PIONEERING A NEW MODEL OF MIDWIFERY CARE:
A PHENOMENOLOGICAL STUDY OF
A MIDWIFERY GROUP PRACTICE

Submitted by
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All research procedures reported in this thesis received the approval of the

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Signed: _____ Anne Moore 14 /08/09

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'As we are liberated from our own fear, our presence automatically liberates others'.

<div align="right">Nelson Mandela</div>

ABSTRACT

This study explores the essence of the experience of midwives working within a new midwifery model of care: A Midwifery Group Practice (MGP) and is one component in a quality assurance project to evaluate the new service.

In March 2005 the Re-Birthing Report was released in Queensland. This report reviewed maternity services in Queensland and contained key recommendations and guiding principles which were subsequently endorsed by the Queensland Government. The Re-Birthing Report clearly articulates that maternity care in Queensland must change to meet the needs of women and families birthing in Queensland in the 21st Century (Hirst, 2005). Consequently this report was the catalyst for the metropolitan hospital in Queensland where this study was conducted, to implement a Midwifery Group Practice (MGP) model of care. A recently published Federal Government Review of Maternity Services in Australia has also made recommendations that will potentially enable midwifery models of care to be implemented throughout Australia (2009).

An extensive review of the literature outlined relevant key issues including significant gaps in Australian research relating to case-load midwifery practice. No Australian research was found to specifically explore the midwives' experiences when pioneering new midwifery models of care, such as a MGP.

The philosophical approach adopted for this study is Hermeneutics (interpretive) phenomenology. Hermeneutics is considered most relevant to this research as it is grounded on the ontological view that the interpretive process is the experience. Therefore, through phenomenology this study interpreted the essence of the experience of midwives pioneering a new model of midwifery care (the phenomena). Purposeful sampling was employed for this study as each participant was 'selected' purposefully for the contribution he or she could make towards the emerging theory. The study received ethical clearance and approval by the Health Service Human Research Ethics Committee and the Australian Catholic University Human Research Ethics Committee.

Semi-structured interviews were conducted, recorded and the information de-identified when transcribed, providing a rich source of data for analysis. The chosen method of data analysis employed was guided by Gadamer's theoretical model. This model is underpinned by the *hermeneutic circle of understanding* as proposed by Heidegger, which is viewed as one between pre-understanding of the phenomena and understanding. The hermeneutical circle is a circle of interpretation that moves forward and then backward beginning at the present and it is never closed or complete.

Through this process of rigorous understanding and interaction the phenomenon under study was uncovered. The researcher became immersed in the data whereupon after transcribing the data further reflected and identified categories and themes. This process allowed a highly fluid process until a point of data saturation was reached.

Essential elements which emerge from the midwives' experiences are revealed in this study and these will potentially impact on the sustainability of new MGP services. These essential elements are: work/life balance, shared group philosophy, group antenatal care, peer support/ case management, and organisational support. Notably and fundamental to all the elements that emerged from the midwives' experiences, was a Cultural of Trust.

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LIST OF ABBREVIATIONS AND DEFINITION OF TERMS

ACM

Australian College of Midwives
A national peak body for midwives, setting professional practice and educational standards

AMA

Australian Medical Association
The Australian Medical Association represents the registered medical practitioners (doctors) and medical students of Australia. Their philosophy statement is: 'We work with the membership to promote and protect the interests of patients'.

ANMC

The Australia Nursing and Midwifery council (ANMC) identifies matters, which impact on, or are relevant to statutory nursing and midwifery regulation.The ANMC establishes, reviews and promotes a national standards framework for nursing and midwifery practice in Australia. It undertakes assessments of internationally qualified nurses and midwives consistent with the registration and/or enrolment requirements of the Australian Nursing and Midwifery Regulatory Authorities. ANMC initiates and participates in relevant projects on regulation that aid the future growth and development of the nursing and midwifery professions.

Analytical/ Technical Model

This model can also be termed a Mechanical model and places pregnancy and birth in an intervention paradigm, where there is   potentially a high-risk situation that requires dedicated care and access to the best knowledge and technology that is available. It refers to the term 'Mechanics' as one that pertains to the involvement of manual labour and skills such as the nature of a machine; a biomedical led model (Davis-Floyd, 2001).

Autonomous Practice	Defined as independent, self sufficient, self governed and self directed practice, whereby midwives and women become the decision makers
Biomedical Model	A medical model that identifies the medical practitioner as the expert to manage the pregnancy and birth. The pregnancy and birth are seen as symptoms of a disease or organic condition that requires treatment (Davis-Floyd, Barclay, Daviss & Tritten, 2009).
Case-load Midwifery Model	Case-load midwifery is an example of a midwifery-led model of care which requires an on call component. The philosophy in case-load midwifery is that a midwife enters into a professional partnership with the pregnant woman. This allows for equality, shared responsibility, informed choices, empowerment, individual negotiation and self-fulfilment for both the woman and the midwife. The care is woman centred, pregnancy and birth are viewed as normal and healthy life events and continuity of care is ensured by having one primary midwife as the main caregiver (Queensland Nurses Industrial Award, 2006; Davis-Floyd, Barclay, Daviss & Tritten, 2009).
Contextual/Relational Model (Organic)	A model that places pregnancy and birth in a life context which is predominantly a low-risk natural process that requires care and support, with medical intervention as needed. The term 'Organic' is described as one of occurring gradually and naturally, without being forced, while consisting of elements that exist together in a natural relationship enabling organised efficiency; midwifery-led care (Hirst, 2005).
Holistic Model of Birth	A midwifery model of care that comes from a woman-centered approach, defining women as the active agents in their pregnancy and birth. The woman's body is viewed as normal and pregnancy and birth are a healthy and normal part of

the woman's life. It takes a holistic integrated approach defining the body as an organism and not a machine, while viewing the mind and body as one and the mother and baby as one unit (Davis-Floyd, Barclay, Daviss & Tritten, 2009).

Humanistic Model of Birth	This model stretches across the divide between the technocratic and holistic models. Humanism counterbalancing the technocratic medical model with a softer approach to make a more relationship, partnership related model. It is often seen as superficial, such as making a birthing room more humanistic by decorating the room and covering the machines (Davis-Floyd, 2001).
Lead Maternity Carer	New Zealand model of care where a midwife or doctor register with the woman as the Lead Maternity Carer (LMC). The LMC may then claim payments and is responsible for coordinating and/or providing care during the pregnancy, birth and post birth periods. This process encourages and promotes continuity of care for the woman. There is also an on-call component as with the MGP/case-load model/midwifery models of care (Davis-Floyd, Barclay, Daviss & Tritten, 2009).
Midwifery Group Practice	Midwifery Group Practice (MGP) also known as 'Case-load Midwifery', enables women to be cared for by the same midwife (primary midwife) supported by a small group of midwives throughout their pregnancy, during childbirth and in the early weeks at home with a new baby. MGP is also defined further as in the case-load midwifery section above (Queensland Nurses Industrial Award, 2006; Davis-Floyd, Barclay, Daviss & Tritten, 2009).

Midwifery-led Care	Midwifery-led care can also be referred to as a Midwifery Model of care. Midwives are the primary practitioners of these models of care providing continuity of care for the woman during pregnancy, birth and the post birth period. The midwives see pregnancy and birth as a normal physiological event in the woman's life and refer when this deviates from the normal. The midwives working in midwifery models of care have a deep understanding of the physiology and the emotion of birth. Some essential attributes of midwives working in a midwifery model of care are that of empathy, caring, compassion and having a loving touch. There is also an on-call component as with the MGP/case-load model (Davis-Floyd, Barclay, Daviss & Tritten, 2009).
OCNO	The Office of the Chief Nursing Officer (OCNO) develops nursing and midwifery policy & strategy and provides strategic advice on professional nursing and midwifery issues to: Nurses, Midwives, Health Service Districts, the Office of the Director-General, the Minister for Health, and other units within Corporate Office.
Partnership Model	New Zealand model of care where the midwife and woman are in partnership throughout the pregnancy, birth and post birth period. The philosophy is the same as a midwifery model of care with the woman central to the care and an equal decision maker throughout her care with the midwife (Guilliland & Pairman, 1995).
QNC	Queensland Nursing Council is the regulatory body monitoring and setting standards for nurses and midwives in Queensland

RANZCOG	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) is the professional organisation for obstetricians and gynaecologists in Australia and new Zealand. RANZCOG states that it is dedicated to maintaining the highest possible standards in obstetrics and gynaecology in Australia and New Zealand. The primary role of the RANZCOG is to train and accredit doctors throughout Australia and New Zealand in the specialities of obstetrics and gynaecology so that they are capable - professionally and psychologically - of providing the highest quality health care for women
RCM	The Royal College of Midwives (RCM) is the UK's only trade union, professional organisation led by midwives for midwives. The vast majority of the midwifery profession in the UK are members. RCM's mission is to enhance the confidence, professional practice and influence midwives for the benefit of child-bearing women and their families.
RCOG	The Royal College of Obstetricians and Gynaecologists (RCOG) is the professional organisation for obstetricians and gynaecologists in the United Kingdom. RCOG encourages the study and advancement of the science and practice of obstetrics and gynaecology. They do this through postgraduate medical education and training development, and the publication of clinical guidelines and reports on aspects of the specialty and service provision. The RCOG International Office works with other international organisations to help lower maternal morbidity and mortality in under-resourced countries.

Team Midwifery/ Model of Care	Team models are where 6-8 midwives provide care for a number of women. The intent and philosophy is the same as a midwifery model of care or midwifery–led care. However the midwives work rostered shifts that sometimes may limit the continuity for the woman. Team models are usually hospital centred with the limitation of the hieratical systems, policies and processes of the individual organisation, which may also limit the midwives autonomy as a practitioner (Queensland Nurses Industrial Award, 2006; Davis-Floyd, Barclay, Daviss & Tritten, 2009).
Technocratic Model of Birth	A model of birth that constitutes this hegemonic paradigm which influence the behaviours and attitudes of biomedical orientated practitioners. This model views the body as a machine and the patient as an object. The mind is separate from the body. Technological intervention is seen as the norm and biomedical dominance, knowledge and power are the priority. The model is seen from a male perspective with the woman as the object with the pregnancy and birth viewed as a sickness. The mother and baby are separate and each process of pregnancy, labour, birth and the baby are seen as mechanical processes (Davis-Floyd, Barclay, Daviss & Tritten, 2009).

CHAPTER ONE

INTRODUCTION

In March 2005 the Re-Birthing Report was released in Queensland. The Re-Birthing Report clearly articulated that maternity care in Queensland will need to change to meet the needs of women and families birthing in Queensland in the 21st Century (Hirst, 2005). Moreover, this report was the catalyst for the metropolitan hospital in Queensland where this study was conducted, to implement a Midwifery Group Practice (MGP) model of care.

This study explores the essence of the experience of midwives working within a new midwifery model of care: A Midwifery Group Practice (MGP) and reveals essential elements which will potentially impact on the sustainability of new MGP services. Fundamental, to all the elements that emerged from the midwives experiences in this study, was a Culture of Trust.

A MGP or case-load model until recent times was not the chosen model of midwifery-led care implemented in Queensland maternity facilities. This can be directly related to there being no means or method of remuneration for midwives under the industrial agreement prior to Schedule 7 of the Nurses Industrial Award in Queensland (EB6, 2 006). Importantly, the MGP model of care in this study could not be implemented prior to the new industrial agreement for this reason.

Recently, a Federal Government Review of Maternity Services in Australia (2009), made recommendations which include midwives being able to access public

funding for maternity services (Medicare), access to the Pharmaceutical Benefits Scheme (prescribing) and the ability to access indemnity insurance. Importantly Australian midwives may be afforded the same rights and opportunity to autonomous practice as their colleagues in countries such as New Zealand and Canada (Freeman, Timperley, & Adair, 2004; Van Wagner, Epoo, Nastapoka, & Harney, 2007). Essentially, midwives will be able to practice as defined by the International Confederation of Midwives (2005).

An extensive review of the literature (Chapter Two) outlines relevant key issues including significant gaps in Australian research relating to the implementation of midwifery-led models, such as a case-load midwifery practice. No Australian research was found that specifically explored the midwives' experiences when pioneering new midwifery models of care. The review of literature in this thesis explores the emergence of the midwifery profession in Australia and the influence of the biomedical model of care from an historical context. The literature also explores how medical dominance impacted on the development of midwifery-led models of care and contemporary midwifery models in Australia.

It also became evident during the review of literature that different authors use a range of terminology when referring to the different models of care, these have been further defined in the section 'list of abbreviations and definition of terms' (pg.viii). Therefore, for the purpose of this study it is important to understand, that the term Midwifery Model of Care essentially encompasses all of the following models, Contextual/Relational Model (Organic); Holistic Model of Birth; Midwifery Group Practice/ Case-load Midwifery; Midwifery-led and Team Midwifery.

Furthermore, the term Biomedical Model of Care essentially encompasses the following models; Analytical/ Technical Model (Mechanic) and Technocratic Model of Birth.

In March 2005 the Re-birthing Report was released in Queensland (Hirst, 2005). This report reviewed maternity services in Queensland and contained key recommendations and guiding principles. The recommendations and principles were subsequently endorsed by the Queensland Government.

The role of the midwife in Queensland is discussed within the Re-Birthing Report, with the report also recognising that Queensland maternity services had evolved over a long period of time. Maternity care in Queensland and Australia until the late 1940's was mostly provided in the home and births were attended by midwives. From the 1950's to the present responsibility for pregnancy, birth and post-birth care had gradually shifted from the community to hospitals, with increasing involvement and management by medical staff and specialist obstetricians (Hirst, 2005).

However, during the shift to hospital based maternity care, there was no evidence of maternity services being planned within a strategic framework to guide the way forward in a systematic manner. More importantly, there was no indication of any involvement of the most important key stakeholders, the women (Hirst, 2005). Hirst identified two distinct cultures in the milieu of maternity care in Queensland and two groups of decision makers with philosophical differences regarding pregnancy and birth. Hirst's re=birthing Report refers to these cultures of maternity

care as Contextual/Relational Model (Organic) and Analytical/Technical Model (Mechanic).

Hirst describes the Contextual/Relational (Organic) Model as one that places pregnancy and birth in a life context which is predominantly a low-risk natural process that requires care and support, with medical intervention as needed. The term 'Organic' is described as one of occurring gradually and naturally, without being forced, while consisting of elements that exist together in a natural relationship enabling organised efficiency; a midwifery model of care.

The Analytical/ Technical (Mechanic) Model places pregnancy and birth in an intervention paradigm, where there is potentially a high-risk situation that requires dedicated care and access to the best knowledge and technology that is available. Hirst refers to the term 'Mechanics' as one that pertains to the involvement of manual labour and skills such as the nature of a machine, a biomedical led model of care. It is therefore important to understand more about the medical model in Australia, that Barclay et al. (1989) had described twenty years prior.

The Biomedical Model of Maternity Care

Philosophically the biomedical model views the female body as a defective machine, therefore as described by Davis-Floyd, the biomedical model conceptualises childbirth as a dangerous event (2001). In the biomedical model the role of midwives is viewed as one of an obstetric nurse, assisting the doctor, historically this has been the model that has evolved in Australia. Importantly,

Barclay et al. (1989) described this 'private industry' as unsustainable twenty years ago.

In private Australian maternity facilities, the midwives provide support (obstetric nursing) for the specialist obstetricians who care for the woman during her childbirth experience. Midwifery care provided during labour and birth often consists of more than one midwife whom the woman has not met before, therefore care is often fragmented (Homer, Davis, Cooke & Barclay, 2002; Homer, Davis & Cooke, 2002). Essentially specialist obstetricians provide care for normal healthy pregnant woman, which traditionally is provided by midwives in countries such as the United Kingdom (UK), New Zealand, Holland and Canada.

Advocates for the biomedical model propose that pregnancy and birth is a dangerous event and that their model reduces risk to the mother and baby, however this justification is not supported by evidence. For example, a recent study in Holland, which included a nationwide cohort of 529,688 low-risk planned home and hospital births with the midwife as the primary carer, concluded that a planned homebirth did not increase the risk of perinatal mortality or severe perinatal morbidity among low-risk women when efficient, effective referral and transfer systems are place and most importantly the women are cared for by highly educated midwives (De Jong, van der Goes, Ravelli, Amelink-Verburg, Mol, Nijhuis, Bennebroek gravenhorst, & Buitendijk, 2009). A cohort of 529, 688 is significant and further supports midwives as primary carers for normal healthy pregnant women.

Therefore, the Australian re-conceptualisation of birth as a dangerous event best undertaken in an acute care setting overseen and cared for by specialist obstetricians is not supported by these overseas findings (Barclay, 2008). Furthermore, evidence indicates that women who receive fragmented care, such as that provided by biomedical models are more likely to have medical interventions including epidurals and episiotomies (Shorten & Shorten, 2000).

In the UK the philosophy of midwifery care, is also contrary to that of the biomedical model in Australia. For example, a position statement in the United Kingdom by the Royal College of Midwives (RCM) and the Royal College of Obstetricians and Gynecologists (RCOG) supports homebirth for women with uncomplicated pregnancies. Furthermore, the position statement states that a home birth may confer considerable benefits for women and their families and that there is ample evidence showing that labouring at home increases a woman's likelihood of a birth that is both satisfying and safe (Royal College of Obstetricians and Gynaecologists/Royal College of Midwives, 2007).

Choice and woman centered care

Both the midwifery and medical professions support care that is women-centered and it is acknowledged in the re-Birthing report that the biomedical model is not sustainable especially in rural units. Hirst describes one such public maternity unit in Kingaroy where the Medical Superintendent delivers most of the babies and had only one vacation in three years. Thus, providing more flexibility for the midwifery workforce would enable case-load arrangements, particularly for midwives working in rural settings. Women clearly articulated in the review that they wished to

remain in their local communities for the birth of their babies. Therefore, by adopting new approaches to maternity care that give women more choice, access and continuity, in a framework of quality and safety, is the way ahead for maternity care in Queensland (Hirst, 2005).

Importantly Hirst (2005) identified that there needed to be the provision for choices in the way midwives provide care i.e. team care and case-load. Therefore, Hirst suggested that supporting different models, and approaches such as a Midwifery Group Practice to provide maternity care, would meet the needs of the women. Continuity of care with a known and trusted carer was identified directly or indirectly by over half of the reports and consumer submissions, notably this was an important choice for the consumers. Most significantly choice, in terms of care approaches especially during labour and birth, was also raised by over half of the consumer submissions (Hirst).

The Re-birthing Report also explored approaches to maternity care in other Australian states and identified that women in other states were provided with a wider range of choices. These included community based primary care and homebirth, with care from a midwife as a public sector option for women in Western Australia and South Australia, (at the time of the Re-birthing Report release in 2005). Homebirth, with care from a midwife in the public sector is now also an available choice in the Northern Territory and New South Wales. However, more significantly this service is not an option for Queensland women in 2009.

The Hirst Re-birthing Report (2005) also describes maternity care in the Netherlands, Canada and New Zealand. In the Netherlands homebirth care with a midwife is an integral part of the health system, which has a highly educated midwifery workforce. Canada shares similar geographical challenges as Queensland and a comparable Indigenous population. Most importantly, returning local birthing to Indigenous communities with trained Indigenous midwives has been successfully implemented. (Van Wagner, Epoo, Nastapoka, & Harney, 2007; De Jong, van der Goes, Ravelli, Amelink-Verburg, Mol, Nijhuis, Bennebroek gravenhorst, & Buitendijk, 2009).

Notably, in close geographic proximity to Australia is New Zealand which is geographically different, however other than smaller, it does have comparable demographics. Moreover, the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) from a training and professional perspective encompasses both countries. Therefore it could be assumed, that the RANZCOG professional philosophy would be the same in Australia as in New Zealand? However, it is evident that this is not currently the case as New Zealand has already experienced maternity service reform nearly twenty years earlier in the 1990's.

In New Zealand the major reform of maternity services in the 1990's led to a system where women can choose a Lead Maternity Carer (LMC). The LMC can be a Midwife, General Practitioner or an Obstetrician. Currently over 83% of women choose a midwife as their LMC (New Zealand Health Information Service, 2005). It is the responsibility of the LMC to ensure that the woman has choices in the

management of her care and importantly involvement in the decision-making. New Zealand women can choose where they birth their babies in a hospital, primary care unit or home with their known carer (LMC).

Currently other States of Australia and other places in the world are moving towards the approach that pregnancy and birth are a whole-of-life experience, incorporating wellness, psychosocial care needs and valuing continuity (Homer, Davis, & Cooke, 2002; Passant, Homer, & Wills, 2003; Walker, Moore, & Eaton, 2004; Homer, 2005; Fereday, Collins, Turnbull, Pincombe, & Oster, 2009). The Re-birthing Report recommended that principles and strategies when implemented should result in approaches to care that meet the Contextual/Relational Model (Organic) approach and the needs of women and families in both public and private sectors. The Re-birthing Report supports the introduction of midwifery models of care as a choice for all women who are at low risk for complications and adds strength for significant changes to occur in Queensland maternity services and moreover supports further autonomy of midwives.

For the purpose of this study and the literature review, it is important to define autonomous practice, including what this means for midwives, given that midwifery models of care essentially enable the midwives practice autonomously.

Autonomous practice is defined as independent, self sufficient, self governed and self directed, whereby midwives and women become the decision makers. Although autonomous practice is highly sought after by midwives, there are some difficulties that need to be addressed. For example a key difficulty identified in the Re-birthing Report (Hirst, 2005) is that historically the majority of midwives in

Queensland have not been required to nor have been able to work to their full

scope of practice as defined by the International Confederation of Midwives (ICM,

2005: appendix IX).

Developing a Pathway to Autonomy

Significant changes within the midwifery role over recent decades have exposed a

profession that is subordinate in nature and dominated by medicine from both an

educational and professional perspective, as well as gender, with the majority of

midwives being female. Birth, which is considered a normal physiological event,

has been conceptualised by the medical profession in Australia into a sickness

model that requires treatment (Barclay, Andre, & Glover, 1989; Brodie, 2002;

Barclay, 2008; Purcal, 2008).

Also, historically there has been a significant de-skilling of midwives in maternity

units in Australia which may potentially impact on the change in practice and new

ways of working for midwives in Queensland. Midwifery models of care have been

implemented successfully in other Australian states and in a small number of

Queensland hospitals; however the approach has not been consistent or

structured.

Difficulties that were identified in the Hirst Report (2005) will need to be addressed

by Australian midwives and more importantly Queensland midwives, the State

where this study was conducted. The midwifery profession is progressing and

recent developments of professional frameworks such as the development of

national competency standards for midwives (ANMC, 2006), was a significant

advancement towards a professional framework for midwifery. In 2006, prior to the development of the ANMC standards, midwifery was not identified separately from nursing. In fact midwifery was considered a component of nursing. The national standards were endorsed by the Australian College of Midwives (ACM), a professional midwifery organisation in Australia.

Subsequently, in 2007 the ACM implemented a framework for midwives to record and monitor their continuing professional development (CPD). This included a professional peer review process known as the Midwifery Practice Review (MPR), and a web based program that facilitates CPD portfolio data collection and recording, MidPlus. It is expected that midwives will need to participate in these professional development processes to meet the standards required to provide contemporary midwifery models of care, such as a MGP.

BACKGROUND

Conception of a midwife

My mother was an empowered woman who birthed me, her second child at home in 1961 in a small country town in the United Kingdom. However, the era of the biomedical model of childbirth was fully operational, when I gave birth to my three children in the 1980's. My experiences of birth were neither empowering in a philosophical or a physical sense. In fact, I felt that there had to be a better way for women to have their babies and three months after my last baby was born 22 years ago I set out on this incredible journey from nursing to midwifery, motivated to discover a better way to provide midwifery care.

Therefore, my personal history influences my practice, as a clinician, independent midwife practitioner and midwifery educator with a midwifery career that has been enriched by practising in three countries with very different cultures. Furthermore, my work has continued to focus on improving knowledge, services and policies that may ultimately improve the childbirth experience for women and their families.

At the time of this study I was working as the Practice Development Midwife in a large metropolitan hospital in Queensland where more than 9000 women birth their babies each year. In this role I continued my commitment to support the development of sustainable midwifery models of care and frameworks that would provide practice support for midwives, which was the impetus for conducting this study. In 2007 I was seconded to the Office of the Chief Nurse to write a State-wide Implementation Guide for Midwifery Models of Care (2008) and further facilitated workshops for Health Districts in Queensland to enable services to move forward in a positive, structured and supportive governance framework.

In my role as Practice Development Midwife I developed the frameworks required to implement a new service such as a MGP. The framework comprised of an executive proposal which included an outline of the cost benefits of the model, a plan of the method of implementation, proposed method of evaluation of the new model and importantly the benefits for the women including improved satisfaction and reduced interventions during the labour and birth. This document was informed by literature and underpinned by evidence. As a Practice Development Midwife my role included writing an implementation plan which detailed a step by step approach to implement the model including areas of responsibility and time

frames for evaluation of the model. A critical key component vital to the success

and sustainability of the MGP was a model of Clinical Governance which I

developed in 2006, specifically for the implementation of the new MGP model

(appendix VIII). This model of Clinical Governance contains key components

required to ensure safe, effective and sustainable service delivery. These are:

research and development, risk management, continuous professional

development, clinical audit, complaints management, evidenced based practice,

clinical practice guidelines, credentialing/ professional standards and consumer

participation. The clinical governance model has subsequently been adopted for

statewide implementation of midwifery models of care by Queensland Health

(Office of the Chief Nurse, 2008).

Moreover, my history and background was an inherent component when exploring

the design and methodology for this research. Notably, the methodology chosen,

hermeneutic phenomenology enables my own experiences to be immersed in the

interpretation of the data which is underpinned by Gadamer's theoretical model

which is described in chapter three.

Hospital setting where this study was conducted

This study was undertaken in the largest tertiary referral hospital in Australia with

around 9,000 births per annum at the time. Statistically, these comprised of around

4500 public maternity service births and 4500 private obstetric, Visiting Medical

Officer (VMO) births. The MGP model was an initiative that was supported by the

public midwifery and medical teams. Private obstetricians (VMO's) were

approached in the consultation phase, however there was no commitment or

support from them to implement a MGP model or a continuity of care model for the women in the private service at that time.

The hospital where this study was conducted had provided a midwifery model of care for local women since 1996; most recently a midwifery team approach was piloted from 2002 - 2006. However, midwives had identified shortcomings to the provision of care for women in the existing pilot midwifery team due to recruitment, rostering and remuneration difficulties. It was an unsustainable model and true continuity of carer was rarely achieved. Postnatal care was not offered and the model did not meet the recommendations of the Re-birthing Report (Hirst 2005) which demanded improved postnatal services. Reflection on this prior knowledge and history was essential during the planning and implementation phase of the new MGP.

An essential component of management restructuring (2004-2005) was the appointment of a new Midwifery Director, who subsequently recruited additional senior staff. Moreover, this included midwifery leaders with the knowledge and experience required to implement midwifery models of care within the hospital.

Conception of the MGP in this study

Following extensive consultation and planning, executive support was granted and a decision made to discontinue the pilot team approach. Implementation of a MGP, 'gold standard' model of midwifery care provision, was the Mater Midwives Partnership Program (MMPP). The name was chosen to reflect and recognise the

partnerships that existed between midwives, mothers and all other professionals who may be involved in their care.

The aim of the MMPP was to provide a model of care to women living within the geographical boundaries of the Health District. The model would encompass the recommendations of Hirst's Re-birthing Report and facilitate continuity of care/ carer, which had been demonstrated by the literature to enhance positive health and satisfaction outcomes for both mothers and babies.

All the midwives working within the pilot team in 2006 had substantive contracts within the maternity facility. The group practice model in terms of on call commitments was a completely different way of working to traditional midwifery models, including the team approach. Therefore, it was important that the midwives felt able to make a decision regarding their future working lives. They were fully aware of the pilot status of the team and as such were invited to apply for the midwifery positions in the new MGP model. During this time, in consultation with a working group, the implementation plan and philosophy were developed.

Initially, skilled senior midwives were recruited to the group practice; two of these midwives were members of the original team, with the others making a choice to return to their substantive roles. However, one midwife was more recently qualified and a plan was implemented to provide formal mentorship, which would develop midwifery skills and knowledge. Hence, the model had the capacity to facilitate the professional development of junior midwives transitioning into a case-load MGP, within a nurturing supportive environment.

A Midwifery Group Practice (MGP) is where a small group of midwives work together, case-loading an allocated number of women which is specified in Schedule 7 of the Nurses Industrial Award in Queensland (EB6, 2006). This MGP consisted of seven midwives working autonomously to provide antenatal, labour and birth care (intrapartum care) and postnatal care for a group of women. The midwives maintained a case-load, while also supporting each other for regular time off, including sick leave/annual leave), practice support and education. This model focuses on working together both in a practical sense and a philosophical sense.

In this tertiary hospital setting, women who were accepted into the MGP model of care were 'normal healthy women' with a singleton pregnancy. However, if a woman developed complexities in their pregnancy and required medical input, the MGP midwives, who participated in this study, continued care with a nominated obstetrician. Furthermore, to facilitate the ongoing care by the MGP midwives with the obstetrician and wider medical team, guidelines for consultation and referral were also developed. Therefore, enabling continuity of care for the woman with known carers, midwifery and obstetric if complexities developed during the woman's pregnancy, birth or postpartum period. This was a very different concept to the one-to-one midwifery care provided in a number of birth centre models, whereupon the woman's care is transferred to the medical team when complexities arise. Consequently, the continuity of care from a known midwife is removed and the benefits of continuity of midwifery care for the woman (Walsh, 1999; Green, Renfrew, & Curtis, 2000; Homer, Davis, Cooke, & Barclay, 2002).

Fundamental to this MGP model, was the model of Clinical Governance to support a safe and quality driven service; the implementation of the MGP model of maternity care was supported by the principles and framework of Clinical Governance (appendix VIII). The following clinical governance principles guided implementation of the Mater Midwives' Partnership Program

- Risk management
- Clinical Practice Guidelines
- Continuous Professional Development
- Consumer Participation
- Research and Development
- Evidence based practice
- Complaints management
- Clinical Audit
- Credentialing

A further detailed description of the MGP model of care and how the participants in this study worked within this model of care is included in this thesis (appendix X).

CONCLUSION

Essentially, the recently published Federal Government Review of Maternity Services in Australia have made recommendations that will potentially enable midwifery models of care to be implemented throughout Australia (2009). The outcome of the recommendations made by the Federal Government Review of Maternity, will also impact on how midwifery models of care are developed and implemented in Australia. Although the significant de-skilling of midwives, that was identified in the Hirst Re-birthing Report, will need to be addressed by Australian midwives and more importantly Queensland midwives, the State where this study was conducted, to enable this to occur (2005).

What has emerged from other midwifery models implemented throughout the world are key principles surrounding which models should be built to optimise clinical outcomes and client satisfaction. However, paramount to this is, is the satisfaction and wellbeing of the practitioners who are to be entrusted with delivering these services, the midwives themselves. This begins with their education (competency/ confidence/ self esteem) and the support structures under which they are to work including fair remuneration.

The findings of this study can help inform and guide reform processes, moreover the findings will provide further evidence to support the development and implementation of midwifery models of care. Furthermore, the knowledge gained from this study can contribute to the sustainability of midwifery models of care in the long term.

ORGANISATION OF THESIS

This thesis is presented in five chapters. This chapter has presented an overview and background surrounding the study and its significance to midwifery practice in Australia. Chapter Two presents a review of the literature, critiquing and summarising the known information about midwifery in Australia, both biomedical and midwifery models of care. Literature on contemporary midwifery practice, midwifery and continuity of care/ carer, change in practice, professional challenges/ conflict and educational and support needs of midwives is reviewed. The literature review further identifies significant gaps in Australian research in particular, no Australian research was found to specifically explore the midwives experiences when pioneering new midwifery models of care, such as a MGP.

Chapter three is an in depth description of the design of the study and an explanation of the underpinning methodology. Chapter four presents the data and analysis of findings which include the themes that are termed, Mutual Respect, The Midwives' Journey, Professional Fulfillment and Midwives and Women Together. Chapter five discusses the findings of this study, A Culture of Trust, Fostering and Protecting: A Pathway to MGP and Sharing and Growing: Forging a Pathway Together. These findings are further synthesised in relation to the current literature and finally, study limitations, implications for practice and opportunities for further research are discussed.

CHAPTER TWO

REVIEW OF LITERATURE

INTRODUCTION

A purposeful review of the literature was conducted surrounding midwifery models of care and specifically the experiences of midwives working in a midwifery model of care. When conducting this review of literature it was found that little had been written about the history of midwifery in Australia, specifically from the midwives perspective and experiences. The themes identified in this review of literature are: Contemporary Midwifery Practice, Midwifery and Continuity of Care/Carer, Professional Challenges/ Conflict and Educational/ Support Needs of Midwives.

Notably, the most recent studies that have considered the experiences of midwives have been undertaken in the United Kingdom (UK). No studies have been undertaken in Australia that specifically explore the midwives' experience.

Historical overview of Australian midwifery

Twenty years ago Barclay et al. (1989), identified the challenges of childbirth in Australia as one of medical unionism and a private industry that was no longer sustainable. These authors claimed that this was due to the cost of specialist obstetricians providing services for normal healthy pregnant women. This study found that the medical profession 'markets' itself as the superior product and maintains a monopoly on the marketplace and that private obstetric services have an impact on the economical balance of health care in Australia.

Currently, in Australia, the medical unionism continues and midwives are still not supported by legislation to practice autonomously. However, a recent Commonwealth Government Review of Maternity Services in Australia (2009) has recommended that midwives in Australia should be supported by a budget allocation. This will potentially facilitate the development of new midwifery models of care, such as a MGP. Progress is happening and the proposed amendment of legislation in Australia is currently in the consultation phase. However, it is dependent on significant discussion by key stake holders such as the Australian College of Midwives, Australian Medical Association (AMA), politicians, and policy makers, as to how these recommendations can be implemented, regulated and monitored. Although, the challenges identified by Barclay et al. (1989) twenty years ago remain and the question is, will the medical profession relinquish it's monopoly on childbirth in Australia?

It is, therefore important to explore what these changes may mean for midwives in Australia experiencing a new way of working, who may feel secure working in a biomedical model, which historically influenced the method of education in Australia. What are the challenges for Australian midwives moving forward into midwifery models of care and how are these challenges limited, measured or monitored? Reviewing literature around the key concepts of: Contemporary Midwifery Practice, Midwifery and Continuity of Care/Carer, Professional Challenges/ Conflict and Educational/ Support Needs of Midwives, can aid and inform midwifery, therefore, identifying any gaps that may assist in the development of midwifery models of care in Australia. Essentially, as identified in

the Hirst Re-birthing Report (2005), opportunities for midwives to work in midwifery models of care have been limited in Queensland, where this study was conducted.

In more recent Australian studies, researchers describe the subordination of midwifery from an historical context. Biomedical models of maternity care in Australia are intrinsically linked to the historical conception of midwifery in both Australia and the United Kingdom. Therefore, the relevance of the development of the midwifery profession in Australia is further explored in this review of literature (Barclay et al., 1989; Brodie, 2002; Barclay, 2008; Purcal, 2008).

It is important then to consider the most recent studies of midwives experiences working in midwifery models of care. These have been undertaken in the United Kingdom (UK). No studies have been undertaken in Australia that specifically explore the midwives' experience. The findings of the literature reviewed will now be outlined and discussed using the broad themes of Contemporary Midwifery Practice, Midwifery and Continuity of Care/Carer, Professional Challenges/ Conflict and Educational/ Support Needs of Midwives.

CONTEMPORARY MIDWIFERY PRACTICE

Contemporary midwifery practice includes those midwifery models of care which are social models and that are defined in relation to the woman in both the cultural and social context. This is described by Hirst (2005) as the woman and family being central to the care. The partnership model, as described by Guilliland and Pairman (1995) is one of equal power and decision making between the midwife and the woman. Therefore contemporary midwifery practice is an opposing

paradigm and is contradictory to the biomedical model, which assumes the role of expert with the authority and power of medicine to diagnose and treat a normal physiological event.

Partnerships

Contemporary midwifery practice is further underpinned by models such as the New Zealand Lead Maternity Carer (LMC) model described by Guilliland and Pairman (1995), which describes the partnership and the woman as the decision maker in her pregnancy and birth care. Importantly, fundamental to these models is continuity of care by a known carer and continuous support for women during pregnancy, birth and the postnatal period. Qualitative studies indicate that continuity of care by a known midwife contributes in a positive way to the increased satisfaction of childbirth for women and reduces interventions (Hodnett, Gates, Hofmeyr & Sakala, 2006; Hatem, Devane, Soltani & Gates, 2008; Shorten & Shorten, 2000).

Overall, there is growing awareness of the benefits to women accessing continuity of care such as midwifery-led care and a case-load midwifery practice which are the foundations of the partnership model that has been established in New Zealand (Homer et al., 2001; Homer, Davis & Cooke, 2002; Hodnett, 2004). Although most studies of continuity of care are from a small group of carers, the benefits of continuity of carer that have been identified include a reduced likelihood of antenatal admission to hospital compared to those receiving fragmented care in a biomedical model. Moreover, these benefits further apply to women who develop

complications and require additional care from obstetricians and other medical specialists (Homer, Farrell & Brown, 2002).

Autonomous Practice

Contemporary midwifery practice is essentially and inherently connected to autonomous practice, therefore midwives working in models such as a MGP are autonomous practitioners. Autonomous practice as defined previously enables the midwives and women to become the decision makers, such as a partnership model (Guilliland & Pairman, 1995). However, in Australia a midwifery model currently requires the support and good will of the medical profession to function. This is because midwives in Australia are currently not afforded the same legislative rights as their colleagues internationally and this has had a significant impact on the development of midwifery models in Australia.

A Developing Midwifery Profession

Recently, Barclay (2008) conducted a feminist review of midwifery history from colonisation until the 1980s claiming that Australian policies, regulation and most importantly the practise of midwifery all reflected the authority and reverence accorded to the medical profession. Furthermore, Barclay suggested that the decline in midwife-led birth during this time was not due to economics, rather a result of the medical profession creating a significant income within the domain of obstetrics.

Barclay's (2008) perspective is validated by Fahy's (2007) historical study on the subordination of midwifery and Purcal (2008) who explored the politics of

midwifery education in New South Wales during the last decades of the 19th Century. Fahy, concluded that during the period 1886-1928 the medical profession forged an alliance with the nursing profession, further achieving both disciplinary and regulatory control of midwifery. Additionally, Pursal also claimed that the medical profession established midwifery training therefore creating a subordinate class of midwife-nurse to complement medical practice at that time.

The concept of a medically dominated health system that subordinates midwifery within nursing is further referred to by Gould (2008), in the UK. In the Re-birthing Report, Hirst (2005) also identified the two distinct cultures in the milieu of maternity care in Queensland and the two groups of decision makers with philosophical differences regarding pregnancy and birth. Hirst referred to these cultures of maternity care as, Contextual/Relational Model (Organic) and Analytical/Technical Model (Mechanic). It is therefore important to explore studies that are specific to the Australian private biomedical model such as the following study by Shorten and Shorten (2000).

This study was a retrospective analysis of anonymous medical record data using logistic regression models surrounding episiotomy rates was undertaken in a large regional public hospital in New South Wales, Australia (Shorten & Shorten, 2000). Participants in the study sample consisted of 2028 women who delivered a baby vaginally during a 12 month period during 1996-1997. The results demonstrated that privately insured women were estimated to be twice as likely to experience an episiotomy as those women accessing public health services. Episiotomy rates amongst privately insured women in Australia may be higher than is clinically

appropriate, and severe perineal trauma within this study was associated with this practice (Shorten & Shorten, 2000).

Shorten and Shortens (2000) study supports a study by Tracy and Tracey (2003) which was also undertaken in New South Wales, Australia. The purpose of this study was to estimate the cost of 'the cascade' of obstetric interventions introduced during labour for low risk women, for example, induction of labour, epidurals and forceps delivery. Tracey and Tracey's study claims that the initiation of a cascade of obstetric intervention during labour for low risk women was costly to the health system. Moreover, that private obstetric care adds further to the cost of care for low risk women. Importantly, this validates Shorten and Shorten's data, and further confirms the findings of Australian midwifery studies (Barclay et al., 1989; Brodie, 2002; Barclay, 2008; Purcal, 2008).

Therefore, it is important to explore the reasons for this increase in intervention and a review of continuous support for women during childbirth enables further assessment of the evidence (Hodnett, Gates, Hofmeyr, & Sakala, 2006). The Cochrane review conducted by Hodnett, Gates, Hofmeyr and Sakala (2006) is a summary of 15 trials involving 12,791 women which took place in 11 countries involving a wide variety of circumstances. The methodological quality of the trials was graded from good to excellent by the authors and found that women who had one to one support during labour were more likely to give birth without analgesia or anaesthesia and more likely to have a spontaneous vaginal birth. However the review indicated that support during labour and the commencement of epidural anaesthesia may be a directly or indirectly part of the cascade of interventions that

leads to an increased caesarean section rate. The review did not report any adverse effects.

A review of continuity of caregivers by Hodnett (2006) involved two studies with a cohort of 1815 women, both trials compared continuity of care by midwives with non-continuity of care by a combination of physicians and midwives. Hodnett, noted the trials to be of good quality with significant reduction in intervention rates and increased satisfaction of care recorded by the women. Hodnett commented that there were beneficial effects with continuity of care identified by both studies, however, it was not clear whether these were due to greater continuity of care or to midwifery care. Therefore, it is essential that literature around continuity of care/carer is also explored more thoroughly.

MIDWIFERY AND CONTINUITY OF CARE/CARER

A central component of a case-load midwifery practice such as a MGP is continuous support in labour, which has a positive impact on birth outcomes and the women's experience (Hodnett, 2004; 2006). A MGP is defined in the Queensland Nurses Industrial Award as a 'Case-load Midwifery Model'. It is also referred to as 'Group Practice' i.e. a small group of midwives (two or three) with a focus on continuity of care and carer approach, which provides antenatal, intrapartum and postnatal care for a defined number of women, (Queensland Nurses Industrial Award, 2006).

There are a number of studies that have explored continuity of care/carer, the clinical outcomes and the woman's satisfaction with midwifery models of care

(Homer et al., 2001; Homer, Davis & Cooke, 2002; Hodnett, 2004; Fereday, Collins, Turnbull, Pincombe, & Oster, 2009; Turnbull, Baghurst, Collins, Cornwall, Nixon, Donnelan-Fernandez & Antoniou, 2009). This evidence is also aligned with the benefits of midwife-led care (Hatem et al., 2008). Moreover, women who receive continuity of care/carer during pregnancy and childbirth are less likely to give birth without analgesia or anesthesia and more likely to have a vaginal birth (Hodnett et al., 2006).

A Cochrane systematic review conducted by Hatem, was published that reviewed midwife-led care versus other models of care for childbearing women (Hatem, 2008). The review summarised the findings of 11 trials involving 12,276 women in a wide variety of settings and health systems in four countries. Part of the sub group analysis found a significant difference between team models of care and case-load models of care. For example, in the case-load models of care there was a reduction in neonatal death at greater than or equal to 24 weeks gestation. Moreover, this analysis supports the midwifery group practice model which is essentially a case-load model. Recommendations for further research were also made in the review including community case-load models of care such as MGP models. However, the focus of the recommendations was on intervention rates and standards of care rather than the midwives' experience and work/life balance.

One study of a team approach to midwifery care was conducted in North Queensland. This study explored the experiences of 22 midwives to determine their perspective of the team midwifery model (Walker, Moore, & Eaton, 2004). Four focus groups were undertaken with the midwives identifying themes that had

influenced their experiences such as organisational characteristics, team structures and accountability. The findings of this study, undertaken 11 months after the implementation of the model, recommended a review of existing power relations/ bullying within the health care organisation.

In 2001, a new model of case-load midwifery care was established in the Birth Centre at St George Hospital, a metropolitan hospital in New South Wales (NSW). A prospective longitudinal evaluation following 10 months implementation described the experiences of four newly graduated midwives. The three key methods of data collection were skills inventory, interviews and focus groups, and a time and motion study of work hours. This randomised control trial concluded that the reorganisation of maternity services to enable women to receive continuity of care has benefits for women (Homer, et al., 2002). However, the authors concluded that the benefit of a known midwife caring for a woman in labour required further research.

An evaluation report of the MGP model implemented in Adelaide, South Australia, concluded that midwives working in the MGP role were satisfied with their job in particular the continuity affirmed in their practice and their professional role (Homer, 2005). In summary, the study identified that the midwives had some difficulties with managing the on-call hours and management styles, but overall midwives reported that their skills had increased to include the full scope of practice (International Confederation of Midwives, 2005).

Significant for Australian midwifery are two recent studies conducted in 2009

evaluating a MGP model in South Australia. The first study by, Turnbull, Baghurst,

Collins, Cornwall, Nixon, Donnelan-Fernandez & Antoniou (2009) evaluated the

clinical effectiveness of the Midwifery Group Practice (MGP) in South Australia

(part one), against the clinical effectiveness of the MGP with other models of care

in the hospital. This study compared clinical outcomes between women who

received care under MGP (n = 618) and those receiving alternative care at the

hospital (n = 3548). The significant differences included fewer assisted deliveries,

fewer inductions of labour, less epidural anaesthesia and less perineal trauma for

those women who were in the MGP model. This study found that there was no

significant difference in the incidence of antenatal hospital admissions, postpartum

haemorrhages or neonatal admissions to the special care baby unit or the

neonatal intensive care unit (Turnbull et al., 2009). Therefore concluding that there

are clinical benefits to women receiving care through a MGP model has been

identified in this study, which is be further validated by the Cochrane review

conducted by Hodnett et al. (2006).

The second part of the evaluation into the MGP model of care in South Australia

reported on the women's satisfaction with the model of care (Fereday, Collins,

Turnbull, Pincombe, & Oster, 2009). One hundred and twenty questionnaires were

sent to women who were receiving care from the MGP over a three month period.

Positive scores were received to all the questions and the study concluded that

women were satisfied with their care from the MGP model. However, most

importantly, these Australian studies of an MGP, did not explore the midwives

experiences.

A New Way of Working

It is vital that midwives' experiences are considered when a new way of working is introduced as this can impact on both the professional and private lives of midwives. Therefore, this will in effect determine the sustainability of a new model of care such as a MGP.

As referred to previously a LMC maternity model of care was established in New Zealand in 1992 and in 2005 83% of LMC's were midwives, validation of practice determined by research has been conducted throughout this time (Freeman, Timperley, & Adair, 2004). However, a more recent New Zealand study of LMC midwives revealed some disturbing findings (Skinner & Wakelin, 2007). The remuneration and payment structure in New Zealand consists of a modular payment system, whereby the birth component consisted of a higher dollar amount than the modules for pregnancy and post birth care. Therefore, if the LMC midwife did not attend the birth they would be financially disadvantaged, hence a reluctance to work in groups and share a caseload. The authors did reveal that one option to consider for sustainability of continuity of care and the LMC midwife role was the formation of small groups of philosophically like minded midwives (Skinner & Wakelin, 2007). Thus, this New Zealand study would support the MGP model of care that essentially may provide more work/life balance for midwives who practise continuity of care and on call case-load midwifery.

Exploration of literature around alternative ways of working that may inform a new MGP model revealed an alternative model of antenatal care and education, referred to as *Centering Pregnancy*. This alternative contemporary model of

antenatal care/education was developed in the United States of America (USA) and aimed to provide more contact time with the women. Additionally, the model gave them the opportunity to connect with other women in their community. Schindler Rising, Powell Kennedy and Kilma (2004), the authors of Centering Pregnancy, describe a theory of social support that empowers women and facilities a strong relationship with the group of midwives providing the care. Therefore, to avoid the issues identified by Skinner and Wakelin (2007), a similar model of antenatal care/education to the *Centering Pregnancy* model was utilised when implementing this MGP.

A further study that explored a new way of working was conducted during the implementation of a midwifery development unit (MDU) in Glasgow United Kingdom (UK). This study found that the midwives had a positive attitude and increased job satisfaction in their new role. This was a prospective cohort study (Turnbull, Reid, McGinley & Shields, 1995) was undertaken to examine the changes in midwives' attitudes to their professional role.

Therefore, it is important to consider studies undertaken over the last eight years in the UK of new midwifery models and the midwives experiences (Dimond, 2002; Warwick, 2002; Ball, Curtis, & Kirkham, 2006a; Ball, Curtis, & Kirkham, 2006b; Ball, Curtis, & Kirkham, 2006c; Kirkham, 2007). These studies revealed that organisational factors, including low staffing levels and unsupportive management, contributed to the undermining of midwives' opportunities to provide the type of midwifery care that they would have chosen to provide, such as a MGP model. Moreover, these factors contributed to many midwives leaving the profession

(42%, n = 409) (Ball, Curtis & Kirkham, 2006). Midwives who left their practice reported feeling stressed which is a finding also reflected in other studies (Carlisle, Baker, Riley & Dewey, 1994; Sandall, 1995, 1997, 1998; Bakker, et al., 1996; Mackin & Sinclair, 1998). Moreover, the study by Ball et al. continues to remain the catalyst for further research of issues surrounding the midwifery work force internationally.

Stevens and McCourt (2001; 2002) evaluated one-to-one midwifery practice during the implementation of the changing childbirth initiative in England from 2001-2002. The changing childbirth initiative was implemented in England to facilitate women's choice of a holistic, social model, midwifery model care for women, rather than a biomedical model of care. During several evaluations over this period of time it was suggested that team schemes may increase job stress for the midwives involved.

A new way of working for midwives and change in practice may pose challenges to the midwives pioneering a MGP model. Therefore, consideration when implementing a MGP in Australia should be given to an article written by Martin (2008). Martin suggests that midwives in the UK needed qualities such as willpower, motivation and determination to successfully implement evidence into practice.

Midwifery practice in Australia has historically focused on team midwifery models, which have significantly higher workloads, involve shift work and on-call and can therefore be a major cause of occupational stress (Stevens & McCourt 2001;

2002). Several studies have also suggested that midwives experienced 'burnout' because of over commitment (Todd, Farquhar & Camilleri-Ferrante, 1998; Hicks, Spurgeon & Barwell, 2003; Walker, Moore & Eaton, 2004).

In a study of a team model in North Queensland it was noted that the midwives autonomy was also limited by the hospital. This led to added stress and an increased workload, which was brought about by this particular team model, which led to the midwives requiring further professional development and support to continue (Walker, Moore, & Eaton, 2004).

A series of narratives were written by midwives from a MGP in Blackburn West in the UK. The narratives included the inception, building up and the success of the MGP (Fleming, 2006; Fleming & Downe, 2007; Fleming, Birch, Booth, Cooper, Darwin, Grady & Downe, 2007). Fleming and Downe described how the midwives not only cared for the women and their families, but that they also cared for the wellbeing of each other in the MGP. This key theme the authors termed, a 'Shared Group Philosophy'. For example, if a midwife in the practice had a personal issue or needed relief, a colleague from the group would cover without question. Importantly, this change in practice and new way of working was managed effectively by the MGP who developed a 'Shared Group Philosophy' that worked for the group and enabled time off call.

Workplace Culture

It is significant to note that overwhelming evidence has recently emerged from the UK which identifies a need for cultural and organisational change in contemporary

midwifery practise. One of the main problems identified was bullying by managers

and by midwife colleagues, this may be a contributing factor to the attrition of

midwives in the UK, which should also be a consideration when exploring the

experiences of midwives (Dimond, 2002; Ball, Curtis, & Kirkham, 2006a; Ball,

Curtis, & Kirkham, 2006b; Ball, Curtis, & Kirkham, 2006c; Kirkham, 2007).

Kirkham (1999) suggested that the culture of midwifery in England emerged as

one of service and sacrifice where midwives lacked rights, the rights that they

were required to offer to their clients. Kirkham's study tried to establish an

understanding of midwifery culture in England and conducted in-depth interviews

in five very different sites across England. Kirkham found that the caring attitudes

of the midwives often led them to feel that they needed to accept the additional

'burden' from their increased workload.

Furthermore, significant studies and reviews in the UK, utilising methods such as

surveys through the Royal College of Midwives (RCM), identified common themes

in contemporary midwifery practice that contributed to midwives' attrition from the

profession. Of most significance is the study; "Why do midwives leave?" which

was conducted in 2001 by Ball et al. (2006a). This study was jointly funded by the

Department of Trade and Industry (DTI) and the RCM in response to the constant

attrition of midwives in the UK and is the catalyst for further exploration of issues

surrounding the midwifery work force in the UK. Therefore, studies conducted in

the UK validate the recommendations made by the relatively small study

conducted in North Queensland by Walker et al. (2004) which recommended that

a review should be conducted of the existing power relations within that particular

health care organisation in North Queensland.

It is important then to consider Australian studies when referring to workplace

culture and those that refer to a subordination of midwifery in Australia (Brodie,

2002; Fahy, 2007; Barclay, 2008; Purcal, 2008). These researchers associated

subordination with the role of the midwife, including a lack of autonomy, job

satisfaction and significant midwifery workforce attrition. Therefore, to achieve

sustainability it is vital that this body of literature is considered when implementing

midwifery models of care in Australia.

PROFESSIONAL CHALLENGES/CONFLICT

It is important to explore the literature around professional challenges and conflict

to enable an understanding and inform the development of future midwifery

models in Australia.

Researchers, who have examined the historical dilemmas associated with

midwifery in the United Kingdom (UK), describe midwives as an oppressed group

(Kirkham, 1999; Ball, et al., 2006). Ball et al. claim that modern midwifery in the

UK is very much defined by the powerful profession of medicine. Whereas, Hunter

(2004) focuses explicably on the emotion work of midwives, importantly other

recent studies have explored stress and burnout in midwifery and describe the

aspects of the emotional nature of midwifery practice (Sandall, 1998; 1997; Mackin

& Sinclair, 1998; Kirkham, 1999). Kirkham and Stapleton (2000) argue that the

culture of midwifery in the UK has a profound effect on midwives experiences,

these findings are also reiterated in the recent investigations as to why midwives leave the profession (Ball, et al., 2006). Chronic staff shortages, low morale and bullying by managers in British midwifery have been widely documented as possible reasons for midwives leaving the profession (Ball, et al., 2006). Furthermore, challenges to professional role boundaries had the potential to generate further friction between other healthcare professionals (Hicks, Spurgeon, & Barwell, 2003). For example, Kirkham (1999) identified key concerns for community midwives who attended an annual week of updating in the hospital delivery suite. The community midwives disclosed these feelings to Kirkham (1999) together with another constant theme which was identified as a feeling of distrust. These feelings presented a barrier between the community midwives and the delivery suite midwives. Kirkham also found that a secondary process, resulting from the tensions of oppression is the fear of change, something that the midwives in Australia will also need to be mindful of during this period of change in practice and ways of working.

Lynch (2002) conducted a study in the UK titled 'Care for the caregiver', which explored caring for the caregiver in a global context. Lynch claimed that through understanding the causes of stress, exhaustion and burnout, professional challenges could be addressed. Therefore change could be achieved, including political and legislative change. A study by Fahy (2001) can also be aligned with the study by Lynch. Fahy claimed that ethical midwifery practice and decision making should include the emotions and feelings of consumers and midwives. Both studies conclude that, midwives who listen to each other, care for each other, can affect a change in practise by exploring alternative models of midwifery care.

In comparison, a cross sectional study by Bakker, Groenewegen, Jabaaij, Meijer, Sixma, and de Veer (1996) identified 'burnout' as a psychological syndrome of emotional exhaustion, depersonalisation and reduced personal accomplishments. The practice and personal issues of 200 Dutch community midwives in independent practice were measured over a three-week period. Data was collected using a questionnaire and the implications for practice that emerged from this study were that, when a higher percentage of births occurred at home instead of hospital, the chance of burnout was lower. Moreover, was the additional stress attributed and influenced by the hospital environment, organisational hierarchy or management conflict?

The future of midwifery depends on strengthening and developing the profession and the recognition of the common struggles that midwives have, such as developing and maintaining an autonomous midwifery profession (Lynch, 2002). Fenwick, Butt, Downie, Monterosso, & Wood, (2006) explored the priorities for midwifery research in Perth and determined that from a midwife's perspective, the highest ranked topic for potential research was 'examining the professional issues that impact on midwives' clinical practice'. These issues included midwifery and medical collaboration and horizontal violence in the workplace.

When evaluating a one-to-one midwifery practice, Stevens and McCourt described a confusion and tension that was generated by the change in practice. The findings can be compared to those of Kirkham who identified similar challenges of confusion and tension that impacted on the midwives professional role. Kirkham

described these as a catalyst for further friction (Kirkham, 1999; Kirkham & Stapleton, 2000).

Conflict is not isolated to midwives practising in alternative midwifery models, as conflict was also found between team midwifery models and highlighted as a problem in the study of the team model of care in North Queensland (Walker, Moore & Eaton, 2004).

A study by Woodward (2000) explored relationships between nurses and medical staff in a palliative setting and midwives and medical staff in a maternity setting. Notably, nurses enjoyed good interdisciplinary relationships with medical staff and relative autonomy within the palliative care setting, in contrast midwives had to cope with tensions and constraints on their scope of practice by doctors in maternity (Woodward, 2000). In a study of collaborative experiences by Miller (1997) conflict was reported as significant in areas such as, clinical practice (100%), power inequities (92%), financial difficulties (66%), gender issues (58%) and lack of role understanding by their collaborating partner (70%). Overall, the central issue to emerge from this research was the use and abuse of power in professional relationships. (Miller, 1997; Woodward, 2000).

Thompson (2005) also identified that emotions and feelings were an element of conflict between workplace/service provider ethics and personal/professional midwifery ethics. For instance, Thompson (2005) identified that emotions and feelings reflected the impact of conflict between workplace/service provider ethics and personal/professional midwifery ethics. Moreover, the emotion surrounding

midwifery practice and childbirth may potentially contribute to the conflict that is encountered and is a key source of emotion work for participants, such as those midwives participating in this research and as identified by Hunter (2004).

A recent publication by Davis-Floyd, Barclay, Daviss and Tritten (2009) explored models in New Zealand, Holland, Canada, Samoa, Australia, UK, Japan and New Mexico with the aim to demonstrate that models of care had been created that set a global standard of excellence in maternity care. Notably, these birth models were essentially midwifery models of care and the importance of the ideology of midwifery models of care was clearly articulated in the text (Davis-Floyd et al.,). Different ideologies and philosophies which are significant to midwifery models of care and biomedical models are described by Davis-Floyd (2001). Davis-Floyd et al. refers to these as the Holistic Model and the Technocratic Model. These models were critrical components when the authors described birth models that don't work and birth models that work (Davis-Floyd et al., 2009). Hirst (2005) describes these ideological and philosophical differences, as Contextual/Relational Model (Organic) and Analytical/Technical Model (Mechanic). All of these authors describe these models as being from different paradigms, one that places pregnancy and birth in a natural life context which is a natural process a midwifery model of care (Holistic or Contextual/Relational Model). Additionally pregnancy and birth are placed in an intervention paradigm, where there is potentially a high-risk situation or sickness that requires dedicated care and technology, a biomedical led model of care (Technocratic of Analytical/Technical Model).

These paradigms described by Davis-Floyd, (2001), Hirst (2005) and Davis-Floyd et al. (2009) are also identified in recent Australia studies that claim Australian policies, regulation and the practise of midwifery all reflect the authority and reverence accorded to the medical profession (Brodie, 2002; Fahy, 2007; Barclay, 2008; Purcal, 2008). Therefore, it is critical that during this time of change in practice and culture within midwifery in Australia that support and structure is provided for the midwives to guide them on their professional journey and encourage them to remain in the profession.

EDUCATIONAL/ SUPPORT NEEDS OF MIDWIVES

It is vital to support midwives working in a true autonomous framework where additional skills are required. For example, reflective skills, clinical skills, conflict resolution skills and being able to work together and utilise concepts such as the 'shared group philosophy' that was successful in the Blackburn MGP (Fleming & Downe, 2007; Fleming, Birch, Booth, Cooper, Darwin, Grady & Downe, 2007). For transition to different ways of practicing, such as case-load midwifery which includes an on call component for the midwives providing the service, it is important that previous studies that identify stress or burnout for midwives are considered. Thus, it is critical that the educational and practice support needs of midwives are also explored in this context.

In an ethnographic study by Woodward (2000) in the UK, the concept of caring and how caring values manifest clinically are explored from an educational perspective. Woodward compared observational and interview data in this qualitative study of the differences in care delivery within a palliative care unit and

a maternity unit. The analysis that appeared from the data suggested that caring values such as, those identified by the Blackburn West MGP, where the midwives cared about each others wellbeing were eroded in the maternity setting. It was suggested by Woodwood, that the implementation of theoretical frameworks would facilitate reflective practice. This practice was encouraged within palliative care but not within the maternity setting (Woodward).

Additional literature was also explored from two very different and diverse studies to enable a broad review and identify whether any common themes were revealed that would be relevant to the education/support needs of midwives. The first, a study of the lived experience of Angolian midwives (Pettersson, Svensson, & Christensson, 2001) and the second study, explored midwives' and physicians' experiences in collaborative practice in California (Miller, 1997). The midwives stated they needed experience and additional skills such as, reflective and clinical skills to be fully prepared for their work as midwives in these more autonomous roles.

A consistent theme was identified in the majority of studies which suggested that educational frameworks and professional support structures are required to provide a healthy transition for implementing midwifery-led care. Support, practice development, participation, skilled and supportive management are essential (Turnbull, Reid, McGinley, & Shields, 1995; Hildingsson & Haggstrom 1999; Kirkham, 1999; Watson, Potter, & Donohue,1999; Kirkham & Stapleton 2000; Stevens & McCourt, 2002; Hunter, 2004; Walker, Moore, & Eaton, 2004; Lindberg, Christensson, & Ohrling, 2005).

Also identified by Stevens and McCourt (2002) was that the midwives' sharing of knowledge and experiences became an important catalyst for cohesion within a case-load midwifery group practice. Once established this information and knowledge was shared and passed on to subsequent midwives as part of the education and orientation into the case-load midwifery practice.

The evaluation report of the MGP in Adelaide, South Australia (Homer, 2005) revealed that five of the six midwives perceived that they had to work beyond the role of a Midwife. However, one of the recommendations that emerged from this evaluation report was the need to up-skill other midwives to relieve the MGP midwives.

The future of midwifery depends on strengthening and developing the profession and the recognition of the common struggles of midwives. As such, there is scope for developing and maintaining an autonomous midwifery profession (Lynch, 2002). Effective education programs need to be developed in Australia that are not underpinned by the medical model will assist with the recruitment and retention of midwives in the profession (Purcal, 2008). For example, the model described by Passant, Homer, and Willis (2003), where newly graduated midwives have the choice of working in a midwifery led model of care, may potentially avoid the disappointment as described by Purcal (2008).

The educational needs identified are inherently connected to the professional challenges, in terms of the midwives responsibility and accountability for their own practice. Effective education programs need to be developed in Australia that are

not underpinned by the medical model and will further contribute to the recruitment

and retention of midwives in the profession in Australia (Purcal, 2008). Therefore,

it is important to identify through the literature potential professional challenges for

midwives that may impact on the implementation of a new model of care such as

the MGP.

Moreover, as discussed previously it is even more important that Australian

midwifery leaders consider the historical significance of Australian midwifery

practice when promoting normal birth and planning midwifery models of care.

SUMMARY

The majority of the studies included in this literature review, researched care

provision, outcomes and women's experiences and do not focus specifically on the

midwives' experiences. Notably, there is limited research conducted in Australia.

Therefore, it is important that the gaps, which exist within the literature, particularly

the limited research, specifically exploring the experiences of midwives embarking

on case-load midwifery models of care. Moreover, it is vital that further research is

conducted within the context of Australian midwifery and case-load midwifery

models of care. Research in this area will enable and inform midwifery leaders and

relevant organisations in Australia how best to implement midwifery-led models of

care such as an MGP model which incorporates case-load practice.

It is clear from this review that there has been considerable research into the

experience of women and childbirth specifically in the UK following the changing

childbirth initiative (Spurgeon, Hicks & Barwell, 2001). Moreover, other significant

studies conducted include the attrition of midwives out of the profession in the UK and retention of skilled midwives was clearly identified as challenging. For example, many midwives were considering moving or even leaving midwifery practice had case-load practice not been implemented (Warwick, 2002; Ball, Curtis & Kirkham, 2006; Kirkham, 2007).The literature suggests that although case-load midwifery practice may not appeal to all midwives the profession may potentially be losing strongly motivated midwives because of the predominance of biomedical models of maternity care.

Furthermore, the literature indicated that increased job satisfaction can be aligned directly with recruitment and retention of midwives within the profession and that there is a need to provide alternative models of midwifery care to achieve job satisfaction.

It would be beneficial to the development of the midwifery profession in Australia to be able to identify the experiences of midwives embarking on a new midwifery model of care, which may be influenced by many factors including the educational frameworks compared to that of the UK educated midwives. Furthermore, the evaluation report of the Adelaide MGP identified there were improvements to be made to sustain midwifery models of care in Australia, such as, improving skills, collaboration and communication (Homer, 2005).

Literature suggests midwives from other countries are more accustomed to autonomous practice, which is different for Australian midwives, where working to the full scope of practice as defined by the ICM (2005) was identified as a key

difficulty in Queensland (Hirst, 2005). The LMC model of midwifery practice, which essentially facilitates autonomy, has been established in New Zealand since 1992, with validation of practice determined by research throughout this time (Freeman, Timperley & Adair, 2004). However, the recent telephone survey of LMC midwives identified issues with the sustainability of this model of care in the long term and must be considered when developing midwifery models in Australia.

This literature clearly illuminates the importance of why a new model of midwifery care needed to be developed and this informed the development and implementation of this model. Also, the literature revealed how essential it is that Australian midwife leaders have an understanding of the historical significance of Australian midwifery when promoting normal birth and planning midwifery models of care.

Chapter Three presents the research methods used in this study of the experience of midwives pioneering a new model of midwifery care, a MGP. Data collection processes and analysis will be described in relation to the midwives experiences and a description of ethical considerations and methods used to ensure research rigour will be outlined.

CHAPTER THREE
DESIGN OF THE STUDY

BACKGROUND

For many years midwives have debated with medical colleagues the initiation of changes in practice that influence the normal physiological process of birth. The challenge for midwifery that has occurred, through the medical dominance of childbirth and the power struggle between medicine and midwifery, appears to be integral in the quantitative/qualitative debate (Grbich, 1999). This study used a qualitative approach. Phenomenology was the chosen philosophical approach because it enabled exploration of the social, psychological and spirituality of midwifery practice and was the most suitable approach to explore the essence of the experience of the midwives who participated in this study including the meaning midwives ascribed to their lived-experience. The holistic nature of midwifery and the importance of the psychological aspects of childbearing women and birth are also captured by using phenomenology.

This study aimed to interpret the essence of the midwives experiences, the phenomena, rather than describe the experiences of midwives working in a new midwifery model of care. Hermeneutical phenomenology is an approach that acknowledged and valued the meaning midwives ascribed to their lived-experience (Roberts & Taylor, 2002). Through this process of rigorous understanding and interaction then the phenomenon under study can be uncovered (Speziale & Carpenter, 2007). Therefore, hermeneutical phenomenology was a suitable framework and methodology for this study as

midwifery questions are often unable to be addressed by purely traditional scientific methods.

The explanation for the methodology chosen for the study includes a discussion of the philosophical underpinnings of phenomenology including the phenomenological movement and the philosophical basis as its paradigm (Spiegelberg, 1982). An overview is provided of Husserl and his student Heidegger (1889-1976), Heidegger later became a leader in hermeneutic phenomenology and was considered a pioneer of phenomenology. The work of these philosophers and the ideas of Hans Georg Gadamer (born 1900) a leading philosopher in phenomenological thought and a student of Heidegger is explored in relation to the development of phenomenology and its relevance to this research. Finally, the difficulties that may present with the chosen topics such as sampling, participants, data collection, data analysis and human rights are also addressed.

METHODOLOGY

Midwifery appears be best suited to qualitative research because this approach enables midwives to reflect on midwifery practices and women's personal, social and cultural needs and experiences. Qualitative research offers the opportunity to focus on finding answers to questions that are centred on social experiences, such as, how it is created and how does it give meaning to human life (Denzin & Lincoln, 1994). Knowing how social experiences construct an individual's reality is important for the development of science, therefore in this context an exploration of ways of knowing is appropriate (Speziale & Streubert, 2007) Therefore, if the

ontological (assumption about the nature of reality) position is that reality is apprehensible, then the positivist framework becomes the reference point. Studies undertaken in a positivistic way provide helpful information however they do not explore or portray the experiences of people as they encounter various phenomena (Speziale Streubert, & Carpenter, 2007).

Phenomenology, a word derived from the Greek word *phenomenon* is described by Ray (1994) as to *show itself.* Holloway and Wheeler (2002) suggest that Phenomenology refers to the Greek word *phainomenon* meaning 'appearance' and the essence of phenomenology is reflected by this notion. In research, the core of experience can be uncovered through phenomenology. Thus, phenomenology can determine the *essence* of an event or phenomena. For instance, phenomenology is the most worthwhile approach to discover what it means to experience the loss of a baby, or what is the essence of caring for a woman in labour or how does it feel to practise midwifery in a different way.

Historical Development of Phenomenology

The phenomenological movement has a long history which began around the first decade of the 20th century and as such has been divided into three phases: the preparatory, the German and the French. Hence, there exist philosophical differences between the phases which in turn lead to difficulties in accurately defining and outlining phenomenology (Mezquita, 1994; Ray, 1994). For example, the philosophic underpinnings of phenomenology are influenced by the different philosophers who have different interpretations of phenomenology during these three phases.

The philosopher Kant (1724-1804) helped create a foundation for phenomenology to distinguish between two forms of reality. Firstly, phenomenal reality or the appearance of things as they are perceived, conceived, interpreted, thought of and secondly, noumenal reality or *things in themselves*, (Stumpf, 1994). Phenomenologists studied the perceivable world at a time that the noumenal world was thought to be inaccessible (Fitzgerald, 1995). Phenomenologists believed the instant a human being observed, or engaged with an event or object it becomes a *phenomenon*. Kant opened discussion about human rationality and is also attributed with questioning the very fundamental nature of reality as seen through a Cartesian lens. Cartesian thinking involves a scientific binary position that involves learning, which by nature is rational and abstract and it has been challenged by new approaches, particularly in the human sciences (Kant). New phenomenological perspectives include feminist, humanistic and critical theory (Fitzgerald, 1999; Speziale Streubert & Carpenter 2007).

The preparatory phase followed this initial phase and sought to answer questions that religion could not provide (Brentano 1838-1917; Stumpf, 1848-1936) and the primary focus during this time was to seek clarification of a concept. Speziale and Carpenter (2007) described this as intentional means whereby consciousness is always foremost. Moreover, Speziale and Carpenter examined Merleau-Ponty explanation that interior perception is possible without exterior perception and that it is anticipated that the world and the phenomenon are connected in the consciousness of unity, enabling a way for realisation of oneself in consciousness (Speziale Streubert & Carpenter). Since the time of Descartes (1596-1650) and

the period that is called *Enlightenment,* however traditional scientific views have

dominated the Western world (Fitzgerald, 1995). *Enlightenment* was a time when

knowledge was separated from religion. Furthermore, it was thought that it was

possible for the human dimensions of life together with the natural world to be

examined by humankind without referring to religiosity (Stumpf, 1994). Stumpf also

argued that knowledge could be found through a rigorous method of detached

scientific observation (1994).

Philosophy blends the disciplines of epistemology 'how do we know?' and

ontology 'what is being' (Cohen & Omery, 1994). Within the roots of

phenomenology the ideas of epistemology and ontology were important to Husserl

and Heidegger as well as the transcendental and eidetic (descriptive) and

hermeneutic (interpretive) ideologies (Cohen, 1987; Cohen & Omery).

The German phase of phenomenology was dominated by Husserl (1859-1938)

and Heidegger (1889-1976). According to Holloway and Wheeler (2002) Husserl's

contribution to the movement was his search for rigour and his criticism of

positivism (all knowledge is derived from the senses and linked to inquiry of

experiment and observation). Further, Husserl developed phenomenology

because at the time he was concerned about the direction of philosophy and that

after Descartes all philosophy had taken a scientific worldview as the starting point

that is different to a subjective experience (Benner, 1994).

Husserl's primary philosophical focus was on the nature and origin of all

knowledge (Mezquita, 1994). Mezquita suggested that phenomena cannot be

separated from the *experience* itself and that the way to understand phenomena would be through descriptions by those experiencing the phenomena (Ray, 1994). Husserl defined this as "being of the world" (Ray, p. 120) and outlined three key components to this approach that are pivotal within nursing research. The components are known as essences, intuiting and phenomenological reduction or bracketing.

Essences represent the basic units of common understanding of any phenomenon and Husserlian phenomenology emerged as a search for the philosophical foundations of logic but evolved into the study of the logical structures of consciousness (Husserl, 1964). For instance, Speziale and Carpenter (2007) describe essences as elements that are related to the true or ideal meaning of something and essences are those concepts that give a common understanding to the phenomenon that is being investigated. Moreover, Speziale and Carpenter claim that essences emerge in both isolation and in relationship to one another; therefore essences embody the basic units of common understanding of any phenomenon. Thus, phenomenological reduction enables pure "seeing" of the essence of the phenomenon (Husserl, 1964).

Intuiting is an accurate interpretation or eidetic comprehension of what is meant in the description of the phenomenon that is being studied (Husserl, 1982; Spiegelberg, 1965). Speziale and Carpenter (2007) describe this as being the process in phenomenological research that results in a common understanding about the phenomena being studied. Husserl wanted 'Transcendental Phenomenology' to gain acceptance as a science that was rigorous, this three

step approach contained *Anschanng,* a term used to describe looking at phenomena, being conscious of that phenomena, and intentionality involving *bracketing* or separating one's own beliefs and experiences.

For example, intuiting, in the phenomenological sense, would require the researcher to imaginatively vary the data until a common understanding about the phenomena emerges. Phenomenological reduction and bracketing are perceived as necessary for rigorous foundations in research (Paley, 1997). Reduction or bracketing enables researchers to put on hold every assumption that is normally made including logical and common sense beliefs that they may have.

Intentionality is having a clear intention to observe phenomena with as pure a mind a possible and *bracketing out* is removing from observation ones own preconceived thinking or ideas (Cohen & Omery, 1994). Bracketing or intentionality facilitates conscious recognition to be achieved and therefore a pure description or the essence of a phenomenon to be explored. Thus, researchers examine their attitudes, prejudices and beliefs to bracket these out and, in a sense, remove them from influencing the research. Husserl strived for discovering the truth that was unique and that would not be bound by a time or place or an individual (1964). Additionally, Husserl believed that to do this one chose to suspend natural attitude and open his consciousness to an innocent mind-state or naivety, he believed that the essence of phenomena could be clearly felt and seen and that it was free from cultural chaos (Husserl, 1964).

Furthermore, Husserl proposed that essences evolved when moving beyond

individual cases or ideal types of logical experiences and intuiting or logical insight

was based on careful consideration facilitated by deconstruction and then

reconstruction of previous ideas (Mezquita, 1994; Paley, 1997; Ray, 1994).

Bracketing and phenomenological reduction are important features of

phenomenological method and the actual 'doing' of Husserlian phenomenology.

The complex nature of bracketing has been debated widely by people such as

Crotty (1996) and Paley (1997). Husserl used the combination of

phenomenological intuiting, bracketing and awareness of the intentionality of

consciousness and then meditated on the phenomenon. This he termed

transcendental subjectivity, whereby transcendental thoughts could be understood

as conferring meaning via the knowing self or ego, reflecting on itself (Ray, 1994).

Husserl later referred to this as phenomenological reduction that had a

methodological element to it that appeared to align with the way research is

comprehended (Cohen & Omery, 1994). Moreover, Husserl preferred the

researcher to be removed from the research to observe the phenomenon properly

and eliminate preconceived ideas. Furthermore, Husserl had wanted his student,

Heidegger, to build on his work in phenomenology, however, Heidegger chose to

transform Husserl's work and rejected many of the philosophical underpinnings of

Husserl.

Thus unlike Husserl's work, Heidegger's philosophical focus was concerned with

the meaning of *being* (presence in the world) (Cohen & Omery, 1994). Heidegger

referred to the way human beings existed, acted or were involved in their world

(van Manen, 1990). Two new concepts emerged from Heidegger's work, inter-subjectivity and life-world, relationships and presuppositions were viewed as necessary to understanding (Mezquita, 1994; Ray, 1994) and by recognising the role of historical influences, experiences could be understood in a new way (Ray, 1994). This is contrary to Husserl's theory as Heidegger described the life-*world* as a world of everyday experiences that are often not noticed unless they are specifically examined. Moreover, this concept is now central to current phenomenological tradition (Cohen & Omery, 1994; Mezquita, 1994).

This is discussed in depth by Dowling (2005) who described the work of Heidegger as exploring the lived experience and advocated hermeneutics as a research method that was clearly grounded on the ontological view that the interpretive process is the experience. The ontological view being that of the assumption about the nature of reality and hermeneutic phenomenology is designed to unveil concealed meanings in the phenomena (Spiegelberg, 1982).

Furthermore, Gadamer (1976) elaborated by noting that hermeneutics bridges a gap between what is unfamiliar and what is familiar in our worlds. Gadamer, a student of Heidegger, was a crucial figure in the further development of philosophical hermeneutics and extended Heidegger's existential ontological exploration of understanding.

During the Second World War phenomenology moved from Germany to France. The French phase of the phenomenology movement was influenced by psychology and psychiatry and the key figures were Sartre (1905-1980), Merleau-

Ponty (1908-1961) and Marcel (1889-1973). Sadala and Adorno (2002) supported Merleau-Ponty's view that 'each body' has its own structures while selecting ways to adapt, which are never repeated either with itself or others or at other moments or places.

Ricoeur, another key figure in the French phase, had a focus on the inter-subjective, as well as the issues of communication and language (Holloway & Wheeler, 2002). Merleau-Ponty (1905-1980) articulates phenomenology as an existential mode of being that is experienced through the body, the aim of which is to focus on achieving a direct and primitive contact with the world as it is experienced immediately. Additionally, these ideas informed the work of van Manen who believed that life world existence can be differentiated, not separated but forming an intricate unity (van Manen, 1990).

Embodiment and being-in-the-World are the primary concepts of this third phase (Spiegelberg, 1982, Cohen, 1987). Embodiment meaning the fundamental awareness of and belief in concepts that are specific and that all acts are constructed on the foundations of perception and the basic awareness of phenomena (Streubert & Carpenter, 1999). Sarte was most influential in the movement during the French phase, his writings and ideas concentrated on articulating the existence and essence, therefore this phase is often quoted as preceding essence (Cohen, 1987).

Nursing and Phenomenology

Midwifery as described in Chapter One has been historically defined by nursing in Australia and still currently is not viewed as a profession in its own right in this country. Therefore, it is important to explore nursing and phenomenology to gain a broader understanding of the approach chosen for this study.

Nurses have aligned themselves with a qualitative approach to research since the 1960's and in the 1970's began to cautiously explored phenomenology as an investigative approach. By the 1980's the use of phenomenology had been wide spread in nursing research (Todres & Wheeler, 2001). In the human sciences such as nursing, phenomenology focuses on the study of things within human existence, this includes valuing the meaning people ascribe to their experience (Roberts & Taylor, 2002). Van Manen a current day phenomenologist describes phenomenological research as the study of lived experience (van Manen, 1990) therefore allowing nurses to explore the lived experience of people involved in nursing practice including whole experiences of any kind (Roberts & Taylor, 2002). Interestingly, phenomenology as an approach is reflective of the views of nursing theorists who stress that understanding patients' perspectives is central to providing individualistic holistic care (Cohen & Omery, 1994; Ray, 1994).

Phenomenology further developed and emerged in nursing research in the 1990's (Beck, 1994) with Cohen and Omery (1994) highlighting the phases and schools associated with the phenomenological movement and the differences between descriptive and interpretative phenomenology (Todres & Wheeler, 2001). Further discussion among qualitative researchers occurred and resulted in exploration of

the traditional European approach and the emergence of an American approach (Caelli, 2000). Caelli perceived that the focus on "know-how, meaning and clinical knowledge" common in nursing research would be explored more effectively in American phenomenology rather than traditional European phenomenology (p. 371).

However, critics of this 'new' American phenomenology emerged. For example, Crotty (1996) asserted that much of the phenomenological research conducted by nurses was not '*pure'* phenomenology as founded by the European philosophers. Crotty described the 'new' phenomenology as subjective, descriptive and lacking critique. Further, Crotty suggested that nurses "dressed" their phenomenological studies in "Heideggarian livery" rather than attempting to apply Heidegger's philosophy to their research (Crotty, p.76). The work of Crotty also included exploring the views of phenomenologists such as Heidegger who contextualises the phenomenon within everyday life activities. Finally, Crotty devised a methodological research process from the core of these combined theoretical positions, which may provide further clarity for nurse researchers (Crotty).

Crotty's view however has been strongly criticised by Giorgi (2000a). Moreover, throughout the literature in the 1990's there was a diverse and critical debate fulminating where there were a number of quite damming critiques of how phenomenological research has been handled (Crotty, 1996; Paley, 1997; Paley, 2005). All the same, a balance may be found in this differencing of opinion, whereby it is possible that nursing as a profession can undertake research that is rigorous (Koch, 2006).

The literature also outlines that it is common practice for nurse researchers such as Koch (1994) and Beck (1994) to adapt tried and tested phenomenological techniques to better align with research questions thereby challenging the credibility of phenomenology (Paley, 2005). For instance, Koch attempted to address the problem of establishing rigour in qualitative research by introducing the concept of decision trails arguing that the trustworthiness of a study can be established if the reader can audit the events, actions and influences of the researcher (1994).

Beck (1994) also addressed the problem of reliability and validity in phenomenological research purporting that reliability and validity are the two areas where the criteria of logical empiricism appear to be imposed on phenomenology as a research method. It cannot therefore be assumed that validity and reliability share the same meaning in phenomenology and logical empiricism.

Further, Guba and Lincoln's (1999) four criteria for rigour in qualitative inquiry, applicability, neutrality, truth-value and consistency are suggested as offering phenomenologists a suitable alternative to the logical positivistic terminology. Therefore, nurse researchers may use such frameworks as these to demonstrate trustworthiness, which would mean methodological soundness and adequacy. For instance, when nurses aim to grasp the essence of the phenomenon under study, they will also demonstrate some understanding of the human condition.

Nursing is frequently described as a caring practice. Therefore, a phenomenological view that incorporates caring, combined with a comprehensive definition of practice, is most suitable to nursing. Furthermore, it allows for description of nurses caring practice from both a patient and nursing perspective (Spichiger, Wallhagen, & Benner, 2005). Nursing practice is viewed as an art as well as a science hence the rationale of phenomenological studies developing in popularity with nurse researchers. It is the nurse that is with the patient or woman and her family, listening to stories, talking to people, assessing physical, psychological and psychosocial needs, and providing holistic care. Morse and Field (1996) described qualitative research as having a powerful effect on practice, policy change and most importantly on humanistic practice therefore strongly supporting the undertaking of phenomenological research in nursing.

Midwifery and Phenomenology

Qualitative studies have the potential to assist midwives more fully understand the context and meaning of similar clinical situations that occur. Cluett and Bluff (2000) explored phenomenological approaches and interpretation in the context of midwifery research. This included a comparison of the philosophy of midwifery as the provision of care based on the physical, social, psychological, emotional, spiritual and educational needs of women. Thus, a phenomenological approach is applicable to midwifery because understanding all aspects of the phenomenon or all aspects of women and care can be explored through phenomenology.

Moreover, as midwives form relationships with women and these relationships may be required to explore the meaning of a phenomenon in midwifery it may be

difficult to ensure some aspects of phenomenology such as reduction or bracketing. Therefore, the challenge is to ensure validity and rigor is maintained including a balance in theoretical perspectives, when moving from pure phenomenology into essential phenomenology and hermeneutics, which will provide a fertile direction for qualitative research in midwifery practice (Todres & Wheeler, 2001).

Additionally, it is important that trustworthiness and credibility are demonstrated, for example, where the participants recognise the meaning that they give to a condition or situation within their own social context they find the 'truth'. Further, the hermeneutic challenge is to reveal what is hidden in the *taken for granted* world of practice, by being in the world places us in context with things, with people, with political tensions and all that is present and absent within our awareness. MacKinnon, McIntyre and Quance, (2005) perceived hermeneutic phenomenology would enable exploration of the everyday experiences that may be invisible or unseen. MacKinnon et al. employed a hermeneutic phenomenological inquiry to study the experiences of the nurses present during childbirth.

Caelli, Downie and Letendre, (2002) also chose a phenomenology to research parents experiences of midwife-managed care following the loss of a baby in a previous pregnancy. Caelli et al. believed this approach reflected the responsive and sensitive nature of research relating to a life-changing event. For example, phenomenology facilitated interpretation of the recipients' experiences and also enabled an understanding to be acquired of what health care providers could do at

the time of the loss. Thus, a phenomenological approach can demonstrate the complexities of midwifery and midwifery practice to be deconstructed and reconstructed without focusing only on the physical nature of the 'lived experience' and are inclusive of the more challenging aspects that encompass holistic care (van Manen, 2001).

The advantages of phenomenological approaches are that they have evolved through the historical phases with influences from theorists and social scientists which enable the nurse or midwife researcher to become open to the structure of the essence of others' experiences of a particular phenomenon (Grbich, 1999). Deconstructing and reconstructing knowledge using a theoretical framework such as hermeneutic phenomenology will provide a methodology that captures the holistic nature of midwifery. Hermeneutic phenomenology acknowledges and places value on the meaning midwives ascribe to lived-experience. Therefore phenomenology is considered a suitable framework and methodology in situations where midwifery topics are unable to be addressed by purely scientific methods (Roberts & Taylor, 2002).

A Heideggerian hermeneutic focus for research is important in particular to the human and caring profession of midwifery, researchers using this perspective can therefore be less focused on conventions such as bracketing preconceptions. Therefore, allowing researchers to uncover the meaning of a phenomenon in ways that are workable and relevant to improving everyday clinical practice. It is as if Heidegger uses a lens to view the world form the inside utilising all the senses, in particular intuition that is most relevant to midwifery practice (Heidegger, 2005).

To gain a picture of the whole essence of the midwives' experience may only be achieved by listening to and understanding the midwives experiences. Therefore, this listening enabled an understanding of the world of midwives who are experiencing a new way of working, one which provides one-to-one midwifery care and continuity of care to women and their families.

Therefore, it is important when undertaking a study that encompasses midwifery, that spirituality as an integral part of midwifery practice is not forgotten within the new age of technology. Reflective practice is vital in midwifery practice and when exploring the holistic nature of midwifery it is critical to embrace a suitable methodological approach and utilise a framework such as that proposed by Walsh and Downe, which may potentially allow these concepts to be explored as a whole (2005).

The researcher's ability to completely bracket personal experiences when describing the phenomena is identified as a possible barrier to this research, and, as it is an important feature of Husserl (descriptive) phenomenology, will not be the approach of choice for this study. Importantly the experience of the researcher will enhance interpretation of data surrounding the phenomenon, fusing together the researcher's beliefs and experiences with those of the participants having the potential to provide a richer data source.

Importantly the hospital ethical research scientific sub-committee (SSC) did request clarification of the role of the researcher and questioned whether this

would limit the information from the participants or limit confidentiality in the practical sense. This was addressed in the response to the SSC (Appendix VI) and is further discussed in ethical considerations.

Hermeneutic phenomenology is an approach that will acknowledge and value the meaning midwives ascribe to their lived-experience (Roberts & Taylor, 2002). Through this process of rigorous understanding and interaction then the phenomenon under study can be uncovered (Speziale & Carpenter, 2007), hermeneutic phenomenology is a suitable framework and methodology for this study as this area of midwifery practice could not be addressed by purely scientific methods.

Sampling

Purposive sampling is the most common method of data generation in phenomenological inquiry and was used for this study. This form of sampling enables those individuals who have actually experienced the phenomenon, the opportunity to share their knowledge on the phenomenon that is under study (Speziale Streubert & Carpenter, 2007). Purposive sampling is defined by Crookes and Davis (1998) as judgemental sampling that encompasses a conscious selection of certain elements or subjects to be undertaken by the researcher for inclusion in a study. Therefore, purposive or purposeful sampling was chosen for this study to enable rich data to be obtained from the participants who were chosen for their personal knowledge, including their knowledge of the phenomenon under study. These informants had special knowledge and experience, such as a particular status or practice (Holloway & Wheeler, 2002). A

small sample size is considered appropriate in qualitative research and the sample

size of 6-8 that was available for this study was considered and appropriate to

allow collection of sufficient rich data (Polit & Beck, 2006).

Participants

The midwives that were recruited into the MGP were purposefully selected for the

data they would be able to provide. Each participant was 'selected' purposefully for

the contribution he or she made toward the emerging theory (Hansen, 2006).

Importantly, the MGP was the only case-load or one-to-one midwifery model being

implemented in a tertiary unit in Queensland, at the time of this study.

Furthermore, the MGP midwives continued to provide care for the women if

complexities developed during the woman's pregnancy and birth in collaboration

with the obstetric medical team.

A total of 7 Midwives were case-loading at the time of this study:

    4 midwives commenced 1st October 2006 (3.8FTE)
    1 midwife commenced mid October 2006 (1.0FTE)
    1 midwife commenced 1st December 2006 (0.8FTE)
    1 midwife the end February 2007 (0.8FTE)

The participant profile table (Figure 1) revealed a range of experience and prior

knowledge of working in a case-load model and was considered when analysing

the data.

The midwives participating in this study were in the age range 30-50 years. There

were no midwives in the 20-30 year age bracket, which is consistent with the

average age of midwives internationally. Prior midwifery experience varied form

one year to twenty two years and importantly only three midwives had prior

experience in a case-load model, one Australian midwife and two midwives from

the UK.

Midwife	Year qualified as a midwife	Previous midwifery experience case-loading yes/no	Fulltime or Days per week	Time working in MGP model prior to data collection
Leanne	1986	No/ pilot team model	Fulltime	10 months
Rosie	1982	No/ pilot team model	Fulltime	10 months
Mary	1995	Yes/ birth centre	Fulltime	9 months
Chloe	1993	No	4 days	10 months
Christina	1986	Yes/ UK model	Fulltime	10 months
Jennifer	2006	No/only as a student midwife	Fulltime	8 months
Rachel	1999	Yes/ UK home birth/community team model	4 days	6 months

Figure 1: Participant Profile

The midwifery unit manager initially approached the midwives from the MGP who

were purposefully selected to participate in this study (Appendix I). If the midwives

were interested in participating then further discussion on the proposed research

was undertaken such as providing the participants with information (Appendix II)

and consent documentation (Appendix III). Consent, when obtained, was

voluntary and at any time the midwife may have withdrawn from the study without

penalty, comment or question. Participation in this study did not impact on the

midwives' position as employees of the Health Service and confidentiality of

personal and study information was maintained and safeguarded. All the midwives

agreed to further discuss the study and following the discussion, were given the

participant information (Appendix II) for review and signed the consent

documentation (Appendix III).

Ethical Considerations

Ethical clearance was required for this study from the organisation and the

Australian Catholic University (ACU); this process involved an application to the

Hospital Research Ethics Committee (HREC) including review by the Scientific

Sub Committee (SSC). A number of questions emerged from the SSC (Appendix

VI). However, the researcher responded to the questions posed by the SSC and

the application progressed to the HREC for approval. Approval by the HREC was

granted on the 26th April 2007 (Appendix IV); following this an application was

submitted to the ACU for ethical clearance, which was granted on 29th June 2007

(Appendix V).The SSC (Appendix VI) questioned the role of the researcher and

whether a management role would limit the information received from the

participants, the response to the SSC was as follows:

> The researcher conducting this study, who is also the Practice
> Development Midwife (PDM), has no line management responsibilities or
> authority to manage the participants. The PDM role is centred on education
> and practice support, therefore the PDM is in a suitable position to
> undertake the data collection because, as described by Speziale and
> Carpenter (2007), the potential to influence what is said in the interview is
> reduced.

In the chosen methodology it was essential that the response to the SSC

contained clarification around the approach chosen for this research. Therefore

the response to the SSC further encompassed the following comprehensive

explanation:

In qualitative research it is often important that the researcher is sensitised to the phenomenon of interest. Without relevant knowledge and experience of the research topic there is a danger that data will be missed due to the naivety of the researcher. This is important throughout the whole process of data collection and analysis and includes the first naïve reading of the text as a whole; formulating thoughts about its meaning for further analysis. The second step is structural analysis in which patterns are identified that can be meaningfully connected. This is referred to as interpretive reading. The third step is the interpretation of the whole and involves reflecting on both the initial reading as well as the interpretive reading to ensure a complete and comprehensive understanding of the findings.

When applying an interpretive phenomenological approach to research it is important that careful examination of the researcher's role is required as well as the data analysis and any ethical issues that may be connected with this type of methodology. Therefore, this will be addressed through the reflective journaling of the researcher's experience during the interviews and data collection (SSC response, appendix VI pg.2).

The interviews were tape recorded and the information then de-identified when transcribed to the word processed document. All participants were given pseudonyms for the purpose of analysis. Any documentation displaying findings with identifying names was kept in a locked cabinet in the researchers' office at the hospital. Only the researcher had access to this information. Any research reports or publications resulting from the study do not have details allowing participants to be personally recognised; pseudonyms were used and all information de-identified.

There was no perceived direct risk to the participants in this study. However, there was some concern that there was the potential that the midwife may become distressed during the interview. For example, the midwife may be affected by having to relay the experience of a woman that had encountered a traumatic event such as domestic violence or an intrauterine death. Therefore, it was explained that if such an incident occurred the midwife would be given the opportunity to turn

off the recorder and make a decision whether to continue with the interview. The midwife would be given the opportunity to attend hospital staff services for support or seek peer support depending on the level of distress.

Although it was unlikely, it was not impossible that a participant might disclose a situation that may be perceived as unsafe practice. This possibility was anticipated and the following arrangements were made. If an issue of perceived unsafe practice was relayed or identified during the interview the researcher would seek peer support from the research supervisor and a clinician. The midwifery unit manager, Ambulatory Services agreed to act in this supervisory capacity if required. Therefore, in the event of an unsafe practice disclosure, which was deemed to be necessary to act upon, it would be managed by a process of peer review, reflection and risk management depending on the event.

Data collection

There is a number of data collection methods associated with qualitative research, however interviews are a proven data collection method in a range of situations including qualitative research projects. The interviewers are able to elicit the views of interviewee's (Hansen, 2006). In qualitative research it is important that the appropriate type of interview is used and that the interview facilitates in-depth understanding of the phenomenon. Hansen (2006) traces the history of interviewing back to the 1920's including the development of semi-structured interviews as a separate and distinct method in the 1960's. Although, it was noted that the majority of social scientific research during this time, used survey or questionnaires and utilised a quantitative method. Qualitative interviewing

emerged in the 1970's and 1980's as a distinct data collection method. In health related research such as nursing and public health studies (Hansen, 2006). For example Hindley, Hinsliff and Thomson (2006) used semi structured interviews to describe the views and experiences of midwives undertaking continuous fetal heart rate monitoring in a group of low risk women. The researchers believed this approach was holistic and, by using an interview tool derived from a literature review, felt that the data would enable a greater understanding of midwifery practice.

When conducting a semi-structured interview the interviewee uses an interview guide with a list of interview questions. However, the questions are open-ended and it is not expected that the same question would be asked at each interview. Additionally, the interviewer is expected to ask further questions to clarify answers given and to be able to diversify and pursue another line of questioning if required. Researchers that utilise semi-structured interviews are likely to interview the participant on several occasions and need to be skilled at building a rapport with the participant, listening and being able to prompt and respond to the interviewee. While maintaining a rapport with the interviewee the interviewer must also maintain the distinct role of interviewer without being dominant or controlling enabling the conversation to flow and be driven by the interviewee Hansen (2006).

The aim of this study was to understand the world of midwives who are experiencing a new way of working and to gain a picture of the whole essence of the experience; therefore, data collection occurred through semi-structured interviews. Interviews were conducted to enable the midwives to tell their 'story'

revealing the essence of their experience, thus enabling a truthful and transparent

interpretation of data. Trigger questions were utilised to generate discussion while

providing flexibility (Hansen, 2006).

Interviews, of approximately 60-90 minutes were conducted in the period from July

to August 2007, at a mutually agreed time and venue. A second interview was not

required to further explore and clarify themes that emerged in the first interview.

The questions utilised for the semi-structured interviews were.

- Can you tell me about your experience working in the Midwifery Group
  Practice?

- Did you feel confident to practise in this new model?

- Can you tell me about the support you needed to work in this way? (Prompt
  if required from midwifery and medical staff)

- How did you feel about case loading in a tertiary environment? (Prompt if
  required: caring for women who had previously undergone a caesarean
  section.)

These trigger questions facilitated the flow of conversation while ensuring the

participants remained focused while re-telling stories.

Further, the researcher completed a reflective journal during the data collection

phase (Smith, 1999). The purpose of the reflective journal was to complement the

data collected by providing an avenue to record non-verbal communication and

align it with statements made by the participants. For example, if the participant

was fidgeting or not providing eye contact this was recorded and aligned with what

was being said at the time. Reflecting on the body language was one method that

was used by the researcher to identify whether a further interview was required in

order to seek clarification. Additionally, the reflective journal provided an audit trail to improve the rigour of the study (Appendix VII). For example, 'Leanne looked really happy, smiling lots when describing her family and how it was working for her'.

Data Analysis

Gadamer's theoretical model, underpinned by the *hermeneutic circle of understanding* as proposed by Heidegger, which is viewed as one between pre-understanding of the phenomena and understanding was the method of data analysis employed for this research (Dowling, 2005; Koch, 1996). Moreover, the rationale for choosing this method is embedded within the description and understanding of Gadamer's theory, a method that is most suited to this research as it enables the researcher (Practice Development Midwife) to become immersed in the research.

The hermeneutical circle is a circle of interpretation that moves forward and then backward beginning at the present and it is never closed or complete. Through this process of rigorous understanding and interaction the phenomenon under study can be uncovered (Speziale & Carpenter, 2007). Gadamer's ontological perspective suggests that an understanding is a mode of being (Koch, 1996). With the idea of Gadamer's hermeneutic circle keeping the dialogue open through questions and interviews allowing conversations that are non-directive and an open approach allowing the participant to take the researcher with them when telling their story (Koch, 1996).

Prejudice was a term Gadamer (1975) used to describe the meaning a judgement

formed before all facts and elements that have created and determined in a

situation have been completely examined. Therefore, prejudice in this context is

not negative but positive in that it is important for a researcher to be aware of their

own prejudice when conducting a phenomenological study (Koch, 1996). The

researcher is an instrument of the research and becomes immersed within the

research and the phenomenon under study; ones own prejudice as such informs

the language that is used when writing (Crist & Tanner, 2003).

History influences an individual's *horizon*, as according to Gadamer (1975),

horizon is a concept associated with understanding. Thus, Gadamer proposes that

horizons are the prejudice of foreknowledge which can be used in disciplines such

as nursing and midwifery. Horizons can expand and be re-examined, which,

according to Gadamer, represents a range of vision that includes everything that

can be seen from a particular vantage point (Gadamer; 1975; Koch, 1996). This is

described by Gadamer as a 'fusion of horizons', the prior knowledge or historical

horizon and the present new knowledge, therefore this prior and new knowledge

merge together and an understanding of the experience develops (Gadamer,

1975).

It was important that the researcher develop a rapport with the midwives and the

power base was as equal as possible. Rapport building involved sharing

experiences of working in this way and the creation of a context of intimacy. The

experience of the researcher enabled a greater ability to interpret the

phenomenon, fusing together the researcher's beliefs and experiences and also

that of the participants, thus providing a richer data source. Furthermore, it was

acknowledged that to ensure the power base was equal between the interviewer

and the interviewee would be challenging and required significant thought and

planning prior to the interview. Thus, the researcher approached the interviews

from a partnership perspective, involving the participants in all aspects including,

time schedule, venue and environment. The participants chose the venue for the

interviews; this included the MGP room, gardens outside the community antenatal

clinic and a coffee lounge, therefore determining the environment. A context of

intimacy and equal power base was further achieved by engaging with the

participants as midwives in a supportive and collegial manner, sharing

experiences and stories prior to and during the interview process.

This hermeneutic phenomenological study followed Gadamer's approach and the

hermeneutical circle, enabling through a process of rigorous understanding and

interaction, the phenomenon under study to be uncovered (Speziale & Carpenter,

2007). Moreover, the essence of the phenomena, the midwives' experiences

pioneering a new midwifery model of care in a tertiary unit, was uncovered.

Additionally, this enabled interpretation and the true meaning of what it is to be a

midwife 'Being-with' the woman they are caring for in a midwifery model, that

provides one-to-one midwifery care and for the researcher to become immersed in

the research.

The researcher was immersed in the data whereupon after transcribing the data it

was read and reflected on to assist with identifying categories and themes. This

process allowed a highly fluid process until a point of data saturation was reached

(Hansen, 2006). During this process of analysis if a new theme was identified, then a second interview was planned to achieve data saturation. However, no further themes were identified, so no second interviews were conducted.

Collecting and transcribing data and, importantly, reading and reflecting on data, are an essential part of this method of analysis and was completed by the researcher to enable familiarity and allow expansion and connection between different aspects of the data (Gadamer, 1960/1998). Therefore, it is important to reflect at this point on the writings of Gadamer, who wrote, that questioning was an essential aspect of the interpretive process as it helps make new horizons and understandings possible:

> Understanding is always more than merely re-creating someone else's meaning. Questioning opens up possibilities of meaning, and thus what is meaningful passes into one's own thinking on the subject. To reach an understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were. (1960/1998, pg. 375)

Three main steps for analysis of data are described by Speziale and Carpenter (2007), these are first the naive reading of the text as a whole formulating thoughts about its meaning for further analysis. The second step being structural analysis and identifying patterns that can be meaningfully connected, this is referred to as interpretive reading. The third step is the interpretation of the whole and involves reflecting on both the initial reading as well as the interpretive reading to ensure a complete and comprehensive understanding of the findings. When applying an interpretive phenomenological approach to research it is important that careful examination of the researcher's role is required as well as the data analysis and any ethical issues identified that may be connected with this type of methodology.

Therefore, this was addressed through the reflective journaling of the researcher's experience during the interviews and data collection. In accordance with the qualitative tradition of credibility, as opposed to the quantitative traditions of validity and reliability it was necessary to keep a reflective journal during the data collection period. The journaling was also used to reflect and provide an additional data source to ensure transparency and truth are maintained.

Research rigour

Rigor and overall success of a phenomenological study may be improved by utilising strategies such as purposive sampling, respondent validation, transparency of the method analysis by the researcher and triangulation (Hansen, 2006). As such purposeful sampling was the chosen technique for this study. While the sample was small, each participant 'had been selected' purposefully for the contribution he or she could make toward the emerging theory. It was this selecting that ensures that the theory is comprehensive, complete, saturated and accounts for negative cases.

Overall, the results can be described as a road map that helps the clinician comprehend the social settings, relationships with clients and families, as well as develop theoretical constructs for further exploration (Kennedy & Lowe, 2001). Roberts and Taylor (2002) suggest that midwives and nurses are 'thinking workers' engaged in a job which requires them to ask questions and discover 'trustworthy knowledge' since the answer is fundamental to the profession (p.307).

While purposeful sampling in itself does not confer rigour it does enhance credibility (Hansen, 2006).

Rigour can also be enhanced through the utilisation of theories to enhance data collection and data analysis processes. Gadamer's hermeneutical circle approach was relevant to this research as it assisted with informing data collection and analysis through the guiding nature of the theoretical perspective (Speziale & Carpenter, 2007). The hermeneutic circle kept the dialogue open through the questions and interviews with the midwives, allowing conversations that were non-directive and an open approach allowing the participant to take the researcher with them when telling their story. Koch (1995) stated,

> Hermeneutics invites participants into an ongoing conversation, but does not provide a set methodology. Understanding occurs through a fusion of horizons, which is dialectic between the pre-understandings of the research process, the interpretive framework and the sources of information (p.835).

Following the French phase there were a number of philosophical minded social scientists, including Giorgi (1970) and van Manen (1990), whom it was proposed misused methodological concepts resulting in a continuing lack of rigor (Giorgi, 2000a, 2000b; Paley, 1997). Thus, Grbich (1999) proposed that it is essential for researchers to avoid reducing the techniques and principles surrounding phenomenological traditions derived from the works of Husserl, Sartre, Merleau-Ponty and Heidegger. Therefore, this research followed Gadamer's approach and the traditional theoretical underpinnings to ensure the trustworthiness and rigor of the study.

A researcher who has experienced midwifery practice in this way can listen to the

midwives stories without judgement and would have the insight to encourage the

flow of conversation. An experienced midwife would have the experience to be

able to reveal and interpret the meaning of those stories; this is part of the inter-

subjectivity and the role of a researcher in Heideggerian research.

Additionally, a technique utilised in this study to ensure trustworthiness of data

was researcher reflexivity and completion of a reflective journal. As previously

mentioned a reflective journal was kept to aide transparency but the reflective

journaling also provided an audit trail, therefore enhancing the rigour of the study

(Smith, 1999).

CONCLUSION

Phenomenology is a process involving rigorous understanding and interaction to

enable the phenomenon being explored to be uncovered (Speziale & Carpenter,

2007). Furthermore, hermeneutical phenomenology was a suitable framework

and methodology for this study as midwifery issues are often unable to be

addressed by purely scientific methods. Additionally, hermeneutics is grounded on

the ontological view that the interpretive process is the experience. Thus, unlike

descriptive phenomenology undertaken by Husserl, Heidegger's philosophical

focus is concerned with the meaning of *Being* or *having a presence in the world*

(Cohen & Omery, 1994).

Heidegger perceives that the essence to understanding people or situations is in

exploring the way human beings existed, acted or were involved in their world (van

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Manen, 1990). The researchers' ability to completely bracket personal experiences when interpreting the phenomena was identified as a possible barrier to this research. However, the experience of the researcher did enhance interpretation of data surrounding the phenomenon. Thus, by fusing together the researcher's beliefs and experiences together with those of the participants, had the potential to provide a richer data source.

Therefore, through phenomenology this study aimed to interpret the essence of the experience of midwives pioneering a new model of midwifery care (the phenomena), rather than describe the experience. Furthermore, this study aimed to understand the perceptions of midwives undertaking a new role and exploring what it was to be a midwife 'being-with' the woman and providing a one-on-one approach to care which is afforded through adopting this model. The philosophical notion was reflected on in this study, in that the midwives experiences were intricate and unified as one in the everyday lived experience of their midwifery practice.

The study explored the experience of midwives who had been involved in pioneering a new model of midwifery care. Moreover, the experience of midwives working in a case-load midwifery model such as a MGP has been identified as a significant gap in Australian research literature. The data obtained from this study may be used to inform the overall evaluation of the model of care and furthermore, identify any gaps in implementation. For example, during an interview a midwife might describe a case where no support was available in the clinical environment. If a theme was identified where there was insufficient support in a clinical area this

information could be used to inform practices and enable improvements to be made to the service. The presentation of the data and the subsequent analysis is now presented in Chapter four.

CHAPTER FOUR
PRESENTATION OF DATA AND ANALYSIS OF FINDINGS

INTRODUCTION

This chapter presents the findings of the phenomenological study into a Midwifery
Group Practice (MGP) model of care, which is outlined in Chapter Three.

Adopting Gadamer's approach to facilitate the emergence of themes resulted in a
circle of understanding of the midwives' experience of pioneering a new model of
midwifery care. Thus, themes and sub themes were constructed and are
presented in this chapter. The title for each of the themes reflects the essence of
the participants' experiences that emerged from the data. Exploration and
synthesis of the participants' dialogue enabled the emergence of the themes. Each
theme was a continuum of the chosen theoretical process and it was during
interpretation and reflection that sub themes evolved. The sub themes are also
represented in diagrams, which are intended to illustrate and aid understanding of
the participants' experiences.

Mutual Respect is the theme that encompasses the sub themes named:
W*elcoming, Whole of Organisational Support* and *Trust.* Mutual Respect is
illustrated diagrammatically in Figure 2 to demonstrate how the sub themes
effectively funnel together and are reflective of how purposeful, committed and
focused the participants were to the MGP. These sub themes clearly demonstrate
the participants' determination to make the MGP work, thus an *Economically
Responsive and Responsible Midwife* is constructed from the participants'
descriptions. Revealing, how the midwives valued and maintained the

responsibility for budget integrity and maintenance of the day to day management of the MGP practice.

Moreover, from the day to day management, organisational support and the trust embedded within the theme Mutual Respect, a further theme that is termed, The Midwives' Journey emerged. The Midwives' Journey is essentially the emotion and conceptional journey the midwives' experienced pioneering the new MGP. This theme consists of a group of sub themes: *Emotive Expressions, Transitional Adaptation* and A*daptation to a 'Thinking Worker'*, which essentially reflect how the midwives' were feeling emotionally during their experience. The diagrammatic illustration Figure 3, termed The Midwives' Journey, further demonstrates how the sub themes were integrated and intrinsically connected throughout their experience.

Inherent to the themes Mutual Respect and The Midwives Journey is the theme, Professional Fulfilment, this theme emerged from the significant dialogue that the participants articulated throughout the period of interviews and data collection. Professional Fulfilment encompasses the midwives' experiences during this time of adjustment to the new way of working and reveals the essential components that contributed to the professional growth that the midwives experienced. The thematic diagram, Figure 4 illustrates these essential components that collectively formulate the theme Professional Fulfilment. These are the sub themes of: *Experiences, Knowledge, Capable, Knowing, Transparency, Safe spaces, Respect, Control, Confident and Professionally Fulfilled.*

Midwives and Women Together is the final theme with sub themes that emerged

and encompassed the midwives experience of working in a new model of

antenatal care. Midwives and Women Together, illustrates how significant

passages of dialogue connect in a circle that is meaningful to the midwives.

Prejudice is a judgment formed before all elements and facts in a situation have

been completely examined, explored and reflected upon (Gadamer, 1975). This is

significant when interpreting the data in this theme and the sub themes, as

historically midwives have not previously utilised a group antenatal model of care.

The sub themes that evolved following this period of interpretation are *Women and*

Sharing and consist of significant words and phrases that emerged during this

period of dialogue and interviews with the participants. The terms adopted to

describe and illustrate the themes are reflected upon during the presentation of the

data in this chapter, which commences with Mutual Respect.

MUTUAL RESPECT

Mutual Respect is meaningful as it is reflective of how purposeful, committed and

focused the participants were to the MGP and to the success of the

implementation of a new model of care. Moving forward and backward throughout

the interpretation of the data revealed factors that the participants perceived were

needed to pioneer and sustain the model. The foreknowledge and history of the

midwives practice and experiences merged together with new experiences,

enabling interpretation and understanding of the theme and the sub themes that

emerged. Moreover, the diagrammatic illustration Mutual Respect (Figure 2)

demonstrates how the three important sub themes integrate, and flow through a

funnel. Therefore, this enabled the midwives inherent ability to be economically

responsive and responsible to be constructed from the description of their experiences. The meaning of these sub themes are interpreted and further explored below to enable understanding of the midwives experiences.
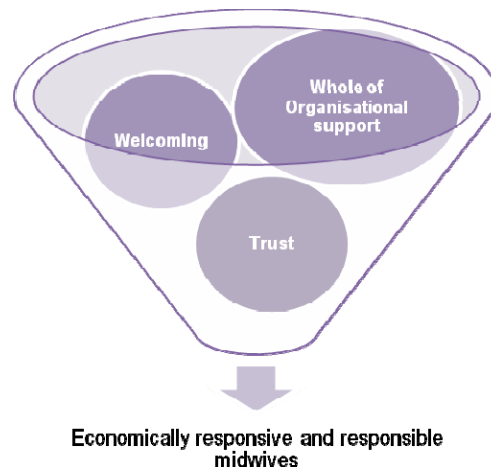

Figure 2: Mutual Respect

Whole of organisational support

Data revealed that all of the participants identified that *Whole of Organisational Support* was a key element to the success of the model. For example, support from midwifery colleagues in the group practice and the feeling of belonging to a group thus, not practicing in isolation was significant. For instance, Mary described the feeling of isolation that she had previously experienced when working in a case-load model at another organisation. During the interview Mary explained how she'd felt alone and supported in her practice and by her colleagues. The following quote represents Mary's perception of her experiences:

> Definitely huge benefits in terms of case-loading but not been isolated, but there's a real sense as having worked, as I have said I worked as a case loading midwife in a variety of other settings and this is by far the nicest way look incredibly rewarding it's um, oh how would I sum it up? I do believe the midwifery group practice is………I do think the model of care that we're working with works and I think it works beautifully.

Also evident in the data was the fact that the midwives perceived there were

partnerships that had formed between colleagues throughout the organisation as a

direct result of the framework used to implement the model (appendix VIII). For

instance, Chloe who had practised as a midwife for a number of years in other

Australian maternity facilities declared that, "this is a partnership model; it's not a

hierarchy system that I have worked in before". Further, all participants believed

that gaining support from the whole organisation was paramount to the ongoing

success of the model and for the (future) sustainability of the model. For example,

Chloe claimed, "definite number one is to get the support from everyone, so

without the support from everyone within a health care facility it's not going to

work" and,

> We have the support from the obstetric team, we have the support from the
> education department like you and you know we have the manager……..
> That you know everybody knows what we're doing and everybody's
> involved in some stage so that um, so it's not just a little elite group who
> work by themselves.

These assertions clearly demonstrate the need for practice development support

in particular, from midwives that have previously experienced the challenges of

implementing new models of midwifery care. From my own experience, pioneering

a new midwifery model of care within a maternity healthcare environment that

historically does not foster a culture of change and innovation in practice, presents

challenges to those endeavouring to affect changes. I had reflected on my own

experiences during this phase of the study and written these thoughts in my

reflective journal:

> 2000-2002 I worked in a great new model of care that provided continuity,
> midwifery colleagues and management did not understand or support us in
> our model… no frameworks, no structure and management dismantled the

model, we ended up working shifts not on call for the women. The midwives who worked in the unit, not the model, thought we were enjoying our work too much. They, the unit midwives, decided we needed to work some eight hour shifts on the ward, not on call. Come in and see how hard they worked … didn't care what the women wanted or us, just that we were enjoying our work too much! Never understood that....

Experiences prior to the commencement of the MGP were inherent with how the midwives felt during their experience. For example, Rachel described her experience as "I don't feel as if I have been managed from above" and Mary claimed, "I have the support of my colleagues and we've all been working together and also where we are because we're all happy, we are all happy to be employees of the hospital none of us are fighting the establishment".

Welcoming

Integral to organisational support was the sense that the midwives involved in the group practice were made to feel welcome, thus the sub theme *Welcoming*. Feeling welcome was important as I had participated in the recruitment process which involved some of the participants having to relocate. Five of the midwives in the group practice were recruited from overseas or another maternity facility in the State, The feeling of being welcome was expressed by all five midwives such as Chloe who commented, "I feel I'm a part of wherever I go and work I feel very welcome". Furthermore, Christina said,

> I don't know what happened in the interview process but any way you managed to get us all to click and work well together (laugh). So it's worked really well even for like new people coming in, its been quite good. I mean that's our experience from our team anyway.

However, during the interviews when the midwives described the feeling of being made to feel 'welcome' they were assertive in their dialogue. Although this may

appear insignificant when exploring a new model of midwifery care, it was apparent throughout the interviews that all the participants thought differently. Data collected illustrates that these midwives demonstrated an ease with their relationship with each other that could be described as a 'kinship'. Moreover, all the participants identified feeling welcome as a significant dynamic that augmented and increased the positive nature of their experience.

For example, Jennifer who had recently relocated from overseas felt strongly about being made to feel welcome and stated "people have been very helpful when I have asked". The significance of feeling welcome for these midwives facilitated a sense of being wanted and therefore enabled them to be comfortable pioneering a new model of midwifery care.

Trust

All participants expressed that being trusted was significant to their experience in the MGP, therefore the sub theme *Trust* is revealed. Moreover, three of the midwives described a time in their career when they perceived there was a significant lack of trust from both colleagues and the organisation which impacted on their experience.

The following comment by Leanne is reflective of the participants' perceptions of trust, "it was great to feel that we were so trusted and had such a responsibility to set up and make something work". Furthermore, Christina commented,

> I mean that's got better as well as people have grown to know us and
> perhaps trust us a bit more you know, um right from you know Doctor J.,

who is more familiar with us now. You know we feel comfortable going to him I'm sure he feels more comfortable talking to us and discussing things, I do feel you know that the trust has built up you know um you know it feels quiet comfortable with the way that we are caring for women.

From my own experience, a trusting relationship that included positive interactions between midwives and the medical staff has the potential to reduce the risk of adverse events. Therefore, improved outcomes for women and their families were key possibilities. My journal reflection supports this:

> Working in the team model in 2002 I called in a paediatrician for a baby who was born early at 34weeks, no support on site and I had to phone this doctor who 'told me off' for calling her late in the evening! Told me to get the emergency doctor, he was scared and just watched as I resuscitated the baby.. No supportive process in place for unanticipated events and so rude, didn't even get to debrief!

Additionally, having a pre-understanding of the need for *Trust* from within an organisation was significant during data analysis. For instance, the prior knowledge and historical horizons that I have experienced when working in a management role, including that of reviews such as the Review of Maternity Services in Queensland (Hirst, 2005) facilitated an understanding of the experiences of the midwives. Importantly from my own experience, having the confidence and avenue to discuss, consult, plan and refer cases in a supportive environment could reduce risk. This experience, fused together with that of the participants, provides a richer data source. Having the confidence and avenue to discuss is also illuminated within my reflective journal writings:

> I feel like a member of the team, as a Practice Development Midwife I work with the Medical Director, he fosters respect, invites me to present at medical education sessions, not segregated, midwifery/medical, trusting and working together in a practical way. Different from the previous hospital I worked, the Medical Director there told all new doctors never to trust the midwives! I really wanted to leave I felt unsafe as a midwife…

Mutual Respect involves a process of evolving assimilation of the sub themes

whereby the concept *Economically Responsive and Responsible Midwives*

emerges. Thus, participants who perceive they have *Whole of Organisational*

Support, feel *Welcomed* and trusted within their work environment are

Economically Responsive and Responsible when pioneering a new model of care.

Meaning, the midwives consciously endeavoured to monitor and be mindful over

time management and the cost of resources. Essentially, the following comment

by Mary demonstrates the meaning of this sub theme, "I really wanted to make

sure that we were working within a budget' and we were economically managing

the group practice".

Reflective journal entry:

> Why is this so important to Mary? Her facial expressions are intense,
> determined, she moves to the edge of her chair and leans her elbows on
> the table, I wonder what experiences have influenced Mary to feel so
> strongly… Has something happened, did management use the budget to
> impact change in her last position? Something happened for Mary to feel so
> strongly, not sure what.

Reflecting further on the data revealed that Leanne also stated this strongly also,

"it was great to feel that we were so trusted and had such a responsibility to set up

the model and make something work".

With further in depth interpretation of the significant passages of dialogue within

the theme The Midwives' Journey, the following sub themes emerged, *Emotive*

Expressions , Transitional Adaptation and Adaptation to being a 'Thinking Worker'.

These are now explored further.

THE MIDWIVES' JOURNEY

The theme The Midwives' Journey and the sub themes that emerged are

illustrated in Figure 3. This figure illustrates how the participants explained and

described emotions that they experienced during the transition and adaptation to

working in the group practice. For example, the midwives perceived that they

functioned more autonomously, Rachel said, 'I am enjoying the time management

that way I can sort my own time out and have a couple of easy days but then have

some hectic days …. So I'm enjoying the on-calls I don't see them a problem

really". Moreover, Mary stated that it enabled "a professional transparency in

practice and therefore we were being accountable for our practice".
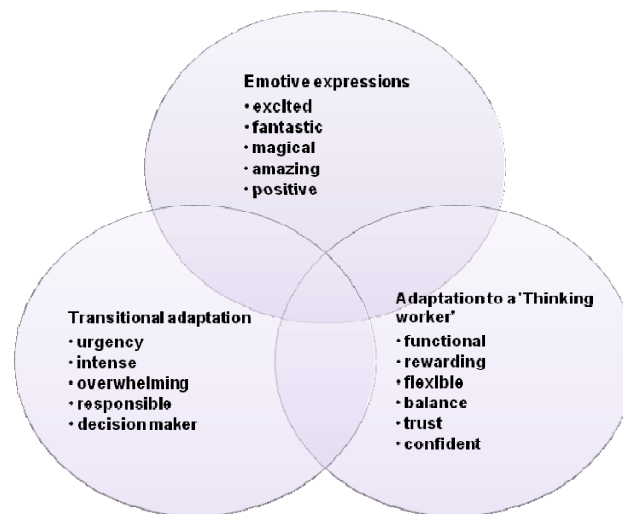

Figure 3: The Midwives' Journey

In general the participants evolved and developed the MGP as clinicians and

women. As Figure 3 displays, the Journey of the participants illuminated an

interweaving of *Emotive Expressions, Transitional Adaptation* and *Adaptation to*

being a 'Thinking Worker'. This enabled an understanding of the participants'

conceptual experience, including the new way of working in a MGP.

The midwives' experiences in the MGP necessitated them having to think and

analyse the decisions that had to be made within their own practice. Chloe stated,

> It's hard for me to explain but it's that everybody has their knowledge and
> we're actually putting our heads together and it's validated by everyone you
> know, everybody is quiet comfortable speaking from their heart and sharing
> their knowledge.

Through interpretation by moving forward and backward through the significant

passages of dialogue within the theme and sub themes the term '*Adaptation to a*

Thinking Worker' emerged. Meaning, that when the midwives were functioning in

an autonomous case-load model they had the ability to plan, think critically and

make decisions rather than taking direction from a medical officer. This way of

functioning was viewed positively by the midwives as opposed to previous

encounters with the biomedical model whereby the midwives were directed and

felt submissive. The following comment by Leanne supports this view "there's a

respect for the fact that we are responsible professionals and that we are doing

what were meant to do".

Interacting and becoming immersed in the participant's dialogue enabled details

surrounding their previous experiences to emerge. For instance, whether they had

previously worked in a case-load model affected their responses and the

importance that they aligned to this concept. Further, the participants' ability to

adapt and develop is affected by emotion which has an inherent link to how they

also adapted to being accountable, a thinker and decision-maker, I labelled this,

'Thinking Worker'.

Emotive Expressions

The first part of the Midwives' Journey is underpinned by emotion thus; this sub

theme is referred to as *'Emotive Expressions'.* The participants expressed their

emotions throughout the interviews in a transparent and meaningful way. For

instance, their past history and knowledge merging together with the new

experience of working in a group practice. Leanne claimed "to sum it up, oh well I

cant do it in one word you know it's been fantastic". Mary had previously felt

isolated when working in a case-load model, however within the MGP she stated,

> Absolutely I'm not isolated, I'm not working on my own I have got
> professional answers to my professional questions and lets face it non of us
> are at our best after working twelve hours you know and um so I can always
> call someone in, just even to come in and take over from me.

The expressions that emerged from the participants' experiences are

characterised by emotion and demonstrated the depth of enthusiasm and passion

the midwives held. For example, the midwives' entering the MGP model had

foreknowledge and expectations as outlined by Chloe who communicated, "I have

always had the dream of being a real midwife as in, looking after women from the

beginning to the end and actually being able to provide them holistic care and

involve families". Additionally , Rosie claimed, " I was looking forward to it and I

was feeling very positive, I have not been disappointed" while Leanne revealed, "I

came into it fairly excited and wanting it, really wanting, it to work".

When reflecting on the interviews it became clear that the midwives who were

recruited from within Australia were particularly enthusiastic and were eager to

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share their feelings and more importantly, how long they had been waiting and looking forward to the introduction of a model of care such as the MGP. This is validated by Leanne previously and further supported by Mary and Chloe's statements, who are midwives recruited from Australia. Mary stated, "I have the support of my colleagues and we've all been working together. Also we are where we are because we're all happy, we are all happy to employees of this hospital. None of us are fighting the establishment". Chloe's enthusiasm was also clearly evident, "all together it's been an amazing experience and I'm so pleased. I think it's turned out to be, the absolutely best job I have ever had in my life". Further, the positive nature of the participants approach to the new model was extraordinary in its intensity and flowed through their Journey (Figure 3).

For instance, Jennifer revealed, "it's definitely a positive experience". Chloe described her experience as, "altogether it's been amazing experience and yeah I'm so pleased that, I think it's turned out to be the absolutely best job I have ever had in my life". Furthermore, Rachel suggested, "it's been really good, really good, as much as I want to go home I don't because this, it's just magical, just to be, I think working with the team is just really good". Finally, Leanne claimed, "it's just been fantastic, so rewarding and I feel so much more fulfilled in my work and I think when I feel that way I'm actually a better person too, I'm happier at home you know".

These *Emotive Expressions* further merged together affecting the *Transition and Adaptation* of how the participants developed and adapted their practice to a new way of working that was more autonomous and required additional knowledge and

skills to be utilised. This sub theme and process of the participants' development

that emerged from the data was termed, *'Transitional Adaptation'*.

Transitional Adaptation

Within the Midwives Journey, the sub theme *Transitional Adaptation* emerged

which describes the meaning and interpretation of adjusting to practicing in this

distinctive and new way. Thus, the participants' experienced a transition from a

biomedical model of working to a holistic/organic model, the MGP. This new

method of practising encompasses case-load midwifery and a group antenatal

model of care. Participants also further described more expansive expressions

and feelings of intensity, urgency, overwhelming. Furthermore, I interpreted these

concepts as being related to the role of decision-maker when caring for women

which reveals what is further termed a '*thinking worker' ,* this is explored later.

Rosie described this as," intense, it is busy, you have to make a lot of decisions

and you make the best decisions you can for those women at that moment."

Additionally, Rosie claimed,

> The difference with this model is you get to know the women, you can um,
> and you get to know them so well you can meet their needs as that evolves
> as part of your practice. Therefore you don't have an urgency to put things
> in place because you know you are going to be there.

Therefore, *Transitional Adaptation* was defined by the participants as the midwives

having more responsibilities, Chloe described her transition to case-loading and

how it impacted on her experience as, "a big case-load as well and it seemed

initially a bit overwhelming." However, the additional responsibility during this

transitional phase was constantly perceived as positive by the midwives and is

evident throughout the data. For example, Chloe stated that "there's a respect for

the fact that we are responsible professionals and that we are doing what we're meant to do". Furthermore, Jennifer simply summarised her adaptation to the model by saying, "I have got a lot more responsibilities". Jennifer described the extra responsibilities as the "whole package", which she describes as the pregnancy, birth and postnatal care, not just focusing on one area of care such as postnatal or birth.

Thus, this transitional phase of adapting to the new way of working in the MGP encompassed the participants emotions, foreknowledge and previous work experience, Furthermore, the participants developed and adapted to being 'thinking worker's' and the final sub theme which emerged is termed *Adaptation to a 'Thinking Worker'* and illustrates the complete experience of the participants' journey.

Adaptation to a 'Thinking Worker'

The essence of this sub theme was best described by Chloe who claimed, "there's a respect for the fact that we are responsible professionals and that we are doing what we're meant to do……….so I think that's important to have that trust". This comment further demonstrates evolving trust and the emergence of what I have referred to as a *'Thinking Worker'.* Inherent to being a '*Thinking Worker'* is the flexibility that is enabling and empowering for the midwives'. For example Rachel stated,

> I am enjoying the time management that way I can sort my own time out and have a couple of easy days but then have some hectic days that are my doing rather than…. So I'm enjoying the on calls I don't see them a problem really.

Rachel described this further as,

> Tuesdays and Thursday are my long days, I make sure that I use them effectively because I know that Emily is usually at nursery…….. but I'm normally in once the kids are having their tea so I make sure that these are my long days and my other days I am around if I'm not called out. So I suppose it's that flexibility of time management plans unless I get called out then it could change but, so it's just, knowing that it is flexible and not thinking that it's rigid.

Further, the participants perceived that the flexibility in their practice allowed them more time with their families in particular working less night shifts and late shifts. Significantly, five of the participants referred to a reduction in the number of nights that they worked now as a case-loading midwife, Rosie describes this as,

> For me its less nights, even though every woman I have had has laboured at night, but it is still less nights, I think because of how many I was doing before, even though I was doing three shifts a week, I mean I was doing three shifts a day, three shifts at night, so I was doing six twelve hour night shifts a month, and for me that was a lot of nights, and I found it exhausting to get over.

Additionally, and most importantly, the participants believed that working as a midwife in a MGP enabled more time to be given to the women for additional support and education. For example, Chloe and Rosie describe this as,

> Chloe: I'm home for dinner almost every night………I'm home much more when my family's home now than I was before, I don't work evening shifts, you can arrange your life around the kids at school and your partner's work with the women your looking after, so its only really birth.

> Rosie: The flexibility works in my favour because I can do things that I need to do for my family when I need to do it, and I can work my home visits and everything around it, um and which is great…… In this model I'm working my own time-table, so if I need to sit with a woman for two hours then I will sit with her for two hours because that two hours is well invested into her future.

Leanne also stated, "I've probably been home more evenings now than I ever was when I was working shift-work and part-time". Christina added that the flexibility

impacted on the care that she provided because she was "able to be flexible in the amount of times you see women um you know just very individualised".

Therefore, the midwives' experience of working in a case-load group practice and the meaning that they ascribed to this was influenced by foreknowledge and prior experiences in other organisations. Moreover, prior knowledge appeared to have a positive impact on their experience in the MGP. For instance, Mary claimed that there were benefits to working in a group practice compared to her previous experiences with case-load practice. Mary explained that where she worked previously as a case-load midwife she only had limited midwifery support and for her practice and no regular support from the other case-load midwives. Therefore, if Mary was unavailable or sick there was no guarantee that the supporting midwife would have met the woman prior to her birth. Additionally Mary did not provide any postnatal home visiting in her previous position, the women attended the Birth Centre if they needed any postnatal care. Mary commented that this MGP model was "the most functional model of care I have worked in, um it's rewarding in terms of having the opportunity to meet the women, being able to guarantee the women that they will have met their carer".

This MGP model was implemented with a clear framework of clinical governance (appendix Vlll). However, within this structure there was also flexibility and trust from the organisation to empower the midwives and enable them to organise their own work in a way that would benefit them as individuals and as a group. Moreover, this method could sustain the model and provide cohesion within the MGP, Chloe statement supports this method, when she revealed that "I think that

was one of the things that have made us so successful for all the seven of us, is

that we have worked it out ourselves". The flexibility and adaptation to a '*Thinking*

Worker' were enabling and empowering for the midwives as further confirmed by

Rachel and Christina, who said,

> Rachel: I think working with people who have the same philosophy, so I completely trust handing my women over, to Christina and Chloe. I'm not bothered if I am on a day off, or I have had four days off and that they're going to look after them…..So I suppose it's that flexibility of time management

And

> Christina: we're built as a team and that you know if you have to do something, then someone can take your call for a couple of hours, if there is something special you want to do, so I think that's been all around us as a team as well you know not feeling guilty about somebody else because you just do it for each other now … so it balances

Following these admissions, I became further immersed and intrigued and

connected to how the participants experienced pioneering this new MGP and

throughout our interactions was more able to reflect and explore the meaningful

dialogue. Furthermore, this facilitated interpretation of a fusion of horizons

whereupon the prior knowledge merged with the present new knowledge and an

understanding of what it means to be a '*Thinking Worker'.* This is demonstrated by

Chloe's statement, when I asked her what would be needed to ensure the success

of further MGP models:

> I think it's important that each group develops their own dynamics. I think we need to be careful once a new group hopefully starts, that we don't tell them, that this is the way you should do things and that they work it out for themselves and the dynamics around how they do things.

Also apparent from the data was the notion that the participants perceived that

working in a model such as the MGP enabled them to practise midwifery in a way

that that met their needs as professional midwives and importantly provided a

quality service for the women.

Additionally, I found the willingness of the participants to share and reflect

throughout the interviews was extremely rewarding as it was fluent and natural.

For example, Christina's perception of how the model was significant for her was

evident by her statement,

> Ah, I just love it and I would never, I don't know, I just would not, unless I
> absolutely had to, I would not want to work in any other way this is how
> midwifery should be you know. Um and it's the care that women deserve all
> women deserve this type of care

Importantly, as demonstrated in The Midwives Journey (Figure 2) *Emotive*

Expressions, Transitional Adaptation and *Adaptation to being a 'Thinking Worker'*

are fundamentally connected. These concepts cannot be considered in isolation

as the meaning and theme are highly related. Additionally, the data demonstrated

that an integral part of the participants' experience of pioneering a new model of

midwifery care, included what is termed The Midwives' Journey. However,

Professional Fulfilment is the theme that includes the culmination of important and

critical dialogue that emerged when the theme was further synthesised and will

now be explored.

PROFESSIONAL FULFILMENT

Professional Fulfilment encompasses a range of concepts that are visions of

everything that the participants perceived from a particular vantage point

(Gadamer, 1976). The sub themes that emerged from this theme indicate that the

participants working in the MGP believed that they had developed professionally

as midwives through utilisation of knowledge and skills. Importantly the language,

'professionally fulfilled' was described by three of the midwives and the other four

midwives described the meaning of Professional Fulfilment, which is important

when viewing an expansion of horizons. Furthermore, I believe this is highly

significant when describing the theme Professional Fulfilment and can best, be

described as beginning with the experience followed by layers of influencing

factors that result in a feeling of being professionally fulfilled. The flow of

experiences that emerge from Professional Fulfilment is interpreted and explored

to enable further understanding and encompasses the midwives' experiences

during this time of adjustment to the new way of working. The essential

components that contributed to the professional growth that the midwives'

experienced are illustrated in Figure 4. These are the sub themes of: *Experiences,*

Knowledge, Capable, Knowing, Transparency, Safe spaces, Respect, Control,

Confident and Professionally Fulfilled.

Experiences

Knowledge

Capable

Knowing

Transparency

Safe spaces

Respect

Control

Confident

Professionally fulfilled

Figure 4: Professional Fulfilment

Surprisingly the data revealed that when the participants embarked on their role as a midwife within the MGP they did not anticipate nor expect to develop professionally or grow in their midwifery knowledge and skills. This claim is supported by the following data. Rosie claimed "I feel that it has added to my professional growth, I like feeling I have got control over the situation and that I am not leaving things to fate or chance". While Jennifer stated "I actually think it's a big learning curve that actually gives you a lot of different experiences… because it's the whole package and the fact that it is through the whole antenatal and postnatal period… so you learn a lot more. I have learnt a lot more". The following examples by Mary and Leanne further support this claim, Mary "I'm not working on my own I have got professional but answers to any professional questions".

> Leanne: I feel that I have developed more professionally and also practically with the longer postnatal period, you know for some of the first time mums and in terms of some of the breast feeding issues and parenting issues they have, so I feel that I have developed professionally.

The data as indicated by Jennifer's statement was that the participants' knowledge increased by exposure to new experiences as well as previous experiences and foreknowledge from working in different environments. It is from these significant passages of dialogue that I was able to interpret that the participants believed it was critical to have an environment that nurtured and encouraged participation. Leanne described this as,

> The people that we work with I think we have such a great respect for each other and we um appreciate each others needs for, in terms how well you do on a night shift for instance and while we can work twelve hours strictly, some of us get more tired while we are doing a twelve hour night and so we respect that and back each other up.

And

It's been really just so rewarding um professionally and personally I think I have grown as a person as well working with women in this way and working so closely with my colleagues um I haven't just made better friendships with them but you know it really has helped.

Additionally, Christine claimed that they had more time available and opportunity to attend to their own professional development and learning, Christina's view was that,

We're built as a team and that you know you can't do something, then someone can take your call for a couple of hours if there is something special you want to do, so I think that's how it's been all around for us as a team. As well you know not feeling guilty about somebody else taking your call because you just do it for each other so it balances it.

Further, the participants stated that an important factor that contributed to their professional growth was to have a safe space for discussion, reflection and learning. During the interviews the participants reinforced the importance of having time to reflect and learn. In particular, this was identified by the participants as being achieved by having a weekly case management discussion with peers such as midwifery and medical staff. Of significance, this was supported throughout the data. For example, Chloe articulated how important weekly case management meetings were claiming,

We have our Tuesday group meetings and um every time I come on a Tuesday I think this is pretty amazing you know it's such a safe space…it's such a safe space everybody really, um feels confident in their capabilities and are not scared of speaking out and being a part of a conversation that you know… I have learnt so many things… I have learnt a huge amount of things and I guess as a midwife you're always learning. But in the last eight months I've learned more than I learnt for many, many years.

Chloe was asked to give an example to support her statement and she said,

Actually getting all the background of all these tests and what you know, what they mean and what they might mean for women, and the fact that we're all involved in that discussion…. Its hard for me to explain but it's that everybody has their knowledge and we're actually putting our heads

together and it's validated by everyone you know every body's quite comfortable speaking from their heart and their knowledge… there's a respect for the fact that we are responsible professionals and that we are doing what were meant to do

The case management meetings provided an opportunity to share knowledge and impart information which further empowered the midwives. Additionally, the meetings facilitated the development of mutual respect and collegiality prompting the midwives to continue to practice holistically. Thus, it is clear from the data that all participants perceived that the case management meetings provided an opportunity to develop professionally in a safe and trusting environment, while facilitating the acquisition of knowledge. Furthermore, the following comments by Rosie and Leanne support this claim,

Rosie: The case conferencing on a Tuesday is absolutely excellent um, we feel really well supported by Doctor Robert (Rob) Jones and um everyone has the opportunity to bring stuff and put it on the table.

I think what's made that so successful is Rob because he is so supportive and you know as far as his education input has been wonderful the things…. he will explain everything and you really do learn a lot.

And

Leanne: In terms of learning, you know some of the um information that we've been able to share, you know at case conferences and things like that I think, I feel that I have developed more professionally…guess professionally much more fulfilled.

Throughout the data collection period it became evident that one of the most significant changes in midwifery care associated with the MGP model was the alternative method of antenatal service delivery. An alternative approach to antenatal care was integral to the professional growth and learning that the participants revealed they had acquired. When the model was implemented current evidence informed the decision to provide an alternative method of antenatal care for the women. The aim was to provide a model of antenatal care

that would be robust, while enabling midwives to have time off call without the

ownership that can be present in case-load midwifery models therefore, essentially

reducing the incidence of burnout for midwives. The participants' experience of

this model of antenatal care led to the theme Midwives' and Women Together and

the significant passages of dialogue that emerged from the interviews also created

sub themes. The theme Midwives' and Women Together and the sub themes that

emerged will now be further explored.

MIDWIVES' AND WOMEN TOGETHER

All the midwives described how the MGP model enabled them to work together

with the women across the continuum; they all told stories of women they had

cared for that demonstrated this. For example, Leanne's experience with a woman

who had a vaginal breech birth, Rosie's experience with a woman who didn't

speak English which she describes as, "excellent, because it is very tailored to

each women's needs, like the little anxious Muslim girl who was just terrified".

Also, a woman cared for by Christina who came back to the group for

breastfeeding support and debriefing from her previous birthing experiences.

However this section focuses specifically on the method of group antenatal care

that was implemented and the midwives experiences of this.

How the MGP Group Antenatal Model Worked

The group antenatal model implemented by the MGP was informed by the

Centering in Pregnancy Model (Schindler Rising, Powell, Kennedy & Klima, 2004),

providing antenatal care and education in a group setting. Midwives in this model

provide antenatal care within a group setting using yoga mats while facilitating

discussion and education with the women. This difference essentially changed the model of care from a service that normally operated from a 'closed door' method, (one to one consultation in a room with a midwife) to a transparent engaging method (group setting) that was shared with midwives and women.

Community venues within the geographic area serviced by the hospital were sourced by the Midwifery Unit Manager and the Practice Development Midwife. These were located at a community child health centre and a community hospital. Suitable rooms that would accommodate three midwives and eight to twelve women at a time were booked for two sessions a week, each group antenatal session was for a two hour period. Women were given information around the group antenatal sessions when enquiring about the model or at their first visit booking with the MGP midwife, which was conducted at the woman's home. Opportunity was always available for the woman to have a one to one private visit with their MGP midwife if needed for examination, personnel or cultural reasons either at the woman's home or a clinic room at the community venue.

Three to four MGP midwives all with a case-load of women worked from each of the venues, each group evolved slightly differently, however the principles of governance around the model remained the same. All MGP midwives that were available attended each of the group sessions where possible. Women were invited to attend at any time during the two hour session, however if they needed a specific time for their antenatal assessment then the MGP midwife booked protected time. Therefore, providing the women with the opportunity to meet and develop a relationship with all the midwives in the MGP they were booked in to for

their care. This method facilitated women achieving a known carer during labour and birth even if their primary MGP midwife was taking allocated days off call. Allocated time of call is critical to sustain case-load model and achieve a work-life balance for the midwives, this is supported by the literature and the data. Rosie's statements reveal how the model achieves a work life balance for her and how Rosie trusts her MGP colleagues by feeling confident to guarantee the care the women will receive:

> Whether I am there or not I know my colleagues are going to do the same things. I know that, and I can guarantee that they are going to support my women the same as I will and that was what I could never do before…..Makes you feel very confident that when you are going to have days off, you know that whoever I have turned my pager over to I don't have to think, gee I hope she doesn't put her on the bed and give her an epidural. You know, I know that wont happen because we all work on the same wave length, we are all totally individual in I guess the way we talk to the women but our philosophy is the same….Now when I am working I am 5 days out of the house, I do less night time work and I am home to sleep, which is much better for me.

One group developed a flexible approach to both the attendance and woman led education topics which were facilitated by the midwives present. The other MGP group developed a more structured approach around the education topics and it was decided to facilitate attendance of the women to the gestation of the woman's pregnancy. Both approaches evolved directly around the midwives case-load and the women accessing the service. Notably, one MGP covered an area that included a higher percentage of non English speaking families, therefore the structured approach worked more effectively for these women. All antenatal group sessions were evaluated by the women and responded to by the MGP as appropriate.

The participants described an evolution of the service and a philosophy that I further explored and reflected on while completing the reflective journal, Mary described this evolution of the service as, "it's very fluid and relaxed". I was able to interpret from the data that there was a sharing that involved women and midwives together in the community, further building the capacity and strength of women.

Group Antenatal Care: the Midwives' Experiences

The group antenatal model of care initially posed challenges to the midwives. The challenges became evident during the process of reflective journaling. For instance, I noted that Mary became quite expressive with her non-verbal communication when describing her experience of the group antenatal and the challenges that both she and the other midwives had experienced. Mary described one of the venues as being 'particularly difficult', as it only accommodated eight people comfortably rather than the ten to twelve at another venue. Further, both Mary and Leanne expressed difficulties with the venue setting and equipment which impacted on their experience. On reflection I viewed this as a challenge that they did not need when implementing a new model of midwifery care.

It was apparent from my reflective journaling and by following the chosen method of analysis that the foreknowledge and past history of the participants practice influenced their experience of the group antenatal care and the dialogue was significant. My reflections and journal writings when exploring the midwives experiences of the group antenatal care revealed:

The keenness is there with all the midwives, the body language positive, although Rosie and Leanne seem hesitant at times when describing the group sessions, did they find it challenging, something new that they had never experience or done before?

Additionally, during the interviews two of the participants described a feeling of isolation when practising in a biomedical model. Although, they further described the sharing of information, support and trust from peers in the group antenatal model of care as engaging and supportive. For example, Chloe and Rosie expressed feelings of isolation in prior models of care they worked in, for instance,

Rosie: It was extremely isolating because you did you clinics on your own, you did postnatals on your own and you did your labour ward on your own, so you never really come together unless you had your own down time.

And

Chloe: It's always been that one on one with women you put them in the room and you sit and do all the antenatal care and then they go out and they walk home and nobody talks together out-side that door.

Moreover, four of the participants described how previous experiences with colleagues and the lack of trust and support that they received also impacted on their awareness and capacity to build on their practice, therefore developing professionally and clinically. Further, by working in a group antenatal model they felt supported in their practice and this promoted the development of the group antenatal care model. As I looked for meaning and understanding of the participants' experiences of this change in practice, I considered Mary's description of how she and her colleagues had always anticipated working in a traditional antenatal model, as that was the way it had always been done. Therefore, a group method would be surprisingly different for Mary's former colleagues, the following statement of Mary's illustrated what transpired to her personally when moving from one model of antenatal care to another,

That's probably how it's going to be for the next ten years and that's how it's always been and that's the expectation that you will continue with that and I think everybody will be quite horrified if I said, well I'm just going to meet all the women I'm caring for in one of the rooms on a Monday you know (laugh) in a group setting.

Midwives' and Women Together (Figure 5) defines the intimate nature of the relationship between women and midwives and importantly the sharing relationship that emerged. Rosie and Mary described this as follows,

Rosie: Does allow the women to get to know us over that time and they kind of get to know each of us as different people too, because we all add different things, we have different information that we share and that's good.

And

Mary: But the actual antenatal visit is mainly about sharing yourself with the group, people connecting with your local community, connecting with other mothers, I've got a group of midwives and so they're just that right from the beginning' there's a general sharing and there's just sharing of the pregnancy you know.

The intimate nature of the relationship between the midwives and women is further demonstrated by Christina, who describes the relationship as:

We've got one woman who, I think gave birth back in February from a really nice group of women and they phoned me with concerns about one of the women in their group who was feeling very low. So they were obviously caring about her and phoning me up to say, what do you think, is there any thing that they can do to help. I actually let her self heal within the group and that's just great, because that woman was pretty alone really, and she got the added support from me and the other girls in the group

And

I always say to women, look you know if you do want to talk about something private just text me before hand or when you come in just say, do you think we could have a private word and this works really well.
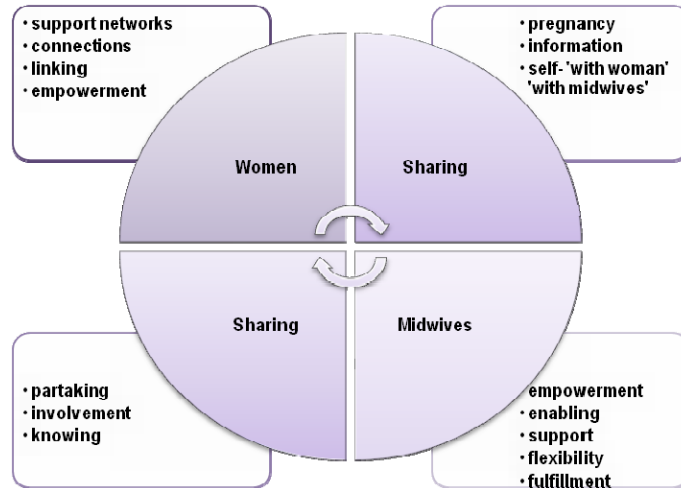
Midwives' and Women Together Figure 5

The foreknowledge and historical practices of the midwives influenced the

experience of the midwives and the meaning they ascribed to their experience.

Most importantly the power base between the midwives and women became

equal. Moreover, a sharing of experiences and intimacy emerged from the data,

midwives with women, women with women and midwives with midwives. For

example, Leanne described the experience as professionally fulfilling and more

giving to women claiming,

> I'm enjoying working in the group antenatal session, its um fulfilling because
> you feel as well that you're just giving so much more to the women that you
> can just give in a one on one because they get the benefit of the discussion
> and um you get opportunities to be facilitating which is professionally, um a
> good thing to be doing.

Rosie also described how the model had empowered the women she was caring

for:

> The women feel empowered because they feel that they've had so much
> involvement in there own birth and they have felt in control. We've really
> encouraged them to speak up for what they want and what they don't want.
> To be the decision makers in the process and then that's gone on to make
> them feel more confident as they go ahead with their babies.

The participants' inherent belief in the model and commitment to the philosophy of woman centred care is evident throughout the data.

Furthermore, the capacity and passion to practise in a model that is based on a sharing group model of care such as, Midwives and Women together (Figure 5) is demonstrated throughout the dialogue. For example, Rosie stated that "the group antenatal model is a 'model' which allows the women to get to know us over that time and they kind of get to know each of us as different people too, because we all add different things, we have different information that we share". Chloe said, "we are part of a group of women and we just have some skills that we need to use at that time and may have other skills".

Thus, demonstrating the inherent belief that the participants' were working in partnership with women they were caring for in the MGP model. All of the participants in this study perceived that the women were enriched by their experience of the group antenatal sessions describing the women's experience of the model in a positive way.

During the interviews I asked the participants to tell me a story of a woman who had experienced the model and how they perceived the benefits of group antenatal care. One of the stories told by Christina encompasses the holistic nature of the care throughout the continuum of the woman's childbirth experience,

> She just said it was better because of the flexibility and that there wasn't any limits to the fact that we could get to know each other so well. I think she never had postnatal home visits at home before so she didn't have that

side of it, and the fact that we all knew each other so well and she knew the other midwives as well and what has happened since then is that um out of our antenatal sessions there's a lot of mother groups that come together and she's one of them….actually let her self heal within the group and has kinda gone now you know so um that's just great, cause that person was pretty alone really, and she has got the added support from the other girls in the group

The midwives also indicated that they believed that the women benefited from their experience in the group antenatal sessions. For instance, Rachel claimed, "I think the women are empowered" which is an important statement that demonstrates the effectiveness of the model of care.

During the interviews the participants described (on more than one occasion) that the group antenatal sessions 'linked' women together with other women in the community, on reflection and exploration of this I believed that this was a means of enabling and empowering women. For example, Christina said that "I think the women do like it and its really good to link women together that's the most effective thing about it" and Leanne stated that "they just get a lot more out of the group setting, a lot of different conversations and facilitating discussion arises from the group and the women".

The participants also revealed that the women returned to the antenatal group following the birth of their baby and this was not planned nor expected. However, the women returning to the group sessions to share their birth experience in an intimate and supportive environment was perceived as important and contributed to the midwives perception of the effectiveness of the group antenatal model as Chloe outlined,

> A lot of women come back, as well they all come back at some stage with there babies and that wasn't really something we planned but it was just something that worked……they all see babies come and they all tell their story they all tell how they went and talk a lot about breast feeding to the other women.

The midwives care extended beyond planned antenatal or postnatal visits.

Reference to the support services available to women were an integral component of the antenatal and postnatal care provided to women in the MGP model, this was innate within the data. The participants' involved in this study describe this as 'connecting with other mothers'. However, Rachel's perception was that 'they are all meeting and they are all getting that experience of being a positive parent, of being confident that they're having a baby, its all learning, its natural it's just an everyday thing'.

The midwives participating in this study described their experience of the group antenatal care when pioneering the MGP in this study. For example,

> Mary: But the actual antenatal visit is mainly about sharing yourself with the group people connecting with your local community, connecting with other mothers, I've got a group of midwives and so they're just that, right from the beginning there's a general sharing and there's just sharing..

Schindler Rising et al., also cite a midwife participating in the Centering Pregnancy model,

> 'I think that I have revisioned what it means to be a midwife because, like many midwives, I came out of school wanting to catch babies. I think that what midwives really are about is helping mothers give birth to themselves, that's what we do that's important and that's how we impact the baby. And in some ways almost anybody can catch a baby, but it is a much more complex process to help a woman give birth to herself as a mother for that baby'; (unpublished focus group data, 2002).

The midwives' rhetoric of their experience is evident throughout the data and can be expressed through Women and Midwives Together. Figure 5 illustrates how a circle of understanding emerged from the women and midwives when group antenatal care was implemented. Rigour is maintained by following the chosen method of analysis and merging the historical experiences with the new experiences of the participants' experiences of providing this model of antenatal care. Moreover this further contributes to an understanding of the midwives experience pioneering a new model of care.

CONCLUSION

Mutual Respect, The Midwives' Journey, Professional Fulfilment and Women and Midwives Together, are all intrinsically linked and connected in a way that, when viewed as a whole 'range of vision', are the ingredients that formulate an MGP. Thus, as described in chapter one, midwifery is holistic and organic in nature, moreover, the midwives experience pioneering the MGP model of care in this study is also holistic and organic. This is confirmed by the themes and sub themes that were revealed in this study, which encompass the midwives' experiences from a conceptional, emotion and practical sense, of the new way of working in the MGP. These themes and the sub themes which evolved and emerged are embedded and intrinsically connected to the experiences of the midwives in their entirety. Therefore, the midwives' experiences of working and pioneering a MGP model of care encompass the themes and the clusters of sub themes that have been illustrated diagrammatically.

The literature in chapter two identified that a social holistic model such as this, with an equal power base between the midwives and women has the potential to effectively improve outcomes. This is contrary to the biomedical model of dominance and control that was also explored in Chapter Two.

The participants' 'passion' for midwifery and the model of care was significant throughout the data collection phase and was further illustrated by the sense of trust and whole of organisational support that the midwives described. Therefore, the meaning of their experience and central to this experience was the opportunity to practice in a model that fulfilled their passion for midwifery. Thus, the trust that was embedded in the model by the organisation affected how they perceived their role within the MGP and empowered them as practitioners.

Significantly the group antenatal care complemented the contemporary midwifery model that was implemented. However, the group model of antenatal care did initially posed challenges that were predominantly resource based and not practice based.

Trusting partnerships developed within each MGP, between the MGP and the organisational management, the education team and most importantly trusting relationships and partnerships developed with the women and MGP midwives. A model that empowers the midwives with 'trust' will empower the women cared for. Therefore the midwives experience of pioneering a new model of midwifery care; a MGP, in essence comprises of what is termed in this analysis as Mutual Respect, The Midwives Journey, Professional Fulfilment and Midwives and Women

Together. The meaning of these experiences is further explored in the next

chapter where a review and synthesis is conducted.

CHAPTER FIVE

REVIEW AND SYNTHESIS

INTRODUCTION

This study explored the experiences of midwives who participated in pioneering a new model of midwifery care, which was a case-load Midwifery Group Practice (MGP). The review of literature (Chapter Two) found that little had been written about the history of midwifery in Australia, specifically from the midwives perspective and their experiences of working in a case-load midwifery model such as an MGP. This was identified as a significant gap in Australian research when reviewing the literature and the data obtained from this study may further contribute to this. Moreover, Australia will need to consider the extensive research conducted in the UK when implementing a midwifery model, in particular the UK literature that identified the retention of skilled midwives was improved, with the implementation of a case-load midwifery practice (Spurgeon, Hicks & Barwell, 2001; Warwick, 2002; Ball, Curtis & Kirkham, 2006; Kirkham, 2007).

Hermeneutical phenomenology was the chosen methodology for this study and the method of data analysis employed for the study was guided by Gadamer's theoretical model and underpinned by the hermeneutic circle of understanding (Gadamer, 1975). The method chosen is described in Chapter Three, Design of the Study. Gadamer's proposal that horizons are the prejudice of foreknowledge was used to analyse the dialogue gathered from the midwives participating in the study, therefore allowing the horizons to expand and be re-examined. This was described by Gadamer as a fusion of horizons, the prior knowledge or historical

horizon and the present new knowledge. Gadamer's approach was particularly

significant when exploring the midwives' experiences in this study, given that the

midwives originated from diverse midwifery settings including the UK.

This study revealed themes and sub themes which resonate strongly with the

universal themes identified in the review of the literature. For instance, midwifery

and continuity of care/carer, the biomedical model of care, autonomous practice,

educational/ support needs of midwives and professional challenges/conflict. The

themes identified in this study are Mutual Respect, The Midwives' Journey,

Professional Fulfilment and Midwives and Women Together.

These themes and sub themes are further reviewed and synthesised in this

chapter and a discussion surrounding the implications for midwifery practice and

the development of case-load midwifery models of care in Australia. Notably, the

review of literature identified multiple knowledge gaps within midwifery in Australia

and significantly limited research into the experience of midwives practising in

case-load models of care in Australia, such as a MGP.

DISCUSSION

Embedded within the data which was discussed in Chapter Four are the trusting

partnerships within each MGP. The trusting partnerships revealed a confidence in

the ability and integrity within the MGP midwives to care for the women, such as

when a MGP midwife was taking days off call. Mary described the MGP midwives

as a cohesive group, this trusting relationship was described in the literature and

can be termed a 'shared group philosophy'.

Importantly it was the '*trust'* that empowered and which made it possible for the

MGP midwives to guarantee the care provided to the women when they were

unavailable or off call. Therefore, achieving the work/life balance required to

sustain the service. The group antenatal model of care that was implemented

facilitated the work/life balance and the trusting relationships that emerged from

the data, such as described by Rosie and the MGP midwives in the previous

chapter.

Sharing of information at the case management meetings was identified as an

essential component by all the MGP midwives, moreover revealing a feeling of

support from their peers and being 'safe' when discussing cases.

Most importantly organisational trust was evident throughout, the Midwifery Unit

Manager encouraging the MGP midwives to develop their own identity and ways

of working together as a group. Organisational trust was also demonstrated by the

role of the Practice Development Midwife who was supported by the Midwifery

Director. This included the writing of the MGP model proposal and implementation

plan for the hospital executive, with the support from the Midwifery Unit Manager.

Importantly the MGP model was implemented within a model of Clinical

Governance (appendix VIII), which contained clear principles, framework and

guidance. This MGP model empowered the midwives with 'trust', therefore it will

empower the women cared for.

The key finding of this study is that *a Culture of Trust* is the essential component to contemporary midwifery practice. A Culture of Trust is critical to the success of MGP models such as the one explored in this research. The diagram below reflects the key findings of this research and of which I have termed Practice Essentials (Figure 6).
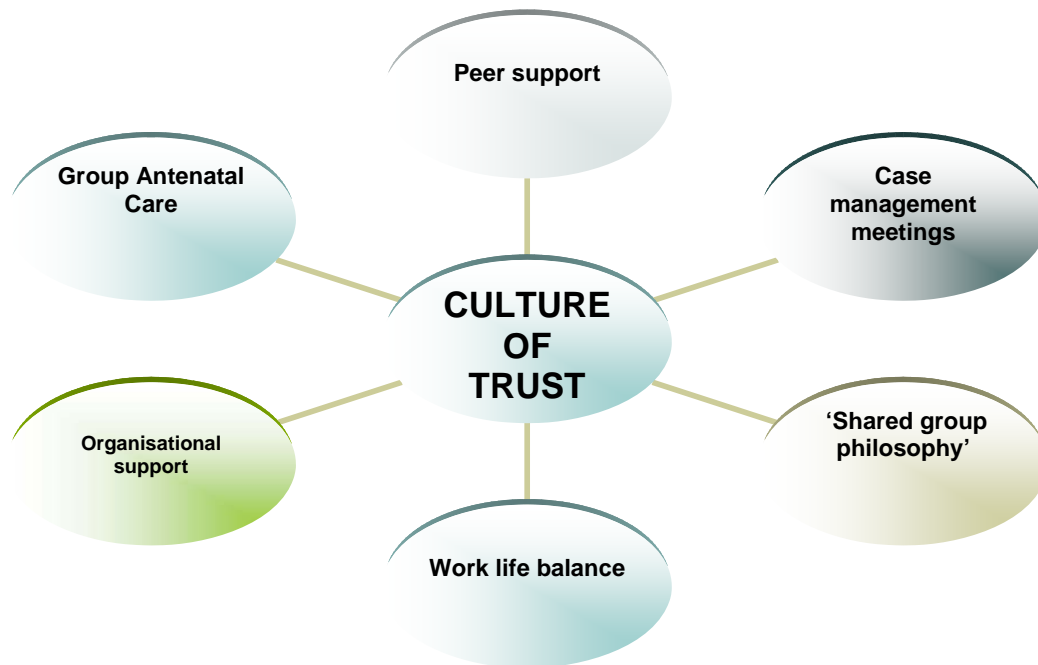
Practice Essentials
Figure 6

Contrary to Dimond (2002), Warwick (2002), Ball, Curtis, and Kirkham (2006a), Ball, Curtis, and Kirkham (2006b), Ball, Curtis, and Kirkham (2006c) and Kirkham (2007), the MGP midwives in this study, revealed that they felt supported and trusted. Furthermore, the two distinct cultures identified by Hirst in the Re-birthing Report (2005), midwifery and medicine (the two groups of decision makers with philosophical differences regarding pregnancy and birth), found a way to work together. Midwifery and medicine, that Hirst referred to as, Contextual/Relational

Model (Organic) and Analytical/Technical Model (Mechanic), developed a trusting

and supportive relationship in the MGP model of care (Hirst).

A Culture of Trust

As reported in the previous chapter, this study identified that a positive whole of

organisational approach is essential when implementing new models of care.

Fundamental to this is Mutual Respect and the essential component of *Trust*

identified in this study encompassed, gaining trust from the whole organisation,

including colleagues, medical and midwifery peers.

Through a rigorous method of interpretation, guided by Gadamer's hermeneutic

circle of interpretation, the theme and the group of sub themes which are termed

'Mutual Respect' emerged. A further review and synthesis of the midwives'

experiences of feeling welcome trusted and supported within their work

environment revealed economically responsive and responsible midwives. These

experiences were inherent to the midwives' positive experience of working within

the MGP model of care. The midwives genuinely considered the overall

management and efficiency of the practice and ultimately engaged in the whole

experience of both the clinical component and the practical management of the

MGP.

Upon further review and synthesis of the sub themes, 'welcoming', 'whole of

organisational support' and 'trust', significant language was revealed. For instance,

'welcoming' was intrinsically related to the term 'friendly'. 'Trust' was aligned with

'faith' and 'hope' and finally 'support' was related to 'backing', 'confirm' and

'provision'. This language is significant within the context of this study and illustrates the positive approach and manner demonstrated by the midwives pioneering this new model of midwifery care. The consistent employment of this language by the midwives throughout this study further demonstrated how the midwives perceived the entire experience and how it impacted on their midwifery practice in a positive and constructive way.

Further exploration of the literature outside the context of midwifery was undertaken to gain a more in-depth understanding of how the midwives perceived their experiences that they articulated as 'welcoming', 'trust' and 'whole of organisational support'. These sub themes are essentially connected and the fundamental key in these sub themes is 'trust'. It is also significant that 'trust' has been explored in a variety of previous studies within the health-care environment. For example, research has examined trust in a variety of contexts applicable to this study including the implications of trust in nursing practice (Pask, 1995), and trust between health organisations (Walker, 2001). Trust has been identified as the foundation of good communication and coordination of competent health-care (Pask, 1995; Thorstensen, 2001).

Furthermore, literature outside the context of health-care service delivery has revealed that 'organisational trust', is a fundamental ingredient and an unavoidable dimension of social interaction (Mayer, Davis & Schoorman, 1995). Further, Mayer et al. proposed that there is a level of trust and perceived risk however, trust is also empowering. This theory is reflected in the implementation of new models of care such as a MGP. Furthermore, because this study illustrated the need for

organisational support the significance of trust is paramount in the context of whole of organisational support. Trust from the whole of the organisation, including colleagues, medical and midwifery peers further creates a welcoming environment. If the midwives were pioneering a new model of midwifery care in a culture that did not foster such innovation and trust, this may potentially have posed a 'risk' to the organisation

Thus, the midwives described their experience within the MGP as that of being trusted. Recognition of trust was evidenced bu the whole of organisational support given and which was perceived as a quintessential ingredient to the successful implementation of the MGP. The midwives participating in this study articulated throughout the interview process that they were supported by the organisation and notably, by the Midwifery Unit Manager and the Practice Development Midwife. This also impacted on the sustainability of the service, which they subsequently achieved. For example, an additional MGP was implemented in 2008 within the organisation.

The midwives participating in this study referred to the positive relationships with both medical and midwifery colleagues in particular within the birth suite environment. For example, Leanne described how she felt that there was a great deal of respect for the MGP midwives from the medical staff in the birth suite and she always kept her birth suite midwifery colleagues informed of where she was at, in terms of the care for her women. This Leanne believed facilitated positive collaborative relationships with the midwives, in particular the birth suite midwives and medical staff. The MGP midwives stated that they also had a trusting and

respectful relationship with the nominated obstetrician. Therefore, the theme

Mutual Respect and the sub themes that emerged from this study may be key

recommendations when implementing similar MGP models in other organisations.

Essentially Mutual Respect significantly contributed to the success of the midwives

pioneering this new model of midwifery care.

The midwives' experiences in this study were fundamentally positive and are

contrary to the experience of the community midwives in the study conducted in

the UK by Kirkham (1999). In Kirkhams' study, cultures of fear were identified with

one community midwife comparing her experience to that of a lioness going into

another pack and that pack waiting to attack. The findings of this study do not

support Kirkhams' constant themes and feelings of distrust between the

community midwives and the delivery suite midwives that Kirkham identified in her

study. The culture of 'horizontal violence' was also described in further studies

and declared as a barrier to trust (Kirkham & Stapleton, 2000). Of note this study

does not confirm these issues identified by Kirkham and Stapleton as the

midwives did not reveal any of these cultural challenges and experiences. When

specific attention is paid to creating a culture of mutual trust and respect then the

challenges and/or barriers noted in the earlier work of Kirkham and Stapleton

(2000) can be avoided.

More importantly, in the context of Australian midwifery, the findings of this study

are different to the findings of the evaluation of a MGP in Adelaide South Australia

(Homer, 2005). Homer made key recommendations which included further

development of collaborative relationships with the core hospital midwives and

medical colleagues, suggesting that these relationships required improvement. However, this study illustrated that collaborative relationships emerged as a result of implementing the MGP model, such as Leanne's earlier explanation of the relationship with her birth suite colleagues. Therefore, there appeared to be an improvement in hospital relations, which emerged from the structured approach adopted for the implementation of the new MGP model; this was facilitated by the Practice Development Midwife and the Midwifery Unit Manager.

Hatem, Devane, Soltani and Gates (2008), in a Cochrane Review of Continuity of Care Midwife-led versus other models of care for childbearing women, claimed that government and hospital policies affected how midwives were 'allowed' to practice. In particular Hatem et al. claimed that the organisational structures of institutions further limited the midwives ability to practise midwifery-led models of care such as an MGP case-load model. Therefore, this review by Hatem et al. are reflected in the findings of this study and the meaning the midwives ascribed to their experience pioneering this particular MGP model of care. Significantly, the midwives participating in this study were *allowed* to practice midwifery as they believed midwifery care could be delivered due to the support attributed by the organisational structures and policies that were put in place during implementation of this model. Most importantly, the MGP model proposal, implementation plan and the essential model of Clinical Governance (appendix VIII).

Importantly, this study identified that a positive whole of organisational approach is essential when implementing new models of care. Moreover, it can also be determined from the findings that emerged from the theme 'working in a 'trusting

and supportive organisational environment' that management strategies and frameworks need to be in place, such as the model of Clinical Governance (appendix VIII). The aim of these strategies and frameworks should be to nurture, construct and determine positive effective working relationships and to implement policies and guidelines to sustain the new midwifery model of care, which is reflective of Hatem et al's., review of midwifery-led care.

The success of the midwives pioneering this MGP case-load model can be directly attributed to a 'shared group philosophy', which Mary termed as a trusting and cohesive group, such as that described at the Blackburn West MGP (Fleming, Birch et al., 2007; Fleming & Downe 2007).

Furthermore, the second theme The Midwives' Journey and the sub themes which include *Emotive Expressions, Transitional Adaptation and Adaptation to a Thinking Worker',* present a vision of the professional journey that the participating midwives were engaged in during the implementation of the MGP model. This vision is reflective of essential themes identified in the literature such as the educational frameworks and professional support structures, which were defined by the Clinical Governance model implemented, and therefore required to provide a healthy transition for implementing midwifery-led care (Turnbull, Reid, McGinley & Shields, 1995; Hildingsson & Haggstrom 1999; Kirkham, 1999; Watson, Potter & Donohue, 1999; Kirkham & Stapleton 2000; Stevens & McCourt, 2002; Hunter, 2004; Walker, Moore & Eaton, 2004; Lindberg, Christensson & Ohrling, 2005).

Three of the midwives who participated in this study had recently migrated from the UK and this may have potentially contributed to their positive, autonomous approach when pioneering a new midwifery model of care. In the UK midwifery is underpinned by legislation and professional frameworks, for example the changing childbirth movement, which commenced in the late 1990's that promoted midwifery-led care and autonomous practice (Hicks, Spurgeon & Barwell, 2003). However, even with this grounding in autonomous practice, Gould, who conducted a study in the UK, claimed that there was a subversive subculture that was a risk and that this subculture impacted on safety (2008). Notably the UK midwives participating in this study did not demonstrate subversion in their practice or character.

The participants' passion and commitment to midwifery and the women that they cared for was apparent throughout the study. Overall the transition and adaptation to working autonomously and being a *thinking worker*, which included making significant decisions in partnership with the women they were caring for, did not pose any significant difficulties for this group of midwives. Rosie had described this as knowing. For example, Rosie previously had described how the model had empowered the women she was caring by involving them in the decision making process.

The commitment and passion revealed by the midwives participating in this study is contrary to the culture, such as that described by Kirkham (1999), in another UK study. Kirkham described a culture of service and sacrifice where midwives lacked the rights of women, the rights that the midwives were required to offer their

clients, notably this study by Kirkham was conducted 10 years ago. Throughout

this study there was no evidence of this culture of service or sacrifice and the

midwives participating did not describe such a culture as that described by

Kirkham. Rather they described new knowledge and experiences that enabled

them to practise midwifery in a way that met their own needs as professional

midwives and further claimed that they were 'professionally fulfilled'. This theme is

explored also in this chapter.

The theoretical approach adopted for this study enabled exploration of the

midwives' history, foreknowledge and roles as contemporary practicing midwives.

It is therefore fundamental to acknowledge the theory that underpins this study

and importantly the analysis, whereby Gadamer's approach proposes that

horizons are the prejudice of the foreknowledge of the midwives participating in

the study. The midwives participating in the study brought with them their own

history. The midwives from the UK and the midwives from an Australian

background collectively merged their horizons which illustrate the 'shared group

philosophy' that is referred to by Fleming, Birch, Booth, Cooper, Darwin, Grady

and Downe (2006; 2007a; 2007b).

It is important to consider the Australian studies that refer to subordination of the

role of midwives in Australia, which is aligned to Gould's findings of a subversive

culture in the midwifery profession in the UK (2008). Specifically those of the

opinion that the subordination within the role of midwives in Australia may be

related to the history and development of midwifery in Australia, as described by a

number of Australian researchers and discussed in the review of literature,

(Barclay et al., 1989; Barclay, 2008; Brodie 2002; Fahy, 2007; Purcal 2008). In this context it is the prior knowledge or historical horizon of the Australian midwives participating in this study and the present new knowledge of these midwives that further merge together.

It may then be considered that the Australian midwives in this study were influenced by their history and the culture of subordination in Australia midwifery (Barclay et al., 1989; Brodie, 2002; Barclay, 2008; Purcal, 2008). However, when sharing their experience of pioneering the MGP with the midwives from the UK and experiencing a model that fostered trust and mutual respect the Australian midwives did not reveal any subordination within their roles as MGP midwives. The Australian midwives in this study did not support the opinion of the Australian researchers' claim that midwives in Australia have a subordinate role. However, as stated previously there are a small number of participants in this study and it is possible that these Australian midwives had different history and 'horizons' that influenced their practice and experiences.

The midwives participating in this study demonstrated what may be termed a 'shared group philosophy' as described by the Blackburn West MGP (Fleming, Birch et al., 2007; Fleming & Downe, 2007). Moreover, the midwives pioneering this new model of midwifery care effectively achieved a transition and adaptation to autonomy and to being a thinking worker. The sub themes 'emotive expressions', 'transitional adaptation' and 'adaptation to a thinking worker' which were the Midwives' Journey were fundamental components of their experience pioneering the MGP. Therefore, it can be concluded that the midwives

participating in this study did indeed have a *shared group philosophy* because they

were sharing, caring and supporting each other (Fleming, Birch et al., 2007;

Fleming & Downe, 2007).

Fostering and Protecting: A Pathway to MGP

The key finding in the theme Professional Fulfilment was the immense importance

attributed by the midwives to the case management meetings and the opportunity

to reflect on their practice in a safe and supportive team environment. This finding

is validated by the literature, with support, participation in practice development,

identified as essential to the development of midwifery models of care (Turnbull,

Reid, McGinley & Shields, 1995; Hildingsson & Haggstrom 1999; Kirkham, 1999;

Watson, Potter & Donohue, 1999; Kirkham & Stapleton 2000; Stevens & McCourt,

2002; Hunter, 2004; Walker, Moore & Eaton, 2004; Lindberg, Christensson &

Ohrling, 2005). Additionally, Stevens and McCourt identified that midwives' sharing

knowledge and experiences is an important catalyst for cohesion within a case-

load MGP (2002). Moreover, the Re-birthing Report refers to the Netherlands

where homebirth care with a midwife is an integral part of the health system and

midwifery is a highly educated workforce (Hirst, 2005).

When the midwives participating in this study embarked on their role as MGP

midwives they did not anticipate nor expect to develop professionally or grow in

their midwifery knowledge and skills. Professional Fulfilment is the theme that

emerged from the in depth interpretation of the dialogue. Therefore, as described

by Gadamer (1960/1998, p.389) this theme and the significant dialogue that

emerged, encompass a 'range of vision' that includes everything that can be seen

from a particular vantage point. Which, when synthesised in this study, is 'Professional Fulfilment', the midwives' experiences of professional growth and learning when pioneering the MGP.

The theory that underpins this study is an essential aspect of the interpretive process that was utilised for this study and Gadamer's view that a person with no 'horizon' is not able to see beyond what is close at hand was significant in this chapter, during the synthesis of the theme Professional Fulfilment. Therefore, it is important to reflect at this point back to the methodology and the writings of Gadamer, quoted in Chapter Four (pg. 84). Who wrote, that questioning was an essential aspect of the interpretive process as it helps make new horizons and understandings possible,

> Understanding is always more than merely re-creating someone else's meaning. Questioning opens up possibilities of meaning, and thus what is meaningful passes into one's own thinking on the subject. To reach an understanding in a dialogue is not merely a matter of putting oneself forward and successfully asserting one's own point of view, but being transformed into a communion in which we do not remain what we were. (1960/1998, pg. 375)

The group antenatal care that was implemented posed additional challenges for the midwives and was also integral to their professional growth and learning. However most significant, was that the midwives claimed the most important factor that contributed to their professional growth and learning was to have a safe space for discussion, reflection and learning. It was revealed in this study that the midwives who participated in the study regarded the time to reflect and learn as an extremely high priority. In particular, this was acknowledged by the participants as being achieved by attending the weekly case management discussion and

reflection with peers, both midwifery and medical. Opportunity to reflect on their midwifery practice was referred to by all the midwives in this study as an essential component of the midwifery model of care.

This study highlighted that it is critical when implementing new models of care, such as an MGP, that a regular case management meeting (sometimes termed by the participants as a case conference), is facilitated and that time is embedded into the model for reflective practice. The importance of this is validated by the literature. For instance, Woodward (2000) compared two different models of care, one in a palliative unit and the other in a maternity unit. Woodward claimed that caring values were eroded in the maternity unit and suggested that frameworks needed to be in place to facilitate reflective practice.

The case management meetings provided the opportunity to acquire knowledge and impart information which further supported the growth of capable and knowing midwives. Case management meetings also facilitated the development of mutual respect and trust with medical colleagues, furthermore resulting in professionally fulfilled midwives. Thus, it is clear from the data that all the midwives perceived that the meetings provided an opportunity to develop professionally and must be embedded in frameworks implementing midwifery models of care such as a case-load MGP.

Sharing and Growing: Forging a Pathway Together

The findings of this study confirm that the midwives' experience of group antenatal care in the MGP was positive. The group antenatal care model implemented by the MGP was described in Chapter 4, and was informed by the 'centering in pregnancy model' (Schindler Rising, Powell Kennedy, & Klima, 2004). This method of providing antenatal care and education initially posed some challenges for the midwives. It essentially changed the model of care from a service that normally operated from a 'closed door' method, (one to one consultation in a room with a midwife) to a transparent engaging method (group setting) that was shared with midwives and women. In the Re-birthing Report, Hirst also suggested that by supporting different models, and approaches to maternity care, the needs of the women could be met. Notably, women's choice, in terms of care approaches was raised by over half of the consumer submissions (Hirst, 2005).

The midwives participating in this study all described the model as 'sharing' that involved women and midwives together in the community further building the capacity and strength of women and families. Therefore the theme, Midwives and Women Together emerged and when further synthesised the understanding of the meaning of this for the midwives participating in this study became evident.

When the model was implemented current evidence informed the decision to provide an alternative method of antenatal care for the women. The aim was to provide a model of antenatal care and education that would be robust, while enabling midwives to maintain a work/life balance, therefore reducing the incidence of burnout for midwives. This is also reflected in the study by Lynch

(2002) who claimed that midwives who listen to each other and care for each other, can affect change in practise by exploring alternative models of midwifery care and by understanding the causes of stress, exhaustion and burnout (Lynch, 2002). Therefore, by implementing an antenatal model of care that could potentially maintain a work/life balance was considered a critical component for this MGP.

Issues with one of the venues within the hospital facility, was identified as problematic and an additional burden to add to the challenges of implementing a new model of antenatal care. Therefore, when replicating this model of antenatal care that is community based, it is important to address the issue of venues and facilities prior to commencement. Importantly, the midwives' care extended beyond a clinical antenatal assessment, and reference to future support services is innate within the data, the midwives involved in this study describe this as 'connecting with other mothers'.

The initial difficulties that were identified with the venues was more than balanced by the benefits of the connection that the midwives described they achieved with the women. Importantly this connection was felt by the MGP as a group and each midwife stated that when they were on days off they were confident that a colleague from the MGP would support the women in a way that was philosophically aligned to the group as a whole. Moreover, as discussed previously facilitating a work/life balance for the MGP midwives and therefore achieving a sustainable MGP model.

An example of an MGP that also achieved work/life balance for the midwives when working in a case-load model by a different method is the Blackburn West MGP (Fleming, 2006; Fleming, Birch, Booth, Cooper, Darwin, Grady & Downe, 2007; Fleming & Downe, 2007). In the Blackburn West model the midwives were divided into two groups of three and devised an on-call system that worked for the group. This system allowed the midwives to be on-call two or three days and nights each week, although where possible, they continued to look after their particular case-load women. This on-call system, as described by Fleming and Downe (2007), appeared effective and enabled a work/life balance to be achieved within the Blackburn West MGP. Fleming, a case-load midwife with the Blackburn West MGP described how team-work made family life possible and further demonstrated how this way of working in fact enhanced her family-life (2006).

Significantly, two of the midwives in this study referred to feelings of isolation, being alone and unsupported by midwifery colleagues when previously working in a case-load model. Therefore, the prior knowledge of the midwives' feelings of isolation, the historical horizons, merged together with the present new knowledge the midwives acquired when implementing the group antenatal model of care. With further review and synthesis, the midwives' descriptions of sharing information, professional growth and support from peers in the group antenatal model of care, which was engaging and supportive, can be confirmed.

This study further revealed that the group antenatal sessions 'linked' women together with other women in the community; therefore it was enabling and empowering for the women. Overall the group antenatal service provided benefits

for the midwives from a professional, supportive perspective and the opportunity to achieve a work/life balance. Importantly the group antenatal care effectively benefited both the midwives and the women in the long term, by achieving a sustainable MGP model.

As previously stated the group antenatal model implemented by the MGP in this study was informed by the Centering Pregnancy model (Schindler Rising, Powell Kennedy & Klima, 2004). The intent of the study was not to focus particularly on this one aspect of the model of care and the midwives' experiences when implementing group antenatal care. However, this study did reveal some challenges with implementation and the additional benefits that were achieved by the group antenatal model of care. The Centering Pregnancy model that informed the MGP model originated in Minnesota, USA, while Schindler Rising et al. (2004) claim that Centering Pregnancy redesigns the way health-care is delivered to women during pregnancy, the authors also acknowledge that it is imperative to explore the effects of the change on health-care outcomes, satisfaction with care, and family health and well-being.

The midwives in this study, and also the midwife cited by Schindler Rising et al. (pg.117) appeared to reflect on their midwifery practice in a deep and meaningful way. Although this study did not set out to purposely explore the group antenatal model of care, the study did reveal that such an innovation in practice, also described by Schindler Rising et al. requires leaders who understand how to spread innovation and respect the diversity of change. Schindler Rising et al. further suggest that Centering Pregnancy has a powerful effect on the women who

participate, as well as the ability to change how midwives practise the art of midwifery.

Overall the findings of this study confirm that the midwives' experiences of group antenatal care in the MGP was positive. Furthermore, this study highlights the need to explore and research alternative methods of providing antenatal care such as a group antenatal model. Significantly, when implementing midwifery models of care in Australia, consideration must be given to Australia's own unique and diverse demographic and geographic challenges. This study was conducted in a metropolitan area of Australia and the impact of implementing a group antenatal model in more regional or remote areas would require further exploration and study.

Study Limitations

Limitations of this study have been identified. However of note, the accounts of the women's experience of the group antenatal care is the MGP midwives own personal interpretation of how the women felt about the care they received. Data was not collected from the women specifically for the purpose of this study although there was a consumer feedback survey completed by the women who were cared for by the MGP midwifery model of care which included an evaluation of the group antenatal care. The positive nature of the midwives experience pioneering this new model of midwifery care in this study was also considered, as there did not appear to be any significant negative experiences identified by the participants in the study.

Some may consider my role as Practice Development Midwife as a limitation. However, I questioned my involvement as Practice Development Midwife with the implementation of the model and whether this would or did influence the analysis in any way. Therefore, a process of rereading and reflecting on the data including the interpretation and analysis was undertaken. Moreover, I looked for clarification in the literature. This process of reflection included perusing a more recent article by Laverty (2003) which described the considerations that must be given to the history and method of hermeneutic phenomenology and phenomenology, with a focus on research and research outcomes that differentiate these approaches. Further, I reflected on the writings of Gadamer and Heideger to maintain intelligibility. The methodology and Gadamer's *circle of understanding* was also revisited to further reflect on the meaning of prejudice as described by Gadamer (1976).

Additionally, I reflected and considered any prejudices that I may have had during this study. However, within the context and theory that is synomous with interpretive hermeneutic phenomenology, prejudice is not viewed as negative but positive. Notably, and most importantly Gadamer's view was that, the researcher begins a process of self-reflection and in interpretive phenomenology the researcher gives considerable thought to their own experience and to explicitly declare the ways in which their experience or position relates to the issues being researched. As the Practice Development Midwife I did consider and declare my own experiences and position throughout this study.

In this circle of understanding the researcher and participants worked together to bring life to the experience explored. Thus, in this study, this was the midwives' experience of pioneering a new model of care. Therefore, it was critical that I, as the researcher was aware of my own prejudice when conducting this phenomenological study (Koch, 1996). Moreover, as the researcher I did become an instrument of the research and became immersed within the research and the phenomenon under study, ones own prejudice as such informs the language that is used when writing (Crist & Tanner, 2003).

Gadamer (1960/1998) understood hermeneutics as a process of co-creation between the researcher and participant, which is in effect what occurred between the MGP midwives and the researcher (Practice Development Midwife). Hermeneutic research demands self-reflexivity, an ongoing conversation about the experience while simultaneously living in the moment and the use of a reflective journal is one way in which the hermeneutic circle can be engaged, moving back and forth between the parts and the whole of the text (Heidegger, 1927/1962). Therefore the reflective journaling that was conducted during this study is a critical component when preserving the rigour of the research (Appendix VII).

Furthermore, it was also important that as the researcher I developed a rapport with the midwives and the power base was as equal as possible, this involved sharing my own experiences of working in this way and the creation of a context of intimacy which transpired. I believe that my own experience as the researcher did enable a greater ability to interpret the phenomenon, fusing together my own beliefs and experiences and also that of the midwives participating in the study.

It is important to acknowledge that a key component is a midwife in a leadership position with the knowledge and skills required to implement a MGP model. This role was identified as essential when implementing a new model of midwifery care and would facilitate the *whole of organisational support* required to sustain the model*.* Essentially, a role such as this should be integral to the organisational structure and leadership when organisations implement a case-load midwifery model of care such as an MGP. This may pose some difficulty for organisations due to the limited number of midwives that have experienced this new way of working.

Implications for Practice

From a midwifery practice perspective, it is important to conduct small studies to gather the knowledge required to inform the implementation of additional case-load midwifery models that can be sustained. Moreover, facilitating the development of new case-load models which foster a work/life balance for midwives working in this way. Therefore, reducing the risk of burnout for the midwives which was identified in the research conducted in the United Kingdom (Stevens, 2002 ; Stevens, 2002;Lynch, 2002) and in more recent times in the Lead Maternity Carer (LMC) model in New Zealand (Skinner & Wakelin, 2007).

There are a number of key elements that have emerged from this study which will have implications on practice and inform the implementation of case-load models, such as the MGP that was pioneered by the midwives participating in this study. Consistent and fundamental to midwifery practice is a Culture of Trust and the elements that emerged from this study. Therefore, these are potentially the key to

successful implementation of a similar case-load MGP and are illustrated in the diagram Practice Essentials at the commencement of this chapter (Figure 6).

In Hirst's Re-birthing Report (2005), the introduction of midwifery models of care as a choice for all women, who are at low risk for complications adds strength for significant changes to occur in Queensland maternity services. The more recent Federal Government Review of Maternity Services in Australia (Commonwealth of Australia, 2009) conducted by Rosemary Bryant, Commonwealth Chief Nurse and Midwifery Officer, made recommendations that will potentially enable midwifery models of care to be implemented throughout the country. These recommendations include midwives being able to access public funding for maternity services (Medicare), access to the Pharmaceutical Benefits Scheme (prescribing) and the ability to access indemnity insurance.

The impact of these recommendations may be an increase in the capacity and expansion of midwifery models of care in Australia, such as the case-load MGP that the midwives pioneered in this study. It is important to recognise that studies such as this are vitally important to contemporary midwifery care and encompassing the Practice Essentials when organisations implement midwifery models of care. Finally, this study identified essential elements that emerged from the midwives' experiences that may potentially impact on the ability to sustain a case-load MGP or midwifery-led model of care.

Implications for future research

Further research is essential to evaluate midwifery models of care and more specifically the experiences of midwives during this transition to autonomous practice in Australia. Importantly for midwives in Australia significant education and up-skilling will be required, to support the development of an autonomous midwifery profession (Hirst, 2005). However, this study has demonstrated that even with the current legislative restrictions, a midwifery model of care can be successfully implemented.

It should be noted that there are only a small number of case-load midwifery models of care currently in existence in Australia. Essentially, there were only five relatively new case-load models, at the time of this study in Queensland therefore, it may be difficult to generate significant numbers for a larger study locally. Moreover, a comparative study of the experience of midwives pioneering similar models of care, in particularly case-load models, throughout Australia would be invaluable. Importantly, a comparative study such as this could potentially identify the barriers and challenges that facilitate or prevent the implementation of case-load midwifery models of care in Australia at the present time.

CONCLUSION

The experience of midwives working in a case-load midwifery model such as this MGP was identified as a significant gap in Australian research literature. This study explored the experience of midwives who participated in pioneering a new model of midwifery care which was in direct response to the Hirst Re-birthing Report (2005), a case-load MGP. By understanding the phenomenon, the essence

of the midwives' experience, this study has been able to identify key components to ensure continuing enhancement of new midwifery models of care.

The essential elements revealed in this study, that will potentially impact on the sustainability of new services are, work/life balance, shared group philosophy, group antenatal care, peer support/ case management, and organisational support. Notably and fundamental to all the elements that emerged from the midwives' experiences, was a Culture of Trust.

The midwives in this study did not disclose any aspects of subordinate practice, nor did they identify any professional issues such as those described in the studies by Kirkham (1999; 2007). However, it is important that organisations, who consider implementing midwifery models of care, consider cultural and professional challenges within their individual maternity services and develop strategies to address these at a local level. Additionally, the midwives who have experience in group practice models also need to be familiar with organisational leadership roles such as the Midwifery Unit Manager or Practice Development Midwife because working together was identified in this study as beneficial when implementing a case-load model of midwifery care. This study identified that a midwife leader with continuity of care or case-load midwifery knowledge and skills, is a key organisational component, which is fundamental to the success and sustainability of a new MGP.

The challenge for Australian midwifery practice is to acknowledge the impact of the historical conception of midwifery on how midwives currently practice. Equally

important is that Australian midwifery leaders must consider the historical

significance of midwifery development in Australia when promoting normal birth

and planning midwifery models of care. The Re-birthing Report recommended that

principles and strategies when implemented should result in approaches to care

that meet the needs of women and families in public and private sectors. Hirst

suggested that the approach should be of a contextual/relational model rather than

a biomedical model. Therefore, supporting the move to midwifery models of care

such as a case-load model (Hirst, 2005).

Importantly, literature revealed that subordination and workplace culture were

associated with significant workforce attrition of midwifery in Australia.

Researchers identified that the lack of autonomy and job satisfaction midwives

experienced, was associated with the development of biomedical models of

maternity care and was intrinsically linked to the historical conception of midwifery

in Australia (Barclay et al., 1989; Brodie, 2002; Fahy, 2007; Barclay, 2008; Purcal,

2008).

Furthermore, the large body of literature that emerged from the UK validates the

findings of this study and the importance of developing a Culture of Trust in the

workplace (Dimond, 2002; Ball, Curtis, & Kirkham, 2006a; Ball, Curtis, & Kirkham,

2006b; Ball, Curtis, & Kirkham, 2006c; Kirkham, 2007). Therefore, it is vital that

midwifery models of care, such as a MGP are implemented, since they are a

critical to the development of the midwifery profession in Australia, from the

historical and workforce attrition context. Essentially, case-load midwifery models

or a MGP model which has a Culture of Trust as a key focus and the essential

elements, which emerged from this study, may then be the catalyst for further development and advancement of midwifery in Australia.

The Australian Government endorsement of the recommendations made by the Federal Government Review of Maternity Services in Australia (2009), need to seriously regard midwifery-led models of care. Midwifery models of care provide continuity of care and should become a real choice for all women, rather than limited to a small number of women and families in Australia. Continuity of care with a known and trusted carer was identified directly or indirectly by over half of the reports and consumer submissions in the Re-birthing Report (Hirst, 2005).

Moreover, this study identified that it is important to provide education around the frameworks that underpin a MGP such as Clinical Governance. This MGP was implemented within a framework of Clinical Governance which contained key principles including research and development, evidenced based practice, continuous professional development, credentialing or standards of practice, complaints management, clinical audit and consumer participation. Honesty and transparency within an organisation will foster and protect a pathway for the implementation of a MGP provided there is a culture of trust. Whereby, the midwives and the women they care for can share and grow forging a pathway together to future MGP models.

This study illustrates the need to empower midwives within a supportive model of Clinical Governance, provide the essential elements to sustain the MGP: Work/life balance, shared group philosophy, group antenatal care, peer support/ case

management, and organisational support. Fundamental and vital to the success

and sustainability of a case-load model or MGP is a Culture of Trust, which will

effectively facilitate and enhance contemporary maternity care for all women in

Australia.

Dear Nurse Unit Manager,

The following study received ethical clearance at the Mater HREC on April 26th 2007. To ensure that the process of recruiting participants is a safe and transparent process, it is planned that each midwife will be informally approached by the Midwifery Unit Manager in the first instance, (this may be by phone or in person).

If when informally approached by the Midwifery Unit Manager the midwife agrees to meet with the researcher to discuss the project further, a meeting with the researcher will then be scheduled at a time that is convenient for the midwife. The researcher will then meet with the midwife to discuss the project and provide the midwife with the information for participants form.

Project Title:

Pioneering a new model of midwifery care: A phenomenological study of a Midwifery Group Practice

This study aims to explore the experiences of midwives during the implementation of a (new) midwifery model of care in a tertiary unit. Midwives currently involved in implementing a new model of care have the opportunity to provide information surrounding their experience with a new way of working.

Midwifery Unit Manager, Ambulatory Services.

Please tick the appropriate box:

Yes- *the midwife agrees to meet with the researcher to receive further information on the proposed study or*

No - *the midwife does not agree to meet with the researcher to receive further information on the proposed study*

Midwifery Group Practice Midwife	Yes	No
Leanne		
Rosie		
Mary		
Chloe		
Christina		
Jennifer		
Rachel		

Many Thanks

Anne Moore
Midwifery Educator/Practice Development Midwife
Mater Mothers Hospital
Raymond Terrace
South Brisbane
QLD 4101
Anne.Moore@mater.org.au

Mater
Mothers' Hospital

Project Title:
Pioneering a new model of midwifery care: A phenomenological study of a Midwifery Group Practice

Investigator: Anne Moore

Principal Investigator:
Anne Moore
Midwifery Educator/Practice Development Midwife RGN RM Masters Student (Research)
E: anne.moore@mater.org.au
W: (07) 3840 8029 Pager 0172

Principal Supervisor:
Jennifer Kelly
Head of School of Nursing & Midwifery, Australian Catholic University
E: j.kelly@mcauley.acu.edu.au
W: (07) 36237175

Information for Participants

Purpose of Research: This study is being conducted in part fulfilment for a higher degree; Master of Midwifery (Research) and aims to explore the experiences of midwives during the implementation of a (new) midwifery model of care in a tertiary unit. This study aims to explore the experiences of midwives during the implementation of a (new) midwifery model of care in a tertiary unit. Midwives currently involved in implementing a new model of care have the opportunity to provide information surrounding their experience with a new way of working.

The information that may be imparted has the potential to improve midwifery practice worldwide. On completion of this study data will be utilised to inform practice through identifying possible gaps in the planning or implementation process of this new midwifery model and to improve of facilitate a higher level of professional practice.

The data will be a component of an overall quality assurance project that will enable comprehensive evaluation of the service.

Your Involvement: Eligible participants will be invited to participate in this study. Each participant will be asked to participate in one-two interviews with the researcher; interviews will be undertaken in a mutually agreed venue. It is anticipated that the interviews will each take 60-90 minutes.

Participation: Consenting to participate in this study is voluntary. If you consent and later change your mind, you are free to withdraw without penalty or comment. Participation in this study will not impact on your position as an employee of Mater Health Services.

Confidentiality of Information: Confidentiality of your personal and study information will be maintained and safeguarded. The interviews will be tape recorded, this information will then be de-identified when transcribed to a word processed document (by the researcher) and all participants will be given pseudonyms for the purpose of analysis. Any documentation displaying findings with have no identifying names and will be kept in a locked cabinet in the Practice Development Midwifery office at Mater Health Services. Only the research team will have access to this information. Any research reports or publications resulting from the study will not have details allowing you to be personally recognised.

If, in the event of an unsafe practice disclosure, which is deemed to be necessary to act upon, it will be managed by a process of peer review, reflection and risk management depending on the event.

Questions or Concerns: This study has been approved by the Mater Health Services Human Research Ethics Committee and you may **contact the Mater Research Secretariat** on 3840 1585, should you have any complaints about the conduct of the research, or wish to raise any concerns. The Research Secretariat may contact the Patient Representative or Hospital Ethicist at its discretion.

If you would like a report of the findings of this research when it is complete please contact the Principal Investigator (details above) a report will be posted to you.

Thank you for considering participation in this study; your involvement is much appreciated.

Kind Regards,
Anne Moore

Appendix (V) Information for Participants2.doc 26.04.2007

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Queensland 4101 Australia
Phone +61 7 3840 8111
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CONSENT FORM

Investigator:

Anne Moore Midwifery Educator/Practice Development Midwife RGN RM Masters Student (Research)
Contact: (07) 3840 8029 Pager 0172 or anne.moore@mater.org.au

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Project Title:
Pioneering a new model of midwifery care: phenomenological study of a Midwifery Group Practice

---

Participants Name:

I have
- o read and understood the information given to me via the 'Participant Information form'

- o had the opportunity to ask questions about the study and am satisfied with the answers and explanations given to me

- o been informed of the possible risks or side effects of the procedures being conducted

- o understood that the study is for the purpose of research

- o understood that the study will involve purposeful selection of participants

- o been informed of confidentiality measures to safeguard and protect all research information and data collected.

- o been assured that I am free to withdraw from this study at any time without comment or penalty

- o voluntarily agreed to participate in the study

- o been informed that participation in this study will involve one to two audio taped interviews.

- o been informed that in the event of an unsafe practice disclosure, which is deemed to be necessary to act upon, it will be managed by a process of peer review, reflection and risk management depending on the event.

Signatures   ………………………………………………………………………
                       Participant   Date

Signatures   ………………………………………………………………………
                       Witness   Date

Signatures   ………………………………………………………………………
                       Investigator   Date

Mater

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MATER HEALTH SERVICES HUMAN RESEARCH ETHICS COMMITTEE

4 May 2007

Ms Anne Moore

Dear Ms Moore

Re: Pioneering a new model of midwifery care: A phenomenological study of a midwifery group practice
Ref №. 1077M

I write to advise that the Mater Health Services Human Research Ethics Committee considered your research proposal at its 23.04.07 meeting.

Approval has been granted subject to the following conditions:
  1. One spelling error on the information sheet – the second principal investigator is referred to as "principle". Please amend information sheet, changing version date and number, print on Mater letterhead and forward to the Research Ethics office so that full approval may be granted.

The Committee confirmed it did not need to review this study again and final approval could be granted between meetings.

The approval will be valid for the duration of the project or three years, whichever is earlier. Please note the following conditions of approval.

- Any departure from the protocol detailed in your proposal must be reported immediately to the Committee.
- When you propose a change to an approved protocol, which you consider to be minor, you are required to submit a written request for approval to the Chairperson, through the Secretary. Such requests will be considered on a case by case basis and interim approval may be granted subject to ratification at the next meeting of the Committee.
- Where substantive changes to any approved protocol are proposed, you are required to submit a full, new proposal for consideration by the Human Research Ethics Committee.
- You are required to advise the Research Ethics Coordinator immediately of any complaints made, or expressions of concern raised, in relation to the study, or if any serious or unexpected adverse events occur.
- Under the *NHMRC National Statement on Ethical Conduct in Research Involving Humans*, research ethics committees are responsible for monitoring approved research to ensure continued compliance with ethical standards, and to determine the method of monitoring appropriate to each project. You are required to provide written reports on the progress of the approved project annually and on completion of the project. The Committee may also choose to conduct an interim audit of your research.

Yours sincerely

Christopher Coyne
Chairperson Mater Health Services Human Research Ethics Committee

Australian Catholic University
Brisbane Sydney Canberra Ballarat Melbourne

✛ **ACU National**

Human Research Ethics Committee

Committee Approval Form

Principal Investigator/Supervisor: Dr Jennifer Kelly   Brisbane Campus

Co-Investigators: Brisbane Campus

Student Researcher: Ms Anne Moore   Brisbane Campus

Ethics approval has been granted for the following project:
Pioneering a new model of midwifery care: A Phenomenological study of a Midwifery Group Practice.

for the period: 29 June 2007 to 31 December 2007

Human Research Ethics Committee (HREC) Register Number: Q200607 24

The following <u>standard</u> conditions as stipulated in the *National Statement on Ethical Conduct in Research Involving Humans* (1999) apply:

(i)   that Principal Investigators / Supervisors provide, on the form supplied by the Human Research Ethics Committee, annual reports on matters such as:
- security of records
- compliance with approved consent procedures and documentation
- compliance with special conditions, and

(ii)   that researchers report to the HREC immediately any matter that might affect the ethical acceptability of the protocol, such as:
- proposed changes to the protocol
- unforeseen circumstances or events
- adverse effects on participants

The HREC will conduct an audit each year of all projects deemed to be of more than minimum risk. There will also be random audits of a sample of projects considered to be of minimum risk on all campuses each year.

Within one month of the conclusion of the project, researchers are required to complete a *Final Report Form* and submit it to the local Research Services Officer.

If the project continues for more than one year, researchers are required to complete an *Annual Progress Report Form* and submit it to the local Research Services Officer within one month of the anniversary date of the ethics approval.

Signed: *K. Pashley.*   Date: 29 June 2007
          (Research Services Officer, McAuley Campus)

(Committee Approval.dot @ 31/10/06)   Page 1 of 1

Anne Moore SSC Committee Response 15.03.07 (Ref. No. 1077M)

To Whom It May Concern,

Thank you for your letter of 9th March 2007. I found the committee's comments very helpful and I am very pleased to be able to provide more detailed information on the areas highlighted by the Committee. Please find attached responses to the questions posed by the SSC and please also note that the title has been changed to reflect more accurately the study.
Regards Anne Moore
Practice Development Midwife,
Mater Mothers Hospital
Ext 8029 Pager 0172

Revised title:
Pioneering a new model of midwifery care: A phenomenological study of a Midwifery Group Practice Ref No. 1077M
Previous title: the lived experience of midwives working in a new midwifery model of care: a Midwifery Group Practice in a Tertiary Unit

At its March 6 2007 meeting the SSC reviewed this study and recommended it return to the SSC as there were a number of questions.
Summary:
Part of a quality assurance project to evaluate a new service of a midwifery group practice model of care.
Objectives:
Establish whether further supportive frameworks are needed to achieve sustainability of service
To inform the overall evaluation of the midwifery group practice within the MMH and demonstrate improved service.
Participants: Midwives in the midwifery model of care practice (6 – 8)
Methods: Qualitative study using hermeneutic phenomenology using focussed interviews of 60-90 minutes with midwives about their experience. Interviews will be taped and then researcher will identify themes and evaluating these themes.
Protection of privacy is by the use of pseudonyms.
Unstructured interview process. The Committee considers the information will be very dependant on the investigator.

SSC *Questions and comments*	Response
Is this study being conducted (in part or entirely) to fulfil requirements for a higher degree? Researcher needs to inform participants that this study is part of her Masters program (if that is the case).	This study is being conducted in part fulfilment for a higher degree: Master of Midwifery (Research). A statement to this effect has now been added to information letter for participants (see attached).
Focused interview is proposed as the data collection method. It is unclear whether this is for groups or individual midwives?	Semi-structured (focused) interviews will be used to interview the participants (midwives). "Focused interviews" is the correct term applicable to interviewing individual participants, whereas focus group interviews (which are not being used) are used with groups of participants. Focus groups are not used in Phenomenological studies.
The questions for use in the focused interview (Appendix vii) are brief and could benefit from the addition of cues to assist those not responding to initial questions. The 2nd question is not open-ended and thus unlikely to generate more than a yes/no answer.	The second question was typed in error, and was from an earlier draft and has since been modified. It now reads, "Can you please tell me how confident you felt to practise using this model?" Questions such as, "Please can you describe how the experience was for you?" will be posed. This will allow the flow of conversation to be enable/facilitate the participants/midwives to tell their stories. However, some prompts have been prepared in relation to questions 2-4. These prompts will be used to focus the interview on the research topic if the participant does not provide the data spontaneously: • Question 2 example: in the clinical area/education/communication • Question 3 example: support from midwifery and medical staff • Question 4 example: caring for a woman who would like a vaginal birth following a caesarian section

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While a 2nd interview may occur, this research method usually requires the researcher to take the findings back to the study informants. Please explain the processes in relation to 2nd interviews in more detail.

Achieving saturation of data was not referred to as a means of knowing whether the number of informants is sufficient. While the Committee acknowledges that there is a finite number of eligible participants, analysis should probably include some estimation as to whether saturation has been achieved.

Interviews are a rigorous method of data collection method, which are used in a range of situations in particular, qualitative research projects. Interviews enable the researcher/interviewer to elicit the views of interviewees (Hansen, 2006). In qualitative research it is important that the appropriate type of interview is used, Moreover, it is important that the interview facilitates in-depth understanding of the research phenomenon of interest.

Semi-structured (focused) interviews will be used to gather data that will provide information about the way the midwives experience and understand their work and role in a new midwifery model (Grbich 1999). Additionally, the interviews will enable the midwives to tell their 'story' (this is essential to a phenomenological approach). The goal of phenomenology is to understand the lived experience through intensive dialogue with persons who are living the experience (Polit & Beck, 2006).

Interviews of approximately 60-90 minutes will be conducted during April–May 2007 at a mutually agreed time and venue. If required, a second interview will be conducted to explore further and clarify themes that emerged in the first interview.

Phenomenological reduction will be used as a method of analysis to reveal the essence (a phenomenological construct) of the midwives' experience. Iterative/thematic data analysis is a method of data analysis that stems from a tradition of qualitative research where the researcher is guided by the data collected (guided by the research area of interest). It attempts to identify the important themes that are embedded within the raw interview data. The iterative aspect of thematic analysis is the way that the researcher repeatedly moves between different aspects of their research; collecting data, transcribing and reading data, reflecting and interpreting and then collecting new data (Grbich, 1999).

Collecting and transcribing data and, importantly, reading and reflecting on data, are an essential part of this method of analysis and must be completed by the researcher to enable familiarity and allow expansion and connection between different aspects of the data.

During this process of analysis a new theme may be identified that requires a second interview to achieve data saturation and it is at this time when a second interview will be conducted with a participant and this highly fluid iterative process will continue until a point of data saturation is achieved and where no new discoveries are occurring (Hansen, 2006).

Pseudonym/ confidentiality: this researcher is the practice development midwife and the Committee is not sure what management role she has with the participants. Will this: 1. limit the information received from the participants? 2. Limit confidentiality in a practical sense? If so should another researcher conduct the interview and de-identify tapes prior to analysis by researcher?

The researcher conducting this study, who is also the Practice Development Midwife (PDM), has no line management responsibilities or authority to manage the participants. The PDM role is centred on education and practice support, therefore the PDM is in a suitable position to undertake the data collection because, as described by Speziale and Carpenter (2007), the potential to influence what is said in the interview is reduced.

In qualitative research it is often important that the researcher is sensitised to the phenomenon of interest. Without relevant knowledge and experience of the research topic there is a danger that data will be missed due to the naivety of the researcher. This is important throughout the whole process of data collection and analysis and includes the first naïve reading of the text as a whole; formulating thoughts about its meaning for further analysis. The second step is structural analysis in which patterns are identified that can be meaningfully connected. This is referred to as interpretive reading. The third step is the interpretation of the whole and involves reflecting on both the initial reading as well as the interpretive reading to ensure a complete and comprehensive understanding of the findings.

When applying an interpretive phenomenological approach to research it is important that careful examination of the researcher's role is required as well as the data analysis and any ethical issues that may be connected with this type of methodology. Therefore, this will be addressed through the reflective journaling of the researcher's experience during the interviews and data collection.

This hermeneutic phenomenological study will follow Gadamer's approach and the hermeneutical circle, enabling through a process of rigorous understanding and interaction, enabling the phenomenon under study to be uncovered (Speziale & Carpenter, 2007). Moreover, the essences of the phenomenon of midwives' experiences pioneering a new midwifery model of care in a tertiary unit will be uncovered.

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	Furthermore, to be able to interpret the true meaning of what it is to be a midwife "being-with" the woman they are caring for in a midwifery model that provides one-to-one midwifery care requires the researcher to become immersed in the research itself. Importantly, the experience of the researcher will enable a greater understanding, which in turn enables the researcher to interpret better the phenomenon; fusing together the researcher's knowledge, beliefs and experiences with that of the participants. This provides a much richer collection and analysis of data. It is important to note that traditional concepts such as 'bias' are redundant within qualitative research, as the intention is not for the researcher to distance themselves from the research in order to 'objectify' it. Rather the opposite is true: it is accepted, and indeed intended, that the researcher does influence the data collection and analysis processes. What is important is that the researcher is open and honest about their 'position'. This is particularly consistent with interpretive approaches to phenomenology, which do not support the use of 'bracketing' - a process associated methodologically and philosophically with descriptive phenomenology - as a means to prevent 'bias' (Polit & Beck, 2006). To ensure transparency and truth are maintained (in accordance with the qualitative tradition of credibility, as opposed to the quantitative traditions of validity and reliability), the reflective journal that will be completed during the data collection period will be used to reflect and provide an additional data source. The researcher will be immersed in the data whereupon after transcribing the data it will be read and reflected to identify themes. This process will allow a highly fluid iterative process until a point of data saturation is reached (Hansen, 2006) Therefore, the researcher, who is the Practice Development Midwife, is the most appropriate person for data collection and analysis, and this is entirely consistent with interpretive phenomenology. Furthermore all participants will be informed of the role of the researcher prior to commencement of data collection and will be assured that confidentiality, truthfulness and transparency throughout the research process will be maintained.
It is unclear whether taped data will be transcribed or whether only the analysis of the interviews will be transcribed.	The taped interview will be transcribed verbatim as soon as possible following each interview. It is intended that each taped interview will be listened to at least twice prior to transcribing, following which the data will be analysed.
The SSC were unclear about qualifications of the supervisor, in particular with respect to the methodology proposed for this study. Please provide more information. This is of interest to the Committee because the investigator appears to have had some training but perhaps little or no previous research experience.	Please refer to the "Request for Ethics Approval of Research. *Mater Research Ethics, Augibny Place, Mater Hospitals Complex* (11/06) which does not seek or request that a university academic supervisor supply information surrounding qualifications and/or expertise surrounding the methodology, it merely requests the Supervisors name, title and signature. However, in light of the request the Principal Supervisor, Dr Kelly undertook a major and minor phenomenological study for her PhD. Additionally, Dr Kelly lectures tertiary students in the area of qualitative research. Further, both supervisors have extensive experience supervising higher degree research students in qualitative research. This response has been provided by the Principal Supervisor, Dr Kelly and the Co-Supervisor, Prof Paul Fulbrook.

It is difficult to see how this study will address the second objective of the study. How will the second objective be answered through the interview process? Reviewing the Mater Midwives Partnership Program document some of the evaluations are:
   a.   There is a projected monetary saving with the use of this model of care.
   b.   Enhanced positive health outcomes (page 7 of the document) and
   c.   Consumer satisfaction.
Will these be addressed in this study? If so, please explain how.
	It is important make clear that this research is not an evaluation study of the Midwifery Group Practice. However, the findings will provide valuable information about the new model, which can then be used to inform further developments of the service. The focus of this study is entirely upon the midwives' experiences. This is particularly important because the new model represents an innovative way of working, which is unique to this tertiary centre, and in Queensland. In this context, the Mater is at the forefront of maternity care provision in Queensland. There is no intention, therefore, to study monetary saving, health outcomes, and consumer satisfaction. However, it is very likely that some midwives will identify some of these themes when they are describing and evaluating their role. Please note that the documents provided for the ethics application as appendices were intended only to inform the committee of the background against which the Midwifery Group Practice model was developed.
	
	This study will explore the experience of midwives who have been involved in pioneering a new model of midwifery care. Moreover, the experience of midwives working in a caseload midwifery model such as a Midwifery Group Practice has been

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	identified as a significant gap in Australian research literature. The data obtained from this study may be used to inform the overall evaluation, furthermore identifying any gaps in implementation of a new model of care. For example, during an interview a midwife might describe a case where no support was available in the clinical environment. If a theme was identified where there was insufficient support in a clinical area this information could be used to inform the overall evaluation and enable improvements to be made to the service. In a thorough review of the research literature, which was undertaken by the researcher in preparation for this study, themes such as lack of organisational support, stress and burnout were identified as being significant and contributing to midwives leaving the profession. If similar themes were to emerge from this study, the organisation would be able to use the findings as an evidence base from which to develop strategies to address them. To achieve sustainability of a service, recruitment and retention of skilled midwives is vital. By providing a model of care in which midwives can practice more autonomously than the previous model allowed, it is likely that greater job satisfaction will be experienced.
There is a consumer feedback form within the documentation but no reference to it in the submission. Is this part of the study? If so, the purpose, participants, procedures/methods used to distribute and collect the feedback form, analysis to be applied etc. should be described in the application. Consent for this feedback is also likely to be necessary, since it is temporally beyond the scope of usual hospital contact with maternity patients. If the investigators do not intend to seek consent, a specific case for that would need to be made to the HREC. These late questionnaires also raise the risk of events such as contacting a mother whose infant has subsequently died or been taken into care, so the HREC is likely to want to hear more information about how mothers will be contacted for this feedback.	As noted above, consumer feedback is not part of the study. The documentation was provided as information for the committee in order to provide a sense of the whole quality process and evaluation of the service. The consumer evaluation is completed following transfer from the hospital to the Midwifery Group Practice Midwife during the postnatal period while in the normal scope of care (up to 6 weeks postpartum) and returned to the MMH. A feedback consent form is completed and filed in the patient medical record, which allows for information to be collected about the care women and families receive in the facility.
If concerns about unsafe practice are recognised how is this to be managed? Procedures should be explained and this should also be on the information sheets and consent forms.	There is no perceived direct risk to the participants however there is some potential that a midwife may become distressed during the interview. For example, the midwife may be affected by having to relay the experience of a mother that has encountered a traumatic event such as domestic violence or an intrauterine death. If this occurs during the interview the interview will be discontinued and the midwife will be given the opportunity to attend Mater Staff Services for support or seek peer support depending on the level of distress. Although it is unlikely, it is not impossible that a participant might disclose a situation that may be perceived as unsafe practice. This possibility has been anticipated and the following arrangements have been made. If an issue of perceived unsafe practice is relayed or identified during the interview the researcher will seek peer support from the research supervisor and a clinician. The Midwifery Unit Manager, Ambulatory Services has agreed to act in this supervisory capacity if required. If, in the event of an unsafe practice disclosure, which is deemed to be necessary to act upon, it will be managed by a process of peer review, reflection and risk management depending on the event.
What role do the investigators have in the implementation of the program? Risk of bias will be high if the investigators have a role in the implementation program. The researcher may partly get around that with	The role of the Practice Development Midwife is of education/ practice support of the implementation process and this will be acknowledged from the beginning of the study. Additionally to achieve research credibility the following strategies will be implemented: researcher reflexivity, purposeful sampling, transparency of data collection and analysis methods, as outlined in the following summation of research

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more structured interview questions and also with the methods suggested under point 11. However, this potential source of bias will probably need to be acknowledged in any report of the study.	rigour. Importantly, these processes will improve the quality of data and overall analysis of the project (Hansen, 2006) and are consistent with the chosen methodology of interpretive phenomenology.
	
	Research rigour
	Rigour can be enhanced through the utilisation of theories to enhance data collection and data analysis processes. A theory associated with data collection and analysis was put forward by Gadamer and is known as Gadamer's Hermeneutical Circle (Speziale & Carpenter, 2007). Gadamer's hermeneutical circle approach is relevant to this research as it assists with informing data collection and analysis through the guiding nature of this theoretical perspective. The hermeneutical circle is a circle of interpretation that moves forward and then backward beginning at the present and it is never closed or complete. This method of analysis will allow the data to be viewed from a particular vantage point, moreover allowing a process of rigorous understanding and interaction enabling the phenomenon under study to be uncovered (Speziale & Carpenter, 2007). The hermeneutic circle will keep the dialogue open through the questions and interviews with the midwives, allowing conversations that are non-directive and an open approach allowing the participant to take the researcher with them when telling their story (Koch, 1996).
	    The strategy of purposeful sampling used in this study will facilitate collection of rich data from the participants. Moreover, while purposeful sampling in itself does not confer rigour it will enhance credibility of the study (Hansen, 2006). Purposive sampling is increasingly common strategy particularly when an unusual group is being studied – such is the case with the Midwifery Group Practice Model (Polit & Beck, 2006)
	    Furthermore, a technique utilised in this study to produce trustworthy data will be researcher reflexivity and completion of a reflective journal to complement the data.
	    The completion of a reflective journal by the researcher during the data collection period will compliment data and importantly will provide transparency during data collection and analysis. Additionally, this process will provide an audit trail to enable truth and validity to be maintained (Smith, 1999).

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5   5

Reflective Journal Extract

'Setting up the recorder made us both nervous, soon forgot it was there…….
Leanne said how much she really wanted to work in this model, wanted it so
much, I remember feeling that way too (quite a few years ago now!). We had to
move tables to the garden area because of the noise from staff at lunch on the
next table, didn't seem to cause a problem with the flow of the interview, just
carried on from where we left off……'

'Leanne was so helpful and focused during the interview, really did not need any
prompting after first trigger question. Whole manner was open/ honest, I felt quite
humble/ privileged really. Leanne looked great, seemed expressive/ passionate
and maintained eye contact throughout the interview……'

'Interesting how Leanne shared the family stuff with me and how her family were
so much more interested in her work now as a MGP midwife. They asked how the
birth went, or if the call was another one (baby). Something they had not done
before, Leanne said they had not been really interested in her job at all before
being a midwife now working in the MGP looked to mean so much more to Leanne
now… was she really unhappy working in a biomedical role and why was it so
different now???'

'Leanne looked really happy, smiling lots when describing her family and how it
was working for her. She looked relaxed, but keen to share. I wonder how she will
feel after a few years, will it still be so exciting???'

Clinical Governance Model

Elements of Clinical Governance

Risk management

Continuous professional development

Research and development

Clinical Governance

Clinical audit

Consumer participation

Complaints management

Credentialing

Clinical practice guidelines

Evidence based practice

Developed by Anne Moore
Practice Development Midwife;
May 2006

International Confederation of Midwives (2005). *International definition of a Midwife*: **Statement release. National Conference, Brisbane, Australia.**

'A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help.

She has an important task in health counselling and education, not only for the women, but also within the family and the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or in any other service'.

The Midwifery Group Practice Model of Care in this Study

The Midwifery Group Practice (MGP) model of care, consisted of a small group of

midwives with a focus based on continuity of care and carer approach, providing

antenatal, intrapartum and postnatal care for a defined number of women.

The MGP midwives developed a guiding philosophy that would be available for

women and their families:

> *'The philosophy of the MGP is to provide women centred care and
> continuity of carer to women during pregnancy, labour and the postnatal
> period in local communities, hospital and at home. Midwives will be the
> primary care providers to women who remain healthy and uncomplicated
> throughout their pregnancy; however if the care required become more
> complex, to maintain the philosophy of continuity care, it will be provided in
> collaboration with other health care professionals. Women will receive
> information to facilitate informed decision making during pregnancy. The
> midwife will empower and support the woman and her family in preparation
> for childbirth and parenthood'.*

Women received ongoing information to facilitate informed decision making during

their pregnancy. Working with the philosophy of the model the midwives believed

that they could empower and support women and their families in preparation for

childbirth and parenthood.

The MGP provided an alternative 'group approach' to antenatal care and

education provision within community settings close to the woman's home. This

type of antenatal care provided women with the opportunity to develop social

networks within their own community (Schindler Rising, Powell Kennedy & Klima,

2004).

A central component of this MGP was multidisciplinary collaboration and teamwork

in both primary and secondary settings. This encompassed appropriate referral to

and care from medical, allied health and associated voluntary organisations. The
midwives utilised the hospital consultation guidelines when providing ongoing risk
assessment during pregnancy and when access to a medical practitioner was
required. A nominated obstetrician provided obstetric consultation and
management planning at case management meetings and when required. This in
turn enhanced continuity of obstetric care within the MGP model.

Ongoing advice and support was provided by the MGP midwife by telephone
during early labour. Intrapartum and birth care was provided by a known MGP
midwife in the hospital setting. The MGP midwife provided continuity of care in the
immediate post birth period. At which time early transfer home was offered from
the birth suite if suitable or transfer to the postnatal ward for a period of up to
24hours if no complications or additional needs were identified. Women were fully
informed of this expectation when booking with the MGP. Ongoing postnatal care
was provided in the home setting within an agreed geographical area, utilising the
Health Service policies and NICE guidelines (NICE 2006). Postnatal care
continued in the community for up to six weeks, on an individual needs basis.

How the Midwives Worked within the Model of Care

Each midwife carried a mobile phone to facilitate communication with the women
and the health care team, in line with workplace health and safety
recommendations. The midwives utilised their own motor vehicles and were
remunerated for fuel costs as occurs within Queensland Health. The midwives
were employed under the provision of the EB 6 - Schedule 7 (Appendix VIII). Sick
leave and annual leave was covered within the group practice.

The midwives had flexibility to organise their own daily workload autonomously, meeting the needs of the women, their colleagues and themselves. They attended weekly case management meetings for case discussions, review and management of ongoing cases and reflection on practice. This meeting was facilitated by the Practice Development Midwife and nominated obstetrician. The midwives were directly responsible to the Midwifery Unit Manager of Ambulatory Services and supported by the Practice Development Midwife. In addition to holding a case-load of women, each midwife also carried a portfolio of additional responsibilities.

These additional responsibilities included; managing access and new bookings to the MGP, risk management, documentation and record keeping standards, student support and facilitation, consumable resource management and ongoing in service education promoting the program.

Each fulltime midwife cared for approximately 40 women per year. Those midwives working part-time took a equivalent case-load, for example if they worked four days a week they would case-load 32 women per annum. The MGP midwives took responsibility for a full case-load from the commencement of the program. The midwives maintained a case-load while also supporting each other for regular time off, sick leave/annual leave and also practice support and education.

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