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# **MIDWIVES:**

## **Preparation and Practice**

**A thesis presented in partial fulfilment of the  
requirements for a degree of Master of Arts in  
Nursing at Massey University**

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## ABSTRACT

The focus of this study is centred upon the perceptions, training and experiences of midwives.

A sample of recently qualified midwives was externally selected and interviewed to provide data for a descriptive study.

The initial results indicated the following needs for midwives: flexible training requirements, realisation of their prior nursing experiences, continuing professional educational needs, expansion of practical experiences to contribute to the development of a growing autonomous midwifery practice.

A beginning model for midwifery practice which is offered to help clarify and integrate aspects of complex and varied issues was developed out of the midwives' perceptions of their education and employment experiences.

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## CHAPTER 1

### Introduction

This research arose from a concern that fewer midwives have been educated in New Zealand since the hospital-based midwifery training programmes were replaced by the technical institutes programmes. Over the last decade this has reduced the number of midwives training to the extent employers at some hospitals have had difficulty filling midwifery vacancies. Although overseas trained midwives have been recruited to fill some of these positions, and in several cases registered obstetric-only nurses have been employed, the lack of New Zealand trained midwives is still a matter of concern for managers of maternity services.

The large reduction in the number of nurses training as midwives, coinciding with the move from hospital-based to polytechnic-based training, suggested the need to identify and describe aspects of this phenomenon, and at the same time view the midwives' past and present employment experiences.

The need to examine midwives reasons for practising midwifery was also acknowledged by Hill in her study of St Helen's trained midwives from 1973-1979 (Hill 1982, p.139). She also stated there is an urgent need for evaluative research into four major problem areas by those administering the technical midwifery programmes, i.e. length of course, further experience on completion, negative attitudes of staff and the effect of student-status in the clinical areas

#### Background to this study

This chapter provides an overview of midwifery history in New Zealand and how preparation to become a midwife has evolved since the 1900s to the present time. It focuses on:

- the preparation of the midwife in New Zealand from 1904 to 1957
- the changing context of maternity services
- midwifery training in the last 25 year
- challenges to the midwifery profession today
- the midwives of today

The influences of the wider society, while relevant, will only be addressed in limited aspects as it is considered to be beyond the scope of this study.

## 1. The preparation and training of midwives in New Zealand during the period of 1904 to 1957.

The first New Zealand midwives were lay practitioners whose only qualification was that they themselves had borne a child. They were also known as 'handywomen' and were expected to accompany and care for women in labour, to deliver the baby with or without the doctor present, to care for both the mother and the child in the days following, and as well to cook, nurse, and be maid for the rest of the family. Their practice came under close scrutiny when the Midwives' Registration Act was passed in 1904 which required midwives to be trained. The belief was that this would raise the standard of obstetric care and reduce newborn and infant mortality rates. Five thousand pounds per annum was allocated for midwifery training. Gradually, over the next 20 years, lay-midwives were phased out as trained midwives replaced them.

Grace Neill, Assistant Inspector of Hospitals and an English trained nurse, came to New Zealand at the turn of the century. She was the architect of the Midwives Bill and was the moving force behind the first midwifery training programme at the St Helens hospitals in this country (Donley, 1986, p.32).

The impetus for her plans was provided by the findings of a New South Wales Royal Commission called in 1904 to investigate causes of the startling fall in the birth rate in Australia and New Zealand. The Commission found that a lower birth rate had occurred only among the so-called 'better' classes, while the 'unfit' were actually having more babies but with an accompanying high infant mortality rate. Grace Neill decided that one way of increasing the population was to lower the infant mortality rate by improving the maternity services for the 'deserving (white) poor'. The Commission recommended improvements in confinement conditions, midwifery practice and hospital accommodation, control of lying-in homes, compulsory registration of illegitimate and stillbirths.

These recommendations provided Grace Neill with the rationale she needed to establish the four St Helens Hospitals. They would not only provide a place where the wives of working men could have their babies under the best conditions but also provide a practical venue for midwifery training.

She believed that intelligent women could best be trained as midwives in obstetric hospitals and through a carefully taught programme, these midwives would raise the standard of obstetrics

generally which would lead to a reduction of infant and maternal mortality rates (Neill, 1961, p.94).

At this time the St Helens hospitals provided midwifery training for both nurses and for women with no previous nursing training (direct-entry midwives). The latter did a 12-month maternity nurse training followed by a 10-month midwifery course, while general nurses did only a 10 month midwifery course to become midwives. Direct-entry midwife intakes at St Helens were reduced by 50 percent in 1923, to make room for the increasing number of general nurses wishing to gain their midwifery certificate.

A Royal Commission of Inquiry was held in New Zealand in 1923, to investigate the high maternal mortality rate, particularly from puerperal septicaemia. It recommended that the training and practice of obstetric nurses should continue and this was followed by the Nurses and Midwives' Registration Act being passed in 1925. After various amendments to the Act were made, the Nurses and Midwives Board was established to approve the training programmes and to regulate their quality.

The two courses of training were:

1. **Maternity nurse training** - This was an 18-month training course in mother and baby nursing for women who had no nursing training. They worked under the supervision of a midwife or a doctor in the maternity annexes of public hospitals. The age limit for these women to begin their training, was lowered from 23 to 18 years.
2. **Midwifery training** - Registered general nurses with a recommended minimum 12-month period of staff nursing experience could undertake a further 6-month maternity nursing programme and register also as maternity nurses. They could then, following clinical practice, apply to undertake a 6-month midwifery course in one of the St Helens Hospitals.

This type of training continued until the late 1950's when the system of including the obstetric component within the basic general nursing programme was introduced.

By 1930 it was clear that the maternity nursing programme was not achieving the desired results. The extended training period from 12 to 18 months and a lowered entry age had resulted in a high drop-out rate among the students. This led to a reduced number of maternity nurses being trained and a significant number of

maternity beds being closed around the country as a result (Lovegrove, 1954. p.96).

Stringent maternity regulations, H.Mt.20 were passed in 1925 and one of the the priorities of the Nurses and Midwives Board was to ensure students were trained in the new aseptic techniques. These regulations required the provision of a sterile environment similar to an operating theatre for the birth.

Babies were also placed on strict routines and confined to nurseries where handling was minimal. An inability to meet these very strict regulations forced many of the 'midwife run' lying-in hospitals to close.

Hester Maclean, Director of the Division of Nursing felt strongly that the role of the midwife was threatened not only by the economy but also by the introduction of the 40 hour week. She saw the midwife as the chief caregiver to mother and baby continuously for as long or as short a time as was necessary. Strictly timed shifts of duty could only disrupt this unique aspect of midwifery and undermine the midwives role and significance (MSIS, 1985).

After the Social Security Act was passed in 1938, midwives had to battle to retain midwifery training, as it was cheaper in economic terms to train only maternity nurses (MSIS,1985).

The Minister of Health in 1945, proposed the closure of the Auckland St. Helens hospital as a new obstetric and gynaecology hospital was to be opened. Doctors argued that maternity training was sufficient and that midwives were not essential. The National Obstetric group of New Zealand Nursing Association (NZNA), which later changed to the Midwives Special Interest Section of NZNA, mobilized, enlisting support which led to the proposal being withdrawn. Instead of closing the midwifery schools, they insisted that more midwives were needed and by the end of 1947 at least 100 were being trained annually (MSIS,1985).

It was Flora Cameron, Director of the Division of Nursing, who in 1957, made changes in the curriculum moving maternity nursing into the general nursing training. These general nurses graduated with a double certificate and were therefore eligible to apply for admission to the six-month midwifery programmes at the St Helens hospitals. The maternity nursing programmes were gradually phased out (Donley,1986, p.99).

Although criticised by both nurses and doctors, this curriculum remained in place until 1979, with obstetric/general nurses being trained in maternity units of public hospitals and midwives being trained at St. Helens hospitals. The passing of the 1971 Nurses Act reduced the registration age to 21, thus allowing registered nurses to commence their midwifery training at an earlier age. But the Act also reduced the status of the midwife to that of a maternity nurse by giving doctors overall responsibility to care for women during their pregnancy, labour and puerperium. Midwives thus lost all opportunities for autonomous practice.

## **2. Changing context of maternity services**

Changes in the preparation of midwives and nurses have occurred at the same time as, and in response to, changes in the political and social climate in New Zealand. Concerns over child health and child preservation were increasingly mentioned around the turn of the century. Up until 1920, most New Zealanders were born at home, or in small unlicensed one-bed homes run by the local midwife. Doctors attended only emergencies and the confinements of the wealthy. Approximately 4% of the births took place in St Helens hospitals, 5% in hospital board maternity units and 25% in private hospitals. However, by 1935, 78% of births were in either private or public maternity hospitals (Mein-Smith, 1986, p.1).

Women accepted these changes for many reasons, enjoying their stay in hospital as a rest from household chores, the care of large families, poor living conditions and difficult economic times. They were also lured by the promise of painless childbirth (Donley, 1986, p.40).

During the period between the two world wars, the medicalisation of childbirth and antenatal care proved to be major themes in the development of New Zealand obstetrics. Official preoccupation with the dangers of childbirth led the medical profession to categorise pregnancy and birth as pathological conditions, according to Mein-Smith (1986, p.53). This philosophy encouraged hospitalisation. While puerperal sepsis was the official target for reform in the 1920s, by the late 1930s pain in labour began to be designated a major pathological feature. Not all forms of pain relief required the presence of a doctor, but 'painless childbirth', which was strongly advocated by the medical profession as a means of removing women's fears of labour, called for both the doctor's attendance and hospitalisation.

The use of sedation was one of the major factors contributing to the medicalisation of childbirth in hospitals. Dr Doris Gordon (1955, p158) began using twilight sleep in the 1920s among her patients. Because the availability of pain relief was based on an ability to pay for private hospital care, sedation as predicted by Gordon, led to 'the establishment of more and better equipped hospitals.' Gordon also stated that 'it would 'encourage a 'better' class of women with superior genes to make their contribution to the Empire's birth rate'.

The Department of Health opposed the use of sedation correlating its use with a big increase in forceps deliveries occurring at the same time in public hospitals (Donley,1986, p40).

Free medical and hospital services for maternity care were introduced in 1939 by the first Labour Government. This also increased hospitalization, although a free domiciliary service was also provided. In 1941 the Social Security Medical Benefit gave every pregnant woman free ante, intra and postnatal care from a doctor. This set the pattern for the maternity services that we have today. The midwife seemed superfluous.

In 1978, a group of Auckland parents, who had had babies at home, formed the Home Birth Association. Branches sprang up all over the country and by 1980 the movement had grown to the point where a national conference was held and a national association formed. This movement became a strong political pressure group in New Zealand (Donley, 1986, p.82). In 1990 the Nurses Amendment Act has been changed to once again give these homebirth midwives autonomy to practise and also access to funding.

### **3. Midwifery training in the last 25 years.**

The transfer of the state midwifery schools from St. Helens hospitals to hospital-based control began in 1969 and as Joan Donley (1986, p.48) stated:

'this placed them directly under the control of the medical hierarchy and removed the last vestiges of midwifery influence'.

Midwives' were concerned not only by the complexity of practice but also with the necessity to adjust to technological progress in maternity care. There was also a trend away from hospital-based care to community-based care in the field of maternal and child

health. The adequacy of the six-month hospital-oriented, service-based course was questioned by midwives (MSIS,1985). The New Zealand midwifery training did not qualify for registration in Australia or U.K. where the training was one year. One nurse, Whiteman (1976), who carried out a study on the preparation and role of the midwife in New Zealand, also questioned the training, stating:

'there is an unmet need for community nursing services for the mother and child and that the present hospital-based midwifery programme is not 'effective' in terms of preparing midwives who are prepared to practise for two years or more after qualifying.'

There was a growing awareness at this time of the changing orientation in nursing practice and the context in which nursing education occurred. Dr Helen Carpenter was brought to New Zealand by the Government in 1970, to assess nursing training and to make recommendations about changes in nursing education in this country. She was asked to consider:

- 1) the conflicts between the service needs of hospitals run by medical superintendents and the educational needs of student nurses
- 2) the role of nurses as members of a multi-disciplinary community-orientated health team ( in relation to the planned increase number of General Practitioners available)

Carpenter advocated a more liberal and theoretical nursing education to replace the traditional modified apprentice, hospital-based programmes. This was in keeping with trends occurring elsewhere in the Western world (Donley,1986, p.101). Following these recommendations, the first students of nursing entered Technical Institutes in 1973. The NZNA supported nursing education taking place within educational institutions and worked towards its implementation.

For midwives the debate continued, with numerous committees being set up to discuss concerns about midwifery education. One of these was an ad hoc committee established by NZNA in 1975, to study the factors influencing the midwifery education programme and to make recommendations for the re-organisation and extension of the programme. The committee prepared a paper which included:

- 1) the role and scope of the New Zealand midwife's practice and
- 2) a programme which it considered would meet the requirements for preparation for practice.

This document was referred to the Department of Health and the Nursing Council of New Zealand but any decision to extend and/or alter the midwifery programme was deferred until the whole problem of advanced education for nurses was resolved (NZNA, 1984).

In 1978, hospital boards were notified of the Government decision to establish Advanced Diploma of Nursing (ADN) courses in Auckland, Wellington, Waikato, and Christchurch Technical Institutes. The Maternal and Child Health component of ADN became available with one option leading to the registration as a midwife and another option allowing midwives to extend their knowledge and skills. Wellington Technical Institute was the first to offer the midwifery option as a part of the ADN course, followed by Waikato, Auckland and Christchurch. The initial prerequisites for applicants to attend these courses included: registration as a general and obstetric or comprehensive nurse, with a minimum of 2 years post basic nursing experience, including a period of 6 to 12 months experience in maternal and child health. This meant that a woman intending to make midwifery a career had to go through a six year education programme.

The Nursing Council of New Zealand set up an ad hoc committee in 1980 to clarify the midwives' role. The committee included council members, examination committee members, and the nurse consultant in midwifery to the Council. The function of this group was to:

- 1) clarify the competencies expected of the midwife at the time of sitting the State examination leading to midwifery registration, and
- 2) identify areas of consensus in the opinions of registered midwives in New Zealand in 1980, concerning these competencies.

A consensus level of at least 80% was reached for 99 of the 113 items surveyed and there was a relatively uniform level of consensus between the three areas of midwifery skills, namely ante-partum, intra-partum and post-partum areas. The committee saw a need for:

either the beginning midwife practitioner to have some form of practice following registration, or for the midwifery programme to be extended

the current course to contain a greater depth of practice of midwifery skills

continuing education for all practising midwives which should be organised by the employers (Nursing Council of New Zealand, 1980).

In February 1980, the National Executive of the NZNA established an ad hoc committee to develop a Policy Statement on maternal and child health. This was adopted by the NZNA conference in 1981. Its stated purpose was to reinforce the role of the nurse in the area of maternal and infant health in line with the changes in nursing education. It firmly classified midwifery as "nursing services" and defined the midwife as a nurse, and midwifery as a post basic nursing qualification. This set the philosophical base for the Nurses Amendment Act of 1983. This Act reinforced the role of the obstetric nurse permitting her and several others to carry out maternity care under medical supervision. Midwives saw these changes in legislation and education policy as a direct threat to the existence of midwifery and it united both domiciliary and hospital midwives as never before. Change was brought about by political pressure of the Midwives' Section of NZNA and by many consumers expressed dissatisfaction with their childbirth experiences. Women had started questioning the medical approach to birth as the only way to have a baby.

A group of homebirth women and professionals formed the 'Save the Midwife Society' which attracted national membership and disseminated information about midwifery education of which the public were previously unaware (Donley, 1986, p.108). This in turn mobilized other consumer groups to support the cause. Through the support of consumers, midwives started to listen to what women wanted and together they formed a powerful political pressure group.

A Massey University, Department of Nursing Studies workshop in August 1986 provided an opportunity for over 100 midwives to meet and share common interests and establish significant national networks. This carried through to the first National Midwives' Conference in Christchurch (Midwives' Special Interest Section of NZNA), and then another weekend in Palmerston North in 1988. Midwives became a united voice, fighting for autonomy. They also

felt that NZNA was no longer representing midwives' best interests and Joan Donley, in presenting her paper "Midwives or Moas" at the second National Midwives conference in Auckland in 1988, challenged midwives to form their own professional organisation. The New Zealand College of Midwives was born in April 1989.

A working party of regional representatives from the NZNA Midwives' Special Interest Sections established in 1983, had again made recommendations to appropriate organisations on the educational preparation, the role, the scope and the sphere of practice of the midwife in New Zealand. They recommended:

that the midwifery course be separated from the Advanced Diploma of Nursing and be directed toward the preparation of the beginning practitioner in midwifery.

that provision continue to be made for the admission of registered midwives to the ADN courses in sufficient numbers to maintain development of the midwifery service.

that funding be available for both courses

that the concepts of clinical teaching contracts in approved clinical settings be investigated.

that discussion take place to reconsider the length and structure of the course, and the need for a prerequisite clinical year.

Another ad hoc committee, consisting of three midwives from the Midwives' Special Interest Section and two NZNA representatives, was set up in 1986 by the National Executive of the NZNA to prepare a new policy statement on maternal and infant health. It was considered that the previous 1981 policy statement needed to be revised and updated in the light of current community needs and professional developments.

The Midwifery Policy Statement (NZNA 1988), is based on a premise that a sound midwifery service is a prerequisite for the effective provision of care for women and babies. It also demonstrates a commitment to midwives and consumers and to the future of midwifery.

#### 4. Challenges to the midwifery profession today

The changes to midwifery education in New Zealand highlights the differences between the older more traditional nursing training courses, and more modern thinking of nurse/midwifery education.

Midwifery practice under the biomedical model had placed the labouring woman as a passive recipient of a whole series of procedures unquestioningly accepted as essential for safe delivery. Examples of such procedures were strict admission shaves and enemas for all women in labour and standardized delivery positions. The move to a more holistic model has acknowledged and incorporated a community-based, consumer-oriented midwifery practice. This includes early ambulation and self toileting, improved antenatal screening and education, more consumer participation in the planning of their birth, more options in childbirth positions in labour and delivery, informed consent, a growing demand for home births, and continuity of care schemes with midwives etc. Changes in the role of the practising midwife inevitably leads to changes in the educational system which educates and prepares these midwives.

Midwifery is inescapably involved in social change. The professional requirements, the practice of midwifery and standard of care offered are influenced by many factors, which include:

- current trends in levels of education
- health awareness of women
- increased technology associated with childbirth
- dehumanising effects of technology and services
- changes in the birthrate in New Zealand
- increased cost of health care provision
- cuts in services by area health boards
- concerns over consumer rights and demands
- rise of the feminist movement

The increasing financial cost of providing health care in our hospitals, has resulted in the reallocation of funds and cuts to many services. Many small maternity hospitals around the country have closed. Increased knowledge and education generally among women in New Zealand has led to an awareness of health needs and concerns over consumer rights and demands with many women having strong preferences for more natural forms of childbirth.

Unfortunately, childbirth services in New Zealand have been under the power and control of the medical profession. Control over where the birth should take place, the procedures that should be used and the conditions under which the birth should occur have been in medical hands. Midwives have fought this dominance over the years and now with expected changes occurring with the passing of the Nurses Admendment Act in 1990, midwives will be allowed to work with women to achieve their desires.

Carolyn Flint, a member of the United Kingdom Association of Radical Midwives, describes the role of the midwife in her book 'Sensitive Midwifery' as:

'to be a midwife is to be with women -sharing their travail and their suffering, their joys and their delights. To be a midwife is to engage in a close and intimate relationship which often lasts only as long as the pregnancy, birth and puerperium but the effect of which travels down through the centuries in the image women have of themselves and their abilities and worth. When midwives are strong, women are able to labour safely and without unnecessary interference. When midwives are weak women's bodies are taken over and the birth process is interferred with, often to their detriment.'

The W.H.O. definition of the midwife, which supports the above, is set out in full in Appendix C.

Today, the midwife can be an independent practitioner, adviser, and teacher, with a sound knowledge of science, technical ability, and above all, a willingness to listen and to communicate effectively, and also to confidently stand up for the women they support.

To do this, today's midwife should know about social and technological changes in maternity care. The growth of technology relating to childbirth places the midwife in a patient advocate role so she is able to understand and, if necessary, challenge a medical decision in relation to care. To do this midwives need to know how to read and act upon a cardiotocograph print-out of the baby's heart beat, the pH level of the blood, and various other screening tests available to detect any abnormalities. They should also be able to explain what is happening, to the mother.

## 5. The midwives of today.

New Zealand midwives today are a mixture of graduates from all these different training programmes.

The following section considers midwives, their training, the need for midwives and the numbers of midwives practising in New Zealand.

### a) recent midwifery graduates

The following two tables illustrate the consequences of the changes that occurred in preparing midwives for practice:

Table 1 compares the number of midwives being trained at the four hospital-based training centres up to 1979 with the much lower numbers being trained at the Technical Institutes from 1980-1989.

Table 2 shows at which Technical Institutes the 301 midwives did their preparation for midwifery between 1980-1989.

Table 1: The number of midwives trained in New Zealand in both hospital board and technical institute programmes between 1976-1989

Year	Hospital Boards	Technical Institutes
1976	157	
1977	185	
1978	163	
1979	120	4
1980		13
1981		17
1982		28
1983		19
1984		33
1985		25
1986		32
1987		44
1988		41
1989		45

Source: Nursing Council and the Technical Institutes supplied these numbers

Table 2: The number of midwives trained and qualified at the technical institutes in New Zealand from 1979 to 1989.

Year	Wellington Polytech.	Christchurch Polytech	Waikato Polytech	Auckland Polytech	Total
1979	4				4
1980	2		5	6	13
1981	8		5	4	17
1982	8	6	5	9	28
1983	4	6	6	5	19
1984	8	6	6	13	33
1985	4	3	5	13	25
1986	9	5	8	10	32
1987	12	7	10	15	44
1988	14	4	7	16	41
1989	15	4	7	19	45
Total	88	41	62	110	301

Source: All the Technical Institutes supplied these numbers.

A marked reduction in the number of midwives training in New Zealand occurred after the midwifery programme became educationally-based (see Tables 1 and 2).

Two questions are asked at this stage:

why has this occurred?

what will the long term effects be from these reduced numbers?

The perceived shortage of midwives in New Zealand led the Hospital Boards Association to form a working party in 1983. Their aim was to:

ascertain whether a shortage of midwives actually existed, if there was a shortage of practising midwives, to examine the reasons for this and to recommend ways in which a shortage might be overcome

They considered the decrease in the number of midwife trainees had three possible causes:

1. midwifery is now regarded as one of several career options in specialised nursing rather than another qualification to be gained while working
2. for many nurses preparation to become a midwife now involves the sacrifice of a year's nursing salary in return for the standard tertiary bursary. This can be a significant financial sacrifice.
3. lifestyles and attitudes to family commitments and work have altered in recent years through the impact of changing marriage patterns and the early return of women to the workforce after childbearing. These factors have helped influence the number of nurses who are able to undertake study away from their home environment.

The working party concluded that 'the new midwifery courses had not been running long enough to allow the prediction of a possible future shortage of midwives'. They recommended:

'a further review be undertaken in about 3 years' time'

'that employers should not expect a new graduate to accept sole responsibility in any setting until that graduate has had a period of supervised experience'

'that retraining programmes are made available for those wishing to return to midwifery after a number of years away from practice'

'that part time work and job sharing be encouraged'

'that there is a more flexible funding arrangement through the Department of Health to enable nurses to do their midwifery training'

'that nursing resource planning be closely reviewed as to its impact on midwifery supply'

'that there be a public reaffirmation of the Midwifery Policy Statement (NZNA, 1981), on the role and function of midwives within the nursing

service' (Hospital Boards Association Working Party, 1984).

The Department of Education published a report 'The Evaluation of the Advanced Diploma in Nursing Courses' in 1987. The minimal midwifery content of the ADN was criticised by many midwives and midwifery graduates alike. Some of the criticisms were:

'that the nurses who chose it are immediately presented with an anomaly. Though their nursing skills may be enhanced to some extent in the midwifery course these nurses are only fitted to practice midwifery at beginner practitioner level and therefore require supervision while consolidating skills and knowledge. The workload imposed on these nurses who are attempting to work at two levels of learning i.e. as a new practitioner in midwifery and as a skilled practitioner, is deleterious to progress within the course'

'that there was a need for a greater amount of clinical experience during the course'

'that the midwifery option should be substantially modified or a separate midwifery programme should be offered'

These criticisms suggested the need for educators to adapt their teaching programmes to meet the specific needs of the midwifery students.

Commenting on the education and preparation of midwives in New Zealand, Field (1987, p.16), stated:

'that much of the content of the ADN programme is needed for tomorrow's midwife who will need good communication skills, a good grasp of teaching and an ability to evaluate research.'

She recommended that the programme needs to be turned around for those doing midwifery, namely: midwifery coming first and the ADN part second.

The Minister of Health announced that from 1989 there would be a dual option for midwifery preparation, that some technical

institutes will offer a midwifery course which is not part of the Advanced Diploma in Nursing, while a limited number of Institutes will still offer the ADN and midwifery option.

Auckland, Wellington and Otago-Southland polytechnics offer the midwifery-only course, while Waikato and Christchurch offer the ADN and midwifery option. The midwifery courses are now also available to part-time students over a two year period, for example, there are ten full-time and seven part-time students doing their midwifery course in Wellington in 1990.

1990 has seen a significant increase in the number of midwifery students throughout New Zealand, e.g:

Auckland	36
Wellington	17
Christchurch	6
Waikato	11
Otago/Southland	9
Total	79

In summary, preparation for being a midwife in New Zealand has evolved from a six-month hospital-based programme to being part of a tertiary-based programme of the ADN. at Technical Institutes from 1979-1988, to also being a separate midwifery programme being offered at three different Technical Institutes from 1989.

Many New Zealand nurses, however, still combine overseas travel with obtaining further qualifications, such as midwifery. The course in England is hospital-based and 18 months in length after registered nurse training. In Australia it is still a 12 month hospital-based training.

#### **b) the need for midwives in New Zealand.**

The number of births and the number of women of childbearing age are used in conjunction with Table 5 (the number of midwives in New Zealand) to describe the current situation in this country.

Table 3: The total number of births and stillbirths in New Zealand from 1977-1988.

Year	Total Live Births	Stillbirths
1977	54179	413
1978	51029	364
1979	52279	348
1980	50542	349
1981	50792	332
1982	49938	297
1983	50474	269
1984	51636	261
1985	51798	254
1986	52824	249
1987	55254	265
1988	57546	277

Source: Department of Statistics (1987).

The total number of births and stillbirths in New Zealand from 1977 to 1988 and shows a steady increase in the birth rate since 1985 which has implications for practising midwives

Table 4: The estimated age distribution of women within the fertile years of 15-45 years, in New Zealand, as at 31 March 1988.

Age Group	Female Population
15-19	152930
20-24	138050
25-29	143470
30-34	132250
35-39	121000
40-45	104800
Total	792500

Source: Department of Statistics (1987).

These tables indicate there is an ongoing need for midwives. i.e.:

There is one practising midwife to 1470 per head of population in New Zealand or one midwife holding the

qualification but not necessarily working, to 831 per head of population.

There is one practising midwife to 348 women of childbearing age in New Zealand

**c) how many midwives are there in New Zealand?**

A nationwide profile of midwives in New Zealand is provided in Tables 5 to 7 from the 1989 provisional figures provided from the Department of Health.

Table 5 illustrates the numbers of midwives in New Zealand with practising certificates showing a midwifery qualification. Table 6 illustrates the age range of these midwives and Table 7 illustrates the geographical area where these midwives are practising.

Table 5: All nurses holding an annual practising certificate with a midwifery qualification in 1989 compared with 1984 and 1986 numbers.

Year	R.M only	RGON/RM	R.Comp/RM	Total
1984	228	3483	120	3831
1986	199	3285	130	3784
1989	207	3285	209	4030

Source: Department of Health (1989 figures provisional)

Table 6 illustrates the age range of the current population of midwives of which 71% are over 40 years and 4% under 30.

The question is, what will happen when those over 50 resign or retire?

With such an age distribution and the low numbers doing their midwifery training unless some change occurs there will eventually be few midwives left to practise in New Zealand.

Table 6: The age range of the midwives practising in 1989 compared to the 1986 numbers.

Age of midwives	R.M.only		RGON/RM		R.Comp/RM	
	1986	1989	1986	1989	1986	1989
20-24	-	-	5	2	1	4
25-29	2	-	228	70	25	27
30-34	2	-	396	267	17	33
35-39	32	4	498	380	9	19
40-44	38	46	404	449	7	18
45-49	35	43	411	347	12	11
50-54	23	41	324	369	9	8
55-59	21	21	222	198	12	13
over 60	11	14	126	109	5	6
not recorded	1			98		6
<b>Total</b>	<b>165</b>	<b>168</b>	<b>2713</b>	<b>2190</b>	<b>104</b>	<b>139</b>

Source: Department of Health (1989 figures provisional).

Table 7: The distribution of the population in New Zealand to the ratio of midwives working in those geographical areas for 1989.

Town/Geographical area	Population	No. of Midwives	Ratio
Whangarei/Northland	40212	147	1:273
Auckland	820754	1012	1:811
Tauranga/Bay of Plenty	53097	188	1:282
Hamilton/Waikato	97907	303	1:323
Napier/Hawkes Bay	51330	129	1:397
Wanganui/Manawatu	40758	234	1:174
Wellington & Hutt	325697	469	1:694
Christchurch/Canterbury	299373	429	1:697
Dunedin/Otago	106864	189	1:565

Source: Department of Health (1989 figures provisional)

Table 7. illustrates that there are fewer midwives per head of population in each of the four main centres, namely Auckland, Wellington, Otago, and Christchurch.

In comparison, in June, 1981, Hon Gair, the then Minister of Health, stated:

'there were 3621 midwives with practising certificates in New Zealand, i.e. one midwife to 1856 people or one midwife to 822 women in New Zealand in 1981. Therefore there is not a shortage of midwives but a maldistribution of midwives. Many midwives choose not to practise midwifery and this needs to be looked at' (Hill, 1982, p.139).

The figures for 1989, showing one midwife per 1470 people, indicate similar results, that there is not a shortage, but a maldistribution of midwives and a significant number of midwives who are not working.

Thus, the aim of this thesis is to provide a description of the midwives' training and work experiences, thereby addressing the above concerns. In order to do this I decided to approach those recently trained midwives to learn and clarify from them their perceptions about their training and midwifery practice.

Two focusing research questions are used to guide my study in the areas of midwifery education and practice.

- 1) How was their polytechnic training perceived by the recently qualified midwives?
- 2) What organisational and professional factors are perceived by the midwives as being present in the workplace that encourage them to remain practising within the profession?

Before learning about the stories that the midwives had to tell, a descriptive overview of information relevant to the two research questions will be addressed in the literature review.

## CHAPTER 2

### Literature Review

This literature review, which is divided into two sections, will provide information relevant to the two research questions concerning the midwifery profession, namely:

**Section 1.** To provide a description of the midwives' perceptions of their training.

The literature focuses on the following which puts the question in context:

- reasons why nurses choose to do their midwifery training
- the midwives' intentions to practise
- the intention not to practise midwifery
- evaluation of the midwifery course

**Section 2.a)** To identify and outline the organisational factors as perceived by these midwives, that influence them to stay practising now and in the future.

The researcher identified the following factors from the literature as possible contributors to this phenomenon and these categories will therefore, provide the structure for this review:

- midwifery variables in selection
- socialization process
- orientation
- job satisfaction
- retention factors
- maintenance of competence and continuing education
- career development

**Section 2.b)** To describe the midwives' perceptions of the future developments and challenges to the midwifery profession

The researcher identified the following challenges as being important in this section:

- professionalism
  - philosophy and ethics of the profession
  - research in midwifery
  - autonomy or control of midwifery practice

medicalisation of birth  
consumerism

## **Section 1. The midwives' perceptions of their midwifery training**

### **1.1. Reasons for doing midwifery training.**

The reasons for doing midwifery training have been explored in the United Kingdom (Mander,1987.a.; Williams,1979; Robinson,1985.a; and Golden, 1980), in Australia (Barclay,1984) and in New Zealand (Hill, 1982). It was found that the main reasons for taking midwifery training in these above countries were:

they thought it would help them to achieve their career goals and at the same time improve their career prospects.

a more personal reason was a desire to complete or round off their general nurse training

because they liked babies

wanted to prepare for their own childbearing

wanted a change from an existing job

needed a qualification to 'work abroad' i.e. midwifery training was a prerequisite for missionary or VSA work in developing countries.

This last statement supports the suggestion that midwifery is regarded as necessary for practice in other countries.

While this has been explored in New Zealand and similar responses were obtained, these studies were carried out before the midwifery training was moved to Technical Institutes (NZNA, 1975 and Hill, 1982). In this study of St Helens midwifery graduates 1973-1979, carried out by Hill(1982, p.152), she found there were other reasons why they chose to do their midwifery training, e.g:

had always enjoyed obstetrics and wanted to learn more

felt inadequate working in an obstetric hospital without the midwifery qualification

to augment paediatric training/nursing

later moving to a rural area where midwifery would be useful

### 1.2. Intention to practice as midwives

Hill (1982, p.153), stated in her study that

'it was surprising and encouraging that 82% of the students recorded an intention to practise midwifery and this was later reinforced when 85% did practise using their midwifery qualification'.

Only 10% actually intended to practice as midwives after qualifying in Australia (Barclay, 1984). Similar results were found in the United Kingdom, according to Mander (1987.a. p.34), who stated that

'a surprising proportion of qualified midwives are lost to midwifery immediately after the completion of their midwifery training'.

She examined this phenomenon, and found that the value of midwifery to a nurse may be its perceived ability to advance her career. This use of the midwifery qualification to advance a career in nursing may operate in one of a number of ways:

to gain promotion,

to broaden the experience of nursing before she specialises.

Hardy (1983), terms this phenomenon the 'lateral movement syndrome'. She considers that such movement is necessary for the nurse to gain credibility both in her own eyes and in the eyes of her colleagues and potential employers. Midwifery is perceived, by nurses and by potential employers, as evidence of a 'breadth of experience', thus indicating that the nurse has shown her commitment to nursing by working in a field which, in many of its features, is significantly different from nursing. The need for the nurse to show this commitment by undertaking further relevant study may be a reason for the attraction of the midwifery qualification to nurses and their employers.

Robinson (1986.a.), in another study in the United Kingdom, compared the views about the midwifery training, held by two groups, i.e. the group of midwives who took the 18 month course and the group who took the 12 month course. One of the reasons for increasing the length of the midwifery training in the United Kingdom, was to provide the students with greater opportunities to

develop confidence in their clinical skills. This it was hoped, would in turn, lead to an increase in the numbers who wished to practise midwifery after qualifying. The results of the study showed that newly qualified midwives who had taken the 18 month course were more likely to state:

they had sufficient time for clinical experience,

they felt adequately prepared for the various responsibilities of practising as a midwife.

they intended to practise midwifery after qualifying.

The relationship between career intentions and experience of training was found to be complex and Robinson suggested that the experience gained during the 18 month course had a much greater effect in convincing students that they would enjoy making midwifery their career.

### **1.3. Intention not to practice as midwives**

Studies of the midwives who, after qualifying, expressed a definite intention not to make midwifery a career have been undertaken in three countries. All had similar results.

Robinson (1986.c.), in the United Kingdom, asked the midwives the reasons that led to their decision. These included:

greater job satisfaction in general nursing;

a lack of job satisfaction in midwifery;

better promotion prospects in general nursing;

plans for further training;

family commitments;

working abroad.

In New Zealand Hill (1982), found that the group of non-practising midwives in her study expressed less intention to practise as they had only done their training to change their existing job, or to improve their career prospects.

However, in Australia Barclay (1984), found that nearly one-fifth chose not to remain in midwifery because they found more job

satisfaction in general nursing. Her survey showed motivation to work as a midwife was not strongly felt by the majority of candidates and few changed their minds as a result of their training. The survey also showed that many midwifery education programmes had antiquated curriculum designs and implementation. Midwifery students frequently believed they were poorly treated as menial members of the workforce, rather than as learners. The institution's service requirements were seen as taking precedence over the educational needs of most students.

#### **1.4. Evaluation of the midwifery course**

The midwives in Hill's study (1982, p.156) expressed some measure of enjoyment in their midwifery training in terms of the clinical work and theoretical content and commented on specific aspects of the course that they particularly liked or disliked, e.g:

would have preferred a longer course

disliked student status and the treatment of students

negative experiences with other students

disliked the number system

disliked the impersonal antenatal clinic

enjoyed the follow-through nursing assignments

lack of correlation of theory and practise

Similarly, most of the midwives in Golden's study (1980, p.193) enjoyed their training, although some found the attitudes of midwives towards the pupils difficult to cope with. Their confidence was undermined when they were 'treated like first year nurses' and given no credit for their previous nursing experience. A large number of these midwives also stated there was not enough time spent on clinical teaching by the hospital midwives working in the clinical setting. The three areas in which a high proportion of midwives felt inadequately prepared were:

home confinements

caring for babies in special care units

teaching groups of parents

care of babies in the labour ward e.g. resuscitation of the babies.

Similar findings were found in the Australian study by Barclay (1984, p.16). The midwives in her study believed they were adequately prepared for work in antenatal clinics and ante and postnatal wards. In labour wards, however, they felt inadequately prepared to care for mothers and babies. Over half the midwives felt less confident of their ability to teach parentcraft groups, although they felt adequately prepared to teach individual mothers antenatally and postnatally. A majority of the midwives enjoyed their training while the remainder were ambivalent, or disliked it. The majority stated that the work itself was inherently rewarding and enjoyable, despite problems they had with the training programmes and the attitudes of staff towards students.

The problem of attitude, as expressed in the three studies above, was one of the most important reasons cited by midwives as interfering with their enjoyment of training. It reflects an undesirable attitude in the management of student midwives, which must diminish the quality of the environment for clients as well as students.

Since these overseas studies all had similar results, this research study further explores the issues and has identified influencing factors which contribute to midwives decisions to practise.

### **Section 2.a. The factors that influence midwives to stay practising within the profession.**

In the present study, the following factors in the nursing and midwifery literature were identified by the researcher as playing a part in whether the midwife choses to practise or not. They were used as a structure for the review and also as a basis for the questionnaire.

- 2a.1 midwifery variables in selection
- 2a.2 socialization process and orientation
- 2a.3 job satisfaction
- 2a.4 retention factors
- 2a.5 maintenance of competence and continuing education
- 2a.6 career development

### 2a.1. Midwifery variables in selection

Midwifery staffing problems attributed to poor retention may, according to the literature, be corrected by improved selection of midwives for the job.

Studies by Robinson (1980), and Bendall and Pembrey (1972), suggest that learners change their employment plans during or after their training, for reasons associated with their perception of the environment in which they are working. The reaction to this perception is influenced by the individual's personality.

Mander (1987.c.) undertook a study of 473 new midwifery students, in Scotland, over a three year period, to investigate changing employment intentions in association with non-retention. She identified certain variables or predictors namely, age, marital status, education and nursing experience associated with continuing midwifery practice which could be utilised by midwifery managers to assist selection in order to control retention in midwifery. These were :

1. new midwives with longer nursing experience were more likely to leave midwifery. Those with less experience i.e; no nursing experience or less than 12 months as a staff nurse, were significantly more likely to practise as midwives.
2. those student midwives with higher educational attainment were significantly more likely to practise midwifery on qualifying. There was widespread perception of greater occupational stability among more educated and intellectually able employees, which may relate to the tendency to remain in an area of greater personal investment.
3. younger midwives (24 and under) were significantly more likely to implement their intentions to practise midwifery than older midwives.
4. the effect of a person's marital status on their employment decisions was usually attributed to a combination of gender and family responsibilities, which caused them to cease employment for longer or shorter periods.

Although of interest, the research design did not allow repetition of this study.

## 2a.2. Socialization process and orientation

Studies in the field of socialization for the nursing role, by Kramer (1974); Speedling, Ahmadi, Kuhn-Weissman (1981); Ahmadi, Speedling, Kuhn-Weissman (1987), all of the United States, consistently found a clash of perspectives between the new graduate and the world of the hospital i.e. hospital structure and careers. They have suggested that

'during the socialization process the student nurse develops a conceptualization of her career which is structured along horizontal rather than vertical lines. This means that while job dissatisfaction, role strain and the like, play a part in reducing the average length of service for hospital staff nurses, there is an antecedent expectation that multiple shifts of job site will be part of one's career trajectory.'

'as attitudes, perspectives, and behaviour are shaped to fit the needs, norms and cultural patterns of the organisation during the training and the initial employment phase, it makes sense to expect that both conflict and change will occur relatively early in the new graduate's career as a hospital staff nurse and midwife' (Ahmadi, et al. 1987, p.119).

In "Reality Shock", Kramer (1974), directly links turnover rates in new graduates with job dissatisfaction. Her research clearly showed that job satisfaction is a crucial factor in postgraduate job tenure and maintenance of a nursing career. While discussing the various aspects of socializing the new graduate, Kramer pointed out that the graduate and the subculture receiving her must make adjustments concurrently. Creating a climate of professional socialization produces an atmosphere fostering more rapid skill acquisition, a swifter assumption of full responsibility and a higher degree of competence in the end. To establish such an environment, Kramer outlines a planned socialization programme. She exhorts the employer to identify the orientee's personal goals so they may be channelled to the institution's benefit.

According to Vogt, Cox, Velthouse, and Thomas (1983.p.66), **orientation** is:

'the ability to locate oneself in one's environment with reference to time, place, and people: to ascertain one's true positions with respect to attitudes and judgements'. The organisation's formal

orientation programme after training should serve as a guide to facilitate new employees in orienting themselves in their new environment. They go on to state that:

'the combination of time and activities that comprise orientation is designed to provide sufficient information to enable the new employee to practise the professional skills she brought to the organisation. It is a time for investigating one's physical and emotional surroundings, one's colleagues and equipment, one's strengths and growth goals. It is a process of sharing expectations, defining relationships, and building communication patterns'.

A well planned, coordinated and executed orientation, according to Fredericks (1981), can fulfil psychosocial needs and gratifyingly reward established staff, new graduate orientees and experienced nurse orientees. Satisfying them all will not only stabilize the work force but also improve its quality without extra expense.

Another study by Hinshaw, Smeltzer, and Atwood (1987), described an orientation programme which had preceptors to help nurses become a part of the system and acquire the job skills needed to feel competent. They also stated that nurses feel a lack of competency and group cohesiveness when they were required to give care on units with which they were not familiar.

The above studies point out the importance and advantages of having an orientation programme available to all new graduates to enable them to settle into the work environment with the aim of giving them job satisfaction and, ultimately, retention in the work place.

### **2a.3. Job satisfaction**

Registered nurses/midwives constitute the largest professional group providing health care in hospitals. However, as the following studies indicate, they are increasingly finding the hospital a less satisfying place in which to practise.

Mumford (1976, p.287.), defined job satisfaction as:

'the fit between what the employee was seeking from work and what she was receiving' or in other words, the fit between job needs and expectations and the rewards received from the job"

The study of job satisfaction - the factors that cause it and its impact on organisational life - has evolved over the years. According to Pincus (1986, p.19), several trends in job satisfaction research are discernible within the nursing and midwifery field. Early studies reveal the importance of personal factors, such as family and education, as contributors to nurses' job satisfaction (Diamond and Fox, 1958). Results of more recent job satisfaction studies, however, suggest nurses have increasing concerns connected with work and organisational issues, such as autonomy (Bush, 1988, and Slocum, Susman, and Sheridan, 1972); supervisory style (White and Maguire, 1973); interpersonal relationships with superiors and co-workers (Everly and Falcione, 1976); and organisational climate and self-esteem/recognition (McCloskey, 1974).

Sources of job satisfaction Maslow's theory of motivation (1954), is based on the internal drive of individuals to attain goals to meet certain needs. He defines motivation as

'a state of having an internal force that moves one to some kind of action'.

Goals are determined by an individual's need in a certain set of circumstances. Maslow categorizes and ranks these needs into a hierarchy, beginning with the most basic and graduating to the highest self-actualization. According to his theory, an individual's most basic needs must be met first before he/she can advance to a higher level.

Employers are interested in turnover and absenteeism, both of which are related to motivation. As a result of his study of man's need to avoid pain and to grow psychologically, Herzberg (1966) related Maslow's theory to the employment situation and suggested a dual factor theory of motivation. This theory, the motivation-hygiene theory, holds the factors that determine one's job satisfaction are separate from factors that determine one's job dissatisfaction.

The satisfiers (motivators) are related to the nature of the work itself and the rewards gained from job performance: achievement, recognition, self-actualization, responsibility, job security and status, personal relations, work itself, and pay. These feelings may originate from several sources, e.g. one's self, superiors or peers.

Dissatisfiers are associated with one's relation to the work environment: policies and procedures, working conditions, salary security and supervision. Bragg (1982); Everly and Falcione (1978); Slocum, Susman and Sheridan (1972); White and Maguire (1973); McCloskey (1974), have all carried out studies in this area.

Based on Maslow's theory the five variables/needs that Mumford (1976), associated with job satisfaction are identified and grouped under three headings:

- a) needs associated with personality
  - knowledge needs
  - psychological needs
- b) needs associated with work role and performance of work activities
  - support /control needs
  - task needs
- c) needs associated with employee values
  - ethical and moral needs

In a study undertaken by Slocum et al.(1972, p.338), needs satisfaction was analyzed for professional and nonprofessional hospital personnel. It was found that, for professional employees, a significantly positive correlation existed between job performance and psychological (intrinsic) satisfactions, e.g. prestige within the organization, job security, and job autonomy.

McCloskey (1974, p.239), in her study, concluded that external rewards such as salary, hours and fringe benefits may draw a person to a job, but internal rewards relating to the psychological needs of the individual were what kept him there and stimulated him to do good work. Both Maslow and Herzburg stated that, to motivate a worker successfully, rewards must be linked to the needs which are most desired and least attainable. This study, which also revealed that psychological rewards were more important than safety or social rewards in keeping nurses on the job, found that:

younger nurses and new graduates had the highest turnover.

single nurses stayed no longer than married nurses

the spouses' salary did not affect turnover

there was no difference between baccalaureate and diploma nurses

higher pay did not keep a nurse, nor was she influenced by an offer to work in a speciality area, e.g. in intensive care.

Many studies in the United States, show similar findings, all of which can be summed up by Bragg (1982, p.22), who found that nurses were concerned about the challenge inherent in their work and that autonomy and self - actualization were the major factors in their job satisfaction. She concluded that hospital administrators should reduce non-nursing functions and increase the nurses' input into decisions concerning their jobs.

In New Zealand Wills (1978, 1985, 1986) has carried out three studies to measure the level of nurses' satisfaction with nursing and found most of them were satisfied with their career choice and aspects of nursing such as interaction with patients. Significant levels of dissatisfaction were apparent in relation to: conditions, aspects of professional environment and organisational matters. Areas of highest dissatisfaction included: staff levels, physical working conditions, the management of the institutions and the level of respect afforded nursing.

Similar results were found in a research study carried out by Stewart-Dedmon (1988, p.66) in the United States. Its purpose was to relate the type of nursing education to satisfaction with selected job characteristics. She found that the baccalaureate nurses were less satisfied with their jobs, particularly in the areas of opportunities for independent action, self growth, high levels of responsibility, and utilization of expertise.

In a research study carried out by Pablo (1976, p.37), he suggested that women may have a higher need than men to be challenged and stimulated by more self-actualizing work and may need more recognition and emotional support.

In contrast, Tannenbaum (1962, p.236), found in his research that individuals who were not able to exercise control are, in general, less satisfied with their work situations than those who have some power, and their dissatisfaction often has the quality of apathy and disinvolvement. When an individual is in control, added dimensions of personality come into play and enhance the energy she puts into her work. She is likely to be more identified, more loyal, and more active to the organisation. As control increases so does her satisfaction.

Job satisfaction is seen as the central component in this research study of midwives - what it is, how it can be achieved and what management can do to maintain it.

#### **2a.4. Retention factors**

Women in the workforce. As midwives are mainly women, issues relating to womens' employment are relevant to a study of midwives.

It is not known how many women leave work soon after graduating or qualifying in a particular health occupation. However, a significant proportion do leave for varying lengths of time, often to raise a family. The employment patterns of women who are midwives are similar. They leave work to have a family. Sometime thereafter they may return part-time and later full-time to work. There appears to be little difficulty in attracting women back into the health services, but a number of adjustments in employers' attitudes, staff management, education, and promotion practices are seen as necessary (Department of Health, 1983).

A number of predominantly female occupations experience difficulty in recruiting people to senior positions. Reasons for this could include, the structure of the institution, the socialization of women, unrealistic role expectations and limited mobility due to a predominantly married female workforce. Women with prolonged absences from work have also often been unable to achieve the level of experience associated with most senior positions McCloskey (1974, p.239) stated in her study that most nurses wanted to attend educational programmes but didn't want promotion above head nurse position.

The increase in the number of part-time persons employed to reach full-time equivalents, creates a greater demand on staff administration facilities and resources. Employers must balance the possible advantages of greater flexibility and productivity against the increased costs and complexities of personnel management. One of management's basic responsibilities is to ensure that all members of staff have responsibilities commensurate with their level of knowledge and expertise. Employers, often seen as working against those women who have joint family and work commitments, could be far more innovative in employment practices e.g. rescheduling work hours, modifying job descriptions or promoting job sharing schemes (Department of Health, 1983). Job sharing can be defined

as two people sharing not only the functions of one particular position but also the responsibility (Buchan,1987).

One study by Synder-Hill (1982, p.20) related recruitment and retention problems to the professional nurse's search for satisfaction with nursing work. Professional satisfaction focused on the opportunities for decision making. She considered staff development programmes played a major role in this area.

#### **2a.5. Maintenance of competence, and continuing education**

According to Crowe (1981, p.31) the basic midwifery education in each country is designed to equip a woman (or a man), to become a midwife who will give an optimum standard of care to a woman and her family during childbirth and who will prepare parents for the responsibilities of parenthood.

This high standard of care can be maintained by continuing education throughout her professional life. Education is not just the acquisition of new knowledge, for knowledge means little unless it is applied. It makes one aware that there is knowledge that can be acquired and used to meet particular needs. The skills required to achieve a good standard of care are complex. Therefore continuing education is not only a necessity but a challenge. By first looking inwards at herself, then outwards to the environment in which she works, a midwife can make decisions about the knowledge she requires. As the midwife looks inwards, she may face a number of questions about the possibilities of, and constraints in, furthering her education. She needs to ask:

Has my work changed, and what particular skills do I now require which I did not require a few years ago?

Will my domestic commitments allow me to undertake a course of study away from home or are there means of education provided locally?

What are my personal limitations which need strengthening?

In looking outwards, the midwife begins by acknowledging that, throughout the world, midwifery education needs to be considered against a background of society and family life, changing patterns in maternity care, associated professional, scientific and technological

advances, and the political influences of the time (Crowe, 1981, p.31).

Increasingly, promotion within the health service occupations is becoming dependent not only upon experience but also the knowledge acquired in postgraduate studies. Continuing education programmes, however, often do not cater for the part-time employee. Such programmes are usually full-time and are increasingly becoming centralised as regional or national courses, rather than being offered by individual employers. Regional midwifery courses are being offered by community colleges and technical institutes.

Given the particular needs of female midwifery students as outlined above, it would seem necessary to make greater provision for a wide range of continuing education programmes that can be undertaken on a part time basis. Otherwise large sectors of the work force may be excluded from skill maintenance and preparation for more senior positions (Department of Health, 1983).

A number of different **continuing education programmes** could be made available, for example:

a wide range of extramural studies offered by either a Technical Institute or a University.

a greater use of intensive vacation courses or summer schools and the utilisation of existing campuses at Technical Institutes or Universities.

the development of local multi-disciplinary programmes to facilitate communication between different occupational groups.

Not all women with dependents are interested in responsibility and promotion. This also applies to some unmarried women. There are women who prefer a job with limited responsibility and sufficient income for their needs. They may achieve this by working part-time and pursuing leisure time activities. These people still require well developed staff training programmes if they are to maintain their expertise in a constantly changing work environment (Dept. of Health, 1983, p.40).

**Staff development programmes**, according to Snyder-Hill (1982, p.21), should teach professional staff nurses/midwives to participate in organisational decision making. The result is

increased quality of care, efficiency and cost effectiveness and a reduced turnover of nursing personnel. Staff educators can facilitate favourable change by offering programmes which promote an open, trusting climate and leads to growth within the individual staff nurse.

The expected rewards for the individual nurse/midwife are increased job satisfaction and high morale. For the patient there will be increased quality of care as a result of the nurse's greater personal and professional accountability. The organisation will realize greater efficiency and cost effectiveness through sharing decision-making efforts with professional nurses/midwives. Staff educators will be rewarded too, because they will be leading a more permanent staff toward achievement of quality nursing care and increased job satisfaction.

In the United States, McCloskey (1974, p.239) found that most nurses/midwives wanted opportunities to attend educational programmes and to receive credit for other courses. They also wanted career advancement opportunities other than to head nurse position, and recognition from peers and senior nurses.

The New Zealand Department of Health (1983, p.39), in their discussion paper, "Women employed in the Health Services" also stated that maybe it wasn't possible to fill the senior positions even if the midwives wanted them, because they required a lot more experience in management

Those women who re-enter health service occupations as their child-rearing responsibilities become less demanding should attend **refresher courses**. The requirements of such a programme differ according to the level of experience attained prior to leaving the workforce, and the duration of absence. Two important issues related to such courses are:

whether it should be compulsory to attend the courses to update skills and knowledge at specified intervals

whether the employer will meet the costs of the programmes.

Being recognised as professionals and having opportunities for professional growth were seen to produce high satisfaction levels among staff and to have an influence on their retention in an institution. Strategies to achieve this satisfaction are numerous and include: continuing education, research development and projects, tuition reimbursement, professional recognition for achievements,

committee responsibility, and career mobility within one institution (Hinshaw et al. 1987, p.15). In this article, 'committee responsibility' is the term used to indicate the inclusion of selected individuals in the decision-making and policy-planning groups within a hospital.

Clarke (1989, p.288) found in her study in the United Kingdom, that there was a great need for midwives to have some form of further education once they had qualified. It was needed to:

provide stimulation and motivation

maintain standards of practice

enhance contact with midwifery students in a learning situation

She found the midwives did attend locally held study days, and also read professional journals to update and extend their knowledge and skills. She concluded that the planning of any continuing education programmes for midwives should involve the potential recipients. When asked what they wanted in a programme, midwives emphasized, clinical practice, teaching and assessment (including communication skills), management skills, the importance of research in midwifery, and opportunities to discuss midwifery as a career.

These findings were also supported by both Bowman (1982) and Calkin (1979), in their studies. They found that staff development was a process that should meet the ongoing needs of the nurse and the work situation. These programmes can act as change agents in the health care organisations where they operate.

Continuing education programmes generally covered three main areas:

orientation of new employees

ongoing educational support for changes in programme or policy

communication of new developments relevant to the patient care

Bowman and Calkin both concluded that the use of traditional educational strategies alone were less effective in maintaining and improving organisational effectiveness than staff development

techniques. They believed there should be a marked expansion of the later which included a consultative approach.

The Midwifery Policy Statement (NZNA. 1988.b. p.10), states:

'the highest standard of midwifery practice and service is based on the continual development of critical thinking skills through education, the responsibility of the midwife to provide support and be supported by peers is essential. The need for support is recognised as necessary for new practitioners undertaking orientation programmes, for those moving to less familiar areas of practice, for midwives desiring to return to the workforce and for continuing and refresher education. The importance of enhancing the status of knowledge, sharing knowledge, accepting personal responsibility for learning and assisting peers to develop professionally is acknowledged.'

Professional midwives, in the United Kingdom, according to Verber (1984, p.227), are identified as those who study the available knowledge of midwifery, who are registered as a member of the midwifery community, who are accountable for their midwifery decisions and actions, and are constantly learning, formally or informally.

This is also supported by Roch (1983, p.38), in England, who states that continuing education is one of the hallmarks of a profession, and is crucial in midwifery, as it equips midwives to accept responsibility for their knowledge, clinical skills and judgement, and decision making.

The need for continuing education programmes including staff development programmes and refresher courses are seen as playing a major part in enhancing the midwife's professional role, maintaining her expertise in a constantly changing work environment and providing job satisfaction for her while she is practising.

#### **2a.6. Career development**

Walker (1976); McRae (1983); Kleinknecht and Hefferin (1982), discuss the importance of career-path planning and career development. Most employees move through a 'patterned sequence of positions or roles, usually related in work content', during their working lives. Career paths are considered to be objective

descriptions of sequential work experiences, as opposed to subjective individual feelings about career progress, personal development, status, or satisfaction (Walker, 1976, p.2).

In the study carried out by McRae (1983, p.58), he stated that the individual employee is, of course, responsible for their own career development, but the organisation can provide valuable support by making sure that employees receive career path information from their managers, for example through a performance review process.

Kleinknecht and Hefferin (1982, p.30), describe a career development model in their paper, that can help nurses to both determine their preferences for specific nursing career areas and positions and to work toward self-directed personal and professional growth. The model, as they see it, provides a framework for career development programmes that can help nurse administrators identify opportunities for restructuring nurses' work experiences, making them more interesting and challenging. The resulting professional growth and subsequent contributions to the institution benefit both the employer and employee.

At any level of practice and in every area of speciality regardless of their time in practice, all professional nurses must ensure that their knowledge and skills are appropriate to meet the demands and challenges of today's practice. Midwives should similarly be responsible for evaluating trends and issues in professional practice and seek appropriate means to enhance their professional competencies.

A midwifery career development programme should also encourage and assist midwives to plan their own careers. The plan should be flexible, allowing time for adjustment to new roles and activities, periodic reassessment of needs and interests, and modification of goals and plans as needs and interests change. The effectiveness of such a programme would vary with the participant's level of interest in planning for the future, but should help them to evaluate their personal and career interests and needs, set long and short range goals, outline a realistic plan of action, and delineate a practical time for carrying out that plan.

Since the skills of the midwife can have a profound effect upon the population within which she practices, there is a need to provide and maintain an excellent professional service. The role and scope of practice of the midwife varies from country to country, but every midwife is basically concerned with the health and safety of mothers, babies and their families.

The approach of the individual midwife to the development of her own professional career will be influenced by her general education, basic training, family and cultural background, current cultural needs in her area of practice, motivation, demands and pressures of previous, present and anticipated workloads and responsibilities, and various career options that are available to her. There are many approaches to building a career, the important points are that a midwife cannot professionally afford to make retrograde decisions or to remain static. Progress in a chosen career is ultimately a personal responsibility and no midwife should see herself as beyond the reach of a progressive professional programme.

In summary, the issues noted in the literature relate to the selection of student midwives, to midwives' initial work experiences and access to orientation programmes, to methods of recruitment and retention of the work force, to levels of satisfaction with current status and to the availability of further education programmes. The question raised is:

What are the career and employment options available to midwives in New Zealand at the moment?

### **Section 2.b. The midwives' perceptions of future developments and challenges to their profession.**

Peters (1986 p.4.), stated in her address to the first National Midwives Conference held in Christchurch (Midwives Special Interest Section of NZNA),

'irrespective of what choices we make about our midwifery profession now and in the future, our real imperative is to ensure that midwifery survives as a profession, not subordinate to any other professional group, not undocumented, nor unorganised nor under educated, nor non-represented where decisions are made, but rather as a strong independent profession in close harmony with those whom we serve, caring for them and ourselves.'

She recommended that midwives should not

'passively accept status quo but rather set the pace and negotiate the terms under which midwifery moves forward to meet the challenges of tomorrow. The midwifery of the future will reflect the

midwives of today, what they did or did not do, what they foresaw, their vision and commitment.'

Current issues, developments and challenges for the midwifery profession in the future are considered under the following research headings:

2b.1 professionalism

philosophy and ethics of the profession

research in midwifery

autonomy or control of midwifery practice

2b.2 medicalisation of birth

2b.3 consumerism

communication and patient advocates

**2b.1. Professionalism**

The midwife is accountable to her clients, her employers and her colleagues, and as well as to herself. She thereby has individual and collective responsibilities. Every midwife has a responsibility to deliver a high standard of safe, effective care, and can be held accountable if she fails to do so. Crow (1983), believes this care should also be "morally good" and midwives see this as an integral part of their professional code.

The following is a review of the midwifery profession which is currently being developed by midwives who believe that the starting point of any professional group is its philosophical and ethical statements.

**2b.1.1. Philosophy and ethics of the profession**

A professional organisation, such as the recently established New Zealand College of Midwives, does for its members what they can not do for themselves. It collates the philosophy, the ethics, the education programmes and the standards of practice for its members. The leaders of the group represent the members for purposes of policy decision making.

The philosophy for midwifery practice (Midwifery Policy Statement, NZNA 1988.b), is as follows:

'Midwifery is a profession concerned with the promotion of women's health. It is centered upon sexuality and reproduction and an understanding of women as healthy individuals progressing through the life cycle.

Midwifery is: dynamic in its approach; based upon an integration of knowledge that is derived from the arts and the sciences; tempered by experience and research; collaborative with other health professionals.

Midwifery is holistic by nature, combining an understanding of the social, emotional, cultural, spiritual, psychological and physical ramifications of women's reproductive health experience; actively promoting and protecting women's wellness, promoting health awareness in women's significant others; enhancing the health status of the foetus when the pregnancy is ongoing.

Midwifery care is delivered in a manner that is flexible; creative; empowering and supportive. Clients play a role in shaping midwifery. Midwifery care takes place in the context of mutual support'.

#### **2b.1.2. Research in midwifery**

The midwifery profession has a body of knowledge which is expanded and evaluated by research, and is organised into theories and models.

A generic and holistic model for midwifery practice, which was prepared by a group of practising midwives at Massey University in a week-long workshop in 1986, provided a background focus for this research study. The model reflects the philosophical viewpoints of the midwives who assembled it and describes midwifery practice as:

1. focusing on a child-bearing woman embedded in a family context of her own defining
2. having as its purpose the reproductive health of this family unit
3. seeing the midwife as an agent, educationally prepared and practically experienced, working collaboratively with the mother's ability to gain and maintain control over the reproductive process, especially the birthing phase.
4. using ways and means that blend scientific knowledge, art, intuition and ethical wisdom; and utilize other professions and technology in accordance with the woman's choices.

5. providing an environment which ensures optimal comfort and safety for mother and baby
6. with the whole, energized by love"

In keeping with the focus on the organisational context of midwifery practice, step 3 of the model has been modified by the researcher as follows.

3. 'seeing the midwife as an agent, educationally prepared, practically experienced and organisationally supported, working collaboratively with the woman enhancing her ability to gain control over the reproductive process especially the birthing process.'

The following midwives, Roch (1983) from England; Matson (1984), and Carter-Brown (1984) from Australia; Strid (1987) and NZNA (1988.b.), all stress the importance of carrying out research to evaluate midwifery practice. Roch (1983, p.39), states

'it is good to see more midwives involved with, and initiating research projects, and showing that valid research can be carried out on a relatively small scale with resulting improvements in patient care.'

Carter-Brown (1984, p.65), writes that there appears to be three major problems in midwifery research:

'there seems to be an aura of mystery surrounding research itself

midwives are not always aware they are participating in research

there is a lack of appreciation as to the importance of all types of nursing research to the practice of midwifery.'

She goes on to say that 'part of the midwives professional role is to communicate their applied research to other midwives'. Midwives therefore need to:

'gain more skills in the organisation of research and to put their findings in writing.

they should be committed to research as a basis of midwifery. For midwifery to maintain its autonomy it must be based on objectively determined factual data.'

Midwifery research in New Zealand, according to Strid (1987, p.17), is required to redefine childbirth, accurately assess who is at risk, decide what is a desirable outcome, and define acceptable and/or necessary procedures.

This view is supported by Matson in Australia (1984, p.403), who sees a need for:

'systematic planning is a strategy to assist midwifery in adapting to the evolving needs of midwifery practice and education. Continuous monitoring of the changes in the midwifery environment requires preparation of the midwife in research methodology. Midwifery has surely arrived at a point where it must assume responsibility for its own research. Midwives today are being asked more than ever before to document the worth and quality of their practice. Research can help us with answers to these and many other practice-related questions.'

According to the Midwifery Policy Statement (NZNA.1988.b, p.11),

'the aim of continually working towards the improvement of midwifery practice and the delivery of maternal and infant nursing services is dependent on the quality of education and the preparation of midwives to undertake/participate in research. The need for each midwife to critically examine her practice and the context in which it is delivered is recognised while acknowledging that time may be a constraint.'

Midwifery research is clearly considered to be important by the above authors. The New Zealand College of Midwives should therefore develop its own ways of evaluating midwifery practice and extending knowledge in order to improve patient care.

### **2b.1.3. Autonomy or control of midwifery practice**

Midwives have long said they would like to practise autonomously, since they believe this would lead to women having continuity of care. The previous legal requirement giving ultimate responsibility to a medical practitioner was seen as breaking this important bond between midwife and mother. Midwives argue that birth is a normal life process for women that belongs within the family and not within a medical framework.

The passing of the Nurses Amendment Bill in August 1990 has enabled a midwife to take responsibility for the care of a woman throughout her pregnancy, childbirth, and postnatal period. It replaces Section 54 of the Nurses Act 1977 that made it an offence for a midwife to provide a service unless a medical practitioner had undertaken responsibility for the care of the client. The effect of the clause is to allow a registered midwife sole responsibility for the care of the woman and thus places her in a similar and competitive position to that of the medical practitioner.

Now the midwife is allowed more autonomy her scope of practice will be more widely extended into the area of antenatal care and play a vital role in early detection of potential problems and in health promotion.

### **2b.2. Medicalisation of birth**

Two New Zealand midwives, Strid (1987), and Donley (1989), together with the United Kingdom midwives Roch (1983), Towler (1982), Robinson (1985.b) and Pearce (1987), write about the dominance and control of the medical profession over normal reproduction and childbirth. Field (1987, p.16), stated that

'New Zealand was probably the only country with midwives where the doctors is the primary care-giver and the midwife the secondary care-giver when attending to a mother giving birth; in other countries it is the other way around.'

Strid (1987, p.15), stated that the medical profession's present preoccupation with high technology in childbirth is just a more sophisticated strategy to threaten and further undermine the existence of midwives. As midwives are seen as the guardians of normal birth, the continued endangering of their 'midwifery' role in society should be of concern to all women. This danger was noted in the English study carried out by Robinson (1985.b, p.28), on the responsibilities of midwives and medical staff. Her results showed

that the midwife's role was being eroded as medical staff increased their involvement in normal maternity care. The overlap of responsibilities had adverse implications for midwifery practice and education, and for the increased use of resources in the maternity services.

Aaronson (1987, p.225), undertook further research in U.S.A. Her findings offered evidence supporting the provision of alternatives in maternity care, with knowledgeable clients having equal access to and the right to make their own choice from a range of care options. She stated that

'the question no longer can be who provides better care (nurse-midwives or doctors), but rather the question should be which model of care is best for which clients.'

Field (1987, p.17) advocates a birthing centre where midwives function as midwives, with admitting privileges for their clients and where women have freedom of choice in a more homely environment in which families can also be accommodated.

Medicalisation of birth and consumerism are seen as two important challenges with which the midwife, of both today, and in the future, will have to confront.

### **2b.3. Consumerism**

Pressure groups from within society have mushroomed over the past decade. There has been considerable focus on the use of needless technology, and a demand for more emphasis on normal, and, if possible, natural childbirth. Demands have also been made for the pregnant woman to be more involved in decisions concerning her care and in individual preferences such as whether or not she will have an epidural for pain relief, or choosing comfortable positions while giving birth, rather than being forced to follow hospital customs or policies (Pearce, 1987, p.38).

This is also supported by the consumer survey carried out by a NZNA ad hoc committee (1988.a.), and Bickley (1989). Consumer feelings about the services provided by midwives were discussed. This included the consumers' current involvement in decision making, and how they envisaged midwifery services of the future.

With the move to Area Health Boards, and greater community input, consumers and midwives in some areas have been quick to use the opportunities provided by recent changes in the health system to

develop real choices about where women give birth and who provides their care, before, during and after their pregnancy. One scheme that has undergone trials is the 'domino scheme' which provides the woman with a hospital birth and continuity of care from one single midwife. This includes three antenatal visits, attendance at the birth and if there are no problems, discharge within 48 hours for the mother with follow-up visits for two weeks (Roorda, 1989, p.4).

### **2b.3.1. Communication and patient advocates**

Within the last decade, the nursing and midwifery professions have begun a profound revision of their self-view according to Penticuff (1989, p.987) She stated that the nursing literature from the late 1970s to the present reflects a shift away from views of the nurse/midwife as a loyal health team member toward a new view of the nurse/midwife as an advocate of patients' rights. This new standard, incorporating the language of the rights and the virtue of courages, portrays nurse/midwives as advocates, protecting and enhancing the personal autonomy of patients. (Annes & Healey, 1974, p.22) The advocacy role reflects a change in nurses/midwives view of their professions and their own practice.

Midwives can play a very important role as patient advocates, ensuring that women have sufficient knowledge to make informed choices from among their care options.

Questions to answer here are:

Can a person involved in the process of patient care also be an advocate for the patient?

Would an independent outside person be a better advocate?

Are consumers informed and satisfied with the information provided to them by midwives?

The Cartwright Report arose from a specialists' groups attempt to do what they considered to be right for another group. i.e. namely women undergoing treatment for cervical cancer. Judge Sylvia Cartwright in her report "Report of the Cervical Cancer Inquiry" (1988, p.175) gave three important roles for the patient advocates:

1. they would ensure that patients who are involved in research and teaching or undergoing treatment are protected.

2. they would help develop material for the information or, where appropriate, for the education of the patients.
3. they would provide the patient with a means of obtaining more information, such as an avenue to address problems and complaints.

Judge Cartwright also emphasised patient welfare as a necessary focus of attention. Communication was seen as the key factor, opening the door to many of the recommendations. She advocated:

'a system which will encourage better communication between patient and doctor, allow for structured negotiation and mediation, and raise awareness of patient's medical, cultural and family needs. The focus of attention must shift from the doctor to the patient.'

In summary: this literature review has been used as the background for identifying a wide range of research studies related to the two research questions. The interview schedule was prepared with the issues raised by these studies in mind.

## CHAPTER 3

### Methodology

The chapter begins with a discussion in the choice of research design for this study, followed by a description of the population sample and how it was selected. A detailed account of how the data was collected and analysed is provided.

#### **Aim of the study**

As midwifery is facing many challenges at present it is imperative that the views of midwives are considered when planning changes in the educational and practice settings of midwives in New Zealand.

In order to do this, I decided to approach recently trained midwives and focus on their perceptions about their training and midwifery practice.

**Two focusing research questions** as presented previously in Chapter 1 were used to guide my study in the areas of midwifery education and practice.

- 1) How was their polytechnic training perceived by the recently qualified midwives?
- 2) What organisational and professional factors are perceived by the midwives as being present in the workplace that encourage them to remain practising within the profession?

The questions will address the current lack of information in these areas of midwifery education and practice and identify appropriate concepts in order to describe the issues.

#### **Selection of research design**

The relative lack of research-based information on this topic indicates a need for research from differing perspectives. Certainly there is no developed theory within which framework a hypothesis could be tested. Thus exploratory research is appropriate in this field.

Stevens (1985, Chapt.1) points out that good descriptive research needs to precede other forms, otherwise the field will always be limited by what has not been considered. Because of the complex content, i.e. challenges to midwifery practice, changes in midwifery education, influences of the womens' health movement etc. qualitative data, capturing the perceptions, feelings and experiences

of the midwives themselves is the key to better understanding. In-depth interviewing is the method most commonly used for generating this kind of data.

Thus there is a need for a **descriptive exploratory study** of the new education and practice settings as they are perceived by midwives. This was also acknowledged by Hill (1982, p.178).

The availability of overseas studies contributes only a limited amount of appropriate information. The midwifery education situation in New Zealand is somewhat unique among English speaking countries. In Australia and the U.K, midwives have a hospital-based training and their problems are different. Currently their dilemma is:

'how to recruit midwives into the workforce from the large numbers that are trained yearly' (Barclay, 1984 and Golden, 1980).

Overseas quantitative studies carried out on midwives were used as guidelines in developing the semi-structured interview schedule. The research design is therefore descriptive with the aim of identifying concepts and relationships relevant to the new situation.

### **Descriptive Research**

Parse (1981), states that the descriptive method as a mode of inquiry originated in the social sciences. Its findings are based upon conversations and observations. It is a human science method and focuses on discovering the meaning of an event in time. She states:

'the purpose of the descriptive research method is to intensively investigate the background and environmental interactions of a given social unit. This is an organised entity having common characteristics. It can be one person, a family, or a set of persons.' (Parse, 1985, p.91).

Descriptive research, according to Verhonick and Seaman (1978, p.5), is conducted in order to collect new descriptive data, either new facts or exploratory data, as a prelude for further research.

Abdellah and Levine (1965, p.425) also state that the primary aim of descriptive research is to:

'discover new facts, i.e., to provide a factual, descriptive picture of the situation'

Notter (1974, p.25), states that descriptive research:

'describes what is and analyzes the findings in relation to their significance. It is often done for the important purpose of generating hypotheses for future experimental studies, or it may simply be a way of finding out what the facts are (e.g. by means of a survey).'

Abdellah and Levine (1965) are critical of descriptive research. They state:

'it can be considered pedestrian because it does not offer the intellectual challenges of inventing new theory, method or procedure as in methodological research, or of discovering causative or predictive relationships as in explanatory research. It is probably true that some descriptive research commences from a meagre theoretical base and ends with a superficial analytical treatment of the data. It has also been claimed that the largest share of effort in descriptive research is devoted to the routine data-collection phases rather than to more thought-provoking stages of research.'

Descriptive research studies shed light on the variables in a particular situation, and often provide the basis for explanatory research. A common progression has been from a broad descriptive study that uncovers problem areas to explanatory research that investigates the possible causes of the problem.

The above writers suggest that descriptive research is a valuable tool for learning about the meaning that events have for those taking part in them, in this case, midwives. A descriptive approach accords a greater validity to their accounts.

The descriptive method, like other qualitative and quantitative methods, is a research approach encompassing five elements:

- identifying the phenomenon
- structuring the study
- gathering the data
- analysing the data
- describing the findings

The primary purpose of using qualitative and quantitative research methods in nursing is the same:

'to develop nursing knowledge' (Field and Morse, 1985, p.1),

and descriptive research can contribute to both methods.

### **Sample Description**

The midwives selected as the study sample were from a total population comprising the graduates of all Technical Institute midwifery programmes between and including the years 1985-1988. As the study was intended only to identify the relevant range of midwives' perceptions, a random sample was not needed. Rather, midwives were to be selected from those who were working in a variety of practice settings and geographical areas to ensure that an appropriately broad range of concerns would be identified.

Although the Technical Institute education of midwives began in 1980, the population sample was limited to those training from 1985 onwards. These recently qualified midwives were chosen because:

- 1) their training was still fresh in their minds.
- 2) their training reflected any changes that may have been made since the initial education programme was developed.
- 3) their initial work experiences were fresh in their minds.

### **Sampling procedure**

To enable midwives to be recruited from a wide range of employment situations, a request was made to the Nursing Council of New Zealand for its assistance in selecting twenty-five newly qualified midwives to participate in the study. Twenty five was selected as the appropriate number needed to produce valid research.

The Nursing Council of New Zealand was given criteria to use as a basis for selecting these midwives. These were that:

- 1) The midwives were to be selected across the following areas of practice:

those working in large maternity units	14
those working in small maternity units	8
those in domiciliary practice	3

The numbers reflect the proportional distribution of midwives in practice in New Zealand.

2) The midwives were to be selected throughout New Zealand to reflect the population distribution with the majority living in the North Island.

Geographical locations of midwives were requested, to reduce the cost and time of travel. e.g. the South Island midwives needed to be living in Dunedin, Christchurch or Nelson.

This last criterion meant that some midwives were excluded who might otherwise have been eligible for selection.

The Nursing Council of New Zealand was given twenty-five sealed envelopes to address and post to the midwives they selected. This was done without the names and addresses of those selected being made known to the researcher. As the Council had no further input into the study anonymity for the research subjects was achieved.

These envelopes contained the prepared explanatory letter asking the midwives if they would participate in this study, together with a form for response (see Appendix. B). The researcher was assured by the Council that the twenty five envelopes were posted.

### **The midwife participants**

Twenty-five midwives were approached with the Nursing Council's help, with the following response:

- 6 did not reply at all to the request
- 4 replied stating they did not want to participate and gave no reason
- 3 were not eligible as they were non-practising midwives
- 12 replied, were eligible and completed the interview

The next ten midwives were obtained by the following means:

- 6 through a Health Department nurse advisor's introduction
- 3 through a midwife friends' introduction
- 1 personally known to researcher

The initial contact with the study for the six midwives contacted through the nurse advisor's introduction was via the same letter and response form as was received by those selected by the Nursing Council of New Zealand. The remaining four were given the letter

and response form on introduction. All the midwives in the study were females.

The participants interviewed met the criteria in the following way:

- 5 came from the South Island
- 17 were distributed around the North Island from Wellington to Kaitia
- 10 worked in large Maternity Hospitals (over 2000 births a year)
- 12 worked in smaller Maternity Units (less than 2000 births a year)

No recently qualified domiciliary midwives were able to be found.

#### **Male midwives**

There are very few male midwives practising in New Zealand and none were included in the sample. The role of the male midwife is however acknowledged.

#### **Ethical considerations**

Ethical aspects of the research were reviewed and accepted by the Massey University Human Ethics Committee.

The study was planned to ensure that the participants:

1. were free to ask for further information at any time.
2. were free to decline participation or withdraw from the study at any time.
3. were given assurance that complete confidentiality and anonymity would be used when the research was being written up
4. would be given the opportunity to read the study findings after completion (see Appendix. B)

The midwives were told that participation in the study involved one interview, preferably tape recorded otherwise recorded in writing. The researcher's actions were guided by the ethical criteria throughout the study. For example a numbering system was

implemented during the transcription of recorded interview material into analysed data.

### **Data collection and the interview structure**

The interview schedule for this study was developed around the two research questions and was prepared after reviewing the literature. It also incorporated ideas and issues arising from comments heard at a variety of midwife meetings. The interview questions were open-ended and directed toward uncovering the meaning of the lived experience under study.

The interview schedule (see Appendix. A), was organised and divided into three sections, namely:

- a) characteristics of recently qualified midwives, including personal and professional demographic data.
- b) open-ended questions pertaining to their entry to training and their midwifery training experiences.
- c) questions ascertaining to organisational and professional factors that could influence midwives' decisions to practise within the midwifery profession.

This interview schedule was pretested on working midwives. Few difficulties were found and only a small number of questions needing modification.

An **interview** is a face-to-face encounter between the researcher and the interviewee. Specific information related to the objectives of the study are shared (Parse, 1981, p.92).

A guided interview is used when information is required about a topic, and or when the structure of the topic is known but the answers can not be anticipated. It is useful because this technique ensures that the researcher will obtain the necessary information over the required areas, while at the same time permitting the informant freedom to respond and describe and illustrate concepts with personal examples.

Unstructured interviewing is an alternative method in which the researcher gives only minimal guidance and allows considerable latitude for interviewees. It is a favoured technique for qualitative researchers (Bryman, 1988). Some interviewers make use of an interview schedule and others operate with a loose collection of themes which they want to cover.

The quality of research requires the possession of two skills by the researcher. First is the researcher's ability to obtain information, using both interview and observation methods. Secondly, to be successful, persistence and sensitivity are essential in order to elicit information from the data during the process of analysis (Field and Morse, 1985).

The technique used with the selected midwives tended towards a more **guided interview**. Everyone in the sample was interviewed at the place most convenient to them. This varied, with 12 being interviewed in their own home, 10 being interviewed at other places, including homes of friends or relatives or in Palmerston North. One was interviewed at an airport. Only this last venue, with its high noise level, proved unsuitable for comfortable interviewing.

Nine participants had someone in the background for at least part of the interview. Three midwives had someone present all the time. This did not appear to hinder the discussion.

The interviewer introduced herself as a practising midwife. Rapport was readily established with most of the interviewees who were all extremely helpful and interested in the study and therefore willing to share information about their training and work experiences. Twenty-two midwives gave permission for their interview to be recorded on tape. They were told at this time that the tape-recordings would be destroyed after completion of the study.

The length of the interviews varied, with the majority lasting approximately one and half hours. One was conducted over an evening in the interviewee's home, with interruptions for household activities, for nearly six hours. Even though the midwives were assured that the interviews would be confidential and anonymous, four of them (during the interview), still required clarification of this confidentiality and anonymity, before they felt able to divulge some information, especially about their present position.

### **Data Analysis**

The initial data arises from recorded fieldnotes and interviews in the form of the narrative text. According to Field and Morse (1985, p.96) recovering the data for analysis requires:

1. coding the data so that behaviours may be noted and categories recognised and analysed.

2. developing a data filing system that provides a flexible storage system with procedures for retrieving the data.

Parse (1981, p.94) states that data analysis in the descriptive method begins with a careful examination of the subject-researcher interaction, and entails a search for major themes articulated by the subjects about the phenomenon.

Wilson (1985, p.20) states that analysis is:

'the separation of data into parts for the purposes of answering a research question and communicating the answer to others.'

The above mentioned points were followed in this study. The tapes from the midwife interviews were transcribed and all the comments for each question were carefully analysed to enable themes, concepts or ideas to be identified and extracted. These were recorded collectively under headings relating to the research questions. To maintain confidentiality the interview tapes were locked away when not in use.

The data analysis forms the basis of the following two chapters:

**Chapter 4:** outlines a demographic description of the midwives interviewed; their age, marital status, number of dependent children, educational and professional qualifications and experiences.

It also contains the midwives perceptions of their midwifery training at the four polytechnics, including the changes they felt would help new groups of midwives during their preparation and training.

**Chapter 5:** contains the views of the midwives about their initial and present experiences of midwifery practice, specifically organisational factors, such as orientation, acceptance, responsibility, job satisfaction, support, management, and continuing education. Professional factors included the reasons why they wanted to stay in the profession and their views about the opportunities, challenges and future developments for midwives in New Zealand.

## CHAPTER 4

### The Midwives' Perceptions of their Training

During interview, the midwives were asked how they found their training in terms of experience, influences, enjoyment, preparation and about any changes they would like to see happen within the ADN/midwifery programme. They were also asked why they chose to be midwives. Their answers were compared to overseas research studies.

#### Demographic data

The following data pertaining to the research study participants is divided into sections on personal data and professional data.

#### Personal

1. **Age:** this ranged from 25 to 58 years with a mean of: 36 years. The high mean age among these midwives contrasts with the age of students in many tertiary education programmes (i.e. 19 years).
2. **Marital status:** 14 were married, 4 had been married. e.g. (1 widowed, 2 divorced, 1 separated), 4 were single.
3. **Number of children:** this ranged from 1 to 4, the mean being : 2.7 for those who had children. Five married midwives had no children.
4. **Highest educational qualifications:**
  - 5 stated they had no high school qualifications
  - 5 completed school certificate
  - 7 completed university entrance
  - 3 completed bursary
  - 2 have university degrees.

Apart from the two with degrees, 12 other midwives had studied university papers extramurally, including 3 who had gained no formal qualifications while at school.

**Table 9:** Age of midwives at commencement of training related to highest educational qualifications.

	AGE							
	under 35 years				over 35 years			
	none	SC	U.E.	Bursary	none	SC	U.E.	Bursary
A	-	3	2	2	2	-	-	1
B	-	1	2	2	3	1	3	-

A: no university study

B: has completed at least one paper at university

## Professional

### 1. Nursing qualifications:

There were 15 registered general and obstetric nurses

5 registered comprehensive nurses

2 registered only as general nurses - these had to gain their obstetric registration before doing their midwifery training.

Of these 22 midwives, 2 were first trained as registered psychiatric nurses and 2 were registered enrolled nurses, all of whom later gained registration as either a comprehensive nurse or a general and obstetric nurse before beginning midwifery.

Other certificates held included: plunket (2), community (2), and cardio-thoracic certificate (1)

### 2. Previous nursing experience:

a) length of time: this ranged from one woman who had more than 20 years away from nursing after completion of her general training and had no nursing experience. The other midwives had between 1 and 8 years of general nursing experience.

b) varied nursing experiences included: practice nurse, counsellor, district and public health nursing, research nurse, plunket and child health visitor.

When the midwives were asked why 'being a midwife' would add to their nursing experience, they gave the following reasons:

'increasing knowledge'  
 'rounding off nursing training, expanding, an extension of'  
 'getting out of present nursing job'  
 'a happy field to work in'  
 'promotion prospects improved'  
 'opportunity to practise autonomously'  
 'prefer to work with a women's health focus , well women'  
 'midwives always have jobs'  
 'nursing was something to get through to become a midwife',

Overseas quantitative studies carried out by Barclay (1984), Robinson (1986), Hill (1982) and Golden (1980) found that their 'midwife' samples, mostly entered midwifery training between 23 to 25 years.

In Barclay's Australian study most of the midwives had two to three years of general nursing experience. In Golden's English study nearly half had practised as registered nurses for less than a year and a small number had not practised at all, whilst less than half had no obstetric nursing in their general nursing training. From the above information it appears midwives in hospital-based midwifery programmes are entering their training a lot younger and with less nursing experience and less obstetric experiences. There is still a high drop out rate amongst these overseas midwives as soon as they have completed their training.

In comparison, with this research study, there were no midwives under 24 years and only seven between 25 and 29, the majority being over 30 when they entered their student-based midwifery training. Similarly, all but one had acquired obstetric experience during their basic training and all had over one to two years' nursing experience in an obstetric area.

It would appear that nurses entering midwifery training in New Zealand are older, more experienced in nursing, and more willing to stay within the profession. It is interesting to compare these figures with Mander's study (1987) based in the United Kingdom, in which she found that less nursing experience, higher educational attainment and lower age were identified as variables associated with continuing midwifery practice.

## Entry to training

### Reasons for undertaking midwifery training

Some of the midwives explained their reasons for undertaking midwifery training as:

They have always had the desire to be a midwife

'before I started my general nursing I had always wanted to be a midwife. It is special being part of a birth, I know that sounds romantic but I enjoy it. I have also had the unique opportunity of witnessing a home birth.'

Others had been working in an obstetric area and now needed more knowledge in that area:

'after I had worked in Neonatal area for 6 years I decided to do my midwifery. I needed further knowledge about why some infants needed neonatal care.'

'the more I got into it and the more I learnt, the more I realised I knew what I wanted to do--the enjoyment is not only caring for women but also supporting and being with women.'

Several midwives found they experienced a lot of job satisfaction working in the obstetric area because it was a positive place to work in, had a happy atmosphere and they liked working with individual women.

'I have always been interested in women's health and women's health issues and doing my midwifery training was a natural progression from working in the gynaecology ward'

Some midwives stated they considered that having a midwifery qualification enhanced their job prospects.

'I enjoyed working in the area as a practice nurse but I needed to do more and midwifery offered that wider choice and allowed for more options for jobs later.'

'I wanted to do midwifery for another bit of paper because if I shifted to another smaller town it would increase my chances of getting a job'

In comparing the reasons why nurses did their midwifery training, responses in this study were similar to those found in the literature. e.g.

to 'complete' their training as a nurse ---- broaden experience

to achieve or improve career prospects

for job satisfaction ---- likes working in this area

### **Funding v commitment to midwifery**

At the end of their training, they all intended to work as midwives. The majority of them were sponsored by their hospital or area health boards and therefore had to work out their two year bonds; only five were independent students.

Funding of midwife trainees by hospital boards (and now area health boards), still appears to be an issue. Seventeen of the midwife participants had been funded and on the whole, had no financial problems. Lack of funding made a big difference for the five independent students who found they had to work part-time through-out the course to supplement their tertiary bursary, adding more pressure to their already tight schedule.

It was experiences such as these in the past that were looked at by the working party of the Hospital Boards Association (1984). They stated that some consideration should be given to a specific midwifery funding scheme within each board. Direct midwifery sponsorship could overcome the difficulties caused by competition between midwives with those undertaking other advanced diploma courses.

The NZNA (1987), in their comments on the report, 'An evaluation of the ADN courses,' urged the Departments of Health and Education to ensure hospital and area health boards fulfil their responsibilities in providing sponsorship for ADN students and thereby in promoting a well qualified workforce in their area.

### **First practice area working as a midwife**

The majority of the midwives commented that they had expected to work as staff midwives when finished, and nearly half of them specifically stated in the delivery suite area. Only one stated she would like a charge nurse position in an ante or post natal ward in the near future.

### **Career prospects**

Before commencing their midwifery training, over half of the midwives saw development of their own career as important.

'I like working and advancing my nursing career'

'I wanted more qualifications'

Several midwives considered other things were more important to them than developing their career.

'I want to travel'

'My family is more important'

'If I moved town, my chances of getting a job are increased having midwifery'

One midwife stated that gaining experience in midwifery practice was important in preparing her for her ultimate goal of working in the community as a midwife.

## **Midwifery Training**

10 trained at Wellington Technical Institute 1988, 1987, 1986  
 5 at Waikato Technical Institute 1987, 1986, 1985  
 4 at Auckland Technical Institute (A.T.I.) 1988, 1987, 1985  
 3 at Christchurch Technical Institute 1987, 1986

### **Clinical placements**

The hospitals where they did their clinical placement were:

A.T.I.- National Women's, St Helens, Middlemore, Northshore  
 and Waitakere

Wellington - Lower Hutt, Wellington Women's, Wanganui, Elderslie and Paraparaumu.

Waikato - Waikato Women's, Tauranga.

Christchurch - Christchurch Women's, Burwood, Queen Mary (Dunedin), St. Georges, National Women's Neo-natal unit.

### **Clinical experience**

For midwives to qualify they must see specified numbers of particular conditions both normal and abnormal. They must also follow a number of mothers and babies over a length of time to allow them to see the progress and changes in each individual's condition.

The question here is: how many is sufficient? and, do all midwives need the same numbers?

The majority of the midwives expressed very negative concerns about the length of time spent learning midwifery skills, particularly in delivery suite. They stated they needed more time and more experience in that area during their training.

The extra experience midwives stated they needed during their training included more in Neonatal Unit, more in antenatal clinic and ward, and more time with home birth midwives. Their comments included:

'more experience of normal and abnormal deliveries and gaining confidence'

'the whole of midwifery is a hands-on skill'

'I lost confidence when I became a student learning new skills'

Those midwives who came from smaller hospitals wanted more experience in Neonatal unit so they could be confident dealing with small and sick babies when they returned back to their areas.

Some midwives had positive experiences and did not need extra clinical time, particularly those who had skills before they came or were assertive enough to get what they needed from the course, e.g:

'I basically organized my time myself'

'I twisted the system to suit myself'

Similar comments were found in the overseas studies where the midwives stated they needed more time in delivery suite areas followed by more experience in special care baby units and in the community. It has also been generally recommended in New Zealand by various groups that part of the course should be undertaken away from the larger centres in order to give the students the experience of working in a smaller hospital and in the community. Half of the study's midwives had an opportunity to work in different areas, including smaller units.

### **Influences on their perceptions of midwifery.**

Midwives working in hospital and the community, their peers/colleagues and their tutors were the main influences on the midwives' views or perceptions of midwifery while they were doing their training. The midwives had both positive and negative experiences working with the delivery suite midwives. From these midwives they learnt:

'how to handle practical aspects of birth'  
 'how to communicate with women'  
 'skills from midwives although some were not interested in normal births but only high technology'  
 'aimed in on midwives who practice how I want to provide care to my ladies'

They found these midwives to be dynamic, wonderful role models, e.g:

'women working with women'  
 'they were a huge influence, teaching me all I know'  
 'they were all different, and practised differently depending where they had done their training'

On the other hand, some midwives had negative experiences particularly from the delivery suite midwives. The following descriptions were of midwives who:

'were not geared to teaching'  
 'showed resentment towards student midwives'  
 'have been there too long and were not interested in teaching'  
 'put down student midwives'  
 'were not helpful and not as supportive as could be'

'turned off and were indifferent'  
 'were English trained and were negative about the  
 polytec. training'

One summed it up by saying: 'you take the best of all those you  
 come into contact with.'

The **home birth midwives** were a big influence for several  
 midwives and their comments included:

'they were absolutely great and went out of their  
 way to be helpful'

'her approach to midwifery was really excellent, it  
 was real and personal and not a job but a way of life'

'practising as true midwives with continuity of care -  
 they are assertive and confident practitioners'

As many found cause for praise about the **tutors** as found cause for  
 criticism. The midwives stated that it was important that the tutors  
 had good interpersonal and communication skills and current  
 clinical experience, and were willing to participate in the clinical  
 areas with the students if time allowed.

The **women** themselves influenced the midwives by:

sharing their birth experience,

learning about some women's choices or their lack of choices,  
 knowing that all women are different,

raising awareness of different ethnic and cultural groups.

Their **classmates**, who came from a variety of backgrounds and  
 experiences, also influenced the midwives.

Other things that played an important role for the midwives  
 included: attending the second National Midwives' Conference  
 (N.Z.N.A. Midwives' Special Interest Section) in Auckland during the  
 year, attending the home birth conference, completing a research  
 project as a requirement for ADN, and having had personal  
 experiences of birthing.

**Medical staff**, on the whole, had no positive influence on the midwives with half of them making a negative comment about the doctors, for example:

'we learnt what not to do in practise as the doctors still try to control rather than support the woman and her partner.'

'they did not have the same philosophy as midwives'

The influences that these midwives encountered all through their year played a significant part in their approach to practising as independent midwives in terms of role modelling and the learning of midwifery skills.

### **Highlights of the midwifery training**

The midwives stated that they enjoyed the following things about their midwifery training:

midwifery-related factors:

'continuity of care by following-through women under the care of a GP '

'homebirth delivery'

'touch for health lecture'

'working at a small hospital'

extraneous factors:

'comradeship of classmates'

'networking and sharing with intelligent, stimulating women'

personal goals:

'great year---I enjoyed it'

'was able to stand back from practice as a nurse and evaluate what I'm doing and why and how it is affecting me and others'

'time for me---the year was special'

Those midwives who did not enjoy the course stated:

'it was a shock living in a larger city'

'hated it due to pressure and stress away from the family for year'

'nothing inspiring about the course'

As in the studies carried out by Golden (1980), Robinson (1986) and Barclay (1984), this research study asked the midwives if they enjoyed their training. It appears that the majority of the midwives found the work inherently rewarding and enjoyable despite problems they had with the training programme and attitudes of staff towards midwife trainees. More than half of this study's sample commented that they found the comradeship of other classmates was another reason why they enjoyed the course so much.

### **Advanced Diploma of Nursing**

Half of the midwives interviewed spoke very positively about the Advanced Diploma of Nursing (ADN) component of the year's course, for example:

'challenging, stimulating, and bewildering'

'thirst for knowledge, background to what I'm doing now'

'excellent, gave a broader outlook on everything'

'enjoyed it, I couldn't give best to both. I would like to go back and give more to ADN.'

'important way of looking at everything like research'

The remaining midwives did not like the ADN subjects at all, for example:

'it wasn't what I went for, it took a lot of time. I wanted a whole year of midwifery'

'not necessary, I found the first term boring as there was a lot of repetitive work'

'didn't have the energy for ADN, the focus was so wrong and so different with the midwifery state exam at the end of the year'

Some of these midwives stated that the midwifery training should be taken out of the ADN, e.g:

'midwifery stands by itself'

'midwifery is a separate body of knowledge'

'it should be made more clinically based because it is a practical skill'

The aim of the ADN is to improve nursing knowledge and skills and enable the nurse to practice nursing at an advanced level. One of the basic assumptions made about students enrolling for the ADN is that they have a high level of clinical expertise which can be usefully shared with fellow students. Registered nurses enrolling for the midwifery option do not necessarily have this high level of clinical expertise in midwifery, rather they enrol to gain a basic qualification.

### **Changes to midwifery training**

The changes that the midwives would like to see in midwifery training include the following:

length of course should be extended, i.e. one to three years course

'there is not enough clinical time'

'we need a lot more clinical, including domiciliary and community experience'

there should be less reliance on large teaching hospitals

'not all the midwives are going back to Level 3 hospitals, with 3 midwives on each shift. Instead they could be going to smaller hospitals with less births, therefore we should spend time in smaller places and see normal births.'

the practical experience should start at the beginning of the course

'midwifery is a hands-on skill, and learning to communicate with people is important.'

there should be a probationary year afterwards

the courses should be geared to meet the individual student's needs including having more regard for previous clinical experience

'the quality of the experience is important, they should listen to the individual student and see what they want'

This study also supports the ADN evaluation findings that there should be a provision made to separate the midwifery course from the ADN leaving the Advanced Diploma course for registered midwives wishing to further their education. Even though thirteen of the midwives found the general ADN components stimulating, nine did not like these subjects at all because:

it interfered with their midwifery orientation

they found the workload was very heavy and

it took up a lot of time.

#### **Evaluation of their midwifery skills preparation**

The midwives discussed the way they felt their training had prepared them to work as midwives. They made reference to the following selected aspects of midwifery practice:

##### **a) working with women**

Some midwives had previous experiences working with women and hence they felt they had no problems. Some felt that their training gave them the right philosophy to start working with women and some saw communication as an important area. Only one midwife found the course too women-orientated.

##### **b) assisting women to prepare for their birth**

Those midwives who had the opportunity to take an antenatal class or run a series of classes felt quite comfortable with this area:

'I gave a series of six antenatal classes which was traumatic at first but a really good learning experience'

'I ran antenatal classes for adolescent Maori girls which helped me in working with women'

The majority of the midwives had no experiences and no preparation in teaching and stated they needed more practise at this in the classroom:

'I would have liked more of this work as I am moving into that area'

'I didn't do any teaching and it is an area I am really interested in'

They recommended that it would be good to run a course of antenatal classes during their training and become more involved in this.

### c) being flexible

The majority of the midwives found that their training did not extend them in this area as they had always considered that they were flexible:

'it's fine as it comes with my philosophy'

'it's never been a problem nor an issue. It is an honour to be there'

'I am quite able to go along with their wishes as long as they are reasonable'

Several midwives, however, did find that the training helped them become more flexible:

'the training helped although it was not always possible in hospital to be flexible -- the home birth midwives in class, gave us a lot of alternatives which we could use which helped'

Some midwives stated that being flexible came with experience:

'it only comes with more experience, it took six months to become entirely comfortable'

'only after I had built up my confidence as a midwife first'

### d) caring for a woman and her partner during their birth experience

Several midwives felt quite happy about caring for women because of their previous nursing experiences and one midwife had had a lot of experience working with women in labour before her training. Other midwives found the training did help them in this area:

'the tutors were really good'

'I was encouraged to do a lot on my own. I didn't meet the partners much'

Some midwives felt they didn't have much confidence during their training but practising since as a midwife has helped:

'I have learnt a lot more now practising than during my training. I was more interested in the mother, I didn't have the confidence to also attend the partner, I've changed since then'

'I do now, I wasn't sure after registering as I felt nervous and inadequately prepared'

#### e) **handling emergencies**

Again, those midwives who had experienced emergencies during their nursing training or pre-midwifery experiences felt comfortable in this area.

Several midwives found the course did not prepare them adequately and they didn't gain enough knowledge. They stated that through their training they:

- were given basic safety practice
- were given instructions
- found it was quite good in theory
- needed more hands-on experience

'we didn't get enough practical experience on the resuscitation of neonates which I did ask for'

'it depends on the emergency, I feel more proficient now in the postnatal ward having worked in Delivery Suite'

Some midwives felt uncomfortable about their lack of confidence during emergencies:

'I felt panicky inside at the beginning, I had to handle that, I need to gain the experience'

'I'm not very good in this area and still feel uncomfortable about resuscitating babies even though I have practised on dummies'

**f) observing newborn babies**

The majority of the midwives felt fine about observing newborn babies because of their past experiences in paediatrics or neonatal areas:

'Neonatal unit prepared me before hand'

'I relied on my past experiences more than what I was taught although it gave me various perspectives'

'Although I had prior experiences, the training gave me the theory I didn't have'

Some midwives stated they wanted more practical experiences during the course:

'I think I would know what to do, and know if the baby was having problems but I needed more experiences in this area'

'More practical experiences with the tutor would have helped'

**g) coping with grieving parents, e.g. following a stillbirth**

The majority of the midwives again felt really comfortable and confident in this area because of working in the antenatal ward and neonatal unit before doing their midwifery training. They also had previous experiences working with people suffering from loss during their nursing training. Several felt this was more than adequately covered in the classroom:

'We had lots of this in class, i.e. personal knowledge in knowing what to do, what is right to do, and how to feel'

A few midwives had had no experience in this area at all but had some since their training:

'I didn't get a stillbirth until I had been qualified a year, it was quite hard to deal with it. I feel more confident now'

#### **h) assisting a woman to breast feed**

Several midwives stated they felt good about helping mothers breast feed as they had prior experience and/or previous personal experiences of breast feeding.

'I felt adequately prepared because of past experiences with La Leche League'

'I had a good base knowledge before my training'

A third of the midwives interviewed expressed concern that they did not think this subject was covered in very much detail during the course:

'I had none at all, I learnt for myself from books etc.'

'This was not dealt with much, it is a skill you have to learn and it takes a while to learn, to teach a women how to be relaxed and be self-relaxed too'

#### **i) helping a woman adapt to a new situation**

Half of the midwives interviewed found that their training helped them in this area:

'it made you think more widely about different aspects'

Several midwives have become a lot more confident since gaining experience on the job:

'it has come from experience and with contact with other midwives now'

One midwife stated 'I was adapting to new situations myself during my training so was probably not helpful in helping the women'

In overseas studies midwives were asked how well they thought their training had prepared them for the various midwifery responsibilities. The majority who undertook the English or Australian midwifery programmes, thought they were adequately prepared in all areas, although in Golden's study (1980), a high

proportion of midwives felt inadequate when teaching groups of parents, doing home confinements and caring for babies in special care units. This improved when the midwifery course was extended to 18 months in the United Kingdom (Robinson, 1986). The areas in which the study midwives felt most unconfident when they finished their training were: handling emergencies and observing and working with new born babies. A number of the study midwives, especially those who returned to small maternity units, stated that in a large base hospital, there was always someone around to assist with and take control of the emergencies, including flat or sick babies, thus they did not get the experience they needed.

### **The best things about practising midwifery**

On the whole all the midwives enjoyed working with women and their families. Their comments included feeling:

'great', 'quite happy', 'quite comfortable', 'enjoy it',  
'really good'

Seven midwives preferred working with mothers only, and one midwife preferred working only with the babies, but 14 of the midwives stated they couldn't separate the women and their babies, 'they were one being.'

The midwives were asked to describe what they liked best about practising midwifery. These included the following issues:

#### **professional issues:**

The midwives considered two important areas were:

being able to practise continuity of care with the women

'having the satisfaction of seeing a mother from the beginning and caring for her until she goes home'

'seeing a young mum coming in and going home feeling confident'

being an educator

'having the opportunity to empower women, and to educate them not only for their birth, but for the rest of their lives'

**organisational issues:**

The midwives expressed great job satisfaction when working in a happy environment with well women and their families:

'seeing a women pick up her baby after delivery to look at it and smell it'

'having a woman feel good that she's had a good labour'

'being able to engineer an environment to give a family a really good start to parenthood'

'watching a woman adapt to changes happening to themselves and to their body and their own ideas'

'seeing a young mother blossoming into motherhood from the first tentative holding and developing a relationship with her baby'

'giving the women the feeling of being capable and confident and watching them grow'

**personal issues:**

These arise from being "a midwife":

'knowing I have the skills to work with women'

'being proud of telling people "I am a Midwife" '

'knowing what I do is very important and that it makes a big difference to the outcome'

'getting positive feedback about how well I'm doing'

'being at a birth is a privilege and an honour'

The preparation and training of the midwife is the first specific part of their midwifery and work experiences and the important aspects of this will be discussed in the last chapter.

## CHAPTER 5

### The Factors that Influence Midwives to stay Practising

This chapter is divided into two sections containing:

- 1) the views of the midwives pertaining to their experiences of midwifery practice, and
- 2) the midwives' perceptions of the future developments and challenges of the midwifery profession.

**In section 1. organisational factors** that influence midwives to stay practising fall within two periods:

- a) the midwives' work experiences in the first six months of training
- b) the midwives' present work experiences

The organisational factors, identified in the literature as being significant in influencing midwives to stay practising, include the following:

- orientation
- acceptance as a midwife
- responsibility
- job satisfaction
- support
- management issues
- continuing education

**In section 2. professional factors** that influence midwives to remain in the profession are identified.

#### Section 1. Organisational factors

##### The midwives' work experiences in the first six months

Over half of the midwives felt best prepared in the areas of ante and post-natal wards, only some for delivery suite, or for giving childbirth education lectures.

Only one midwife commented: 'I was prepared in all areas as a beginning practitioner'

The remaining midwives felt **least prepared** in the areas of: delivery suite, teaching, giving help with breast feeding. Only one felt she was not well-prepared at all in any area.

One midwife summed it up by saying:

'I don't know if you can be totally prepared - it's an introduction and it depends on hospital policies and the charge nurse on the ward'

The lack of preparedness for work in clinical areas felt by midwives suggests that this needs to be looked at by the educators.

### **Orientation**

Half of the midwives received an orientation programme lasting from one day to four weeks. Although four were promised anything from four to ten weeks, staff shortages and work pressure caused the time to be curtailed. Two insisted on having some orientation.

The others did not have any sort of orientation at all but had worked in the area/ward before doing their training and felt reasonably confident returning there. Seven midwives who did not receive orientation also stated that they did not get a buddy/mentor either.

Overall, the **first six weeks** were found to be difficult by twelve of the midwives, because of:

'the lack of support shown'

'generally feeling uncomfortable about the inadequacy of their midwifery skills'

'working in a different area of the same hospital'.

By and large, the nine midwives who did not find the first 6 weeks difficult went back to areas that they knew.

In the first six weeks:

Ten midwives went to delivery suite  
 Three midwives went to a post-natal ward  
 Five midwives went to an ante-natal ward  
 Two midwives went back to working in all areas

One midwife went overseas for a year and another to a gynaecology ward while awaiting a part-time midwifery position.

On the whole, the beginning midwife perceived the quality of worklife and the quality of care given in the immediate environment as basically sound but she had some areas of concern. If a midwife feels less than adequately prepared to take on a demanding workload with full responsibility, this can lead to feelings of insecurity about herself and her job. Over half of the study midwives who had felt excited about their new position as a beginning midwife found the first six weeks very difficult because of feelings of inadequacy, aloneness and lack of support. They had no orientation programme and were given no buddy or mentor.

As Kramer (1974), Speedling et al. (1981), Hinshaw et al. (1987), all point out in their research studies, it is very important to create a climate of socialization which produces an atmosphere where the new orientee midwife can:

- become part of the system
- establish relationships with colleagues, both midwifery and medical staff
- investigate the environment
- become familiar with the equipment
- build communication patterns
- identify personal goals

This will foster the acquisition of new skills, leading gradually to increased responsibility and resulting in a more competent and confident practising midwife.

### **Midwifery responsibility**

The midwives working in the ante and post-natal wards felt that they were first given midwifery responsibility in the areas of preparing a woman for induction (inserting prostaglandins) and being in charge on the afternoon shift in the post-natal ward:

'I can now decide how to manage a breast feeding problem'

Some midwives felt that they had no extra responsibilities now they were 'a midwife'.

'there's no difference at all as I am doing exactly what I was doing before'

Over half the midwives were first given responsibility in delivery suite, for example, they were given full responsibility for the care of women who were expected to deliver normally.

As many felt confident about doing vaginal examinations, as felt unconfident and unsure about working with syntocinon infusions. Most of the midwives stated that they could call for help if they needed the support.

'we have complete care really but there's always someone there to ask for help and advice'

Taking midwifery responsibility did not appear to be a problem for any of the midwives although they felt more accepted in some areas, e.g. working in the post-natal wards as the only midwife or being 'midwife in-charge' in the smaller maternity units.

The working party of the N.Z. Hospital Boards Association (1984) recommended in their report:

'that employers be advised not to expect a new graduate to accept sole responsibility in any setting until that graduate has had a period of supervised experience.'

It seems that most new graduates are, on the whole, more comfortable in taking midwifery responsibility at this early stage of their working experience.

### **Acceptance as a midwife**

The midwives felt they were being accepted 'as a midwife' by their midwifery colleagues either:

- a) straight away and up to three months or
- b) after five months and up to a year.

One midwife felt she was not at all accepted as a midwife and two were undecided about the issue.

'it took eight months in delivery suite to gain credibility that you are safe'

'I was not accepted even after six months there, by the way they talked about us being there - they

counted us as halves. If you were doing something wrong you knew, but if you were doing something right they didn't tell you.'

Over half of the midwives thought that medical staff accepted them as midwives straight away, especially when the doctors acknowledged their work and asked their opinions, although two midwives stated it took a while to be accepted.

'they had to see if you could do a normal delivery first'

When asked how they knew they were accepted, the midwives identified the following factors:

'recognising practice was OK'  
 'asking questions or opinions'  
 'being given a student nurse or a student midwife to look after'  
 'being left to get on with it'  
 'wearing the label 'midwife'  
 'less checking up on me'  
 'being included in informal chats etc'

A small number identified some major problems, with acceptance particularly by the delivery suite staff. These included:

'the midwives felt threatened by the ADN midwives'  
 'there was a lot of professional jealousy amongst these midwives'  
 'there were some strong personalities'  
 'there was not the supportive atmosphere there should be'  
 'the new midwife had to prove herself constantly'

They felt that being accepted as a 'midwife' was more difficult and ranged over a time span of 'straight away to not at all' especially in areas like delivery suite. Nine of the study midwives who came from small maternity hospitals returned to the same hospital and therefore were familiar with the staff and environment, and were accepted by the midwifery and medical staff. However, there are still midwives in these areas who feel threatened by someone having a ADN qualification.

### Concerns about practice

Midwives identified several areas of practice that gave them considerable concern when they began practising:

- delivery suite
- medical practice/interventions
- emergencies
- information giving / informed consent
- midwifery practice

Their concerns included:

'I was told it was invasive to do vaginal examinations and that I shouldn't do them'

'scrubbing for caesarian sections was bewildering'

'I was aware of what could go wrong and wondered whether I'd be able to handle it, if it did.'

'ignorance of midwives about their own practice concerned me - the fact they don't think they need any on-going education or have to update their skills'

'obstetricians in one hospital doing vaginal examinations on ante-natal patients daily, in another hospital doing episiotomies on all primiparous women (those having their first baby) and giving valium to women in labour'

'still areas of concern are that our hospitals are monocultural institutions which do not provide for the Maori and Polynesian people at all - I still find it distasteful that people are not giving informed consent'

'some of the midwives rupturing the membranes too soon when it wasn't warranted (it was only to see the colour of the liquor)'

'it worried me to see that some women were left alone in labour; certain midwives tended to leave women to get on with it even when they sounded distressed'

'the variability of care given by some of the general practitioners'

Three midwives had no concerns about practice.

### **The midwives' present work experiences**

The variety of the midwives' working experiences and the length of time spent practising in each area, are shown in Appendix E.

The midwives are presently working in the following areas:

delivery suite	10
ante-natal ward	1
post-natal ward	7
in all areas	3
childbirth education	1

### **Job satisfaction**

The midwives' satisfaction with their present midwifery position has been analysed as follows:

Of the ten midwives working in **delivery suite**, the majority said they were satisfied with their present position. Two stated they got personal satisfaction from their job:

'because I feel autonomous I get personal satisfaction out of helping someone through a delivery and having a successful outcome, knowing you have supported the woman the best way you can. You get a lot of positive reinforcement from clients - it's a very easy place to work in as far as maintaining my own self esteem as a practitioner'

'I have achieved most goals I've wanted, by working entirely with women in a women's field. I now feel quite comfortable in my role as a midwife and am up to the stage where I can buddy a new midwife'

Three stated they were still learning as new midwives and two found continuity of care was important to them.

One midwife stated she was not happy in her job in delivery suite:

'it is frustrating working in defined areas such as ante-natal, delivery suite, or post-natal - there is no job satisfaction with fragmented care to the women'

Two midwives were unsure about their present positions in delivery suite:

'I like the work - I hate the politics, and I hate what's going on and what's happening. I'm frustrated with the medical profession and their attitudes and what they do. I'm pleased I'm getting out of it for a while, you get tired of verbalizing things, of saying things the right way, of fighting for patients' rights that should be there but do not exist'.

In the **post-natal ward** two midwives were happy with their job because they were in a position of responsibility and control, and felt comfortable with that.

Three were satisfied with the job, but frustrated with the attitudes of people they worked with and the conflicting advice that the women received.

One was not happy working in a home care scheme:

'I like mothers and babies, I don't like driving. Some women you visit are unaware of the role of the midwife, and I find it is very difficult to educate them.'

One was unsure how she felt because of her mixed placements. She worked two days in childbirth education and two days in the post-natal wards and felt she wasn't in either place long enough to give continuity of care to the women.

The two midwives working in the **ante-natal ward and childbirth education** were satisfied with their jobs, giving as their reason the good support they got either from their staff or the community .

The three midwives working in **smaller units** stated they were satisfied with their positions, although one stated:

'I'm satisfied as far as practising as a midwife, but I wouldn't like to stay in my current position for the rest of my life. If I want to make a contribution to

the future of nursing in New Zealand, the next 15 years will be my peak, so I'd really like to get into a situation where I can extend myself. I can go back to midwifery later.'

Another midwife stated:

'Yes I'm basically happy, I'm doing what I want to do, so why change? It's the other people that are making me dissatisfied, because they say I should be going for a higher position - that's not what I want. I have to come to grips with that really. Ok. - I've got a lot of qualifications and I could be in a higher position but I'm very much a 'hands on' person. A degree doesn't alter what I do, although what I've learnt has been integrated into my practice and given me personal growth.'

#### **The days that the midwives enjoy most at work**

In delivery suite, the days enjoyed are the steady days when:

'a woman comes into delivery suite in established labour and you can give the time and energy into caring, supporting and guiding her through her labour and a normal delivery, and then taking her up to the post-natal ward.'

'there are no doctors around',

'the staff are working well together - no bickering',

'I made an accurate judgment',

'I book in a woman in ante-natal clinic and then meet up with her in delivery suite and we have instant rapport'.

'I don't enjoy the days when it is too busy and the care I give is compromised'

In the post-natal wards, the days enjoyed are those when they have time to spend teaching and talking to new post-natal mothers, helping them to build up confidence in themselves and reassuring them that they are doing well:

'the value of continuity of care and seeing someone tomorrow'

'you come home and feel you really have achieved something, have been able to give the women some of my time, and been able to help as much as possible'

'when the staff get on well'

'I get feedback from someone who acknowledges they feel good'.

In the smaller areas, the midwives enjoyed it all:

'when I've helped a primigravida woman go right through her experience, having no pain relief, it's very exhausting as I give all of myself'

One stated she liked night duty or afternoons because it was more relaxed with fewer doctors and bosses around.

In the ante-natal areas, having good supportive staff on and having a variety of teaching sessions helped make the days enjoyable.

#### **Unique midwifery situations that are enjoyed**

A midwifery situation that the midwives really enjoy being in varies according to the woman's stage of pregnancy or confinement, namely: the antenatal, intrapartum, and postnatal periods.

During the **antenatal period**, some midwives enjoyed the teaching role, getting the confidence of the women, and seeing the results of their teaching:

'It's like a reward seeing a couple during their labour taking control of their experience'

During the **intrapartum stage**, the midwives stated they liked:

a) working with women in labour:

'looking after someone who is really relaxed and wants to do everything naturally, has a really good supportive person and is feeling happy about being in labour'

'where I know she trusts me and trusts herself and she knows shes OK by herself and that she just needs me to reassure her that she's doing alright'

b) working with a couple in the alternative birthing room:

'they can do what they like in there - plenty of privacy'

c) delivering babies:

'it makes you responsible for somebody else, it feels really great because there's an end. I like beginnings and ends especially after you have managed to deliver this lady of a live healthy baby'

d) the arrival of the first baby:

'the absolute thrill of the first baby'

e) the immediate post birth stage:

'their joy when the baby is born and then first placed in their arms, you look up and see tears in the father's eyes and he looks at you and you get that real empathy - the real joy of that moment and the touching of the baby'

'when the baby is born and in that initial period just being with the couple is amazing because every birth is incredible and it never ceases to amaze me'

During the **postnatal period** the midwives commented they liked:

a) a busy day:

'where no ladies have been compromised, and I have given good care to all the ladies'

b) practising continuity of care:

'have enjoyed looking after a woman in labour, delivering her and continuing to look after her in the post-natal ward'

- c) helping situations, e.g. breast feeding, bonding, teaching, twin mother.
- d) helping a stillbirth couple -giving time, advice and caring.

A working environment within which midwives can grow and thrive professionally has been demonstrated to have a positive impact on the quality of patient care as well as on how midwives perceive themselves and are perceived by others (Hinshaw et al. 1987). Of the twenty-two midwives, fourteen were satisfied with their present position as a midwife, six were unsure and two were not satisfied and were doing something positive about it. The days that the midwives enjoyed most correlates with the literature about job satisfaction. They enjoyed:

- 'practising autonomously in some areas'
- 'having responsibility'
- 'the work itself - working with women and their families'
- 'being recognised as a midwife'
- 'being a part of the decision making process concerning their clients'
- 'working with supportive staff'
- 'having enough staff on a shift and not having someone being taken away'

### **Opportunities for midwifery practice**

Opportunities for practising midwifery as they want to in the future were seen as increasing by the majority of the midwives and as decreasing by a small number of the midwives. One was doubtful.

They saw the opportunities increasing if:

- 'midwives were recognised and accepted for what they are worth'
- 'the Nurses Act was amended so the midwife can practice as an autonomous practitioner'
- 'the midwife had personal confidence in her work'
- 'the N.Z. College of Midwives' input continued to raise the profile of midwives, helping them to stand up and be noticed'
- 'increased consumer demand and consumer education continued'

'public awareness of what a midwife's role is increased'

'health care returned to the community'

'continuity of care schemes, e.g. dominos scheme were initiated'

'increasing numbers of women asked for a home birth or to attend a birthing unit (a cheaper option)'

The midwives who did not see opportunities increasing stated they considered it was because of reduced staffing numbers due to cost cutting, and that

'midwives will be a fairly rare specimen the way things are going'.

On the whole, the majority of the midwives said they enjoyed working as 'a midwife', i.e. working with women and their families and watching their initial relationship with their new baby and visitors and also being with and sharing information with other midwives.

### **Dislikes about midwifery practice**

Aspects that the midwives disliked about their practice were expressed as lack of autonomy, the system, the medical and midwifery profession, problems connected with the consumers and the environment:

#### 1) the lack of autonomy:

'not being an independent practitioner with autonomy and therefore being able to make one's own decisions'

#### 2) the system/institution and the way it is organised:

'not being able to stay on with women due to 'shifts"  
 'departmental infighting (between wards)'  
 'co-ordinating a ward with so few staff'  
 'being in caesarian section theatre all day'  
 'having too many extraneous people in general theatre for a caesarian section'  
 'breakdown of care - too little time'  
 'paperwork'

## 3) some of the the medical profession:

'lack of recognition for skills'  
 'obstetric practice in large teaching hospitals - unnecessary medical interventions'.  
 'real difficulty with some incompetent doctors'  
 'not treating me as an educated person'  
 'arrogance of some'  
 'specialist doing daily vaginals on ante natal women'  
 'birth too medicalised'

## 4) the lack of sensitivity towards the women consumers:

'sending women home early with not good back up services available'  
 'seeing women have choices removed from them'  
 'lack of continuity of care'  
 'teaching basic mothering skills and knowing that's the only learning opportunity they'll get'

## 5) certain members of the midwifery profession:

'lay midwives'  
 'being told 'this is an area where you don't need any brains to work'  
 'older, more inflexible midwives'  
 'power games between delivery suite midwives'

## 6) the environment:

'dislike unhappy moments 'there's an awful lot of pain and suffering that goes with it'.  
 'I can't cope with death yet'

**Support**

The support the midwives saw as enabling them to carry out their jobs effectively in their positions at the time of interview, varied according to the area they worked in, who they worked with, and the amount of stress felt by those within the institution. The support was described as being given by:

charge nurse  
 supervisor  
 peers/ other midwives  
 no support

women  
 total support by everyone  
 others, including: hospital aide, a GP, plunket nurse, and a  
 parent centre group.

Generally, the main support was given by midwifery colleagues  
 either peers or senior staff with the charge nurse being mentioned  
 by half the midwives as a good support person:

'the charge nurse is always willing to listen'

One midwife stated she got:

'total support by everybody, from the midwife on  
 duty before her, the midwife on duty after her, the  
 enrolled nurse, the cleaner, the patient, and the  
 principal nurse.'

The support the midwives perceived as being given to them is  
 considered under three subtitles:

managerial support  
 peer support  
 emotional support

Managerial support included:

'getting direction, advice, knowledge and expertise  
 from midwives in delivery suite'  
 'having ward meetings'  
 'basically being left alone to make own decisions'  
 'giving out information'  
 'giving appraisals in a supportive teaching situation'  
 'recognising that it's busy and offering help'  
 'not taking away staff'  
 'availability of staff when wanted'  
 'giving teaching sessions as needed'  
 'advertising study days that are applicable for  
 midwives'

Peer support included:

'sticking together' / 'comrade thing'  
 'discussing things together'  
 'being helpful'  
 'having informal get togethers'

'meeting with other midwives to make changes'  
 'standing up for a colleague, when disagreeing with a doctor'  
 'getting on with the staff on duty and not having to carry staff'  
 'being a friend'  
 'giving praise'

#### Emotional/morale support

'giving encouragement 'yes that was a good thing to do'  
 'giving emotional support'

#### Management issues

The smooth and effective management of a maternity unit requires attention to, flexibility of a 40 hour week, efficient working rosters, being paid correctly, suitable holidays, and having study leave. The midwives comments on these issues included:

how satisfied they are with them generally and how restricting they are for practice

##### 1) 40 hour week

The midwives' views on the 40 hour week varied. A third made no comment. Others said they were used to it and were reasonably happy. But they stated:

'there is a need for more flexibility in the system at the moment, if we want to give continuity of care'

'I don't mind a 40 hour week, I just don't like 7 day stretches'

Some midwives found the 40 hour week very difficult and restricting and commented:

'especially when the midwife comes on the next shift and says 'you must leave, it's my patient now'

'we can choose to stay with a woman in advanced labour but we can't get extra pay'

One midwife recommended that midwives work 36 hours a week only and use the extra 4 hours for reading and inservice training needs.

## 2) Rosters

The midwives opinions on rosters ranged from expressions of frustration to acceptance. Rosters were considered:

'a problem especially in big units'

Those done by charge nurses/supervisors were described as frustrating:

'the person who did our rosters didn't take anything into account and just slotted people into gaps'

'I don't like the rosters at all as I have had to do five nights every three weeks and after six months of that, I feel exhausted'

Those midwives who did their own rostering or self-rostering found they could be more flexible, request changes, swop duties easily and generally felt more satisfied.

One midwife stated:

'you can't run a hospital without them - it's a part of life'

But another commented:

'social rostering is out - people are never satisfied'

## 3) Pay

Over a half of the midwives felt satisfied with their salary and stated:

'I guess I don't assess what I do for what I get, it's here in my heart'

'I can support my husband and kids so it must be O.K.'

'the pay is O.K. especially with penal rates'

Some midwives found the pay 'awful' and 'very frustrating' Their comments included:

'they were barely able to survive'

'their the husband earned more'

'the midwives are extremely underpaid'.

One midwife stated:

'we undervalue ourselves'

and recommended that:

'midwives should get higher allowances, and we should get rid of penal rates as there are a lot of people who sit on weekends'

#### **4) Holidays**

Half the midwives found the availability and the length of holidays quite satisfactory:

'I can get them when I want them'

'if anyone is stressed up and needs a break, we can get away'

Some midwives found getting holidays very frustrating and there were not enough allocated holidays for midwives:

'we need to apply for a holiday at least a year ahead which is not always feasible'

'it's a hassle to coordinate with others especially with part time staff'

#### **5) Study leave**

The majority of the midwives saw that education as vital:

'it should be built into the contract, we must keep ourselves educated as it reflects in our practice'

'it's good to do further study although there are no incentives'

Most of the midwives found study leave was either not available or non existent:

'hard to get due to financial restraints'

'it's unsupported and not encouraged'

Two of the midwives who had recently completed their training stated that 'I never want study leave again' and the other was 'too frightened to ask for more leave'

On the whole, the midwives found that rosters prepared by others were very restricting and lacked flexibility for their practice in working with women and their families. Half the midwives were generally satisfied with their salary (especially with penal rates added), their holidays, and the rosters. They were most unhappy about the unavailability of study leave which was considered vital for the midwives' continuing practise. They recommended the following:

'a refresher course at the end of each year'

'Area Health Boards should consider 'Domino schemes' and employ midwives on contract in order to provide a service for the clients and which will also give more creative flexibility for the units'

#### **Midwives' views of management's awareness of problems**

Midwives interviewed felt management's awareness of the difficulties and stresses of midwifery practice was low. Many managers were thought to be either not at all aware, or not interested, although some were felt to be reasonably aware.

A large number of the midwives stated they considered that higher/top management were **not at all aware** of their difficulties:

'the management is only concerned with finance, they are not going to employ more of us at the moment - we have to cope with what we've got'

'from the Principal Nurse up they see the workload as only numbers, such as a high bed occupancy rate. They don't see the staff as individuals'

'see midwives as an alien force - don't see maternity care as a priority - the women are going to get second class treatment with whatever service management set up'

'need better recognition for speciality'

'Management does not understand the life and death situations that you can find yourself in - they have no idea of intensity of the care we give at all'

Midwives views that some of the management were **not very aware** are expressed in the following comments:

'not aware of the day to day difficulties- they are so busy coping with their own workloads'

'taking away staff and not interested in how busy we are'

'not replacing staff when they leave'

'a manager who can't manage. We need someone who understands the system'

'a manager who is out of touch'

Other midwives considered that the unit level management were **reasonably aware** of the stresses and difficulties that midwives work under:

'can be either supportive or 'switch off' due to own increased work load'

'fairly supportive when they know something out of the ordinary is happening'

'aware of difficulties but how much they are prepared to do about it is another thing - they are under extreme pressure- job security wise and financially - they are aware of it but because of huge stresses they lose sight of it'

The midwives would like management to help in the following ways:

At top management level:

'visit the workers and be seen'

'have an understanding of the midwives' philosophies'

'educate the public as to what 'the role of the midwife' is'  
 'listen to midwives - to those that are doing the work'  
 'work on the career structure of midwives and nurses'  
 'employ a midwife consultant or advisor somewhere in the management structure - someone talking for midwives'

At the unit level:

'need to be and give positive input'  
 'give praise'  
 'use humour'  
 'offer meal relief/other physical help'  
 'replace staff'  
 'readvertise charge nurse's position'  
 'provide more staff, more midwives'  
 'discuss new ideas with staff'  
 'don't move staff around'  
 'allow time for teaching'  
 'provide supportive atmosphere'  
 'allow midwives to have study leave - time to talk about  
 'what's happening - midwives having time out to look at own practice and to talk to other midwives'  
 'sitting and talking also to the women'  
 'being the staff advocate '

A third of the midwives were generally satisfied with the way that their ward/unit was managed. But more than half of the midwives stated they were not, for the following reasons:

'not personally running the ward'  
 'had charge nurse problems'  
 'not having a firm manager'  
 'frustrating when trying to be a patient advocate"of the internal politics and power play amongst the staff'  
 'inflexible staff'

There was general satisfaction with:

'good support given'  
 'positive feedback from the women'

'working in a low stress area'

The areas of greatest satisfaction included working within a good team, working with women, empowering them, teaching them and being present at a birth.

Organisational factors were seen to play a very important part in the every day working life of the midwife. These included communication factors, the support provided to the midwife by colleagues and managers, working a rostered 40 hour week, the pay, the availability of holidays and study leave, and management awareness of the difficulties and stresses that midwives have to work under.

Those midwives who perceived their communication with other staff members positively were more satisfied with their work, co-workers, supervisors and performed their jobs more effectively (Pincus, 1986). The present studys' results showed communication with the supervisors and charge nurses was the major influence on the midwife's job satisfaction and job performance. The midwives comments showed a strong need for frequent, constructive feedback on how they are doing in their jobs especially in large delivery suites. Feedback, given in a supportive way, was felt to improve their job performance, increase their confidence, and strengthen their relationship with their immediate supervisor.

Weisman (1982), stated that hospital practices such as shifting staff to different units as needed, or involuntary rotation of nurses through different units of the general hospital, should be discouraged because:

it did not capitalize on the midwife's experience or integration into a work group and

it decreased a midwife's ability to control her professional development.

This was supported by some midwives in the study, especially those working in smaller maternity units of general hospitals.

### **Rewards and opportunities for midwives**

Working as a midwife was believed to provide a variety of rewards and opportunities. The midwives were shown the following list and were asked to rank items in order of importance to them:

1. working with women and their families
2. using a variety of skills and different levels of skills in any position held
3. achieving goals and obtaining feedback on how well those goals have been achieved
4. making decisions, exercising control, and exerting a degree of control over what is done and how it is done
5. practising midwifery in different areas or settings

The midwives found it difficult to decide which was the most important. Some could not choose at all and others chose 2 or 3. On the whole, working with women and their families was ranked highest.

The majority of the midwives felt they would be able to reach their goals in their present position. Several saw their chances of achieving these rewards and opportunities improving in the future. Three midwives stated that it depended on whether:

'certain things happen, e.g. whether there will be opportunities for people to do research in maternal and child health field. etc.'

'the present situation with staffing will improve'

'the Nurses Act is changed to allow midwives to practice autonomously - it's an exciting era - we will need consumers' help - I can see a lot more opportunities in the future.'

### Values

A list of values was given to the midwives to rank in terms of the most important and the least important. They were ranked in order of importance in the following way:

- a) mixing of employment, family and social life
- b) autonomy
- c) responsibility
- d) respect
- e) working with a variety of professional groups
- f) recognition
- g) promotion / advancement

The four values that ranked highest in the 'very important' column were identified as lowest in the 'not so important' column.

Consistency across the very important column and the not so important column supports the value of the observations.

The values ranked in order of least importance to the midwife were:

- g) promotion/advancement
- f) recognition
- e) working with a variety of professional groups
- b) mixing of employment, family and social life
- d) respect    a) autonomy
- c) responsibility

Nearly half the midwives considered that the value of mixing employment, family and social life was the most important to them, followed closely by autonomy.

One midwife considered that respect, responsibility and recognition were closely intertwined and equally important to her. Others commented:

'without my family and social life I would have tunnel vision'

'my family is most important, my job doesn't take precedence'

The majority of the midwives thought the chances of achieving these personal goals were likely to improve in the future and commented:

'yes it will, when I get my practice together'

'has to, really'

'yes, it will improve, as the future for midwives is optimistic as long as we don't let history repeat itself. We need to get behind each other and support each other'

'yes, if you do a good job and be conscientious about it'

### **Important issues and goals for the midwife**

Other achievable goals and issues that were perceived as important to the practising midwives were identified as:

### 1) professional issues

'being autonomous'

'people asking your opinion and advice as a midwife'

'being a patient's advocate'

'being available to look after women from church who want a christian midwife to look after them'

'being recognized that I am a midwife - capable and confident in my job'

'everything I do is influenced by my practising as a midwife, e.g. a good day at work influences everything else'

'managing to retain being a caring person and developing that'

'the need for more midwives to talk together, for example it is expected that the N.Z. College of Midwives will play a very important part as our professional body to ensure that the necessary policy changes are made.'

### 2) professional education

'ongoing education and updating refresher courses are important'

'extending my role and going into more women's issues'

'my own education - the importance of nurturing women'

### 3) personal goals and development

'increasing my self esteem and self confidence'

'contributing something and influencing futures - the ultimate ego trip'

'gaining respect as a person'

'the whole life style is neat'

'I want my midwifery job to meld into my life and complement it. I also want to keep working on developing me as a person'

'own personal growth being a woman and a midwife'

One midwife summed it up as follows:

'I feel it has taken a while to get where I am, I'm on the road and have heaps further to go, but I've got

to a stage where I take every opportunity that comes by and I love it'

The midwives comments on continuing education, supported the wealth of information that has been written about staff development and training needs. They regarded education as vital and that it was important to:

'meet with other midwives in teaching sessions on the job'

'attend their professional groups, such as the N.Z. College of Midwives' meetings and conferences both national and international'

'attend midwife study days - supported and funded'

'be kept informed about new skills, procedures, new knowledge etc.'

'become more politically aware'

'be able to make decisions and changes together'

## **Section 2. Professional Factors**

As well as ideas on their own personal situation, the midwives were asked about the midwifery profession and what they saw as its future. The reasons why the midwives wanted to stay in the profession now and in the future were discussed, together with what they considered to be the good things about midwifery, the challenges and the developments of the profession.

### **The reasons why midwives stay in the profession**

The reasons why the midwives wanted to stay in the profession now that they were practising are stated below:

a) they enjoy working with women / women's health:

'women finally deciding there are things that they are able to do and which are safe for themselves concerning their health'

'women learning about themselves and their bodies'

b) they like working with mothers, babies and families:

c) being present at a delivery:

'childbirth is the most important event of anyone's life, it is a real privilege being in on it'

d) being a midwife / working as a midwife:

'utilizing all my skills, all my knowledge that I've got compacted into one. I find I'm totally stimulated being a midwife'

e) being a change agent:

'I want to make sure the changes are consumer-driven'

f) having satisfaction with the job

g) working in the midwifery area:

'basically I love the work, I really enjoy it, and can't see myself working anywhere else'

Of the twenty-two midwives interviewed, over half stated that they expected to definitely be working as a midwife in five years' time and longer, working:

'either full or part time in an ante or post-natal ward'

'in private practice with other midwives'

'as a domiciliary midwife doing home births'

'as a missionary midwife overseas'

The remaining midwives stated the following reasons why they would not be working in five years time:

'have two more years to retirement'

'am pregnant and due at the end of November'

'planning to have children '

'am changing my job to becoming a nursing tutor'

'am planning to become more involved with NZNA/Nurses Union/Health Department - nursing policy-making etc.'

'am planning to stay in the field of women's health but not working in a big maternity hospital'

Of these midwives, five stated they would probably end up working as midwives in the long term.

### **A positive future for midwifery**

There were three groupings identified by the midwives as indicators of a positive future for midwifery. These included:

#### **1) midwives were seen as:**

- 'taking action and pressing for more changes'
- 'more conscious of their power to turn tides'
- 'moving together'
- 'sticking up for each other and not being over-ruled'
- 'fighting for the women'
- 'questioning the medical staff about unnecessary interventions'
- 'stating birth is a normal event and should be in normal surroundings'
- 'gaining more autonomy now the Nurses Act has changed'
- 'practising more independently and with groups of other midwives'
- 'having more options for places to work as a midwife'
- 'being cost-effective'
- 'listening to women consumers'
- 'becoming more professionally conscious with the establishment of the New Zealand College of Midwives which will act as a voice for the midwives of this country.'

Seventeen of the midwives who were interviewed, belonged to the College and played a very active role in it.

#### **2) the women consumers were seen as:**

- 'being a lot more assertive'
- 'having more say as to what they want'
- 'having more choices available to them'
- 'being their own advocates'
- 'knowing what they want and saying it, and not using midwives as a means of getting what they want. They need to be aware of standing up for their own rights'
- 'supporting more home births'
- 'supporting domino schemes and planned early discharge schemes'

### 3) the community's increased awareness:

- 'that midwifery is part of women's health'
- 'that the role of the midwife is diverse and that they work in different settings and areas, such as in the community, in hospitals, in delivery suites and in postnatal wards etc.'
- 'that the midwife needs more of a public profile and more public support'
- 'that birth is a normal event and that midwives are capable of being alone with women while they are giving birth'
- 'of the implications of social changes and the increased need for education in the post natal wards to prepare women wanting planned early discharge'

Achievement of the above could be aided through networking, advertising and the media. One midwife suggested that

- 'a television/video programme could be made about the role of the midwife and shown on nationwide television to increase the profile of a midwife.'

### **The immediate challenges for midwifery**

According to the midwives the first challenge was getting the Nurses Act changed. Now this has been achieved, other challenges seen by the participating midwives, as awaiting attention were:

- 'making sure the midwives are being heard, getting into things politically, fighting for autonomy, and fighting to get qualifications recognised'
- 'getting more accepted as a service'
- 'getting out into the community more'
- 'getting more recognition by the public'
- 'promoting the role of the midwife'
- 'standing together as midwives'
- 'preparing midwives to practise autonomously'
- 'having empathy with the women'
- 'listening to consumers and getting them to effect changes that are needed'

### **Changes in the midwifery profession**

In summary, the overall changes that the midwives would like to see in their profession are:

'midwives being recognised for who they are and what they do by the public and by the doctors'  
 'midwives practising independently'  
 'changes to the midwifery training'  
 'direct entry training being available'  
 'more clinical experience in smaller hospitals'  
 'more standardised training between the Technical Institutes'

### **Future developments in midwifery**

The majority of the midwives answered that they were very optimistic about developments in midwifery over the next ten years because:

'there are more midwives being trained although we need to advertise the midwifery training part-time options more widely'

'more midwives are challenging doctors and the use of 'invasive techniques'

'the Nurse's Act will be changed, and this has far-reaching implications for midwives practising in New Zealand'

'we still should realise that it could go, if we don't grasp the opportunities when this happens'

'I am not only lucky enough to be a midwife at this exciting time of change but I also want to be a mother'

'midwives should be careful and not chase the doctors in general practice away as midwives in periphery areas need General Practitioners as a back up. It should be easy to lobby and market ourselves and join up 2-3 midwives with G.P.'s groups to work together'

'more women opting for caring in the community'

'more women will make changes as they get educated as to what the midwife's role is and what she can offer'

The current issues and challenges for the future of midwifery have been identified from the literature review to include:

- professionalism
- medicalisation of birth
- consumerism

These issues are supported and reiterated by all the midwives in this research study.

## CHAPTER 6

### Conclusion:

#### Beginnings of a model for midwifery practice

##### Summary and discussion

The chapter begins with an overview of the study questions, a summary of the important points from each chapter and a discussion of the limitations and implications of the study. This is followed by a description of the building model of a practising midwife. This chapter is based on the assumption that identifying, clarifying and integrating issues are valuable initial tasks in moving towards the future.

This thesis began with a concern about a purported shortage of midwives in New Zealand. Current figures indicated a ratio of one practising midwife to every 384 women, aged between 15 and 44 years. While no criterion has been established concerning the ideal ratio between these two groups, the present ratio appears reasonably adequate. Some questions to answer are:

- how many midwives need to be trained to maintain an adequate ratio?
- how do midwives view their practice?
- why do some midwives not practise?

If only small numbers of midwives are trained each year, when the large number of midwives aged between 45-60 years resign or retire (see Table 6) there will not be enough midwives to work with mothers and babies.

The focus of this research study has been, not on why midwives do not practise, but why they do. This study provides a descriptive account of the midwives' perceptions of their education and employment experiences which should be considered when planning change in these areas. However, one study with limited resources can achieve only a limited amount. It is considered that answers to the following questions may help prevent shortages of midwives.

- 1) How did the recently qualified midwives perceive their polytechnic training?

- 2) What organisational factors are perceived by these midwives as being present in the workplace which encourages them to remain practising within the profession?

The next section summarises the information gained from the study.

## **1. The midwives' perceptions of their training**

### **Who are the study midwives?**

It was found that the mean age of the study participants was 35 years. Hill's (1982) study of midwives, who trained at St Helens Hospital in Auckland from 1973 to 1979, found the majority of the midwives were aged between 23 to 29 years. In those years, most of the midwifery students were recruited from the younger, recently general-trained nurses with a minimum of one year's staff nurse experience.

Unlike Hill's study, over half of the present participants were married women with family commitments and varied personal life experiences. This appears to reflect changing social circumstances and the changing work patterns of women in New Zealand. Their prior educational and relevant professional qualifications were comprehensive. However, after training they seemed less confident in practice than their overseas colleagues, especially in clinical areas such as in delivery suite.

### **Perceptions of their training**

Their perceptions of midwifery, during their training were influenced by their peers, tutors and practising midwives in both the hospitals and community. It was mainly from other midwives that they learned their midwifery skills.

The highlights of their training were the comradeship of the other midwifery students and being able to work with individual women in follow-through case studies. The Advanced Diploma of Nursing's core papers were considered by half the participants to be exciting, challenging and stimulating, while the others found them time-consuming, repetitive, and unnecessary, taking them away from learning about midwifery.

### **Evaluation of the course.**

Only those who had previous experiences in working with women, caring for women in labour, coping with grieving parents, assisting women to breast feed and to adapt to new situations felt confident

at the end of their training period. A small number of the midwives still had little experience in running antenatal classes and strongly recommended that this be a requirement of their course. The majority of midwives felt they were inadequately prepared to handle emergencies, especially the resuscitation of newborn babies.

Suggested **changes** to the present training included:

- extending the length of the course
- lessening reliance on large teaching hospitals
- starting the practical experience at the beginning of the year
- introducing a probationary year after training
- increasing course flexibility to meet individual needs.

In summary, this evaluation indicates, that the education of midwives should be provided by an individualised course to enable specific needs of individual trainees to be met.

## **2. The factors that influence midwives to stay practising**

### **Beginning work experiences**

Because of their own beginning experiences over the first six weeks, the midwives recommended that new graduates be given an orientation programme and a supervised period of time working with a midwife buddy so that they could become familiar with the staff, equipment, and the working environment.

### **Job satisfaction with present position.**

The majority of the participants were satisfied with their present jobs. They stated that they needed support and understanding about their jobs from both management and their peers to enable them to work efficiently.

**Management issues** of concern to these midwives related to working a 40 hour week on rostered shifts, pay, availability of holidays and study leave, all of which play a significant part in the everyday life of a practicing midwife. Their work as midwives is intertwined with many other roles and responsibilities such as family commitments, university study and varied financial commitments, yet they still want the opportunity to improve their practice through extra study.

Working with women and their families was considered the most rewarding aspect of practice. Having autonomy and the successful mixing of employment, family and social life were valued most by

the study midwives, with promotion and advancement considered as the least important.

### **Practising as a midwife**

The good things in midwifery practice were seen as working closely with women through their labour, birth and postnatal period to her discharge home, (this is easier to carry out in smaller hospitals where there is no fragmentation of care), educating women, having job satisfaction and being proud to be a midwife.

### **Limitations of this study**

#### **1) Failure of some midwives to participate in this study**

The desire to interview midwives with a wide range of perspectives was limited by the nonparticipation of some of the midwives approached.

- 1) six did not reply to the request in letter from the Nursing Council for unknown reasons
- 2) four declined to participate but gave no reason
- 3) three did not want to participate because they were not working as midwives.

Thus the sample is somewhat biased, possibly in the direction of those more committed to midwifery.

#### **2) The small sample**

As management needs to focus on numbers of midwives sharing different characteristics, this study can best be seen as an initial one, identifying areas of concern. Follow up studies could use its responses to prepare a more structured questionnaire examining specific points and issues raised with a larger sample.

**3) The complex and integrated nature of the topic** made it difficult to study. With so many changes and challenges in midwifery education and practice occurring, it is possible that some important aspects have not been fully considered.

Future research looking at midwifery education in the 1990s, could cover specific areas not explored in depth in this present study.

These could include:

- a) the growing need for continuing education for practising midwives.
- b) the implications of the Nurses' Admendment Act of 1990 being passed.

What do midwives have to do in order to adapt and practice autonomously as allowed by this Admendment?

### **Implications of this study for midwives**

If educators are to attract students and prepare competent practitioners, and if employers are to successfully recruit and retain midwives, it is important that there is a better understanding of how midwives view these education and practice situations.

Research of the present kind makes an important contribution, and this study could be used by:

1. **educators**, to reinforce the need for continual updating and modification of midwifery courses and for post graduate refresher courses, allowing midwives to keep abreast of changing midwifery practice and consumer needs.
2. **employers**, to assist them to understand what the needs of the midwives are and therefore what they have to do as employers to meet these needs
3. **midwives**, to illustrate the depth and scope of their practice. Future professional development, enrichment and job satisfaction requires a recognition of where they are now, and what they can do to increase their own job satisfaction in order to build and develop their careers in midwifery both now and in the future.

### **The beginnings of a model for midwifery practice**

The present study has identified a range of factors that affect the preparation and employment of midwives. This last section offers a model-in-process which integrates the diverse information given by practising midwives.

According to Wilson (1985.p.264.) a model

'represents some aspect of reality, concrete or abstract, by means of a likeness which may be structural, pictorial, diagrammatic or mathematical  
A model, unlike a theory, does not focus on the relationships among phenomena but rather on their structure or function. A model is essentially an analogy, a symbolic representation of an idea.'

The generic model of midwifery practice, as described in Chapter 2, provided background information for this research study. The main focus on the midwife in practice has been modified to read:

'as agent, a midwife, educationally prepared, practically experienced and organisationally supported, to work collaboratively with a woman enhancing her ability to gain control over the reproductive process especially the birthing process'.

The importance of a model for midwifery practice can be seen as valuable for the following reasons, to:

integrate complex data:

act as an aid in communication:

between midwives and their employers.

for educators organizing their study programmes

for midwives communicating with their clients and colleagues

clarify who the midwives are, and what midwives do, want, and need for:

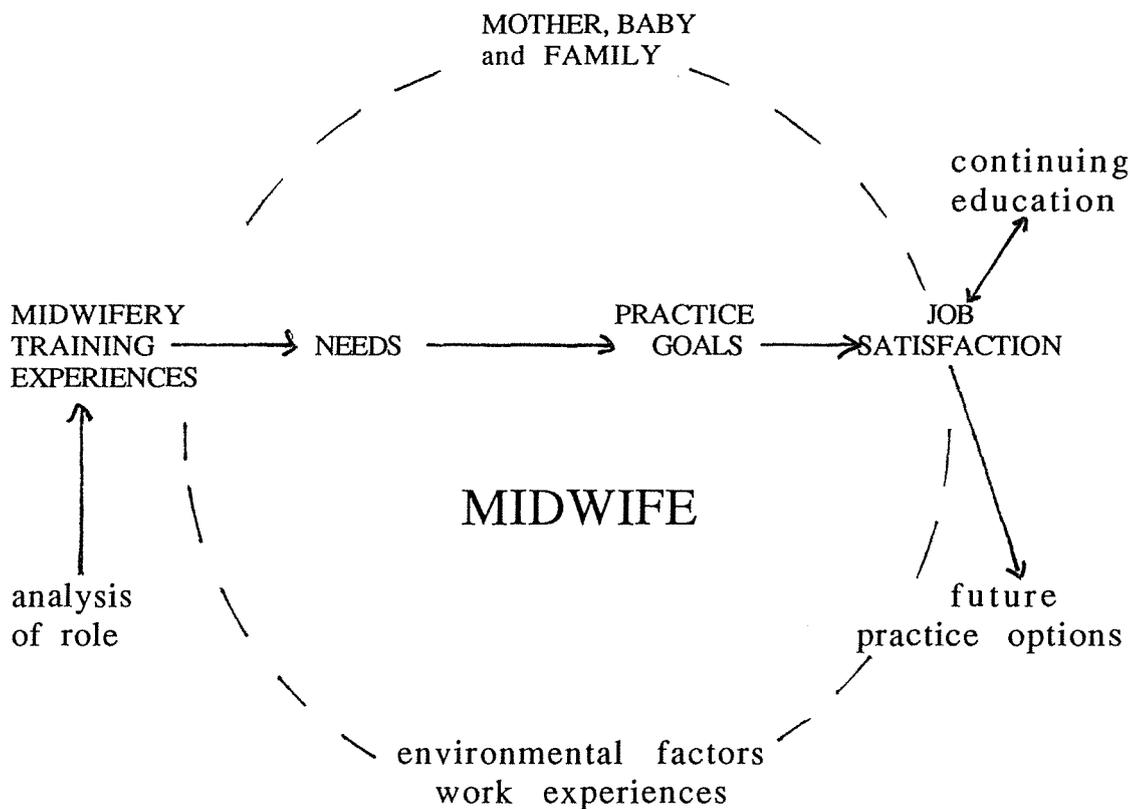
developing their profession

educating trainee midwives

communicating with employers and clients

A conceptual map of the practising midwife as identified by this research, illustrates the concepts identified in this study and the links or relationships between the four phases of the model-in-process, i.e. what the practising midwife encounters in her working environment. It is given at the end to bring together all the varied and complex ideas that the participating midwives shared with me. (see Fig.1. below)

Fig. 1. A beginning model for midwifery practice:



This present model of midwifery practice, which is a building model or a model-in-process, arose out of the newly qualified midwives' perceptions of their training and employment as reported in the previous two chapters. It consists of four phases:

### Phase 1.

The first phase begins as the midwife enters the practice environment and becomes aware of the adequacy, or otherwise, of her midwifery training including her clinical experiences. It covers the first six weeks of practice in any area.

### Phase 2.

After the first six weeks certain ongoing needs should be met enabling the midwife to move through to the next phase. These include:

1. **Knowledge needs.** The midwives expressed a need for greater knowledge. They stressed the importance of continually updating their education both through long term attendance at university, and by attending staff development in-hospital programmes. Midwifery skill workshops are also available at

various Technical Institutes and through different New Zealand College of Midwives' regional group educational meetings.

**2. Peer support needs.** The midwives saw the importance of having midwifery peer support to share, discuss and develop new ideas, knowledge, trends and changes. They especially mentioned that they liked networking with and having the comradeship of, other midwives. They saw the recently established professional College of Midwives as a forum, expressing the views of practising midwives and providing the links between midwives and the community.

**3. Personal needs.** The research showed that many newly qualified midwives in New Zealand are older, more mature and have more life experiences. These include having had children, or a wide variety of professional experiences, such as working in different areas within hospital or community settings. This maturity and experience needs acknowledging. Concerning their present needs, married midwives need flexible holidays and duties to fit their married and social life together with their job.

**4. Interpersonal needs.** These largely involve recognition as a professional and encompass the following:

- a. an orientation programme and a mentor when starting a new job even if it is a return to an area previously worked in. This enables socialization into the work place.
- b. to be accepted and recognised as an educated and skilled practitioner by colleagues, doctors and clients.
- c. to have control and power over certain situations, and acceptance of her expertise in various situations, such as emergencies (a specific example of (b) that was stressed by the midwives).
- d. to have support from not only the people she works with but also from management.
- e. to work harmoniously with other staff in order to achieve a happy atmosphere for the women in their care.
- f. to have more flexibility within the system especially from older practising midwives who have been in their positions for a long time. Flexibility of the hours of work/shifts/time in-lieu and

flexibility of the delivery of care given to the women e.g. more involvement with community-based schemes was mentioned.

**5. Self needs.** The midwives identified the need for certain levels of experience, confidence and assertiveness, that they considered were essential for competent practice.

The above five needs represent the second phase, and have to be addressed if the midwife is to feel strong and confident enough to support the women she is caring for.

### **Phase 3.**

Phase 2 focussed on the needs of the beginning practitioner. This third phase of the model encompasses three practice goals or achievements relating to ongoing professional development.

**1. Personal goals.** These are perceptual and include working within a personal philosophy of wellness and the promotion of womens' health. It includes the ability to say "I am a midwife" and know what that means for self and for women.

**2. Self-focussed goals.** These are:

working as an autonomous practitioner,  
being able to make decisions  
taking responsibility or being 'in-charge' of situations.

These goals arise within the organisational context of midwifery. They are also coupled with the midwife's perception of her role in research and her continual self-evaluation of where she is and what she is doing in order to provide a high standard of care. It includes continuing education and self development programmes.

**3. Client-focussed goals.** The midwives loved working with mothers and babies and enjoyed working alongside a woman in labour. They did not like fragmentation of care, preferring a continuity scheme where they cared for that woman throughout her pregnancy, confinement and post-natal period. They enjoyed the situations where they could help the woman, or couple, and where they had the ability and confidence to empower women to question and ask for alternative choices.

The level to which these goals are achieved is associated with the extent to which needs are met in the earlier phase.

#### **Phase 4.**

As these practice goals of Phase 3 are achieved, the midwife moves on to the fourth phase of the model, encompassing job satisfaction and presumably increased retention in the workplace. **Job satisfaction** arises from organisational, personal and professional factors and includes:

personal satisfaction derived from autonomy of practice  
 maintaining one's own self esteem by taking responsibility  
 leaving work feeling "I have achieved something"  
 getting positive reinforcement and feedback from the clients  
 and colleagues.

This phase is closely linked to the first three phases and represents the achievement of these.

#### **Ongoing development of the model**

If they are to be useful, models need regular review. The above phases have focussed on the midwife in practice. A component within the realms of the midwifery profession needing further development is the analysis of the role of the practising midwife for her own educational purposes and for ongoing monitoring of trainees and practitioners.

This would serve two purposes:

1. provide continuing educational and skill workshops to keep the practising midwife up to date with current trends.
2. feed back into the initial training and preparation of the midwife.

Consumer groups also can play an important role in this analysis by communicating their needs to the midwife.

This model is offered to clarify and integrate aspects of the complex and varied issues relevant to the preparation and initial practice of midwives. Further research and study is needed to ensure adequate numbers of midwives are educated to provide midwifery services to mothers and babies in New Zealand.

## APPENDIX A

### Interview Schedule

#### A. Characteristics of recently qualified midwives.

##### Professional

1. Nursing qualifications and experience.

Registered general & obstetric nurse  
Registered comprehensive nurse  
Registered psychiatric nurse  
Registered psychopaedic nurse  
Diploma of nursing  
Plunket certificate  
Other

2. When did you finish your general/comprehensive nursing training?

Where have you been working?  
What positions have you had?

3. What did you think 'being a midwife' would add to your nursing experience?

##### Personal

4. Educational qualifications.

a) school qualifications  
b) other formal qualifications e.g.university.

5. Age

6. Marital status

7. Number and age of dependent children

##### Entry to training.

First, I would like to begin at the time you decided to train as a midwife.

8. Please describe your reasons for undertaking midwifery training

9. Did you intend to practise as a midwife when you finished?
10. What sort of position did you see yourself working in at the end of your training?
11. At this time, did you see yourself developing your own career, or were other things such as family or traveling more important?

### Midwifery training.

Now, I'd like to move on to discuss your training.

12. At which Technical Institute did you do your midwifery training?
13. What was your age at the beginning of your midwifery training?
14. At which hospital did you do your clinical placement?
15. While you were doing your midwifery training, were there any clinical areas in which you felt that you needed more time to gain experience of the work?

What were these areas?

What sort of extra experience do you think you needed?

16. How did the following categories of people influence your views of midwifery while you were training?

- hospital midwives
- nursing staff (who are not also m/w)
- technical institute tutors
- medical staff
- other

Which of the categories had the strongest influence on your perception of midwifery?

Were there any other things that influenced your views of midwifery?

17. Please outline the clinical areas that you have worked in, since qualifying i.e

place	period of time	area
_____	_____	_____
_____	_____	_____
_____	_____	_____

For each of these areas, how well did you think you had been prepared?

Which area were you best and least prepared?

18. Now that you are qualified as a midwife how adequately do you feel that your training prepared you to work as a midwife?

working with women  
 assisting women to prepare for their birth  
 being flexible, e.g.happy to follow a woman's wishes  
 caring for a woman and her partner during their birth experience  
 handling emergencies  
 observing newborn babies  
 coping with grieving parents e.g. following a stillbirth  
 assisting a woman to breastfeed  
 helping a woman adapt to a new situation

19. Generally, how do you feel working with women and their families ?

Do you prefer mothers or babies ?  
 What do like best about practising midwifery ?

20. What did you enjoy most about your midwifery training?

What other things did you enjoy?  
 If you could make changes in your training, what would they be?

**B. The factors that could influence midwives to stay practising within the midwifery profession.**

**Professional/personal**

Now, I would like to explore your initial work experiences over the first 6 months when you began practising as a qualified midwife.

21. Where were you first employed?

For how long?

22. Did you have a formal orientation programme?

If yes, how long was it?

what did it entail?

were you given a mentor/buddy?

(or)

If no, what happened?

23. Overall, how difficult did you find the first six weeks?

What areas were you first given midwifery responsibilities in?

What were these responsibilities?

When did you feel you were being accepted as a midwife:

by your midwifery colleagues?

by the medical staff?

How did you decide you were accepted?

What areas of practice gave you the most concern?

Now, I would like to change to discussing your experiences in your **present midwifery position.**

24. Where are you working as a midwife at present?

25. How long have you been in this position?

26. Are you satisfied with your present midwifery position?

Please describe the reasons why /why not.

27. What sort of days do you enjoy most at work?

Why is that?

28. Describe a midwifery situation that you really enjoy being in.

What is it about it that makes it enjoyable?

Do you experience this very often ?

29. Thinking of the opportunities for practising midwifery as you want to, do you see these opportunities increasing or decreasing in the future?

Why is that?

30. In summary, what are the things that you enjoy about working as a midwife?

What are the things that you most dislike about working as a midwife?

### **Organisational**

Now I would like to discuss the management of the unit/ward in which you work

31. What support is provided with your present position to enable you to carry out your job effectively?

Who gives this support?

What sort of support is it?

How satisfied are you with the supervisory support?

32. Working in a hospital means things such as rosters, pay etc. I'd like to ask your opinions on a number of these:

40 hour week (lack of flexibility)  
 rosters  
 pay  
 holidays  
 study leave  
 any other?

How satisfied are you with these generally?

How restricting are these for practise?

33. How aware do you think the management is of the difficulties and stresses that midwives experience and have to cope with?

How would you like them to help?

34. Are you satisfied with the way in which your unit/ward is managed?

Please describe the areas of greatest satisfaction

Working as a midwife brings a variety of rewards and opportunities which I'd now like to discuss

35. Employment can provide different kinds of opportunities. Here is a list of opportunities that some employment provides. For each I would like you to indicate how important they are to you personally.

very important                      important                      not so important

---

the opportunity to use a variety of skills and different levels of skills in any position you hold.

the opportunity to practise midwifery in different areas or settings.

the opportunity to achieve goals and obtain feedback on how well these goals have been achieved

the opportunity to make decisions, exercise control, and exert a degree of control over what is done and how it is done

the opportunity to work with women and their families.

Which is the most important to you?

To what extent can you achieve those that are very important or important to you in your present position?

Do you think the chances of achieving these personal goals will improve in the future?

36. The following are things that most people value and for which they can sometimes achieve through their work. For each I would like you to indicate how important they are to you personally.

very important                      important                      not so important

---

recognition

respect

responsibility

autonomy

promotion / advancement

working with a variety of professional people

mixing employment, family and social life

Which is the most important?

Going back over the list that most people value, which is the one you are most likely to be able to achieve ?

Do you think the chances of achieving these personal goals will improve in the future?

37. Are there other thing that are important to you, that practising as a midwife can help you achieve ?
38. Now that you are practising as a midwife, please explain the reasons that you want to stay in the profession

39. Do you expect to be working as a midwife in five years time?  
and long term?

If no, why is that?

### C. Midwifery in the future

As well as having views on their own personal situation, midwives also have ideas about their profession and where they see their profession going

40. Generally, what do you see as the good things in midwifery at present?

How can these be enhanced?

What are the present challenges for midwifery?

Which is the greatest?

41. What overall changes in midwifery would you like to see?

How likely are these to happen ?

42. Overall, are you optimistic about developments in midwifery over the next ten years?

43. Would you like to give one last reason why you do, (or do not), see yourself practising as a midwife in future.

Thank you for participating in this interview.

## APPENDIX B

### Letter to Midwife Participants

Department of Nursing Studies,  
Massey University,  
Palmerston North.

Dear Midwifery Colleague,

I am a midwife, currently undertaking research for my Master of Arts degree at Massey University into the preparation and work experiences of recently qualified midwives.

Midwifery is facing many challenges at present, and it is important that the views of practising midwives are known to those in positions who can influence change. Your views are being sought, on both your midwifery training and your past and present employment as a midwife.

I believe that the knowledge and information gained from this research will be of value to the midwifery profession, to various employers, and to policy makers.

If you agree to participate you will be asked to take part in an interview which will be either tape recorded or recorded in writing.

You may be assured protection of the following rights:

- a) you are free to ask for further information at any time
- b) you are free to decline participation or withdraw from the study at any time
- c) complete confidentiality and anonymity is assured when the research is being written up
- d) opportunity for discussion of study findings will be made available

This research proposal has been approved by the Massey University Human Ethics Committee.

.....2

If you agree to participate in this study would you please complete the attached form and return it to me as soon as possible in the stamped addressed envelope provided.

I would like to carry out these interviews during July and August 1989.

Thank you in anticipation

Yours sincerely,

Judy Hedwig B.A., R.G.O.N., R.M.

To: Judy Hedwig  
17 Palm Avenue  
Palmerston North.  
Phone:063-75998

I agree/do not agree to participate in your research project. (cross out inappropriate)

Name: \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Telephone:      Work      \_\_\_\_\_  
                         Home      \_\_\_\_\_

The best times to phone me are: \_\_\_\_\_  
\_\_\_\_\_

My present midwifery position is: \_\_\_\_\_  
\_\_\_\_\_

## APPENDIX C

### **World Health Organisation's definition of a Midwife.**

"A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventive 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 patients, but also within the family and 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 "

## APPENDIX D

Table 8: The midwives clinical experience since qualifying

Months since qualifying as a midwife

Areas	6	12	18	24	30	36+
Delivery Suite		-----A				
	-----B					
	-----C					
					-----E	
	-----F					
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	-----V				-----S	
Postnatal Ward	-----A					
		----B				
		----C				
	-----E					
	-----H				-----H	
		-----I			-----M	
	-----U				-----Q	
		---V			-----O	
Antenatal Ward		-----S				
		-----O				
	-----D					
	-----G					
		-----H				
	-----I					
	-----Q					

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Areas	6	12	18	24	30	36+
All Areas	-----R		-----J			
	-----T					
Other Areas	-----J			-----N		
						-----S

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\* the numbers refer to the individual midwives

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