, particularly those in nursing and midwifery, are typically female dominated, Samantha's comment suggested exclusionary tactics were used by nursing staff in an effort to undermine caseload midwives.

> *'You know, there were times when you'd walk into the nurses' station and people would go quiet and stop talking about things … there were lots of comments of, "Oh, here you are again, you've bothered to come to work."'*
> [Samantha, caseload midwife]

Samantha commented that as caseload midwives became '*wrapped up in the moment*' with their new and special roles, nursing staff may have felt left out of the excitement or rejected altogether. Samantha suggested a '*sinister negativity around the change*', and that caseload midwives felt much outward hostility directed towards them as the Australian Nursing Federation (ANF) was called on

to investigate the effect caseload, and the loss of midwifery staff from acute medical care, would have on nursing ratios. Alice explained that ANF involvement occurred during phase one of the change process (see Appendix A) and that due to the nature of caseload, midwifery staff were counted as separate to hospital staff ratios. Therefore, hospital-based midwives and nurses viewed the maternity service restructure as a loss of acute staff and an increased workload for registered nurses. Samantha suggested that it was largely left to midwives to continue to communicate with general staff, though this was not reciprocated. Finally, Samantha reported that addressing the issue directly was something she had to do, although she also admitted that she lost friends in the process.

> *'We've got to try and communicate with them* [non-caseload midwifery colleagues] *but they weren't willing to communicate with us … I even had to say to one midwife, "We've been away for social weekends and now suddenly I'm not considered a colleague or a friend even?" … I lost two friends over the change, which was, you know, to this day I think is really sad and awful and shouldn't have been like that.'* [Samantha, caseload midwife]

While Samantha suggested that the overt hostility lasted for approximately six months after the caseload model was introduced, Elizabeth was of the opinion that a more subtle sense of animosity had lingered, with the two groups of staff (caseload and non-caseload) continuing to antagonise one another. Hospital-based nursing staff appeared concerned at how the caseload midwives had set themselves apart – for example, by no longer wearing uniforms. Betty noted the

seemingly 'ad hoc' nature of their work hours added to the impression that they were quite separate to other staff.

> *'It took a while for the rest of the general nurses to get used to us and what we were doing – that we were being paid for not being here. So that was just that mindset; a big thing for this establishment to get used to us coming and going and looking as if we really weren't working hard.'* [Betty, caseload midwife]

It appeared that the caseload midwives were no longer bound by the same set of institutional 'rules'; that they had renounced their allegiance to their colleagues and, in so doing, had ensured that that the old and familiar practices, including requests for help, were no longer possible.

> *'You feel you can't sort of say, "Can you just quickly come and make this bed while the patient is standing up." You don't ask that sort of thing, they're not a member of your team anymore. They're their own separate identity.'* [Elizabeth, caseload midwife]

Betty suggested that general staff lacked an understanding of midwifery roles and responsibilities. She also indicated that nursing staff monitored the midwives' activities onsite as a signifier of how hard they worked. This behaviour by general staff appears to be reflective of 'face saving practices' detailed by Goffman (2003). Feeling undervalued and cast aside, general staff felt bound to protect one another, ensuring the cohesive nursing group remained intact.

Broader resistance was also noted among community members and ex-employees (including midwifery staff) who commented informally to board

members regarding their disagreement with the new model of care. Alice reported that board members were subjected to verbal abuse for agreeing to the changes proposed for the maternity service, that they had limited mechanisms to cope with the ill-treatment they received and that some found the conflict difficult to manage. Alice also highlighted the reality of rural settings, where residents of communities have well-established and close-knit relationships, embedded within a culture that is typically resistant to change.

Caseload midwives suggested that confrontations were sometimes provoked by the distress caused by a change in circumstances, such as an individual's decision to leave (midwifery) employment at the health service and subsequently travel further in pursuit of suitable work elsewhere. The increased travel time and associated costs, along with difficulties with organising child care and negotiating a new work environment, were additional stressors for these community members. All of these factors may help to explain the aggressive stance Alice described:

> *'Board (members), for instance, have had some of our ex-midwives come up to them – very aggressive about what we've been doing and about our change of maternity model. And they have been very aggressively abusing them, and if you're a board member, how do you manage that?'* [Alice, manager]

Alice's quote speaks to the level of 'safety' felt by ex-employees to speak out to board members when in a position with fewer sanctions on behaviour that might impact one's economic state. It is also reflective of the sense of 'ownership' some ex-employees had for health services that were closely linked to community survival and sustainability (Farmer, Prior, & Taylor, 2012). While the irregular

presence of the caseload midwives (for example, when attending their clients in labour or visiting them on the postnatal ward) was seen as indicative that they were indeed working hard, effective time management was reported as an ongoing and problematic issue.

The following section discusses midwifery skills that were identified as necessary for the caseload midwives, but which were not appreciated as such until well after the change had been introduced.

Midwifery skills and additional training needs in caseload practice

Participants identified a number of the following high priority skills that they felt they needed within the context of their new (caseload) practice environment:

1.   recognition of '*deviation from the normal*' during pregnancy, birth and the postnatal period

2.   good time management

3.   communication skills

4.   boundary setting.

Some caseload midwives indicated that they wished to acquire additional skills, including hospital competency with undertaking the 'baby check' prior to discharge and access to ordering routine pathology tests. Lynne held strong views on what skills she felt were required for effective caseload practice; indeed, interview data suggested she often acted as the spokesperson on this subject. Lynne described the need for confident and clinically sound decision-making and strong assessment skills when working as a midwife in a rural setting:

> *'I guess it's recognising the abnormal … making sure that labour is*
> *progressing … having the skills set to recognise what's not normal … We*
> *are employed in a role as being autonomous* [practitioners]. *We should be*
> *able to make those decisions.'* [Lynne, caseload midwife]

Lynne described the demands some of her clients made, and their expectations
about her role, as extending far beyond what might normally be considered as a
midwifery/maternity-related agenda:

> *'Sometimes they* [women] *want to be your best friend too. They want to call*
> *you all the time. They want to talk about marriage problems. You know,*
> *we're not marriage counsellors, we can't talk to their boss at work and say,*
> *"Can you pull back her duties?"'* [Lynne, caseload midwife]

Lynne suggests that women sometimes expected too much of midwives: '[they're]
texting you all the time', and '*if they are awake/want to talk to someone, they're on
the blower'*. This may be explained by the sense of isolation women living in rural
communities experience, particularly those who have recently moved from an
urban environment and who have limited social networks in place. Loneliness may
be especially problematic for women who are newly pregnant, particularly with a
first baby. Lynne added that younger women tended to text regularly rather than
ring, commenting that even diverting her phone on days off didn't reduce the texts,
or her inability to refer minor matters received via text to her colleagues. This was
largely because, although the caseload midwives were issued with mobile phones,
there was no facility to divert text messages.

'Well, you know you're kind of a beck and call girl really. You're at the woman's beck and call. The hospital always talks about setting up boundaries for the woman, but I mean the generation of women these days is that they text you all the time, they don't bother to voice call. So you can divert your phone, but you're always going to get a hundred texts … They see themselves as the only woman you are looking after, so they will text you morning, noon and night.' [Lynne, caseload midwife]

Lynne indicated that she and her colleagues experienced difficulty with setting, and maintaining, boundaries with women in their caseloads. Hence, she resorted to means other than direct communication to manage women she described as '*incredibly needy*'. As Lynne assumed responsibility for caseload allocations, she reported that one such strategy included rotating women around the four midwives in order to dilute, or break up, attachments she considered had become unhealthily dependent and '*intense*'.

'I like to sometimes move some of my women around, give them to some of the other midwives, because I find that sometimes they do get incredibly needy and, you know, sometimes I think it's quite healthy to sort of break it up a little bit. Sometimes the women's relationship with you can get a little bit intense … and sometimes you think, Oh god, do I have to see (X) again?' [Lynne, caseload midwife]

Time management was an ongoing issue for the caseload group, resulting in uneven workload demands, and some midwives working (far) in excess of their allocated hours. Narratives suggested, however, that if all the midwives had managed their time more efficiently, demands would have diminished, or at least

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have been more evenly spread and, most importantly, overtime costs would have been reduced. Mary suggested that while some of the midwives attempted to improve their time management, the way in which they triaged and prioritised care was below her expectations as manager. She referred to time being not '*properly*' managed by some of her colleagues, citing their '*reluctance to make a referral*', a preference to act independently, and assuming prior knowledge and experience rather than acknowledging their deficits. She also noted, however, that pressure to work independently may have encouraged fewer referrals, with midwives concerned that this would signal their inability to manage. It is also possible that some midwives prioritised spending time with women and their families over administrative activities, while the more process-driven personalities in the group operated in the other direction. Striving to achieve a more even balance, with workloads distributed across clients and administration, was an ongoing activity.

> '*Time management is a huge issue, in just ensuring that the midwives are managing their time effectively … The challenge with that is that we've got five* [employed at time of interview] *very distinctive personalities who manage their time and their workloads in different ways.*' [Mary, manager]

Mary described the issue as very challenging, particularly as caseload midwives were heavily reliant on one another. As they continued to be '*rostered*' to days off, mobile phones would be diverted, with colleagues covering incoming calls. Problems arose when some midwives used their pro-rata hours inappropriately. Lynne reiterated her difficulties in setting boundaries and the need for advanced skills in negotiating expectations with clients, and especially with drawing their attention to the limitations in service provision.

'You know, I think we all needed to be able to have, apart from the clinical skill set, some communication skill set about setting boundaries for your woman … I just don't think we've been given a set of skills to help us do that … I think that we could have had some 'art of communication' workshop or something about how you actually can set those boundaries. Because I know not just me, for everybody it's been a problem, for some women and the midwife.' [Lynne, caseload midwife]

Caseload midwives also considered themselves to be lacking in skills concerning the application of information technology in clinical settings. This seriously delayed the revision and introduction of clinical practice guidelines (CPGs) into caseload practice. Lynne, particularly, claimed there was no such need for extended computer literacy for most middle-aged, hospital-trained midwives and nurses. Hence, unless they had acquired university-based postgraduate training, the majority of the caseload midwives were required to learn a new set of skills that they didn't initially realise they needed. Participants' narratives strongly suggested that the support to acquire the necessary information technology (IT) expertise, within the required time frame, was generally not forthcoming. In the following quote, Lynne highlights the degree to which she and her colleagues underestimated the additional IT skills required to demonstrate the necessary competency and professionalism in the new model of care:

'But it [IT] *is just completely new to me. I don't have any university skills. I'm all about pretty borders and things like that from Higher School Certificate. They'd* [the Quality Assurance Committee] *say, "Hyperlink in this bit", and I'm thinking, What the hell's a hyperlink? I don't have that sort of set of*

skills, and when I finished my training it never was about that. We'd come to work and we'd do the work. But since we developed this new model, [we] *have a portfolio* [of additional work] *on top of all the women that you have to look after as well!'* [Lynne, caseload midwife]

In summary, a lack of computer literacy and additional IT and administrative skills such as time management and effective communication (including boundary setting and maintenance) were identified as problematic, with consequences for workload allocation and client care.

Deficits in these skills slowed the progress of change, and were possibly linked to indicators of participant stress, which will be discussed in the following section.

Safety and risk

The rationale for changing the maternity service model was described by participants as a response to safety concerns and increasing risk indicators reportable to the Health Department. Mary identified the need to employ risk management strategies as a justification for the changes introduced into the maternity service, intended to reduce the risk of adverse maternal and neonatal outcomes.

'So the impetus for change initially was that risk management side of things and to improve outcomes for mothers and babies.' [Mary, manager]

Alice suggested that an additional incentive was a desire to meet the needs of local women. As previously outlined, prior to the change maternity staff had worked across the acute general/maternity ward, providing labour, birth and postnatal care while simultaneously attempting to balance the demands of clients

on the general ward. Alice also highlighted the potential for cross contamination, because midwives were required to move from medical/surgical care consisting of potential infections to care of newborn infants with little to no immunity.

> *'We* [health service managers] *believed that we needed to develop a contemporary model, a model that was more in meeting the needs of the woman and pose less clinical risk to the woman. Because if you're a midwife diluted everywhere else – here, there and everywhere – not only have you got an infection control risk but you've got all sorts of other risks going on there.'* [Alice, manager]

Alice described what she considered as the unsafe maternity practices that were commonplace prior to the maternity service restructure. She cited negative maternal and neonatal outcomes and '*near miss*' incidents as '*messes and disasters*', emphasising her belief that the health service was running a high-risk maternity service that did not have the resources or clinical capacity to adequately address actual and potential emergencies. Alice was of the opinion that medical assessment of maternal/neonatal safety and risk were not commensurate with the maternity service capability. Alice states that '*high-risk stuff*', such as inductions, which were undertaken without the necessary support from in-house paediatric and other medical speciality and nursing staff, posed a real threat to maternal/neonatal safety. Hospital administrators also feared litigation challenges arising from obstetric and neonatal incidences.

> *'I felt that it* [previous model] *put the midwifery women [*i.e. clientele*] at a lot of risk and their babies. We were doing things here that, quite frankly, we shouldn't have been doing. I had never come across a place that had had*

so many messes and disasters … there by the grace of God quite frankly we didn't have a maternal death. Some of the things that the obstetric people were doing were way out of what should have been done in a hospital like this. We don't have any after-hours doctors in the house, we don't have paediatrics, you know, we don't have a nursery. We were doing some really high-risk stuff. So that was why we believed that we need to change the model and change how we practised maternity.' [Alice, manager]

The production and revision of CPGs were viewed by caseload midwives as perhaps the most significant and visible example that clinical governance was in progress. Mary described the revised CPGs as likely to improve clinical safety, adding that maternity care would now be delivered in accordance with '*robust*' criteria. Lynne commented on the magnitude of the task and the length of time it took to rewrite the CPGs and to have them approved:

'It's taken me two years of hard slog just to format these clinical practice guidelines and get them through clinical practice forum and obstetric committee … then they have to go to the [health service] *Board.'* [Lynne, caseload midwife]

When discussing staff (other than caseload midwives) reactions to perceptions of safety and risk associated with the caseload model, negative responses were commonly described. Anna was of the opinion that, while management were keen on introducing the changes in order to reduce obstetric risk, general staff felt the caseload model potentially increased risk to mothers and babies due to the greater responsibility given to midwives. The reduction in medical control was

understood as dangerous, which may suggest that staff did not understand the full scope of midwifery practice, had not experienced working with a caseload model and felt wary of reduced medical cover.

> *'They didn't like it; they* [hospital-based nursing staff] *thought it was unsafe and not good.'* [Anna, caseload midwife]

As the introduction of caseload care remodelled the maternity service from all-risk to a low-risk model of care, concerns about safety and risk generated anxiety for staff and community members. Before women were accepted into the caseload model, they were screened by both the onsite GP and the caseload midwives and accepted only when deemed low risk. While maternity-related risk can never be entirely predicted or avoided, Angela's comment about the need to remove '*any risk at all*' suggests this may be an element of heightened concern for her. Angela implied that risk was wider than the concern for the pregnant/birthing woman and her infant, and that concerns for the organisation also needed to be considered in the wish to avoid putting '*anyone at risk*'. As a midwife, working also as a hospital administrator overnight with minimal staff to assist or support her, Angela's comment displayed concern about her duty of care and responsibilities in a risk-averse clinical environment (Scamell & Alaszewski, 2012).

Elizabeth suggested risk aversion in this rural environment was in part a product of women's lack of trust and '*faith in themselves*' to birth normally. Marie highlighted important skills for caseload midwives, noting some of the deficits she saw in others. Marie saw two 'young midwives', one with predominantly home birth experience and the other holding a bachelor of midwifery qualification, as lacking in experience when compared to other older midwives. Marie's assessment may

be less a comment on level of skill, and more a reflection of the cultural change

taken place in maternity education, filtering to the clinical arena as maternity care

has moved from a hierarchical culture to woman-centred care. Such overall

cultural changes, and the educational background more recently qualified

midwives are coming from, perhaps challenges Marie's own professional identity

(Lane & Reiger, 2013). Marie pointed out that facilitating women in labour required

a confidence that comes from experience; she viewed it as an essential criteria for

independent practice (which she compared with caseload); however, she also

commented that some younger midwives '*haven't finished their training*',

suggesting she felt solely gaining a qualification was not necessarily sufficient for

caseload midwifery. Both comments suggest Marie felt caseload exposed

midwives by removing their security blankets and increased their feelings of

vulnerability. Marie may also associate age and experience with competency,

perhaps causing her to lack trust in younger midwives and their ability to cope

unsupervised during labour and birth.

> *'Oh, you really need an experienced midwife, someone who's had good*
>
> *labour ward experience. Because some of the girls, two of the girls now,*
>
> *they're young, they haven't finished their training, and they're the ones who*
>
> *are getting into … They're not coping because I think they feel frightened*
>
> *themselves, but they don't say anything to me.'* [Marie, night duty midwife]

Jenny indicated she felt limitations in midwifery practice inflated risk by

disempowering qualified midwives from advancing their clinical skills. Caseload

midwives were yet to be trained to perform baby checks on well infants prior to

discharge, or be given rights by the health service to order routine antenatal pathology.

> *'It* [lack of clinical training opportunities] *does feel disempowering as a midwife; I think it also introduces issues of safety, to be quite honest … in this role here, where we do have responsibility, and we are expected to deal with emergency situations, then why the heck aren't we, you know, allowed to check a baby for healthiness before they go home?* [Jenny, caseload midwife]

While competencies such as routine baby checks are within the midwifery scope of practice, they are often considered 'advanced' skills in the Australian context. Smith (2010) suggests hindrances for full scope of practice include inconsistent education across differing health service organisations, along with opportunity and support for midwifery practice. There have been mixed responses to extended credentialing for endorsement and eligibility in midwifery (see glossary), seen by some as yet another requirement and by others as an important step to increased autonomy and professionalism (Smith, Brodie, & Homer, 2012).

Workforce pressures, attracting and retaining staff, and the identified response of caseload midwives to the demands of continuity care in this study location are examined in the next section.

Attracting and retaining staff in a rural health workforce

Workforce recruitment and retention of midwifery and nursing staff in rural Australia is known to be a long-term, ongoing issue (Health Workforce Australia,

2013). An ageing workforce, the location of health services, excessive workloads, and limited career pathways impact upon sustainability of services in these settings (Francis & Mills, 2011). Data from this current study confirmed that the lack of midwives available to cover hospital shifts and care for a mixture of general and maternity clients was an important issue that had prompted the change in the maternity service model. Caseload midwifery was seen as a model of care that might provide a specialty career pathway to attract younger midwives to the area, while simultaneously addressing the necessity for 24-hour midwifery staffing. Samantha described the struggle she and other colleagues had faced to guarantee adequate staff cover of hospital shifts prior to the introduction of caseload practice:

> *'We struggled with staffing for various reasons – people went on maternity leave, people moved onto other hospitals – so we couldn't always guarantee that we would have a midwife per shift.'* [Samantha, caseload midwife]

Participants acknowledged that future recruitment and retention of staff might be enhanced by the ability to offer exclusive midwifery employment. Alice was of the opinion that rural health services needed to plan and adapt to workforce preferences and practitioners' skill base in order to remain sustainable. This was somewhat contrary to existing expectations that the workforce should adapt to meet the needs of the rural health service. Alice suggested that organisational flexibility and a greater understanding of the factors motivating contemporary employees were essential to the task of recruiting and sustaining a viable midwifery workforce:

> *'So where do these people think they are going to get the rest of their*
> *workforce from in the future? You are not going to attract a workforce, a*
> *professional midwifery workforce, that will come and look after general*
> *patients, look after palliative care – oh, and just swing by the maternity*
> *woman at the same time.'* [Alice, manager]

Participants frequently reported that employment within the caseload model was the primary reason for their continued service. Lynne, who had worked at the health service prior to the introduction of caseload practice, described her happiness to work exclusively as a midwife.

> *'General'* [nursing] *wasn't something that I wanted to do; I wanted to be a*
> *midwife … So embracing that change where I could just do midwifery, it*
> *was fantastic!'* [Lynne, caseload midwife]

Betty, a mature and long-term employee, reiterated the importance of doing work which she enjoyed and which gave her positive feedback. However, she was also aware that with increasing age the demands of caseload may be too great for her to continue in this employment model:

> *'I can't see myself stopping this work in the near future. So, I guess, as long*
> *as I keep going as I am! And my health is okay, and my mind's alright, and*
> *I'm able to work in this field as a caseload midwife, and I'm enjoying it. I guess*
> *if I get any negative feedback, it's time to stop.'* [Betty, caseload midwife]

Several caseload midwives reported that the model of care was the reason they had originally submitted an employment application:

The model of care bought me here. I'd been working in another hospital and all the antenatal care for those women was run through the GPs in their clinics. So, really, we didn't meet anybody until they came through the door.' [Anna, caseload midwife]

Anna described her desire to remain working rurally in a specialty model of maternity care that was closely aligned with her philosophy of midwifery practice:

'I'm actually really hoping I get long service leave! [group laughter] *I've never considered that before! Two years here. That's the longest I've ever had one job in one place.'* [Anna, caseload midwife]

Edith, who had been employed casually for several years, also described her commitment to woman-centred care as an important reason for seeking permanent employment in the caseload model.

'It was a bit like my dream position. From the ideology that it was a woman-centred philosophy driving that service position. And also that it gave a certain degree of autonomy as a midwife.' [Edith, caseload midwife]

Jenny, a newly employed caseload midwife, indicated that flexible working practices had attracted her from her casual position in a metropolitan hospital:

'I was working casually there was a lot of, "Ah well, maybe I'm working today or maybe I'm not." [soft laughter] *Um, I haven't had a permanent role for a long time. There is more flexibility, in that I can design it my own way how I work.'* [Jenny, caseload midwife]

Mary confirmed the widespread interest generated by the caseload model, and the frequency with which midwives working elsewhere contacted her for information about possible work opportunities:

> *'I get cold calls frequently from midwives wanting to come and work in our service. So, you know, if we were to grow, we could employ more midwives wanting to come and work here.'* [Mary, manager]

Participants described the close proximity of the health service under study to a number of metropolitan centres, and the caseload model of maternity care, as positive incentives for recruiting and sustaining a health service workforce. However, the pressure to achieve higher degree qualifications, in the face of poor prospects for career advancement, was cited as a disincentive – and one which eventually caused Samantha to tender her resignation:

> *'I had also been gently persuaded and pushed forward into doing a master's. And I felt that if I was going to do a master's, that to me meant that I wanted to move up in my career, and if I stayed in* [health service] *there was no room for growth.'* [Samantha, midwife]

Data from this study suggested that the personal rewards associated with the caseload model of care and the interactions with women were strong recruitment incentives. However, encouragement to pursue higher degree studies in the absence of a clearly defined career pathway was seen as a negative aspect of employment in the rural setting within which the study was undertaken. This has been identified as an issue of concern in the literature (Health Workforce Australia, 2012a).

The next section discusses how the caseload model impacted on midwives' private lives, and the associations with workforce issues.

Burnout

Burnout is a workforce issue affecting employee productivity and staff retention, and has been identified as being a result of 'emotionally demanding' professions, specifically midwifery and nursing (Holland, Allen, & Cooper, 2013). It is typically associated with exhaustion, excessive workloads and lack of motivation (Jordan, Fenwick, Slavin, Sidebotham, & Gamble, 2013). Professions such as midwifery have an expected (client or organisational) level of 'emotional labour' associated with the intensity of the relationships with women, causing turmoil for midwives at odds with their feelings and what is displayed to women (Hochschild, 1979). Sandall (1997) brought burnout into the midwifery arena, with a specific focus on continuity care models, suggesting lack of support, high midwifery ideals and reduced home support as associated characteristics of burnout. More recently, literature has suggested organisational encouragement for staff to express anxieties to direct manager responses for supporting staff under stress are a positive action towards employee wellbeing (Holland et al., 2013). The data from caseload participants in this study confirmed what has been reported previously from research investigating burnout in midwives, with participants describing periods of exhaustion and energy loss, particularly when reflecting on work hours spent on '*needy*'' women (Mollart et al., 2013). Participant narratives demonstrated frustration over some women's emotional dependence, which did not appear to dissipate, despite caseload availability and attention. Lynne suggested at times

women wanted more than midwifery skills, wanting her to act as a '*best friend*' and confidante.

> '*… they want to call you all the time and, you know, they want to talk about marriage problems.*' [Lynne, caseload midwife]

Particular reference was made to the rapid expansion in use of mobile technology and caseload midwives' inability to 'turn off' from work on days off. Lynne suggested she was at the women's '*beck and call*' and, although she would try to reduce this by avoiding emails and diverting her mobile phone when off duty, this only minimised her availability to women rather than solved the problem.

> '*… the generation of woman these days text you all the time, they don't bother to voice call. So you can divert your phone, but you're always going to get a hundred texts.*' [Lynne, caseload midwife]

Along with a compulsion to respond, Lynne felt obligated to respond via voice call to avoid the '*lengthy time wasting*' she associated with re-texting. Lynne was also concerned about the lack of confidentiality when responding to women via text, and her ability to ascertain the degree of urgency associated with text-based communication.

> '*Sometimes I never know who the text is coming from. If I see one of the midwive's names, I'll always read it.*' [Lynne, caseload midwife]

Lynne's comments highlighted the differences in mobile technologies used by the caseload midwives. Forti, Stapleton, and Kildea (2013) recently examined the use of mobile technologies and communication strategies in caseload settings. Findings included the increased frequency of text messaging as a primary mode of

communication, and women's preference for this mode of communication. Issues concerning confidentiality and accountability were also reported by the same authors.

While data from several caseload midwives suggested burnout may have been caused by the transition to their new role, others reported they had been similarly stressed prior to the maternity service restructure, and that stressors included work shifts that were left unfilled and inadequate daily clinical staffing levels. Samantha described the constant struggle to cover clinical shifts as rostered hospital midwives were redeployed to caseload practice:

> *'I think all of a sudden* [prior to change] *we lost some midwifery numbers and we couldn't fill the rostered shifts … for a few months there, people were doing lots of overtime to cover it … And when you're a small work force it impacts hugely.'* [Samantha, caseload midwife]

Lynne described her feelings of exhaustion and her anxiety about the lack of options in the event she was no longer able to cope with the demands of caseload practice. She implied that being more assertive, especially regarding boundary maintenance with women, might help to rectify her lack of motivation:

> *'I don't know how much longer I can keep it up. Which disappoints me because I think, fuckin-hell what else am I gonna do? So I think what I need to do is just regroup and work within a few more boundaries and I'll probably go a little bit longer.'* [Lynne, caseload midwife]

Alice believed that the pendulum had swung too far in the direction of accommodating the needs of women and their families. She felt that the caseload

midwives needed to reclaim a healthy work–life balance; that they also needed to consider themselves and their families, because failure to do so had potentially serious implications for their own health and ability to continue to work as a (caseload) midwife.

> *'Now we have gone too far the other way. The woman, the woman, the woman, the woman, the woman, the woman, the woman! Until I'm nearly dead, and I'm having a nervous breakdown and I can't cope anymore!'*
> [Alice, manager]

Some participants claimed that the additional duties they had been given were unfairly distributed. Lynne commented on the uneven responsibility she assumed compared to her caseload colleagues, suggesting managers did not request similar '*extras*' from the others, and adding that the skill of delegating and boundary setting was something she learned through the process of change.

> *'There's so many jobs that I do, it is just ridiculous! Every woman that comes into this service is emailed to me, and I ring them and find out what they want. So it is a massive role, so now I am just delegating a few more tasks.'* [Lynne, caseload midwife]

Several caseload midwives suggested that the change to the model of maternity care benefitted the hospital-based nursing staff because there was less disruption to patient care when the caseload midwives took over responsibility for women in labour.

> *'In the past, if a woman came in and she was in established labour, then a midwife came off the floor, which meant that the other* [nursing] *staff had to*

> *pick up their patient load. They began to see that* [the caseload model] *was*
>
> *a better thing.'* [Samantha, caseload midwife]

The majority of caseload midwives reported feeling guilty and experiencing varying degrees of difficulty when negotiating the needs of their family and accommodating women in their care.

> *'That struggle between balancing family and balancing women. They*
>
> [clientele] *don't care that you're not with your child; they want you to be with*
>
> *them.'* [Lynne, caseload midwife]

Samantha explained the impact that family priorities had on influencing her decision to leave employment as a caseload midwife.

> *'Part of the reason for moving forward wasn't just about my own personal*
>
> *career but my family. I need to be here more for my daughter and her*
>
> *dancing. She dances three nights a week plus pretty much all day*
>
> *Saturday. I don't have my son to support me with my driving around the*
>
> *countryside when my husband's at work…she's* [daughter] *doing the right*
>
> *thing. I need to do the right thing.'* [Samantha, caseload midwife]

Work-related burnout meant that caseload midwives were left feeling stretched beyond their emotional capacity and unable to deliver what they considered a reasonable commitment to the women in their care. Some participants cited the absence of a daily work structure as a significant factor that reduced their ability to cope with the demands of caseload care. Edith described her frustration with being unable to attend the birth of a woman in her caseload because she had

already exceeded her paid work hours for the week, referring to time already spent

caring for other women that week:

> *'If your time allocation to work means that you're not around when someone*
> [in your caseload] *is birthing,* [she] *runs the risk of birthing with a stranger,*
> *which is a conflict* [with the continuity] *you're trying to provide. But you can't*
> *be there 100% for all of the women ... you can't do that in the paid time that*
> *you're a midwife.'* [Edith, caseload midwife]

Elizabeth indicated that although she enjoyed the continuity aspect of caseload

practice, she missed the structure and the daily routines of her former life as a

hospital-based employee. Her inability to adjust to a more independent and

solitary way of working were factors that contributed to her decision to leave.

During the interview, she highlighted the importance of 'team' working in the rural

healthcare environment, and the exacerbation of loneliness felt by some of the

caseload midwives, especially those experiencing strain associated with family

support and competing work responsibilities:

> *'I just struggled on, I guess. It's a bit hard to say how I managed it*
> [work/family strain] *'cause I didn't manage it very well at all! So I ended up*
> *leaving.'* [Elizabeth, caseload midwife]

Caseload midwives identified the emotional nature of caring for women as a

constant pressure, which frequently induced feelings of guilt. This was particularly

the case when they had to ask their caseload colleagues to cover for their

absence at labour and birth, whether this was for planned leave such as holidays,

or unforeseen circumstances such as sudden illness. While for some participants

the lack of routine and structure may have amplified a predisposition to burnout and perhaps resignation, others worked to identify their personal stressors and put mechanisms in place (for example, boundary setting) to avoid or manage these events.

The following section describes how factors identified as causative in caseload midwives submitting notices of resignation were conversely also seen as draw cards to prospective employees.

Caseload practice and the impact on work–life balance and family responsibilities
Although family responsibilities varied, the pressure of child care was of primary concern for several caseload midwives. Anna described her situation as a sole parent and the constant negotiation of care arrangements, and argued she was of the firm opinion that without the support of family and close friends she would not have been able to fulfil her work obligations. This sentiment was echoed by all the caseload midwives with young children.

> *'I'm a single parent, so they need to sleep over somewhere else. I've got my parents in town and couldn't do this job without them, and a number of close friends that all love what I do and are really happy to be a part of someone else's birth story, even if it's just by looking after my kids.'* [Anna, caseload midwives]

Jenny explained that in addition to support from her partner and extended family, flexibility with work arrangements for both parents was crucial in allowing her family unit to function with a reasonable degree of normality. Such arrangements

have economic consequences, however, which may not be possible for all families to accommodate, especially where one or other parent is in a low-paid job.

> *'I have conversations with my husband where he said, "Look, if I had a full-time job, you know, you wouldn't be able to do this." And it's quite true, I wouldn't – he works for himself, he has a flexible job, so I can. And, I guess, to be truthful, the answer is, you know, if it came to the point in my family life that it was affecting our family unit as a whole, then I wouldn't hesitate to change it or just to leave, or stop working in this way.* [Jenny, caseload midwife]

Jenny's warning note, that she would not hesitate to leave her job if she considered parental working patterns were detrimental to the wellbeing of her family, adds further weight to the argument that working arrangements for staff in rural locations cannot be considered in isolation to other concerns.

Edith's narrative also focused on child care and the limited range of options, and the difficulties of parenting small children while working unpredictable hours in a rural setting. She felt '*lucky*' to have older children to help with caring for younger family members. Geographical distance between her place of employment and poor (or absent) public transport facilities added an additional layer of complexity to performing as both a mother and a midwife. Transporting children between different schools and their after-school activities, over what were often significant distances, created an economic burden and increased pressures on her time.

> *'Yeah, child care's always an issue. There's not a lot of facilities for younger kids. Both my kids were primary school aged at the time. Thankfully, the*

structure of my family is that I had two older kids, so I had teenagers while I also had lower primary school kids, so I had built-in babysitters! Aside from the fact that the demographics of where they were schooling meant that you still had to be able to get them all from A to B, um, that was probably the hardest thing, is just making sure that you could still perform as a parent, and still be a midwife.' [Edith, caseload midwife]

Several caseload midwives addressed the issue of child care and professional support from workmates. Some data indicated midwives managed to juggle family and work commitments, though arrangements were not easily negotiated at times. Edith suggested that support from co-workers relied heavily on how their lifestyles were aligned. Edith reported that midwives who shared similar family responsibilities understood one another's demands more easily and were a valuable professional support to each other. Edith implied that caseload practice may unfairly discriminate against mothers with children and child-care responsibilities:

'You know, some women who have got no child-care responsibilities, others still had younger kids or teenage children.' [Edith, caseload midwife]

In summary, participants indicated that family pressures, particularly those associated with child care, were issues of great concern. For caseload midwives with partner/family support, child care was generally manageable, although not without associated stress. It was widely acknowledged, however, that considerable flexibility was needed in partners' work practices in order for the caseload midwives to successfully negotiate their own (unpredictable) working hours and demands. Friendship networks were also identified as important in

providing essential support, without which caseload midwives admitted they may not have been able to cope with the challenging nature of their work. Participants' insights highlighted the importance of employers being aware that stress in the domestic sphere impacts on an employee's capacity to undertake their professional role, and that this may be as important as the technical and knowledge-based skills needed in clinical roles. The data also suggested that caseload midwives needed appropriate and ongoing professional support and a community of people around them when working in roles that demand flexibility and emotional investment.

The next section discusses interpersonal relationships between participants and other multidisciplinary members, along with general community groups, community-based health professionals and the health service organisation.

Organisational and interprofessional relationships

Relationships between different professional groups connected to the health service were described as difficult at times. Participants identified some negative responses to the maternity service changes from groups who misunderstood, or who were dissatisfied with, the proposed local maternity service care pathways. Participants reported the community members (local media) and community-based GPs who were particularly dissatisfied.

While the maternity service lost some clinical obstetric support by natural attrition (that is, due to medical staff retirement), participants identified collaboration between staff directly involved in the caseload model as a strength born out of the

change to caseload practice. These staff included the primary care GP, caseload midwives, the Director of Medical Services and administrative staff.

Anna described the value she placed on the monthly obstetric meetings, referring to them as a '*safe place*' to discuss matters and seek advice from colleagues, particularly senior managers, whom she may otherwise not have an opportunity to speak with directly. Anna demonstrated the importance caseload midwives placed on being 'heard' in the monthly obstetric meetings, a platform that credited their clinical opinions and judgements, while also respecting their knowledge about individual women's circumstances and capabilities.

> *'We've got the monthly obstetric audit meetings, which are great, often very robust. So you have got opportunity to chat to certainly management, managers, your GPs … In a collaborative forum, that's always great, 'cause it is a very safe place to air your opinion and get heard and sort of flesh things out a little bit.'* [Anna, caseload midwife]

Lynne noted that learning how to establish a collaborative relationship with the primary care GP, who worked closely with the caseload midwives in the onsite antenatal clinic, was a necessity when advocating for women in the rural context. Such relationships enabled the caseload midwives to feel more confident when speaking with the GP, to deliver a clear and comprehensive history of care and progress, and to propose a care plan acceptable to all parties. Lynne's quote (below) suggested that to gain trust midwives must indicate to their medical colleagues that they were able to work independently, '*letting them know*' the midwife had a clear understanding of normal parameters and when women deviated from the norms.

> *'… be confident with what you're doing, be able to work collaboratively with the GPs but at the same time as working with them, letting them know you are the clinician here looking after the woman and this is what you want to have happen for that woman.'* [Lynne, caseload midwife]

Learning to work collaboratively with medical staff as part of the caseload team was seen by Lynne as an acquired skill, and one on which time should be spent during the orientation of new caseload midwives. She was of the opinion that this would help to better equip them with the skills to practise more autonomously.

> *'I think it's about orientating her* [new caseload midwife] *to working in that autonomous role, encouraging her to work collaboratively with the GPs, making that phone call to the GPs and saying, you know, "I've got a woman here, I'm not quite sure about her". Talking to the other midwives, that they're comfortable in that autonomous role, helping them to sort of come to those decisions about care for a woman.'* [Lynne, caseload midwife]

Lynne's comment suggests awareness that the medical model had become destabilised by the caseload model, and the potential implications for negative interprofessional relationships with medical staff, already identified between caseload midwives and hospital-based midwives and nurses. In summary, collaboration between the caseload midwifery group and the onsite GP was considered effective by participants, with both groups affording each other a high degree of professional respect.

The following section describes relationships between midwives employed in a caseload role during the change, and other hospital-based midwives who retained their original roles as registered nurses on the acute ward.

Midwives' inter/intraprofessional relationships within, and outside, the caseload model

The transition from the previous (medical) model of maternity care to a continuity (or caseload) model was seen by caseload midwives as a difficult process. Considerable animosity was generated between midwives who were successful in securing positions in the new model and those who were unsuccessful (or who had no inclination in this respect), and staff who were offered continued employment caring for general medical clients. Alice attributed the employment round during phase one of change (see Appendix A) as a '*pilot*', commenting:

> '*We were starting our Rural Maternity Initiative change work as doing the pilot'.* [Alice, manager]

Angela suggested limited pilot employment numbers were heavily linked to block funding (see glossary) received from the Rural Maternity Initiative, which allowed for approximately four full-time employments per year. Angela implied that this arrangement was short-sighted. She asserted that '*excluding people was a mistake'*, and added to friction between midwives, with management undervaluing the loss of midwifery experience to the health service. Angela also suggested management could have been more '*sensitive to the needs of others*', as they did not appear to understand the enjoyment and value midwives derived from their practice and relationships with their clients. Mary referred to the intense competition for the new caseload jobs, where applicants outnumbered the

available positions. Rivalry, and disappointment from those not appointed, created significant unrest that Mary attributes as a '*barrier*' to change:

> '*Those three positions were probably hotly contested and not everyone got them. So there was a level of inclusion and exclusion that possibly created some unrest and I certainly see that as a barrier.*' [Mary, manager]

Edith echoed Mary's view that tensions among midwifery staff were very strained during the early phase of the changes, when advertising and job selection processes were underway:

> '*There was that negativity coming from the midwifery staff who were not part of the team … I guess, the back-biting within the system; you know, that really damaging abrasiveness between midwives … I know it did cause a lot of disharmony amongst the midwifery staff at the time*' [Edith, caseload midwife]

Lynne commented on midwives who were not employed by the health service to work in the caseload group. She described jealousies directed towards caseload midwives as others struggled emotionally to understand how management determined their employment choices.

> '*There were a couple of midwives that weren't accepted into the changing model. One of them said to me in particular, "I can't believe you got the job and not me" … They felt abandoned and they felt that it was them and us.*' [Lynne, caseload midwife]

Angela elaborated on Lynne's statement, commenting that problems arose as midwives who applied for positions in the caseload model, but who were

unsuccessful, felt disappointed and undervalued. The loss of self-esteem was seen as a contributory factor to a number of midwives tendering their resignation:

> *'I think some had applied and not got the* [caseload] *role so I think that that was a disappointment for them … They felt that they were worth a lot less, so their self-esteem was not good as a result. Unless they were part of the team, they felt they weren't part of the scene ... I think they felt they were being excluded from something that they'd enjoyed doing in the past. So they went.'* [Angela, night duty midwife]

Participants reported a build-up of resentment towards caseload midwives who were viewed as having '*starring*', or more prestigious, roles compared to their colleagues who remained on the general ward, where they were also expected to assist with postnatal cover. This was seen by some as a lesser role, thus compounding feelings of resentment. Angela's comment also implied that significantly less value was placed on postnatal care, which she described as a '*chore*'.

> *'We had some wonderful midwives that really moved on because they didn't like cleaning up after a* [caseload] *midwife had come in and done the "starring" role* [overseeing labour and birth]. *So, although they came in and did postnatal work and picked up all those chores after a birth, they felt it wasn't very satisfying.'* [Angela, night duty midwife]

In summary, it appeared that a small number of caseload midwives felt isolated and in opposition to those who desired, but did not gain, employment in the new model. Some of these midwives subsequently left the health service to practise

elsewhere. Midwives who did not gain caseload employment felt undervalued and rejected, leading to increased resentment.

The next section discusses the relationship between local GPs and the health service.

Relationships between GPs and other stakeholders

Throughout the period of change, caseload midwives referred to frequent episodes of friction, particularly between health service management and medical practitioners (obstetricians and referring GPs). Several reasons were proposed for the tensions. The introduction of the new model coincided with the withdrawal of on-call commitments from the local obstetrician, and the lack of 24-hour obstetric cover was perceived as unsafe by local GPs. Also, many viewed the changes as evidence of an overall reduction in services (including maternity). Some participants were of the opinion that some local GPs discouraged pregnant women from booking with the health service by way of protest at the changes proposed. A widely held view was that the combination of these factors resulted in a significant drop in maternity referrals.

Here, Alice described the downward spiralling perception some local GPs had of the health service versus the caseload model, as one was viewed in opposition to the other. It is unclear whether the retiring obstetrician's contribution to local women was adequately acknowledged by management, which may have contributed to a sense of injustice reflected in local GPs attitudes towards the change.

> '*It* [GP support] *started off high, and then, of course, we did the terrible wrong thing by the obstetrician! The lovely obstetrician that had been here forever and ever and had looked after everybody's grandmother right through three generations of women ... That whole time coincided with a whole load of GP politics, given that the GPs and the obstetrician had a very close relationship.'* [Alice, manager]

Alice appeared to view deteriorated relationships as regrettable, describing conflict as one of the '*worst lows'* during change. However, when discussing this Alice also attributed blame, implying the reduced need for obstetric services in caseload caused obstetric back lash from the obstetrician who was described by Alice as '*worrying about his own interests'.* Samantha also perceived the loss of obstetric backup as a negative as it left the health service without obstetric emergency services. Samantha suggested the service change was the main factor finalising the obstetricians wind-down to retirement.

> '*The fact that we lost an obstetrician during that period was a negative, because you didn't always have that ability for emergency procedures … It* [work pattern] *was very spasmodic – you know, sometimes he was available, sometimes he wasn't. People didn't know whether they were calling the obstetrician, whether he was down the back with the cows. He was winding down his practice.'* [Samantha, caseload midwife]

At the time of writing this thesis, no obstetric replacement had been secured by the health service. Lynne indicated an obstetric replacement '*affiliated at the hospital 24 hours a day'* would improve the general community view of the maternity health service and improve booking numbers. She also suggested

booking numbers had fallen by two-thirds compared to the previous (medical) model of maternity care, *'from around 200 to 72',* attributing the drop to the lack of emergency caesarean services.

With respect to relationships between GPs and health service management, Elizabeth suggested that these were more complex than simple dislike for the changed maternity model, believing that GPs were also unhappy with the handling of acute hospital services, and the use of nurse practitioners in the emergency department. Elizabeth accused the GPs of retaliatory tactics by referring fewer women and sensationalising problems in the local press.

> *'I think a couple of the GPs weren't very happy that they'd* [managers] *put nurse practitioners into the emergency department. I think their noses were out of joint, so there were less* [maternity] *referrals. Whenever there was the slightest problem* [it] *was blown way out of proportion, the GPs were on to the paper. We had a good service; we knew our limitations and people weren't prepared to work within those limitations. Well GPs, not midwives.'*
> [Elizabeth, caseload midwife]

Power struggles between GPs and health service management thus seriously affected referrals and the promotion of a viable maternity service. Anna, a newer caseload midwife, was of the opinion that tensions between '*disgruntled*' GPs and health service management were a longstanding problem. She further believed GPs were biasing women with inaccurate or incorrect information, and directing them away from the local maternity service, and hence booking with caseload midwives.

> *'There's a lot of disgruntlement going on with GPs and management … I feel that that's longstanding. You know, I think there's a lot of power play going on. I mean why are GPs not referring women here? … regardless of the practitioner's viewpoint, women need to be given an option.'* [Anna, caseload midwife]

Alice expressed concern about a reduction in maternity bookings at the health service as the service moved from an 'all-risk' to low-risk model of care, as high-risk clientele would be referred elsewhere. The level to which bookings did fall was underestimated by management, although Lynne considered the overall change to have been beneficial from a safety perspective.

> *'The numbers certainly aren't in the shape that they used to be two years ago, three years ago. But I think that the change to the service is good, maybe we might have done more births but we were also doing a lot of bad stuff.'* [Lynne, caseload midwife]

Alice contended that the introduction of the caseload model would appeal predominantly to low-risk women seeking care close to where they lived.

> *'We are appealing to women who are happy to have things uncomplicated, within their own shire, within easy reach of where they live.'* [Alice, manager]

Other participants were of the opinion that women would choose the health service because it was their first preference, rather than because of proximity to their place of residence.

> *'I think that more of the women come because they want to. Not because it's the closest hospital.'* [Samantha, caseload midwife]

Anna suggested that the service was still developing and that, as women became more aware of the benefits, bookings would increase. However, she was also of the view that while the changes would be attractive to some women, they were also likely to act as a deterrent to others, who would look elsewhere.

> *'I think some people love this service, and I think some people will never come here. I think it's a service that needs to grow for more women to be aware of it and to come.'* [Anna, caseload midwife]

Mary suggested that there were similarities between clinicians' patterns of behaviour and those of childbearing women, with some enthusiastically embracing the changes while others preferred the old structures and ways of doing things. These attitudes were particularly noticeable in GP referrals for first-time pregnant women:

> *'Because we don't, we've changed our model um, it's, and we don't have an obstetrician that's available to do emergency caesareans, it's put some of our GPs off referring to us, especially their primips.'* [Mary, manager]

Lynne interpreted the inevitable loss of revenue associated with the decline in maternity bookings as detrimental to relationships between health service managers and medical practitioners.

> *'I think a lot of it was a financial concern as well, because they* [GPs] *weren't seeing every woman … They weren't physically coming to the hospital to see the women so they weren't being involved with the birth. So*

> *I'm sure there were some financial pressures that they were feeling.'*
>
> [Lynne, caseload midwife]

Lynne found the visible negativity perplexing as GP workloads were very heavy and at times difficult for them to manage; caseload could lighten this burden. She reported that GPs were trying to attend fewer hospital births, so expected GPs to welcome the caseload model. Lynne noted that this was not the case as GPs became worried they would become de-skilled while caseload midwives upskilled. Lynne expressed some frustration with GPs wanting less on-call and involvement with births, yet feeling '*put out … defunct and unused'* when the maternity care model changed.

> *'They were feeling that they were going to become de-skilled because they weren't being involved in all the births. But, you know, the GPs at the time were trying not to come to every birth because they still had their clinics to manage and we thought it was a good thing that we didn't call them at 2 o'clock in the morning for a normal vaginal birth. What's that all about?!'*
>
> [Lynne, caseload midwife]

Lynne suggested that medical staff may have felt threatened by midwives asserting themselves, and beginning to practise in a more independent manner, employing a wider scope of practice than previously. It was also likely that GPs who were not privy to daily interactions with hospital staff may not have built a relationship with caseload midwives, and so were wary and untrusting. Lynne was of the opinion that GPs undervalued the role they played in providing clinical on-call support to midwives. It was not clear to what extent GPs were consulted regarding the on-call maternity support for caseload practice they might provide.

> '*One GP in particular thought that we were, you know, he was just going to become defunct and not going to be used, and he had a massive skill base and* [caseload midwives thought] *we knew everything.*'[Lynne, caseload midwife]

It appeared that while GPs did not directly criticise caseload midwives, disagreement between them and the health service was felt by caseload midwives, who viewed the reduction of low-risk referrals as a power play that could affect the maternity service sustainability. Caseload midwives seemed annoyed by GPs' responses, as they felt that referrals of low-risk women to the health service were used as leverage. The new model meant a reduction to medical revenue, earnt in association with hospital births. In addition to this, it was also thought by participants that GPs felt they would be de-skilled and no longer needed. In summary, maternity bookings at the health service appeared to have dropped below expected rates due to changes in women using the service (all risk to low risk only), reduced obstetric services, and reduced GP referrals.

Conclusion

This chapter presented the key findings and themes generated during data collection and analysis. Four themes were presented and addresses in addition to the participants' profiles: change planning, preparedness and response to change; cultural change in the clinical arena; attracting and retaining staff; and organisational (inter/intraprofessional) relationships. The intertwined and intergenerational relationships and the impact of the local community views in response to change is one core theoretical concept that has been identified and linked to each theme throughout the findings chapter.

The following chapter refines the discussion of these key findings through the lens of the rural community and inclusive engagement during maternity care restructure.

Chapter five: Discussion

Introduction

Over the course of the study, participants demonstrated their allegiance to their rural community, and remarked upon their relationship to their local maternity and health services. This study repeatedly highlighted the deep and penetrating, and enduring, nature of change in a particular rural context: that of maternity care provision. Data analysis showed participants' concerns centred on the dissemination of information and the inclusion of community members, along with the renegotiation of roles between hospital-based nursing/midwifery staff and caseload midwives. Negative experiences and competing power bases were understood to emotionally impact on established relationships, in both professional arenas and private domains.

Participants' narratives provided explanations for change that were both internal and external to the health service, and focused on short-term communication strategies, but which were often seen as limiting and problematic for community engagement. Some opportunities to improve communication channels using generation-specific modes for employees and social media strategies for community members were indicated.

Communication throughout all phases of the change process was seen by caseload midwives, in particular, as an issue that could have been better managed by the health service management. All participants, however, also identified inter/intraprofessional communication, boundary setting and navigating relationships between the woman and her midwife as significant new skills required in the context of providing caseload care. In the excitement of

establishing a new model of maternity care, much focus was centred on issues such as clinical expertise and the logistics of planning care. Other skills such as the management of interpersonal relationships (between the woman and her midwife) appeared somewhat overlooked by midwives moving into the caseload role.

Caseload midwives' perception of the local community response to change and visible methods (or lack thereof) by the health service to allow feedback from interested parties is elaborated on in the next section.

Change in the context of a rural maternity service

Participants' reports demonstrated a significant focus on local community responses to maternity service changes. While small changes may be introduced with limited public reaction, an over-riding concern expressed by participants was the negative backlash from the community towards the (caseload) model of care. Narratives from caseload midwives suggested this took the form of local gossip, with some negative media articles centred on the loss of emergency caesarean services. Power relations between community members and health service staff, including clinicians, were clearly articulated. Participants described negative interactions between community stakeholders and non-medical board members, which occurred outside of routine professional forums (for example, board meetings and staff meetings). Complaints from older local women (mothers and grandmothers) who were concerned about how changes would impact on their own and their extended families were made to the health service.

This study highlighted the interwoven nature of relationships, the constant need for (re)negotiation, and the delicate power balance that reflected (or typified) interactions in the rural sector. While the voices of the local community were not included in this study, participants' comments suggested that at least some community members wanted greater involvement in the change planning processes. Non-medical board members were described by participants as particular targets to whom concerns from the community were directed. Some community members appeared to see little distinction between professional and private boundaries, suggesting decision-making in the rural sector may be less removed from public responses than when it occurs in larger metropolitan centres. Some participants, who chose to reside some distance from the local hospital, suggested this was a manageable way to separate business and pleasure (that is, work/non-work). This strategy was largely ineffective for caseload midwives, however, as narratives indicated they nonetheless regularly interacted with women they had previously cared for (for example, while shopping), despite the geographical distance separating them.

While the merging of personal/professional boundaries proved difficult at times, caseload midwives nonetheless appeared to welcome these ongoing connections with women they had cared for, and valued the importance families placed on the midwifery role. Participants' narratives described nursing, medical and midwifery relationships with the health service and the community, and these highlighted their positions of influence. Kilpatrick, Cheers, Gilles, and Taylor (2009) coined the phrase 'boundary crossers' to describe health professionals who are trusted equally by their employing organisation and the community they serve. In the

context of this study, 'boundary crossers' were identified as clinicians who were able to move flexibly between private and professional roles, and were well positioned to foster community engagement with the health services. Because they are known and respected, boundary crossers possess a special ability to position themselves as leaders and contributors to local activities – in this case, promoting rural health initiatives. As people with established networks, they also value community resources and local wellbeing (Kilpatrick et al., 2009).

This study highlighted the ability of clinicians to ascertain the social climate and community sensitivities associated with service redesign. Social and professional connections by midwives with the community in which they lived and worked was a significant element that contributed to the growth of social capital. Putnam (2002) described the concept of social capital as a level of community involvement and connectedness, more often born of unequal and lower socioeconomic circumstances, in which intangible features such as trust, fellowship and goodwill are highly valued attributes that further develop local communities. In short, individuals alone have little capacity to generate social capital; however, by networking and participating as a group member of a social structure (for example, consumer forums, community groups and health networks), strong social capital is built (Dale, 2005). With increased social capital comes the procurement of mutual reward. Benefit is generated for the 'public good' of the community (for example, through fundraising); however, Putnam (2002) also discussed the additional 'private good', gained through friendships and professional networking.

Current research describes the concept of 'private good', particularly related to notions of prosperous neighbourhood conditions (born of high social capital) that

positively influence health outcomes. Research by Farmer and Kilpatrick (2009) suggested that social capital was developed in rural communities by utilising community attributes and people, including boundary crossing clinicians, to influence and maintain health initiatives. More recently, Mohnen, Groenewegen, Völker, and Flap (2011) suggested that differing socioeconomic or living environments impacted on their residents' health by enhancing their wellbeing. Social capital in this study was understood as the connection between the rural community and the health service, based on values and shared ideals, with mutual benefits to both parties, including the redevelopment of maternity services.

Many caseload midwives shared narratives describing their assessment of the social climate and the community responses they had received regarding the changes proposed for the maternity service. Several participants indicated that they were quite involved in community, via family interactions or neighbourhood friendships, from which an understanding of community reactions to change was ascertained. Edith commented that the community perceived pregnancy and birth as something that needed to be 'managed' by doctors and that the loss of emergency services meant *a 'lesser service'* would be provided. Alice maintained that the introduction of caseload midwifery and the ongoing demedicalisation of maternity care equated to the removal of medical input and participation in caring for women; caseload midwives (mis)understood to be *'running the show'.* Samantha made specific reference to the way '*small towns talk',* suggesting responses to change spread quickly and that caseload midwives felt this acutely in their social lives. Elizabeth also recognised that in this rural location '*rumours started spreading'* regardless of the focus or content of conversations, or where

they originated. It is likely that caseload midwives conflated their professional and private interactions when forming their opinions about community feelings.

Participants' narratives suggested that local consumers wanted more information than they received through official channels, and that transparent conversations did not appear to have occurred. Nimegeer, Farmer, West and Currie (2011) noted resistance to health service remodelling often resulted from health service management and community members speaking a different 'language'. Additionally, the level of importance placed on issues altered over time and in response to other pressures. Health service management tended to focus on macro-level national policy, compared with the immediate concerns and experiences that reflected community members' individual circumstances (Nimegeer et al., 2011). This was demonstrated by midwifery management, who were reported by participants to have a '*strong grasp'* on the Rural Maternity Initiative framework (Edwards & Gale, 2007). Comparatively, sections of the community were more concerned about the realities of the changes, such as shorter in-hospital postnatal stays and loss of emergency obstetric services, which were described as the '*worst problems'.* In the context of this study, changes to maternity service policy challenged high-risk women, who now had to travel much further for the provision of maternity care and give birth in unfamiliar surroundings. It seemed that the removal of high-risk obstetric and emergency services, and the introduction of caseload care, was viewed in direct opposition – that is, medical staff 'out' and midwives 'in'. Participants' narratives suggested obstetric cover did not cease overnight but, rather, that the retirement of key medical staff occurred gradually over a few years, with no replacements at the time this research was

conducted. Midwives saw their role as caring for a low-risk specific population of women, with no option for high-risk care once maternity service redesign had been established. Australian maternity service risk aversion has been identified in recent literature. Lane and Reiger (2013) suggest professional tensions originating from assigning caregivers on a high/low-risk basis can reduce the potential for 'highly individualised care' (p.18), thus undermining the purpose of maternity service reform.

The complex and intergenerational relationships between many health service employees and the local community meant that ideas about type and pace of changes often occurred faster than either party were able to adjust to. Nostalgia and/or limited understanding about current health service pressures meant changes were often not readily understood and thus not always easily accepted by community members. Workforce pressures offered little justification or comfort to those midwives who left the health service to work elsewhere. Angela suggested that the '*exclusion'* of some midwives during the change of model was a *'mistake'* and that it was insensitive to the needs of all staff. Additionally, the advancement of midwifery practice in the rural sector may not have been as important to the hospital-based midwife travelling further for midwifery employment, particularly if this change in her circumstances added pressures such as child care, travel costs and negotiating the social and professional climate of a new workplace setting. It is likely that these changes produced a level of social displacement for hospital-based midwives, who may have felt overlooked as important contributors to the health service.

Some participants reported that while they applied for caseload positions, information about the (planned) stages of change was not communicated to them adequately. The next section will discuss the subject of change communication further.

Communication

The value placed on (effective) communication was evident across participants' narratives; however, a planned communications strategy was not reported. Consistently, data analysis reflected a significant need for clear and proactive communication with all stakeholders, particularly during the early period of change. Participants reported that colleagues responded well to face-to-face communication, backed up by email circulation. Narratives suggested that improved online information, specific to the maternity changes, combined with a wider variety of communication strategies for external stakeholders, might have helped allay the widespread community anxiety resulting from limited understandings about the proposed changes.

Face-to-face communication was seen as a particularly important modality for midwifery and nursing staff. The link between communication preferences and the age of stakeholders appeared to be a significant factor with respect to what, how and when communication occurred. Demographic data indicated that study participants were older and consisted primarily of 'baby boomers' (born around mid-1950s) and generation X (born around mid-1970s), which is confirmed by statistical data (Health Workforce Australia, 2013). Research suggests that preferences for certain styles of communication are linked to generational workforce characteristics. Baby boomers, who are known for their long-term

commitment to their employing organisations, place a high level of value on the status of, and the relationship between, supervisors (midwifery/nurse managers) and staff, preferring formal, structured interactions (Brunetto, Farr-Wharton, & Shacklock, 2012). Further research into the baby boomer population suggests that communication must be meaningful, with a preference for face-to-face meetings with like-minded peers, a visible hierarchy, and memo circulation as preferred methods of communication (Bell, 2013). Generations X and Y (born around mid-1980s), on the other hand, tend to dislike hierarchical structures and modes of communication, preferring frequent, and informal, direct communication (Brunetto et al., 2012). These generational characteristics align with the change communication methods suggested by some participants in this study, with data reflecting age and employment history.

Inadequate information about change processes, and a lack of staff inclusion during the key stages, have been linked to change failure (Shute et al., 2012). While participant narratives suggested that change was successfully implemented, certainly improved stakeholder communication was identified as an issue that largely impacted on and elongated the transition process. Additionally, communication strategies that do not use the correct modality preferred by the age groups involved run the risk of key messages being missed, distorted or fragmented (Shute et al., 2012). In addition, groups from different generations must be appreciated as intelligent human beings, albeit with different requirements and attributes. Baby boomers, in particular, value honesty and sincerity as important principles, which stimulate them to receive and act upon information (Bell, 2013). This reiterates the importance of regular and inclusive staff meetings,

in addition to the proactive and consistent engagement with specific staff groups (for example, midwifery and nursing) to discuss proposed changes and seek solutions from those most affected, throughout all phases of the process. In addition to formal meetings, the availability of clinical leaders to confidently disseminate clearly worded information on a regular basis is of great importance, more so in an isolated workforce environment (Brunetto et al., 2012).

Rural communities value positive communication and involvement in local health initiatives, such as contributing to the planning of rural service innovation, which is often under reported (Kenny et al., 2013). Engagement may involve small numbers of community members who work together to develop the most appropriate communication strategies, which are then targeted to a wider audience. With the exponential expansion of the digital age, online communication offers a low-cost and accessible alternative to hard copy materials, especially in the rural setting where the population is likely to be geographically dispersed.

While newspaper media is an available and still utilised (promotional) tool, Anderson (2012) suggests it has been superseded by the use of social media, which has changed how women access pregnancy-related information and how they communicate with each other. Tripp et al. (2014) have highlighted the increased use of mobile and internet technologies by maternity consumers – particularly smart phones, with their capacity to quickly download a diverse array of pregnancy information and related social media applications. Online communications have proven to be an important tool in fostering maternity consumer groups with regard to information sharing (Spoel, 2008).

The use of social media and the continued development of information technologies is an opportunity for health professionals and services to enhance their connection to the communities they serve, including childbearing women (Tripp et al., 2014). Rural healthcare organisations in particular, however, have been slow to adopt social media into their communication strategies (Anikeeva & Bywood, 2013). Alice made her reluctance apparent when she suggested *'it's* [Facebook] *a risk to us as a small rural health service'*. Her anxieties about social media may have been based on her inability to control online discussions or, as a baby boomer, her lack of confidence in mastering the requisite technological skills. Additionally, participants expressed concern that an online presence might increase the potential for breaches to confidential health data. While inexpensive to run, health services often lack appropriately trained staff to consistently monitor online sites and may, therefore, be understandably concerned about the accuracy and confidentiality of material posted online, especially when this concerns their service.

Allowing fears associated with social media to restrict health service expansion, however, may create risks, such as a reduced public profile, which could then affect use by consumers. Warren, Sulaiman, and Jaafar (2014) asserted that connections formed through social media, such as maternity service Facebook sites, can be helpful in establishing ties, trust and shared vision for the organisation and/or group, thus promoting positive civic engagement. A suggested method of combatting social media concerns is the inclusion of consumers and staff in the creation, launching and maintenance of social media sites (Anikeeva & Bywood, 2013). However, online discussion is happening, with or without health

service buy-in, and participation in social networking by health services has the potential to address fallacies in, or confusion arising from, online information. Further to this, an increased social media presence is a low-cost opportunity to publicise health service changes and positively profile the (maternity) service and further engage the public they serve. To do this, upskilling of midwives would be required to assure computer literacy and social media familiarity for online community engagement.

The next section elaborates on community inclusion as a positive change strategy for rural healthcare services and the emerging literature to support this concept.

Community inclusion

Findings suggested that community members were not only seeking inclusion in, and information about, the health service redevelopment; they were also demanding respectful engagement as contributors. Literature notes that involving community and getting locals 'on-side' by placing value in their contributions and knowledge is an important element when developing social capital in rural areas. Farmer and Kilpatrick (2009) have indicated that rural communities are heavily motivated to generate networks, often related to health, that are geared to producing improved social and health related outcomes – for example, walking groups and meeting places such as 'men's sheds'. Men's sheds are commonly a gathering point for rural Australian men to meet, exchange information and support one another. Furthermore, rural communities are resilient, an attribute developed out of a necessity for continued prosperity (often in the face of adversity) and viability, though they may be more focused on local issues that directly affect their experiences (Farmer & Kilpatrick, 2009).

Loyalties and relationships in the context of this study were deeply connected and intergenerational. Stebbing, Carey, Sinclair, and Sim (2013) identified community involvement and connectedness during times of hardship as two particular markers that are important in determining rural resilience during times of drought. Community ties and social bonds may thus act as support structures in times of trouble, as evidenced by Australian rural communities' repeated adaptation to devastating circumstances resulting from fires, floods and droughts.

Similar characteristics have been associated with the sustainability of rural Australian health services (Kenny et al., 2013), as stressors such as unpredictable/extreme climate patterns and lagging economic growth and employment have impacted negatively on health and wellbeing (Rich, Wright, & Loxton, 2012). This explains, in part, the importance rural communities give to building and retaining their local health services, which are viewed not merely as organisations that provide healthcare, but also as industries that generate employment and community revenue. These hidden aspects of service provision encourage families to remain tethered to districts and kinship networks.

Given these issues, ongoing engagement of rural community members by hospital administrators appears prudent, particularly regarding the need for communication strategies that bridge the gap between local concerns and the intentions of policy makers. Kenny et al. (2013) suggest high level community participation in rural health service planning and implementation facilitates a positive response, with communities feeling empowered, and gaining a better understanding of the limits and requirements of their local services.

Rural communities typically claim a sense of ownership over the provision of health services; they want to be involved in decisions, be informed about, and understand, changes that are proposed and made. However, in this study caseload midwives were concerned about an increasing distance between community understandings and maternity change implementation by the health service. Tensions were reported to be worst during the early phases of the changes, though an undercurrent of tension that persisted throughout the study period was also described. Change was increasingly accepted and accommodated, however, as staff and community became used to the new (caseload) model of care.

Data analysis highlighted concerns that the development of the caseload model of care lacked positive, regular, community contribution. Open engagement with local women and their families, to accompany reviews of the maternity service, was a particular quality control recommendation from midwifery participants. Ongoing liaison with community members and consumer groups was seen as a strategy to reduce some of the tensions associated with change, and a means to gain insight into ways of improving a continuity model of maternity care that was specific to the needs of this rural community.

Participants felt that some sections in the community misunderstood the context of change, including why the continuity of care model was developed and the benefits it might bring to sustaining a maternity service in the region. This led to misinformation being circulated, which some caseload midwives suggested was an indication of community resistance to the maternity service and the larger health service organisation. Resistance to change is not unexpected, particularly

because it involves fear of the unknown, a re-definition of roles and multiple changes of policy. McConnell (2010) suggests negative reactions to organisational change may be compounded when stakeholders perceive it as a reduction in, or loss of, resources rather than a gain. This aligns with one participant's perception that the maternity service change was seen as a *'reduction of services, not an enhanced service for woman-centred care'*. Certainly, while a portion of the local community may have been uninterested in changing maternity care provision, women with vested interests and significant influence (such as grandmothers and mothers of women of childbearing age) were proactively engaged and were well informed. In light of the findings from this and other studies (Farmer & Nimegeer, 2014), collaboration between those promoting/managing maternity services and rural community members requires ongoing, consistent development.

While board members provided a conduit for community opinion, community engagement should go beyond survey data, such as that collected during the Rural Maternity Initiative evaluation (Edwards & Gale, 2007). Regular focus group discussions with key stakeholder groups during the planning and delivery phases of change may increase the sense of involvement for community members. This was a communication method suggested as being particularly important for those seeking face-to-face interaction. The importance of implementing focus group discussions during the (re)development of a rural maternity service is supported by recent research findings. Nimegeer et al. (2011) asserted that rural community engagement required a commitment to the building of relationships between a health service and the public it serves. Furthermore, engagement cannot be a one-off intervention; rather, emphasis should be placed on rural community and

health service relationships that are built on trust (Nimegeer et al., 2011). This assessment rang true for study participants, many of whom recognised a positive level of productivity associated with community consultation that was effective because it '*got them on board quicker*'.

Some elements of community and employee consultation were thus seen as positive; however, ongoing face-to-face engagement appeared to have been left off the agenda. Elizabeth requested *'… a bit more consultation'* to confirm what the local community really wanted. Participants described the use of a public relations firm to generate publicity for the caseload model when it was first launched; however, the one-sided communication, primarily in the form of brochure distribution, seemed to be rejected by the community. Later, when the health service re-attempted to engage with the community through a maternity expo, people had '*tuned out*' and were no longer interested, with only eleven people attending. Hence, the importance of health service representatives networking with the community in the public domain. Publicising and encouraging discussion outside the hospital setting may thus be a more effective community engagement strategy to break down barriers and assist people in understanding the need for a redefined health service that is owned by the community, rather than by the health service.

The following section discusses change planning and dissemination of those plans within the healthcare organisation.

Workforce responses to planning and implementing change

The funding and encouragement to develop rural continuity models of maternity care was stimulated by the Rural Maternity Initiative (Edwards & Gale, 2007). Participants involved in the current study indicated that the evaluation of this initiative provided health service management with specific knowledge about different continuity models and their respective functions. The evaluation also provided detailed information about the challenges, limitations and interventions reported by individual Victorian healthcare organisations. Participants' responses from this study suggested that initial investigation and planning for their local service included consumer input, largely generated through survey data as part of the Rural Maternity Initiative evaluation. According to study caseload midwives, health service management appeared well versed in the Rural Maternity Initiative policy and maternity care models; however, there appeared to be some variance in understandings of the differing models of midwifery care by different employees (for example, midwives and registered nurses).

The dissemination of change information, education and the rollout of the (caseload) model of maternity care by clinical managers was described as problematic. The employment of some midwives in the caseload model in preference to others was reported as a source of animosity and rivalry, which was perhaps made worse by the shift from a team to a caseload model. Midwives, who may have come to terms with their initial feelings of rejection when they failed to gain employment during the trial of a team model of care, were still able to work as midwives in the hospital-based medical model, which continued alongside the team for a short time. The move to a fully caseload model reduced the number of

midwives required, and the lack of employment opportunities led to resignations and ill feelings. Without clear dissemination of information by clinical leaders, the gap between hospital-based staff and their caseload counterparts widened. Narratives suggested these hospital-based midwives perceived the maternity service remodelling and re-employment processes as unjust.

The mixed responses from the hospital-based nursing and midwifery staff were a significant issue for a small rural workforce who had previously worked shoulder to shoulder, often over many years. Data analysis suggested that the lack of change readiness among staff, and by extension the wider organisational culture, was problematic and destabilising. Change readiness is a state in which staff share a positive understanding of why change is needed, with new roles clearly defined and organisational protocols and policies developed to support the changing structure (Dückers, Wagner, Vos, & Groenewegen, 2011).

Participants reported a lengthy period of clinical policy and protocol review, commencing after the changes began, when clinical guidelines were adapted or created to meet the needs of a caseload model of care. However, earlier development of guidelines, and dissemination of information to staff prior to introducing the change, may have created a more positive impact on the implementation process (Murray et al., 2010). Approved clinical guidelines, specific to a continuity model of maternity care, might also have provided both the clinical leaders implementing the change and hospital-based nursing, including night duty staff, with a greater understanding of caseload roles and the responsibilities and parameters of the new model of care (Munro, Kornelsen, & Grzybowski, 2013).

Some participants suggested the redeployment of personnel in the early phases of change (see Appendix A), with several senior staff entering new roles, was a rationale for the inconsistent information disseminated to staff. Caseload midwives were also of the opinion that lack of stability in change leadership was a contributing factor, possibly due to a number of influential staff holding opposing interpretations of the newly introduced model of care, and circulating negative opinions among staff.

As previously mentioned, the introduction (initially of a team model of care) was described as a 'trial' period by the health service. Analysis of participants' responses suggested that staff understood this as a time-limited and uncomplicated process, in which team midwifery was to be trialled and eventually fully adopted. However, this did not happen. Rather, the uncertainty continued, and indeed escalated, in the move from team to caseload midwifery. Participants suggested that this was, in fact, a rather complex change intervention and one for which they felt unprepared. The ensuing (negative) reaction by nurses and midwives not employed in the caseload model suggested that continual re-evaluation of the model (Appendix A), as a useful process for measuring change impact, was not fully explained.

While this study did not investigate the use of change theory, data suggested that a number of relevant interventions were nonetheless employed, perhaps as a means of reducing staff resistance to the change process. While no reference to specific change theory was made by participants, Edith suggested that *'… there wasn't a path to follow'* and hence a change theory may have been beneficial,

especially one which was responsive to a dynamic rural environment (Forster, Newton, McLachlan, & Willis, 2011).

Participants within this study indicated that change management and processes improved over time. This was demonstrated when, after several years of change, caseload midwives and midwifery management engaged in reflection on service provision during strategic planning workshops. Participants' narratives suggested that the health service under study began to gradually adopt processes (for example, reflective evaluation) described in change theories (McEvoy et al., 2014), acting on what may have felt right and seemed effective, rather than employing a pre-planned strategy. Future maternity change may be improved by incorporating an appropriate change theory, discussed in the literature review, from the outset (Forster et al., 2011).

As previously stated, the change process was observed to occur in phases (see Appendix A) and strategies to manage change appeared to develop over time and in response to issues that arose. The next section discusses the emotional labour described by caseload midwives throughout the phases of change.

Colleague relationships

Drummond-Hay and Bamford (2009) have acknowledged that difficulties which arise during organisational change are often related to rejection of the proposed change by staff members, especially influential clinicians. Difficulty with adopting new ways of thinking has also been suggested as a barrier for such staff to act as agents of change (Drummond-Hay & Bamford, 2009). Furthermore, Bish, Kenny, and Nay (2013) identified lack of organisational 'buy-in' and 'big picture thinking'

as key issues hampering strategies designed to foster clinical leadership in rural Australian hospitals. In this study, caseload midwives appeared to be taking steps toward adopting clinical leadership as they worked towards achieving greater independence. However, without buy-in from other staff this proved difficult. Caseload midwives reported that colleagues often felt threatened by a perceived power shift associated with the change in midwifery status. Samantha, a caseload midwife, was told by a colleague (whom she once considered a good friend), *'… Oh, you don't need to know about that; you're a midwife, you're not part of this ward'*. While these are not unfamiliar reactions to change, they were significant issues in this setting. The workforce was small, which meant most staff had long-established relationships. Management were seeking to encourage caseload midwives to assume more independence and autonomy, but this altered staff dynamics and fractured some friendships. These effects could not be absorbed by the remaining workforce.

The largely baby boomer workforce, who were more likely to value direct communication strategies and hierarchical structures, tended to find the changed power dynamics difficult and reacted negatively against one another. Samantha, a caseload midwife, succinctly outlined the disruption the changes had on her work relationships. She described an incident in which she lost close friendships with two work colleagues due to the hostilities that arose out of the redefined roles and working groups. The significance of these relationship breakdowns was further emphasised when Samantha described her colleagues as *'next to family'* and the time she spent in the workplace as *'a huge chunk of your life'.* Other caseload midwives' narratives reinforced the notion that change in the rural context can, and

did, penetrate personal and employee relationships, disrupting loyalties, friendships and interactions, which may have been established and maintained over many years.

The greater independence and responsibility midwives assumed in the caseload model was a new occurrence, particularly for staff who had previously worked alongside each other, often sharing responsibilities for acute medical/surgical, antenatal, birth and postnatal care. Change to this equilibrium was seen by some participants as an exciting and progressive step, with midwives being employed solely to provide midwifery care. However, others were of the opinion that the disruption produced by the changes not only altered the existing power balance, but also appeared to alter the social dynamic of the organisation. Hospital-based nursing staff were reported as being wary of the changes imposed, with unsuccessful caseload applicants feeling rejected, night duty staff unsure of their roles, and (successful) caseload midwives feeling unfairly judged and unprotected.

Hochschild (1979) discussed emotional labour in the context of commercial aviation, identifying the stresses workplace 'rules' placed on employees. She asserted that a mismatch between inner feelings and expected (professional) behaviour leads to 'surface acting' – that is, a superficial display of behaviour, nonetheless consistent with expected professional workplace responses. Actual feelings may be suppressed but, because inconsistencies between inner feelings and outer displays cannot be sustained indefinitely, staff may attempt to reduce the gap by altering either their feelings or their behavioural displays (Hochschild, 1979). As the health service under study moved to introduce significant change into a rather traditional and conservative maternity setting, nursing staff and some

midwives felt left '*out in the cold*'. Caseload midwives described behaviour from hospital-based staff that was suggestive of 'surface acting', with Edith referring to *'back biting'* to highlight how staff expressed feelings that could no longer be sustained.

Professor Billie Hunter has drawn on Hochschild's work to explain emotional labour in the context of midwifery care (Hunter, 2001). This research supports the change in staff behaviours described by participants in this study. Hunter (2004), has suggested that emotional work undertaken by midwives may be aligned with the type of practice in which they were involved. Notably, hospital-based midwives placed great importance on workplace relationships and the emotional work associated with navigating differing ideologies and power dynamics. In this study, Edith described the increased emotional work required to (re)negotiate her (caseload) place in the rural health service. She suggested that '*standing your ground*' was necessary to gain staff respect and re-establish '*a certain camaraderie*'.

More recently, Hunter and Segrott (2014) have studied boundary setting between midwives and medical staff using normal birth clinical pathways. The project identified that while boundary setting in the context of normal maternity care pathways highlighted positive midwifery practices, medical staff felt left out and undervalued. They also suggested that medical staff tended to focus on risk-averse behaviours, describing their readiness to intervene and fix problems (Hunter & Segrott, 2014). In this present study, newly established boundaries between different staff providing maternity care increased the professional visibility of caseload midwives, but distressed and disrupted other staff, who were then

unable to maintain their state of 'surface acting'. Schmidt and Diestel (2014) discuss the emotional damage suffered by nursing staff while 'surface acting'; however, they go further to suggest the practice of 'deeper acting' as a beneficial alternative way of emotional regulation. Deeper acting involves the staff member adjusting to the situation or changing their ideas about a situation, rather than simply masking their feelings; deeper acting requires less emotional work with less job-related stress (Schmidt & Diestel, 2014).

Descriptions of deeper acting were not apparent in participants' narratives, as nurses tended to socially exclude caseload staff, and in response midwives started to isolate themselves. Nursing staff also began to comment on caseload midwives travelling between community locations to visit women, rather than working rostered shifts, and their departure from wearing customary uniforms. These issues triggered emotional responses, such as jealousy, regret and a sense of loss that could no longer be easily disguised. Caseload midwives described uncomfortable interactions, typically involving banter between nurses and hospital-based midwives, that she felt was a combination of open and veiled resentments. An example was being referred to as *'only a midwife'* and asked to account for her work away from the hospital base and her non-uniform attire.

The remodelling of the maternity service, including the dismantling of the medical model, and the institution of caseload practice meant that midwifery roles were redefined and legitimised, while the power of nursing and medical staff was reduced. The health service revised and generated new maternity protocols and clinical guidelines that redefined the pathways of care for low-risk women, and diverted high-risk women from the rural facility to centres with specialist skills and

resources. These arrangements permanently altered the professional and personal boundaries that health service staff had previously experienced. Caseload midwives worked closely with the onsite GP; however, a widening 'territorial' gulf between nurses, hospital-based midwives and other GPs employed by the health service was also reported. It is possible that, as new midwifery roles were defined and caseload midwives became less visible to hospital-based staff, and staff meetings were separated into specialty groups, previously held staff alliances deteriorated. Munro et al. (2013) advocated that maintaining a sense of connectedness between staff groups was a key priority, and necessary in the change planning process. Team bonding, joint meetings, and combined in-service activities were identified as supportive functions for staff, particularly in the context of the complex and changing interprofessional dynamics in operation.

The next section moves the discussion beyond emotional labour and discusses the ability of midwives to attain effective work–life balance and, in particular, the issue of burnout.

Burnout and work–life balance in caseload practice
The need to manage relationships with women and families, and an increased demand for computer literacy, were noted by several participants as key skills necessary for caseload practice. As the change process began, differences in clinical skills, antenatal clinic arrangements and administrative tasks created new demands for caseload midwives. These additional role requirements appeared to have been mostly absorbed by the caseload midwives; however, navigating relationships with women and the increased responsibilities associated with caseload practice were sometimes inadequately managed. Difficulties increased

as time went on, and caseload midwives reported that they began to notice women's needs encroaching on their home lives. It is possible that some of the excitement associated with the change and a more visible midwifery presence reduced as work began to affect midwives' private lives and community resistance to the maternity model of care began to develop.

A lack of work–life balance and negativity surrounding the restructure led to caseload midwives questioning how long they might remain in the role. Caseload midwives reported feeling worn out: Elizabeth suggested she felt '... *one hundred years old*', perhaps suggestive of emotional burnout. Maslach and Goldberg identified burnout as a state characterised by emotional exhaustion, detachment from colleagues, lost idealism and feelings of reduced personal accomplishment (Maslach & Goldberg, 1998). Research by Sandall (1997) in midwifery settings suggested that the emotional burden associated with (caseload) care and a possible mismatch between factors such as high (midwifery) ideals, insufficient or inadequate home support and insufficient support within the clinical arena contributed to burnout among midwives. More recent Australian literature, conducted in Victorian metropolitan hospitals, compared 20 caseload midwives experiences to 130 standard care midwives and their account of work stress and burnout related to their roles (Newton, McLachlan, Willis, & Forster, 2014). Results suggested lower burnout and higher professional satisfaction for midwives in the caseload model. Continuity, flexibility and job satisfaction were identified as positive aspects related to caseload midwifery practice, while unpredictable work hours, impact on private lives and navigating the challenge of relationships with women were noted as negative aspects. These negative aspects were suggested

to reduce over time (Newton et al., 2014). When comparing results associated with the rural context of this study, a reduction in caseload anxiety associated with maternity service changes was strongly recounted during phases 2 and 3 (see Appendix A). Negative aspects related to caseload midwifery aligned with Newton et al. (2014), indicating boundary setting and professional/personal supports (or lack thereof) related to midwives' feelings associated with burnout.

While some caseload midwives with older children felt they could manage the demands of work–life balance associated with caseload care, others with younger families reported that they experienced inner conflicts as they attempted to balance their commitments to women with family needs. Participants' reactions mirrored Hunter's findings (2001), which noted that continuity models of care, such as caseload, had implications for midwives' personal lives, with the potential to increase the burden of emotional work. What appears evident from this study is that, regardless of the emotional burden applied to caseload midwives, they maintained an importance associated with care across both professional and personal lives, as demonstrated by Maher (2014).

Edith evidenced the importance placed on 'care' in her life, citing the hardest part of her new role was trying to '*perform as a parent'* while ensuring appropriate care for women. Several caseload midwives with young children made particular reference to the need for substantial family support, including that provided by partners or extended family members (grandparents and so on), as vital in helping to sustain their employment. Anna, a single mother and caseload midwife, suggested her parents' support was pivotal to enabling her to continue to work as a caseload midwife. Other caseload midwives suggested that their first priority was

to their family, with Jenny commenting that while her husband was supportive and able to accommodate her work requirements, if her employment as a caseload midwife adversely impacted her family, she *'wouldn't hesitate to leave'*.

Domestic support was thus noted as crucial; friendships with like-minded staff who understood the strains of mothering while 'caseloading' was also an important element for both group and individual function. Kirkham and Stapleton (2000) identified the need for staff support during maternity service changes, suggesting that mutual support between staff members was effective in empowering and sustaining midwives' practice. Overall, participants acknowledged that domestic stress impacted on their ability to successfully function as a caseload midwife; however, professional support from colleagues within the midwifery group was highly valued.

Caseload midwives in this study suggested that learning how to support one another did not come easily or immediately; however (gradually), they came to understand each other's needs better. Lynne conceded that over time she recognised that support was something that *'all needed'* and that after a period of adjustment to the caseload model she and her colleagues had a *'better idea of how to help each other'.* Fereday and Oster (2010) examined the management of work–life balance in the context of midwifery group practice, and suggested a period of adjustment was required. While a time frame of eighteen months was suggested for midwives to develop the required coping strategies to enable them to best deal with the family pressures associated with on-call work, further research into how midwifery groups adjusted to individual midwives in the group was identified as necessary (Fereday & Oster, 2010). While an on call roster and

the unpredictable nature of caseload work was suggested by Newton et al. (2014) as negative aspects, protective mechanisms were also highlighted by midwives working in caseload models that were seen as encouraging positive job satisfaction. Midwives (parents or otherwise) suggested an improved lifestyle that encompassed protected days off, flexibility and an ability for the midwife to largely determine a work pattern specific to one's individual needs. Such flexibility is less available in other models of midwifery care, particularly team midwifery, whereby shifts remain set to rostered hours, and midwives remain constrained with childcare pressures and reduced scope to work flexibly across the continuum of maternity care.

Boundary setting was seen retrospectively by some caseload midwives as a significant skill required for caseload practice, especially with respect to reducing symptoms of burnout. Lynne, who was particularly bothered by feelings of exhaustion, described as overwhelming the emotional demands made by women she was caring for. Alice recalled caseload midwives *'almost having a nervous breakdown'* as the pendulum of care was seen to swing too far towards the woman's needs; she was of the opinion that it may benefit from returning *'back to the central line'.* Mary suggested that the slow progress made by some caseload midwives to set appropriate boundaries, and control how much time they spent on women's care, was a low point during the change process. This confirmed that adaptation to the caseload model, and the acquisition of new skills, was a progressive issue, and one which required continued support from management over an extended period of time (Kirkham & Stapleton, 2000).

Boundary setting was reported by many caseload midwives as a difficult skill to learn, especially if this had not been previously required. Lynne, for example, contended that her enthusiasm for the changes in the midwifery role made her feel awkward about admitting to being *'100% for the women all the time'*. As a midwife, born at the latter end of the baby boomer era and previously having worked only in a hospital environment, Lynne felt that her skills pertaining to work–life balance, alongside managing continuity of care relationships with women, were underdeveloped.

A recent report of students' experiences of the 'follow-through' experience, in which support was provided by students for women during pregnancy, birth and postnatally, reported difficulties in navigating work–life balance between study, work, home commitments and the provision of continuity of care (McLachlan, Newton, Nightingale, Morrow, & Kruger, 2013). Findings by McLachlan et al. (2013) suggested that the 'follow-through' learning style commonly employed in an Australian bachelor of midwifery course meant that student midwives began navigating issues of work–life balance and the social impacts associated with continuity of care from the first year of tertiary education. Hence, the employment of midwives in the rural sector who have completed studies that employed a 'follow-through' educational strategy may be best suited to modelling underdeveloped or absent boundary setting skills.

Lynne also recognised that boundary setting, in the context of an on-call work environment, was not a skill she had acquired at the time of interview but one that she was working towards. Lynne suggested she needed to be more concerned about her own needs and, while much discussion by caseload midwives

suggested they needed to manage women better, Lynne stated her goal was to '*set some boundaries for myself'*. Carter and Guittar (2014) discussed the emotional work generated by the woman in the context of the midwife–woman relationship. They suggested that women engaged in emotional work to manage issues such as fear, while both parties might engage in emotional work as a means of managing their relationship with each other (Carter & Guittar, 2014).

Additional emotional work was associated with the use of mobile technologies and the reported stress associated with interpreting communication, especially text messaging. The caseload midwives commented on the high level of access women had to them, and the frequency with which they texted, rather than voice called caseload midwives. Lynne suggested that this was problematic, especially because she and her colleagues lacked the facility on their mobiles to divert text messages when they were off duty. Lynne also raised a concern about confidentiality when responding via text stating that *'you never know who the text is coming from'*, and hence she could not confirm her responding text would be delivered to the woman herself, rather than an unknown third party. The need to respond via a voice call to ascertain the urgency (or otherwise) of need was deemed necessary, as Lynne suggested she might otherwise put women at risk by wasting time (mis)interpreting text messages. Forti et al. (2013) recently highlighted the increased use of mobile technologies in the caseload context with research findings reflecting some of the concerns Lynne raised. In particular, confidentiality with text messaging, and the lack of capacity in the mobile technologies used by caseload midwives, were key issues impacting on their off-duty time (Forti et al., 2013). Hence, it might be suggested that the management

of midwives' own boundaries, and appropriate mobile capacity, may lead to less emotional work expended, as both parties navigate the midwife–woman relationship.

The following section examines the strengths and limitations of the study.

Study strengths and limitations

Strengths: This study has produced important knowledge relevant to the development and introduction of a new midwifery-led model of care to rural communities and their relationship to healthcare organisations. The study gives voice to midwives working in maternity services that have been redesigned to meet the needs of local communities. Highlighted within the study is the concept that rural health services foster embedded and intertwined relationships between staff and community members. Maternity redesign can mean a very real shift in the power dynamics, long held between staff groups and the public. This study identified the interdependence between staff and community, and the impact of change on both parties in the context of longstanding professional and personal relationships.

The sense of ownership in rural maternity services by community members was specifically felt by midwives in this study. Highlighted within this research is the strength of intergenerational contributions, and loyalty to service development made by community members. This research adds to the significantly limited body of knowledge pertaining to rural maternity service redesign in Australia and the impact of, and need for collaboration with, communities while enacting maternity service change.

The study highlighted the limited employment opportunities available in the rural sector and the efforts staff make to balance work, family and transit required to remain working in their chosen discipline.

The study design demonstrated a careful adherence to key Grounded Theory methods, such as constant comparative analysis and memoing, and was flexibly developed to maximise opportunities within the small and specific sample population.

Diagramming was incorporated as a Grounded Theory method accompanying constant comparative analysis, which significantly strengthened theoretical sensitivity and the transition from abstract ideas to major theoretical concepts.

Limitations: The study aimed to enrol 100% of eligible participants (n=15). However, only 73% (n=11) were recruited because staff resignations or personal circumstances made recruitment of the full quota of eligible staff impossible. A larger sample size, inclusive of different stakeholder groups, may have provided the opportunity to develop more comprehensive insights regarding community opinions about maternity service change in this rural locality, and the community's vision for future service directions.

Interviews were the only method used for data generation, although participants were offered the opportunity to review their transcripts and make additional comments (see Chapter three). This study may have benefited from re-interviewing participants – particularly newer employees after they had worked within the caseload model for a period of time. Newer staff interviewed early in the study may have been exposed to fewer stressors, or felt less equipped to

comment on factors associated with burnout at the time of data generation. Attending to these issues may have increased the depth of data available for analysis.

Consumers were not included in this study and, hence, broader themes connected to their understandings and experiences of service changes could not be ascertained. A broader participant sample may have developed deeper and more focused understandings about communication strategies specific to this rural setting. The absence of other relevant groups, such as hospital-based GPs, allied health, nurses and other staff was also identified as a limitation. Their inclusion might have been beneficial in generating a more complete picture of the changes that occurred, especially regarding any less visible problems.

Recommendations

Key recommendations are as follows:

1.   The use of an appropriate change theory in preparation for health service change. This should provide for the fluid and personalised nature of rural health service change.

2.   Planned, progressive, community engagement as an important strategy to effect positive change. Early engagement of key stakeholders by health service executives is crucial, alongside routine re-assessment of communication strategies and their effectiveness.

3.   Change communication strategies in the rural context should reflect a combination of communication modes – for example, face-to-face meetings and social media engagement – which are appropriate and responsive to

generational preferences, and which are specific to individual rural
maternity services.

4.   While communication may be considered resource-intensive, the use of
social media is an important engagement strategy that is low cost,
accessible and increasingly relevant across a range of generations and
(online) communities.

5.   Training in interpersonal communication and boundary setting skills should
be provided prior to caseload employment, and included in education
opportunities for clinical midwives and other staff working in similar roles.

6.   Appropriate mobile technologies, with adequate and appropriate capacity
for the communication needs of caseload midwives, is required, and should
be provided in conjunction with practice guidelines. Updating of software
should proceed in line with the recommendations of suppliers. Data security
is a concern that must be appropriately and adequately addressed by the
health service concerned.

Further research

Further research might usefully investigate the influence of a wider range of
consumers (for example, single parents and grandparents) on change proposed
for and within rural maternity services. A particular emphasis could be placed on
consumer communication modalities and preferences.

Further research is also needed into the ways rural women access and interpret
maternity-related information and who they share it with. Research is required into
the impact of internet technologies (such as Facebook and Twitter) on building
and sustaining social capital, especially as it applies to maternity services in the

rural community. A qualitative study using social media to attract participants within rural locations, and examine information transfer and online networking, might potentially identify how internet-based community support translates into real life.

Conclusion

This study adds to the literature by discussing a model of care that employs midwifery continuity in a rural context, and within the remodelled landscape of Australian maternity services.

A qualitative analysis of participant interviews has been carried out in which participant reactions to, accommodation of and negotiation during maternity service change have been identified and discussed. The study also aimed to examine midwives' understandings of consumer use of the redesigned service. The study highlighted a communication and midwifery skills deficit that was noted as an important oversight by the caseload midwives. While much literature focuses on midwifery communication and boundary setting, what sets this study apart is the identification of a need for a more complex skill set for midwives to offset sustained periods of rural medicalised practice. In addition, this study notes signs of burnout associated with reduced boundary setting skills while practising caseload in a location in which the midwife is known, easily accessible and contactable.

Additionally, this study sought to understand how midwives accounted for clients' use of the maternity service. In response to this, the research identifies the interwoven and interdependent nature of relationships within the rural context, and

the level of commitment and ownership felt toward local health services by rural communities. Rural resilience and 'boundary crossing' have been identified as unique characteristics that, when harnessed, have the potential to influence health initiatives and outcomes, and sustainability. This study highlights the significant lack of knowledge in this area and the necessity for further research into community inclusion through maternity service redesign.

The utilisation of change theory into the rural health and, more specifically, the maternity change arena has been identified as a factor that was missing from this research. The use of change theory, and by extension the application of a communications plan accounting for local communities and encompassing intergenerational specific stakeholder needs, was also suggested. The planned use of communication tools such as social media was noted as a cost-effective and accessible initiative that was lacking.

Clinical skills and maternity procedures and policies were identified as important elements to ensuring caseload success within the rural sector; however, the unique skills required to navigate interpersonal relationships in the context of caseload midwifery appeared to have been somewhat neglected. Investment into upskilling caseload midwives in communication techniques and boundary setting was identified as an urgent need.

Finally, support for role re-negotiation for hospital-based nurses and midwives in the context of a small rural organisation with longstanding and interwoven relationships was highlighted. Emphasis was placed on the maintenance of a positive team dynamic during the process of maternity service change in this rural location.

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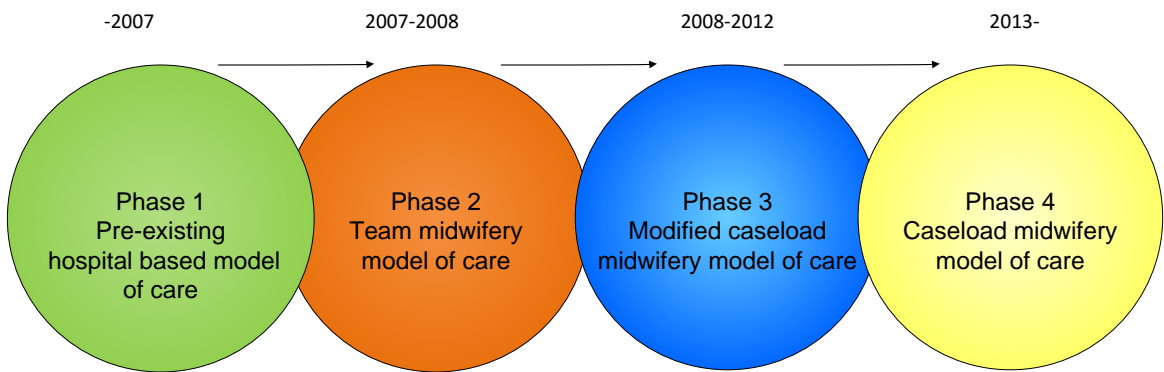
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Appendices

Appendix A: Phases of change

-2007	2007-2008	2008-2012	2013-
Phase 1 Pre-existing hospital based model of care	Phase 2 Team midwifery model of care	Phase 3 Modified caseload midwifery model of care	Phase 4 Caseload midwifery model of care

Phases of change

Appendix B: Participant information sheet

PROJECT TITLE: Maternity care in rural Victoria: midwives perspectives

PRINCIPAL INVESTIGATOR: Helen Stapleton
STUDENT RESEARCHER: Kath Brundell

STUDENT'S DEGREE: Masters of Midwifery by Research

Dear Colleague,

You are invited to participate in the research project described below.

What is the project about?
The research project investigates changes to maternity service provision within [health service under study] and the experiences of the midwives employed within the primary maternity care service. The project aims to analyse the organisational decision for change and how primary midwifery care was instituted by [health service under study].

Who is undertaking the project?
This project is being conducted by Kath Brundell and will form the basis for the degree of Masters of Midwifery by research at Australian Catholic University under the supervision of Dr Helen Stapleton and Dr Val Goodwin.

Are there any risks associated with participating in this project?
There is little foreseeable risk associated with participation in this project. Prior to interview the researcher shall reiterate the study aim, purpose and strict confidentiality regulations. Participants are free to cease involvement within the research project at any time without explanation.

What will I be asked to do?

You will be invited to participate in an interview for a minimum of one hour. The interview shall be conducted onsite at [health service under study] at a mutually convenient time. The interview will be audio taped at the time of interview and transcribed (i.e. typed up afterwards).You will be offered the opportunity to comment on your interview transcript.

What are the benefits of the research project?
The research project will not immediately benefit the participants, however findings may provide insights to the reform of Victorian maternity service provision with recommendations for future improvements.

Can I withdraw from the study?
Participation in this study is completely voluntary. You are not under any obligation to participate. If you agree to participate, you can withdraw from the study at any time without adverse consequences.

Will anyone else know the results of the project?
The research project will be used as the basis for a thesis within the discipline of Midwifery. All data, including interview transcripts will be made anonymous by the use of pseudonyms. Neither [health service under study] nor any participant shall be named or otherwise identified. Confidentiality shall be strictly maintained throughout the research process.

Will I be able to find out the results of the project?
A summary of the project findings shall be made available by the researcher to [health service under study] in the form of a post-study information session.

Who do I contact if I have questions about the project?
For any questions or concerns please contact,

Kath Brundell

PO Box 650, Ballarat, Victoria, 3350

T: +61 3 53365352 M: 0414596963

F: +61 3 53365456

W: kath.brundell@acu.edu.au

What if I have a complaint or any concerns?
The study has been approved by the Human Research Ethics Committee at Australian Catholic University. If you have any complaints or concerns about the conduct of the project, you may write to the Chair of the Human Research Ethics Committee care of the Office of the Deputy Vice Chancellor (Research).

Chair, HREC
C/o Office of the Deputy Vice Chancellor (Research)
Australian Catholic University
Melbourne Campus
Locked Bag 4115
FITZROY, VIC, 3065
Ph: 03 9953 3150
Fax: 03 9953 3315
Email: res.ethics@acu.edu.au

Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

I want to participate! How do I sign up?
You may contact researcher Kath Brundell (see details below) or speak to me in person at the recruitment information session. We will then confirm arrangements for your interview.
Yours sincerely,

Kath Brundell

PO Box 650, Ballarat, Victoria, 3350

T: +61 3 53365352 M: 0414596963

F: +61 3 53365456

W: kath.brundell@acu.edu.au

Appendix C: Participant consent form

PROJECT TITLE*:* Maternity care in rural Victoria: midwives perspectives.

PRINCIPAL INVESTIGATOR & STUDENT RESEARCHER: Kath Brundell

PRINCIPAL SUPERVISOR: Dr Helen Stapleton

CO SUPERVISOR: Dr Val Goodwin

I *.. (the participant)* have read (*or, where appropriate, have had read to me)* and understood the information provided in the Letter to Participants. Any questions I have asked have been answered to my satisfaction. I agree to participate in this study as an interviewee. I understand that I shall be required for approximately one hour. I am aware that the interview shall be audio taped and transcribed*.* I realize that I can withdraw my consent at any time (without adverse consequences). I agree that anonymous research data collected for the study may be published or may be provided to other researchers in a form that does not identify me in any way.

NAME OF PARTICIPANT: ....

SIGNATURE ....

        DATE.................................

WITNESS SIGNATURE: ....

        DATE:……………………..

Please indicate below if you would like to receive a copy of your interview to

provide feedback:

YES: NO:

Please print your email address clearly below

PARTICIPANT CONTACT DETAILS:

Address……………………………………………………………………………………

………………..................

Home ph no………………………………………Mobile ph

no………………………………………...............

Email…………………………………………………………………………………………

…...

....

Appendix D: Participant demographic data request form

PROJECT TITLE: Maternity care in rural Victoria: midwives perspectives.

Please write:

1) Your name, role and briefly describe your professional responsibilities.

2) Details about your training/years of experience as a midwife and highest

professional and academic qualification.

1.   How long have you been employed by the [health service under study] as a

midwife?

2.   Do you live within the [Shire under study]? If so, which area?

3.   Would you consider yourself a local to the District? Why/Why not?

If necessary, please continue your answers below or on a separate page. Please number your additional answers according to the question allocation above. Please bring this sheet with you to your interview.

Thank you,

Kath Brundell

PO Box 650, Ballarat, Victoria, 3350

T: +61 3 53365352 M: 0414596963

F: +61 3 53365456

W: kath.brundell@acu.edu.au

Appendix E: Timeline

PROJECT TITLE: Maternity care in rural Victoria: midwives' perspectives.

	Oct '12	Nov '12	Dec '12	Jan '13	Feb '13	Mar '13	Apr '13	May '13	Jun' 13	July '13	Aug '13	Sept '13	Oct '13	Nov '13	Dec '13	Jan '14	Dec '14	Jan '15	Oct '15	Feb 2016
Literature review	■																			
Develop research proposal	■	■	■																	
Confirmation of canditure									■											
Ethics approval					■															
Data collection						■	■	■	■	■	■	■	■	■						
Data analysis						■	■	■	■	■	■	■	■	■						
Writing of thesis					■	■	■	■	■	■	■	■	■	■	■	■	■	■		
Notice for intention to submit thesis																			■	
Defence seminar																				■
Submit thesis																				■

Appendix F: Interview guide

PROJECT TITLE: Maternity care in rural Victoria: midwives' perspectives.

You and your role

1.   Can you tell me a little about your work as a midwife before the changes were introduced?

2.   How would you describe your role as a primary care midwife?

3.   Can you tell me why you chose to work within this caseload midwifery care model at [health service under study]?

4.   How long can you see yourself employed in your current role? What might make you reconsider?

Process of change

5.   What can you tell me about the reason for the changes in maternity care at [health service under study]?

6.   What involvement have you had with modified caseload midwifery care at [health service under study]?

7.   What factors do you think have helped the transition in models of midwifery care?

8.   What factors do you think have hindered the transition in models of midwifery care at [health service under study]?

9.   What processes, if any, have changed since the modified caseload midwifery care began in 2007?

10.   What have been some of the 'highs' associated with the changes.

11.   What have been some of the 'lows' associated with the changes.

Clientele

12.   How would you describe your clientele and any particular issues they may have? (e.g. Age range, parity, single or partnered)

13.   In your experience what are the differences for women receiving care under [health service under study] modified caseload maternity service?

14.   What differences do you see between the needs of primipara and multipara women.

15.   How would you describe the local residential status of clientele?

16.   How would you describe clientele support networks?

17.   What do you notice about women enrolling in the maternity care at [health service under study] compared with 5-10 years ago?

18.   Is there anything about the maternity service at [health service under study] that you would alter if you could?

19.   Is there anything else you would like to say that I haven't asked you about?