‘My passion is midwifery’: Midwives working across dual roles in the country.

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Statement of Sources

Declaration

I declare that this thesis is my own work and has not been submitted in any form for another degree or diploma at any university or other institution of tertiary education. Information derived from published or unpublished work of others has been acknowledged in the text and a list of references is provided.

……. 30th September 2010

Signature Date

Statement of the contribution of others

This thesis has been completed through the support of the following people:

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Ethical approval was sought and approved by the James Cook University Human Ethics Review Committee (H3199) and the Cairns and Hinterland Health Service District Human Research Ethics Committee (534).

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Conventions used within the thesis

The presentation of the data analysis chapters (Chapters 6 through 8), excerpts from the transcripts were presented. The following conventions were used in the thesis:

All participants were assigned pseudonyms to preserve their anonymity. Where other staff or family members were mentioned by name, these were also assigned a pseudonym.

All direct quotes were presented in italics. At the end of each quote a series of numbers were assigned in brackets. These numbers denote the participant number and the lines of the transcript that the quote was from. For example, (1:23-27) denotes this quote was from participant 1, and the quote is found in lines 23 to 27 of the transcript.

Where the participant may have expressed a word or phrase particularly forcefully or emphatically, this was presented in **bold** font. Three dots (…) at the beginning of a quote denote that the quote commenced part way through a sentence and if contained within the quote, they denote some words were left out, for the sake of brevity.

The words or comments of the author may have been included within the quote to enhance understanding or illustrate a question posed. In these cases the author's words are contained within brackets [ ] and are in normal font, not italics.

List of Figures and Tables

Abstract

Over 130 maternity units closed across Australia between 1995 and 2008 (Bryant, 2009). In the majority of cases these closures were in rural areas and caused by workforce shortages, both medical and midwifery. The potential for midwives to leave rural and remote areas as a result of the closures has serious implications for birthing women and their families residing in these areas, as well as for the already depleted rural workforce. The reduction in maternity services in rural areas has led to a situation where midwives have been required to work in dual roles as nurse and midwife. Midwives in rural and remote areas face many challenges including the difficulty in maintaining midwifery skills, being required to work in nursing-oriented areas for which they may have little current clinical experience or interest, and the fear of working beyond their scope of practice which may result in dissatisfaction with the work environment, a known contributor to staff attrition (Jackson, Mannix, & Daly, 2001). Little is known about the challenges faced by midwives who work in dual roles in rural and remote locations in Australia.

The aim of this study was to describe midwives' experiences of working in the dual role as nurse and midwife in rural areas of far north Queensland, Australia. The methodology was informed by Heidegger's interpretive phenomenological philosophy and data analysis was guided by van Manen's (1990) analytical approach. Data was generated by unstructured, conversational interviews with eight midwives. The interviews were recorded and transcribed verbatim, then analysed and interpreted using the van Manen (1990) hermeneutic phenomenological approach.

Three themes were identified that helped to explain what it is like to work in a dual role as nurse and midwife in rural far north Queensland. These were: Making choices between professional role and lifestyle: "Because I choose to live here"; Integration of maternity and general nursing: "All in together this fine weather" and, Shaped by location: "That's part of working in a small place". A number of sub-themes were also described under each of these themes. The findings revealed that the midwives saw their employment options limited by their rural location, however these limitations were largely accepted as being part of living in a rural area. A number expressed concern that they were deployed back and forth between midwifery and nursing areas, sometimes more than once during the same shift. There was philosophical conflict identified between the biomedical, illness based model of nursing and the partnership, wellness model of midwifery, and concern about the lack of support for midwifery services. While the midwives expressed a preference to work as midwives only, they did acknowledge that the variety offered by the dual role had some benefits in terms of maintaining nursing knowledge and skills. While the participants recognised that in rural areas it is important to be a multi-skilled generalist, they were concerned that midwifery skills could be eroded or even lost with the diminishing amounts of midwifery work available.

A number of recommendations arose out of this study. Further research is needed to examine the extent to which the requirement to work in a dual, or multi-faceted role is an impediment to the recruitment and retention of midwives to rural areas. Appropriate re-structuring of maternity services could provide better utilisation of the midwifery workforce in rural centres, and reduce the current problems associated with transferring birthing mothers from rural centres to larger facilities to birth their baby.

This study also highlighted the need to explore the dual role of the rural nurse and midwife from a nursing perspective. Rigorous evaluation of current rural midwifery-led models of care is important to create awareness of how these models may be able to be effectively implemented in rural settings in the future.

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Chapter One

Introduction and Background to the Study

Introduction

Midwives are essential for good outcomes for mothers and babies (Dahlen, 2006). In some rural and remote locations, due mainly to shortages of staff and current service models, midwives may be required to work in dual roles, as midwife and nurse at different times during a shift or different days of the week. As a result, midwives face many challenges including an inability to maintain midwifery skills, working in areas for which they have little current clinical experience or interest, and the fear of working beyond their scope of practice. Unfortunately, the end result of this problem is often dissatisfaction with the work environment for those midwives involved; a known factor in staff attrition (Jackson, Mannix, & Daly, 2001). Little is known about the challenges faced by midwives who work in a dual role of midwife and nurse in rural and remote locations. This thesis explores the lived experience of midwives who work in such roles, and is focused upon a rural area in Far North Queensland, Australia.

The current situation for midwives and their role within healthcare services in rural areas remains unclear. Essentially, the role of a rural or remote midwife is that of a rural generalist which means they have a smaller proportion of 'midwife work' in their day to day work (Kildea, Kruske, Barclay, & Tracy, 2010). For some midwives, this may mean they begin to be fearful of practising as a midwife. The recognised lack of midwifery practice in the rural areas due to the ongoing closure of rural maternity services has also meant that many midwives are reluctant to relocate to, or

remain in, rural areas (Monaghan & Walker, 2001). Further, reduced opportunities to work to their full scope of midwifery practice in rural areas may be significant contributing factors to midwives' decisions to leave rural areas or cease midwifery practice altogether in these areas (Fahey & Monaghan, 2005; Kildea, et al., 2010).

Hunter (2004) investigated the potential for differing ideologies of midwifery practice to create dissonance for midwives in urban hospitals. It is possible that the same issue could arise for rural midwives who struggle with delivering different models of care across a region. In particular, this issue could be most significant for midwives who are required to practice as both a midwife and nurse at various times during a shift or across their working life. As little is currently known about this phenomenon, the aim of this study was to investigate the experience of midwives working in a dual role of midwife and nurse in rural Far North Queensland, Australia. Developing an understanding of what it is like to work as a midwife and nurse in a dual role may contribute to the development of appropriate models of care for these communities that address the needs of the women and their families, as well as the midwives.

Interpretive, hermeneutic phenomenology, as described by Heidegger, was chosen as a suitable approach for the study. Phenomenology is considered an appropriate approach to use when investigating the lived experience of a particular group and when the goal is to come to some understanding of a common experience (Koch, 1999). Using the hermeneutic phenomenological process, interviews were conducted with eight midwives who are required to work in a dual role of midwife and nurse because of their employment in a small rural facility in far north Queensland, Australia. The analysis of findings was guided by van Manen's (1990) framework

which involves describing a phenomenon of interest by moving between parts and the whole and by a process of writing and re-writing.

This chapter initially provides an outline of my background and what brought me to this study. It then reviews the relevant background information, including the concept of rurality and the health of people living in rural areas, and concludes with an overview of the remaining thesis chapters.

My Background

I came to midwifery, like the vast majority of Australian midwives, from a nursing background. Commencing hospital based nursing training in the late 1970s, I perceived nursing as a career where I could be paid as I learnt, unlike a university degree, and further, as an immediate school leaver I was unsure what I wanted to do and nursing seemed like a good choice. During the latter part of my first year as a student nurse I undertook a one week placement in the maternity unit and although I was enjoying nursing, I knew from that point on that what I really wanted to do was midwifery. At that time in Australia, the only way to gain a midwifery qualification was to become a registered nurse first. I applied for the first available midwifery training place after I registered as a nurse and was made to wait the obligatory one year post graduation before being accepted into the midwifery course. I have worked as a midwife ever since with no desire to return to general nursing.

An incident that occurred during the first week of my placement as a student midwife in what was then called the ‘labour ward’ illustrated to me the important role that midwives play in the lives of birthing women and their families. I was allocated to

care for a primiparous or first time mother, who was well supported by an attentive partner. I spent the majority of my time at the head of the bed, holding the woman's hand and blindly reassuring her that all was well and she was doing a great job, even though I was petrified and had no idea what was happening. As the time of the birth approached, the midwife instructed me to move to the foot of the bed so that I might observe the 'delivery'. The woman refused to let go of my hand so I remained at the head of the bed, trying to see what was occurring over her distended abdomen. To my surprise her husband presented me with a gift the next day and they were both effusive in their praise and appreciation of 'all I had done' for them. This came as a surprise to me, as my perception was that I had no idea what I should be doing. It then became clear to me that one-on-one support and encouragement was valued much more highly than the actual mechanics of 'catching the baby'. From that time on my commitment to midwifery and the importance of supporting the mother and significant other through the birthing process and afterwards, has been unwavering. I have since worked in a variety of midwifery roles in regional and rural areas in Australia.

After registering as a midwife, I worked in Darwin and Cairns, in northern Australia. Both of these hospitals have close links with rural and remote communities that refer women to them for some or all antenatal care and birth, particularly in complicated cases. Large numbers of women in the surrounding regions of these two referral hospitals are required to relocate from their home communities to birth mainly due to concerns around issues of perceived safety (Arnold, deCosta, & Howat, 2009; Kildea, 2003). The impact of this mandatory relocation is felt more strongly by Indigenous, rather than non-Indigenous women due to the cultural implications that birthing away

from the land has for these women (Kruske, Kildea, & Barclay, 2006). Although I had a good understanding of the implications of this relocation for the women and their family, I was less clear about how this impacted on midwives who worked in the area. Eventually I realised that the mandatory removal of women from their home communities to birth, and the resultant loss of services to communities, led to the potential de-skilling of midwives in these areas (Monaghan & Walker, 2001). I also became aware that in small rural hospitals where midwifery services were preserved, midwives were often required to work across areas of the hospital when there were no midwifery clients in need of their services.

The impetus for this study

In May 2005, Re-Birthing: the report of the review of maternity services in Queensland (Hirst, 2005) was released. This Report and its recommendations had a significant impact on my future within midwifery services. The review was commissioned by the Queensland Government in July 2004 to examine pregnancy, birthing and postpartum services across Queensland and make recommendations to enhance choices for women without compromising their safety. Hirst (2005) identified three priority areas for change:

- poor outcomes among babies of Aboriginal and Torres Strait Islander women and the need to make this the first priority for change;
- care for women in rural and remote areas;
- the dearth of post-birth care in the community and the transition from hospital to community care (p.16).

The release of this Report coincided with the closure of the maternity unit at Mareeba District Hospital[1] due to the resignation of the medical superintendent and subsequent lack of medical support for the unit. The Mareeba maternity unit had been cited in the Re-birthing report as an exemplary model of a collaborative service considered to be flexible and family-focused (Hirst, 2005). The unit re-opened as a midwifery-led unit six weeks after closure due to strong lobbying by community and committed midwives who had the support of local, procedural-trained General Practitioners (GPs) and the referral hospital obstetric staff.

Part of the investigations to develop a safe model of maternity care for Mareeba Hospital involved collaboration with the obstetric team of the referral hospital, Cairns Base Hospital. During this time, the decision was made to appoint a Regional Maternity Services Coordinator to assist regional facilities to prevent further closures of maternity services and potentially re-open previously closed services through implementation of new models of maternity care. The development of this position is aligned with the recommendations of the Re-birthing report to provide care for women in rural and remote areas as close as possible to their home (Hirst, 2005). The Regional Maternity Services Coordinator is a midwifery leader, based at Cairns Base Hospital, supporting maternity units in the Cairns and Hinterland, and the more remote areas of Cape York, and Torres Strait Health Service Districts.

I was appointed to this role in April 2006 and immediately commenced meetings with midwives across the region. In these meetings, midwives identified a number of issues common to most facilities in Far North Queensland, Australia. These included

[1] Mareeba District Hospital is a 44 bed hospital in rural far north Queensland, approximately 70 km from the closest referral hospital (Cairns Base) and has about 180 births per year

professional isolation, difficulties accessing professional development programs and opportunities, recruitment and retention difficulties, and impediments to working to the recognised scope of practice for a midwife in Australia. The midwives also discussed the issues surrounding the requirement to work as both a midwife and general nurse in small rural facilities such as Innisfail Hospital[2]. This led to the development of my interest in the area of nursing and midwifery 'dual roles' and what that means to midwives who work in small rural facilities.

Defining the concepts of rurality and remoteness

In discussing issues pertinent to rural areas it is first important to define what is meant by the term 'rural'. Smith (2004) provides several reasons why it is important to define rural and remote. The allocation of resources and services, reducing disadvantage to those in these areas and establishing the populations where people live are all reasons to define the terms. The recognised differences that people living in rural areas have in relation to poorer health outcomes, decreased opportunity for education and lower incomes make it important to be able to classify where they live in order to adequately analyse these differences (Australian Institute of Health and Welfare, 2008a).

These definitions, however, often lack clarity or may differ depending on the motivation for creating the classification (Muula, 2007; Smith, 2004). Research studies and policy documents often use differing definitions of rurality which makes comparisons challenging (Hunsberger, Baumann, Blythe, & Crea, 2009; Wilkinson, 2002). Smith (2004) notes that the classification systems commonly in use to date

[2] Innisfail is a 49 bed rural hospital approximately 90 km from Cairns and has about 250 births per year.

reflect factors such as geographical remoteness, accessibility to services and the size of the population. Other key aspects that play a part in health determination, such as socioeconomic disadvantage and cultural considerations are often not taken into account.

Numerous classifications systems have been developed to define rural and remote in both Australia and overseas. The commonly used systems in Australia include the Rural and Remote Metropolitan Areas classification (RRMA), the Accessibility/Remoteness Index of Australia (ARIA) and the Australian Standard Geographical Classification (ASGC) (Wakerman & Humphreys, 2008). The three systems are compared in Table 1.

Table 1: Rural and Remote Classification Systems

Feature	RRMA	ARIA	ASGC
Factors used	Population size and direct distance from nearest service centre	Road distance in km to service centres with population >5000	A refinement of ARIA
Categories	Capital cities, other metropolitan centre, large rural centre, small rural centre, other rural area, remote centre and other remote centre.	Highly accessible, accessible, moderately accessible, remote and very remote	Major city, inner regional, outer regional, remote and very remote.
Advantages	Logical groupings Based on distance to service centre as well as distance from other people	Uses road distances so better measure of accessibility	Better groups areas with similar characteristics. Provides a greater level of precision in measuring remoteness
Disadvantages	Uses straight line distances rather than road distances All capital cities classified same regardless of population and remoteness.	Dissimilar areas may be given same remoteness scores. Majority of population (80%) classified as living in highly accessible areas so difficult to compare small numbers in other areas.	As with the others, does not take into account socioeconomic and cultural factors

(Adapted from Wakerman & Humphreys, 2008).

Within the populations of these areas, other factors such as Indigenous populations, transport and communications, and the health needs of the population, are then used to typify each area. Accurate classification of populations in areas of rural research is important as the larger distances and reduced accessibility to services impact on the health of rural people. These factors provide people living in rural areas with a different perspective of their health (McGrail, et al., 2005). The ASGC system has been chosen for this study as it provides a specific scoring of each of the four towns from whence the study participants were recruited. This system was used by the Australian Institute of Health and Welfare when producing their Nursing and Midwifery Labour Workforce statistics and so provides consistency with the data accessed for this study (Mills, Birks, & Hegney, 2010).

Health and demography of rural populations

Approximately one third of the Australian population live outside of the major cities (Australian Institute of Health and Welfare, 2008a) however this figure varies depending on the definition of rurality selected and how the definition impacts on the determination of people defined as living in a particular rural and remote area. Generally it is considered that between ten and thirty percent of Australians live in rural and remote areas (Wakerman & Humphreys, 2008), a statistic that includes two thirds of Australia's Indigenous population. The proportion of Indigenous people increases as remoteness increases. For example, only one percent of the Australian population lives in areas defined as very remote yet forty five percent of those residents are Indigenous as opposed to the sixty eight percent of people living in major cities where only one percent are Indigenous (Australian Institute of Health and Welfare, 2008a).

It is well documented that the health outcomes of people living in rural and remote areas are poorer than their counterparts living in major cities. These outcomes are impacted upon by a number of factors related to their place of residence. Rurality has an impact on the physical and social environments of rural residents and these factors are well known determinants of health (Sutherns, 2003). Factors such as social isolation, distance from services, socioeconomic disadvantage and living conditions (Bryant, 2009; Mills, et al., 2010; Smith, 2004), all have an impact on the health of the rural population. As a result, people living in rural communities have higher rates of preventable morbidity and mortality and tend to be older, poorer, and sicker than those living in urban areas (Muula, 2007; Pearson, 2008).

People living in rural areas also have higher rates of smoking and alcohol consumption, higher rates of injury, particularly from motor vehicles and farm accidents, and higher levels of disability and communicable diseases (Mills, et al., 2010; Wakerman & Humphreys, 2008). Higher illness and morbidity rates are thought to be related to the difference in access to services as well as the risk factors faced in the rural environment (Australian Institute of Health and Welfare, 2008b). There are also decreased numbers and diversity of health professionals per head of population in rural locations (Muula, 2007; Pearson, 2008).

Lack of access to health providers, in particular to specialist services, in combination with the high costs, both financial and social, of travelling long distances to access care, has adverse impacts on the health outcomes of rural people (Department of Health and Ageing, 2008). Rural people are also exposed to greater health risks through having to travel long distances, often with worse road conditions and

common occupations in rural areas such as farming, mining and forestry are considered among the most dangerous (Phillips, 2009).

As indicated above, people living in rural areas tend to view their health differently to their urban counterparts. They regard health primarily as the absence of disease and thus services are viewed as curative rather than preventative (Smith, 2004). People living in rural areas tend to present late for diagnosis or treatment, or not at all, due to the difficulties of access and this is a significant contributor to their poorer health status (Humphreys, et al., 2008). Women living in rural areas are known to have higher incidence of diabetes, hypertension and asthma (Australian Institute of Health and Welfare, 2008b; Wakerman & Humphreys, 2008). The reproductive outcomes for women living in rural areas are overall worse than for those in urban communities. These women tend to have babies of a lower birth weight, have increased rates of maternal death, and experience higher rates of stillbirth and neonatal death (Bryant, 2009).

The health status of Indigenous people in Australia is significantly poorer than that of the health of the non-Indigenous population and this is exacerbated for Indigenous people living in rural areas. The fact that approximately twenty six percent of Indigenous Australians live in remote or very remote locations severely impacts on their access to adequate health services and impacts on determinants of health such as income, housing, and nutrition. These impacts on health determinants contribute to the poorer health outcomes (Wakerman & Humphreys, 2008) experienced by this group. Chronic illness, infectious diseases, injuries, mental illness and suicides are all experienced at higher rates in Indigenous people than in non-Indigenous people

(Australian Institute of Health and Welfare, 2006), and all of these influences on health are exacerbated by virtue of living in a rural environment (Mills, et al., 2010).

The reproductive health and health outcomes for Indigenous women and their babies are also significantly worse than the non-Indigenous population. The Perinatal Mortality Rate (PMR) of babies born to Indigenous women is twice as high as that of non-Indigenous babies and although rates have fallen over years, the gap between Indigenous and non-Indigenous PMR remains [see Figure 1] (Bryant, 2009; Johnston, Wills, & Coory, 2008; Kildea, et al., 2010; Van Roo & Houweling, 2008). There is also a higher incidence of low birth weight, foetal alcohol spectrum disorder and prematurity in Indigenous babies (Bryant, 2009; Daly & Smith, 2005; Hirst, 2005). Factors that contribute to these outcomes include higher rates of smoking and alcohol consumption, genito-urinary infections, births to teenage or younger women, later presentation for initial antenatal visit or less visits overall (Bryant, 2009; Daly & Smith, 2005; Hirst, 2005). Barriers to accessing appropriate maternity services faced by Indigenous women include financial hardship, distance from and access to and culturally appropriate services (Arnold, et al., 2009; Bryant, 2009; Kruske, et al., 2006).

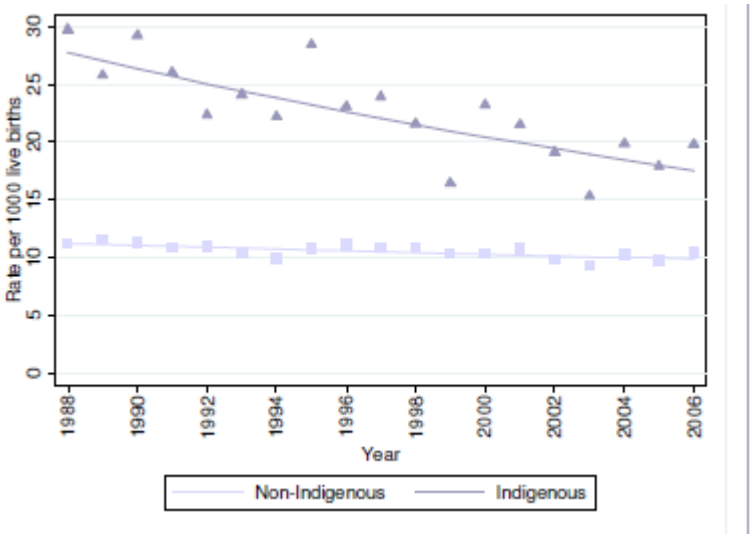

Figure 1. Trend in Perinatal Mortality Rate in Queensland by Indigenous status (Johnston, et al., 2008)

Provision of maternity services in rural Australia.

There is pressure in rural and remote areas to maintain a skilled and competent workforce in the face of workforce shortages, as well as the necessity for rural and remote practitioners to be multi-skilled (Ireland, et al., 2007; Price, 2000). The issue is compounded for midwives who spend only a small part of their time working as a midwife and more of their time working as a generalist in small rural facilities. The challenge for those midwives is maintaining the skills required if a pregnant or birthing woman presents to the facility (Monaghan & Walker, 2001). Declining birth rates in rural areas, which result from the policy that mandates women must relocate for birth to larger regional or tertiary services, has been identified as a potential cause of midwives' deskilling in rural areas (Fahey & Monaghan, 2005). Deskilling has been cited as causing midwives to become afraid of facing obstetric emergencies as a sole practitioner. Declining birth rates coupled with deskilling may cause health professionals, and even the midwives themselves, to discourage women from birthing in their home town or community (Kornelsen & Grzybowski, 2006). A concern for

patient safety also has the potential to lead to voluntary relinquishment of midwifery endorsement and practice by the midwife as a way of avoiding risk. The extent to which the relinquishment of qualifications occurs is unknown. Regardless, the concern over deskilling establishes a need to look for alternative models of maternity care for rural areas.

Over 130 rural maternity units closed across Australia between 1995 and 2008 (Bryant, 2009). This finding was supported by the Queensland Review of Maternity Services conducted by Hirst (2005) where it was documented that in Queensland alone, the number of maternity units had reduced from eighty four to forty eight between 1995 and 2005 [see Figure 2]. In 2009, the number of public maternity units in Queensland reduced by another seven to forty one. These closures are generally attributed to safety concerns due to maternity workforce shortages, whether midwifery, procedural medical, or a combination of both (Brodie, 2003; Hirst, 2005; Robinson, Slaney, Jones, & Robinson, 2010). Whether these closures are actually driven by cost effectiveness initiatives or out of concern for the safety of the women and their families, has not been formally studied or evaluated (Dietsch, Shackleton, Davies, Alston & McLeod, 2010).

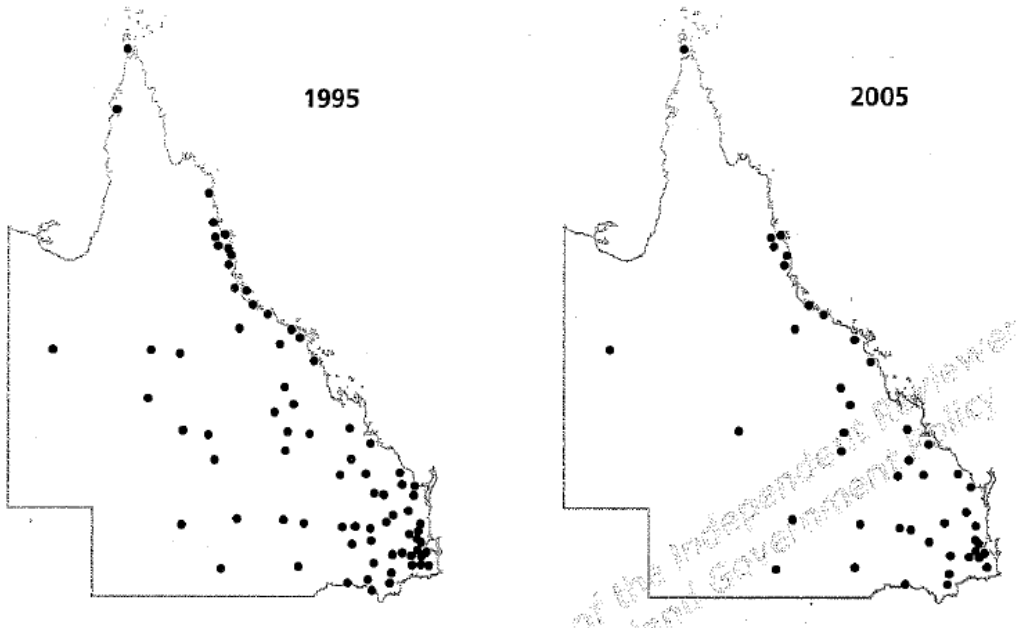

Figure 2. Public birthing facilities in Queensland, 1995 and 2005 (Hirst, 2005).

In Canada, closures of rural maternity services Canada have been attributed to the lack of appropriately qualified health care providers (Kornelsen, 2009), together with centralisation of health services generally in response to financial need and the organisational challenges of service delivery in rural areas (Kornelsen, Moola, & Grzybowski, 2009). Klein, Christilaw and Johnston (2002) described this centralisation as a false economy that leads to a cascade of negative consequences for women and their families. One consequence is further workforce shortages due to potential loss of services such as surgery and anaesthetics, due to the number of doctors required to sustain rosters. The provision of limited services that require women to travel even further to access these services and the increase in adverse clinical outcomes, such as increased frequency of premature births, maternal and newborn complications leading to increased length of stay, and days spent in neonatal intensive care nurseries, are also predicted as a result of health service centralisation in Canada (Klein, Christilaw, & Johnston, 2002; Kornelsen, et al., 2009).

A reduction of health care services has serious implications for birthing women in rural locations of Australia. Inability to access maternity services leaves women and their families vulnerable and increases the stress they feel around this important time in their life (Arnold, et al., 2009; Kornelsen, et al., 2009; MacKinnon, 2008; Wakerman & Humphreys, 2008). The risks for women having to travel some distance for antenatal care and birthing in particular are outlined clearly in the literature (Hirst, 2005; Kildea, 2003; Tracy, Barclay, & Brodie, 2000; Tracy, et al., 2006). Tracy et al. (2006) noted that the unplanned out of hospital birth rate in Australia is now higher than the planned home birth rate. Dietsch et al. (2010), in their qualitative study of the experience of forty-two women from rural New South Wales, Australia, who laboured en route from their local community to a centralised maternity unit, identified two dominant themes. These were that in the calculation of obstetric risk, the dangers of travelling some distance in labour are ignored and secondly that women suffer deprivations in their labour care by being forced to travel in labour and do not have a qualified person to care for them during this time (Dietsch et al., 2010).

Birthing close to home contributes to the social structure of the community (Farmer, Lauder, Richards, & Sharkey, 2003; Tracy, et al., 2006). Lauder, Reel, Farmer and Griggs, (2006) identify the benefits to communities that the presence of health care professionals endow. The psychosocial and financial impact upon women and their families of having to relocate for birth and the resultant anxiety over inability to access local maternity care were also identified in Kornelsen and Grzybowski's (2006) study of rural women in Canada. Australian women who participated in the study conducted by Dietsch et al. (2010) also identified how being made to travel

during labour, and for birth, denied them the right to experience early labour in their own home and questioned a risk analysis that suggested they were safer potentially birthing alone on a road side rather than in a small rural hospital with midwifery support. In addition to the clinical risks of birthing unassisted by the side of the road there are also cultural and social risks to women required to relocate for birth.

In returning birthing services to the remote Nunavik region of northern Canada, it was identified that although risk screening and identification is fundamental to the provision of a safe service, a purely biomedical approach is inappropriate. Therefore, screening should also consider social, cultural and community perceptions of risk in order to provide a culturally safe service to women and their families (Van Wagner, Epoo, Nastapoka, & Harney, 2007). Failure to include emotional, social and cultural risks to women when assessing safety and risk in childbirth has also been identified in the Australian context (Kildea, 2006; Kildea, et al., 2010). It is socially unacceptable for many women to endure forced separations from partners and other children when relocated and this separation also places a financial stress on women and their families (Kildea, 2003).

Distress experienced by Indigenous women, both in Australia and overseas, due to having to leave family and country, particularly to birth, is clearly explained by many authors (Hirst, 2005; Kildea, 2003; Kruske, et al., 2006; Tracy, et al., 2000; Tracy, et al., 2006; Van Wagner, et al., 2007). Australian Indigenous women who are 'not allowed' to birth on their land have stated this leads them to feel culturally unsafe. Women are dislocated from their family, may receive culturally inappropriate care and the link between place of birth and cultural meaning of the land is, as noted

above, of particular concern to many Australian Indigenous women (Hirst, 2005; Kildea, 2003; Kildea, et al., 2010; Kruske, et al., 2006; Wakerman & Humphreys, 2008). Tracy et al (2000) report statistics that clearly demonstrate poorer outcomes for Indigenous women, the majority of whom live in rural or remote locations who are mandated to relocate for some or all of their maternity care.

Culturally safe practice

The concept of cultural safety was first introduced to nursing and midwifery in the 1980s by a New Zealand Maori nurse (Ramsden, 1990). Though cultural safety began with the recognition of the culture of the Maori people, it further developed to include consideration of not just ethnicity but also gender, age, sexual orientation, socioeconomic status and religious or spiritual belief (Kruske, et al., 2006). The concept of cultural safety provides a framework for the provision of midwifery care that gives recognition to the power imbalances present in relationships between health care providers and consumers (Phiri, Dietsch, & Bonner, 2010). The Nursing Council of New Zealand (2009) describes achieving cultural safety as a three step process. The first step is cultural awareness where the nurse or midwife develops an awareness of her or his own culture and the power dynamics of relationships. The second step is that of cultural sensitivity, whereby the nurse or midwife acknowledges a "legitimacy of difference" (Nursing Council of New Zealand, 2009, p. 5) and considers the effect their own life experience may have on others. Finally, cultural safety is identified as an outcome where "safe service is defined by those who receive the service" (Moffitt & Vollman, 2006, p. 229). In other words, practising culturally safe midwifery care means ensuring that a woman's cultural needs are not only identified and planned for, but met.

Safe birthing services

Wakerman and Humphreys (2008) noted that little has been published about what happens when rural people have to travel away from home and family to access general health care. Despite this, midwifery researchers such as Brodie (2003), Tracy et al (2006), Kruske et al. (2006) and Kildea (2003) have highlighted the distress and social disruption women experience at having to leave their community for maternity care. Financial pressures are also placed upon families that are already potentially socially disadvantaged by living in a rural or remote area (Smith, 2004). Hirst (2005) suggests that relocating women for birthing services is in fact potentially less safe than providing a low risk service in their local community. Currently, women will still present to a rural or remote health facility in labour, whether due to time factors or refusal to relocate and consequently the workforce is even less prepared to manage this situation.

Research in rural Washington (Kornelsen & Grzybowski, 2008) found that women birthing away from their local community had increased rates of premature birth and pregnancy complications. Australian authors Tracy et al. (2006) in their analysis of the safety of birthing in smaller maternity units for low risk women found that the risk of operative intervention was higher in larger hospitals and the risk of neonatal death lower in hospitals with less than 2000 births. A number of Australian and international studies have demonstrated the safety of small, rural birthing services (Hundley et al., 2007; Tracy et al., 2006). Tracy et al. (2006) conclude that provision of low risk maternity care in rural areas with appropriate referral mechanisms was as safe, or safer, than birthing in large metropolitan facilities. Similarly, Leeman and Leeman (2002) state that providing maternity care in rural communities produced

better outcomes than when women are required to travel to access services elsewhere. These authors also note that appropriate screening criteria and effective transfer mechanisms allowed rural facilities to provide a safe birthing service. Maternal and neonatal outcomes can be improved in rural and remote areas when maternity services are maintained, as has been demonstrated in remote areas of Canada (Rogers, 2003; Van Wagner, et al., 2007).

In Queensland, the Clinical Services Capability Framework (CSCF) outlines different levels of service capability required depending on the risk characteristics of the woman, pregnancy complications, gestational age of the baby at birth, and other medical support services required to care for the woman and/or neonate (Queensland Health, 2005). The CSF dictates where and to what level, a maternity service can be provided and stipulates the requirement for obstetric and anaesthetic capacity to enable 'safe' birthing to occur. Hirst (2005) disputes these criteria and states there is no evidence to support the view that this level of service is required for a low risk unit. At the time of writing this thesis, the CSCF framework is under review, and it is expected that the revised framework will have capacity for midwife-led care of low risk women in smaller rural hospitals where appropriate consultation and referral pathways exist (Toohill, Pilcher, & Edwards, 2009). It is this author's view that such a change will be welcomed by rural midwives and women alike.

In 2008, a National Consensus Framework for Rural Maternity Services, authored by a number of professional organisations involved in maternity care, was published (Rural Health Workforce Australia, et al., 2008). This document outlined the importance of a multidisciplinary approach to the provision of maternity care for

women in rural areas and identified flexibility as the key to providing appropriate services that match the reality of the rural environment. The six principles of this framework encompass quality and safety of care, access to safe care, models of care appropriate to the rural setting, infrastructure to support services, workforce recruitment and retention strategies, and funding to support rural models of care (Rural Health Workforce Australia, et al., 2008).

Current issues in Australian midwifery

A number of factors that occurred in 2008 and 2009 have the potential to play a significant role in the future of midwifery practice in Australia. The decision by the Council of Australian Governments (COAG) to introduce national registration of health professionals on 1st July, 2010, means that a nationally consistent Nursing and Midwifery Board of Australia (Council of Australian Governments, 2008) has been formed to manage the registration of nurses and midwives across Australia. Although nurses and midwives will be governed by the one Board, there will be separate registers for nurses and midwives in contrast to the current State system where midwifery is contained within the nursing register.

Midwives who acquired their midwifery certification as a post-graduate qualification to nursing, or as part of a double degree program, i.e. Bachelor of Nursing, Bachelor of Midwifery, will have the option to register solely as a midwife. Alternatively, these midwives may request to have their names listed on both registers which will mean they will be required to provide evidence of competence in both nursing and midwifery (Vernon, 2009). Midwives who choose to have their details recorded on both registers will be required to undertake continuing professional development in

both areas. Further, all midwives will have been required to have professional indemnity insurance by July 2010. In the case of hospital employed midwives, this insurance will be provided vicariously by their employer. The Australian Government is developing legislation to cover eligible private practice midwives where birth occurs in a hospital environment but the insurance will not cover midwives attending homebirths (Vernon, 2009).

In addition to national registration, the Australian Government commissioned a review into maternity services in Australia that resulted in the release of a discussion paper in September, 2008, followed by the *Report of the Maternity Services Review* in February 2009 (Bryant, 2009). This Report made eighteen recommendations with regard to the provision of maternity care in Australia, many of which are significant to midwifery practice in this country. Recommendations of particular significance to midwives in rural parts of Australia include midwife access to Medicare and Pharmaceutical Benefits Scheme (helping to improve access to midwifery care for rural women), improving outcomes for Aboriginal and Torres Strait Islander women and their babies (the majority of whom reside in rural or remote areas), restoration and enhancement of rural services including supporting continuing professional development (CPD) for rural midwives, and the development of a National Maternity Services Plan (Bryant, 2009).

In 2009, after the publication of the Maternity Services Review Report, it was announced in the Federal budget that all eighteen recommendations of the maternity review had been funded (Vernon, 2009). The implications of this funding for midwives includes better opportunities to provide continuity of maternity care for

women, provision of funded outreach midwifery services to rural and remote women, greater funded support for CPD, and the development of collaborative care models with General Practitioners or specialist obstetricians (Vernon, 2009). Allowing women access to Medicare and the Pharmaceutical Benefits Scheme for private midwifery care required amendments to legislation.

Amendments to legislation passed in March 2009, allow midwives and nurse practitioners access to the Medicare and Pharmaceutical Benefits Scheme. However, these amendments stipulate that this access to Medicare, the Pharmaceutical Benefits Scheme (PBS), and indemnity in private practice, will be restricted to 'eligible' midwives only. The Nursing and Midwifery Board of Australia have set registration standards for eligible midwives which include minimum experience across the full scope of practice and having undertaken successful completion of a professional practice review program (Nursing and Midwifery Board of Australia, 2010). In addition to this, collaborative arrangements with medical practitioners will be necessary to access Medicare and PBS (Commonwealth of Australia, 2010). Concern has been voiced that enforcing a 'collaborative arrangement' with a medical officer gives doctors control, yet again, over women's ability to access publicly funded midwifery care (Barclay & Tracy, 2010). The issue of advanced midwifery practice is a contentious one in midwifery and nursing circles and will be further discussed in the following chapter (Smith, Leap, & Homer, 2010). Wilkes et al. (2009) highlight that under the International Confederation of Midwives definition of a midwife, midwives are considered competent to provide care autonomously as they are deemed to have the necessary skills needed for the provision of primary maternity care. It is of major concern that the new legislation denies midwives their right to

work without direction from a doctor and is viewed by many midwives as a backward step.

Despite these obstacles, it is clear that women in rural areas potentially stand to gain significantly from these budget reforms due to the current lack of services in their home towns and communities. Midwives in these areas, despite extensive clinical experience, have rarely had the opportunity to work in continuity of care models[3], where they may work to their full scope of midwifery practice, and may fail to meet the definition of 'eligible' (Wilkes et al. 2009). Lack of clarity around the required 'collaborative arrangements' and 'eligibility' has the potential to negate any gains for rural women and their families.

Research conducted in Australia indicates that alternative models of midwife-led care, offering continuity of carer, particularly in rural areas, may be more cost-effective, more likely to attract and retain midwives in rural areas, and be a more effective utilisation of midwifery skills in the face of current workforce shortages. This is of particular importance to rural areas (Kildea, 2003; Kildea, et al., 2010; McLelland & McKenna, 2008; Reiger, 2006). Continuity of care models of midwifery would require more flexible work arrangements than the traditional eight hour shifts currently practised in nursing, but would result in rural midwives being able to work to their full scope of practice, which is argued would ultimately lead to increased job satisfaction and retention (Kildea, et al., 2010; McLelland & McKenna, 2008; Tracy, et al., 2000; Watson, Potter, & Donaghue, 1999). Not only would midwifery led models of care benefit rural women and their families, but they would also assist with

[3] Continuity of midwifery care is where a midwife, in partnership with the woman, provides primary maternity care across the pregnancy, birthing and early postpartum period.

midwife retention in rural areas, however, suggestions to address midwife shortages in rural areas through the use of 'continuity of care' and midwife-led models of care may threaten some midwives in rural areas. For example, current midwives may have been restricted in their scope of practice due to lack of opportunities to practice as a midwife in their current rural location. Therefore, before new models of service delivery can be implemented, strategies must be developed and implemented to support midwives to embrace different models of care and prepare them for their new role. There is also the potential for managers of midwifery services in these areas, experienced in traditional role provision models and rostering systems, to perceive the employment of midwives who are not also registered nurses, as a non-viable economic option for their service. Employing midwife only staff gives less flexibility to service managers to use midwifery staff to fill nursing vacancies (Kildea, et al., 2010).

Conclusion

This chapter provided an overview of my motivation for conducting the study and provided the relevant background to set the scene and describe the current situation for maternity services and midwives in some rural locations in Queensland. Similar issues in rural Canada and the United States were identified in the literature. In addition, pertinent issues for rural midwives were identified. Finally, the purpose of the study and the approach undertaken was also described.

Chapter Two provides an overview of the current literature in relation to workforce with particular emphasis on the role of the midwife in rural settings. The concept of 'role' and the related elements of role ambiguity and role conflict as described in the

literature are also discussed. Chapter Three discusses the chosen methodology of hermeneutic phenomenology including a history of the philosophical basis of phenomenology and gives justification for why this is an appropriate methodology for his study. This chapter also discusses the phenomenology of van Manen and the six methodological themes proposed by van Manen as a means to guide phenomenological research.

Chapter Four outlines the methodological themes described by van Manen in more detail and how they were applied to the study. The research design used in the study is outlined including ethical considerations, selection criteria for participants, method of data collection and analysis and steps taken to ensure methodological rigour. Chapter Five introduces the study participants and gives a brief outline of how long each has been a midwife and how long they have worked in a dual role of midwife and nurse in the rural setting. The context of each interview is also described and reflective diary entries made after the interviews are included to enhance rigour.

Chapters Six, Seven and Eight explore the interpretation of the experiences of midwives working in dual roles as midwife and nurse through the identification of three main themes: (i) Making choices between professional role and lifestyle: 'Because I choose to live here, (ii) Integration of maternity and general nursing: 'All in together, whatever the weather and (iii) Shaped by location: 'That's part of working in a small place'. Each of the sub-themes identified as contributing to each main theme are discussed in these chapters and supported by the words of participants. Chapter Nine discusses the identified themes in relation to the literature, where available, and highlights gaps in the contemporary literature. What is already known

about the topic and new knowledge constructed, are both discussed. Limitations of the study and recommendations for further study are discussed in Chapter Ten.

Chapter 2

Literature review

Introduction

Nurses and midwives continue to make up the largest component of the Australian health workforce. Shortages of healthcare professionals locally and internationally, including nurses and midwives, are most acutely felt in rural and remote areas where nurses and midwives are often the first point of care for many rural/remote residents. However, working in rural and remote locations presents many challenges to nurses and midwives, and can result in problems such role confusion due to conflicting demands on the professional (Corey, 2008). In the case of midwives working in small rural facilities, incongruities in their role may result when the midwife is required to work as both a nurse and a midwife at different times of a shift or across their normal work experience, as is known to occur at some small rural hospitals in Queensland. The need to work in a dual role of midwife and nurse, caused primarily because of the ongoing closure of rural birthing services across Australia, has the potential to impact significantly on midwives and their intention to remain within the rural health workforce. This chapter provides a critical review of the literature that situates this issue and sets the background for the study.

The chapter initially outlines what is currently known about the role of midwives, especially in rural areas when they are required to work in dual roles. An overview of current issues affecting the global health workforce, with a focus on issues of relevance to the rural health workforce, especially nursing and midwifery, is then presented. In addition, the chapter addresses the theoretical underpinnings of

professional role identity and related issues, as a way of assisting the reader understand the relevance of the requirement to work in two roles for the midwife.

The aim of the research was to investigate the experience of midwives working in a dual role of midwife and nurse in Far North Queensland. The motivation for the research was to obtain knowledge about this particular model and how it impacts on midwives' satisfaction and commitment to their role. The study was also undertaken to examine how this role might impact on, or contribute to, the issue of the current midwifery workforce shortage experienced in rural areas and, where possible, to reveal potential solutions that may be implemented in an attempt to help overcome the related issues in the future.

The global and Australian health workforce

It is now recognised that there is a crisis of shortage in the global health workforce (Buchan & Aiken, 2008; World Health Organisation, 2002, 2006). The significance of these shortages and the impact upon health service provision are so substantial that the World Health Organisation's entire 2006 World Health Report was devoted to issues of workforce in health care (WHO, 2006). Nurses and midwives usually comprise the largest proportion of the health workforce in most countries and are recognised as 'front line' staff in most health systems. As a result, shortages of nurses and midwives impacts markedly on the delivery of an effective health service (Buchan & Aiken, 2008). The Productivity Commission, in its report on the Australian health workforce in 2005, projected a shortfall of between 10,000 and 13,000 nurses by 2010 (Productivity Commission, 2005). In 2006, a report prepared for the Council of Deans of Nursing and Midwifery (Australia and New Zealand)

projected a shortfall of nurses for Queensland of 3.8% by 2010 (Preston, 2006), with the potential for this to be 7% if other States low levels improved. This figure was an improvement on earlier projections due to the increased numbers of graduates being produced as a result of an Australian government initiative introduced in 2006 (Preston, 2006) which increased student intakes to nursing courses across the country. Current and predicted shortages are more pronounced in rural and remote areas where recruitment and retention of nurses and midwives have been problematic globally for some time (International Council of Nurses, 2006).

A number of factors are thought to contribute to the projected shortage of nurses and midwives. These include the ageing nursing and midwifery workforce (Duffield & O'Brien-Pallas, 2002; Harris, Gavel, & Conn, 2002; Jackson, et al., 2001), changes to how nurses work, rising patient acuity due to new, advanced technology and shorter lengths of stay (Hayes, et al., 2006; Jackson, et al., 2001), and the 'vicious cycle' of nursing shortages which lead to increasing overtime, workload and high nurse/patient ratios (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Hegney, Eley, Plank, Buikstra, & Parker, 2006; Jackson, et al., 2001). Other contributing factors include the image of nursing in the community (Janiszewski Goodin, 2003), environmental factors such as having little control over one's job and high job demands (Lambert & Lambert 2001), and shortages of experienced staff which puts greater pressure on newly graduated staff (Smith, et al., 2010) all of which are thought to contribute to attrition from the profession.

Buchan and Aiken (2008) however, note that shortages of nursing numbers in some areas may not be an absolute shortage of nurses, rather that the numbers represent a

relative shortage of nurses willing to work in particular locations or capacities. This distribution problem has important implications not only for the recruitment of nurses and midwives but also for the development of strategies to help retain nurses and midwives in particular locations and capacities. If nurses and midwives are dissatisfied with their work environment, or feel stressed due to workloads, they are more likely to leave, which is a significant issue in the face of the existing current shortages (Hayes, et al., 2006). In a large study on nurse staffing, patient mortality and burnout, Aiken et al. (2002) surveyed over 10,000 nurses in Pennsylvania. The study found that of the nurses who reported job dissatisfaction and burnout, 43% reported they intended to leave their current job within twelve months, whereas only 11% of those who reported being satisfied in their position said they intended to leave within the same time frame.

Within Australia, the National Health Workforce Taskforce identified three interconnected factors considered to impact on health workforce shortages (National Health Workforce Taskforce, 2009). Paramount among these factors is the increasing demand for health care workers due to the burgeoning burden of disease, especially chronic disease, coupled with an ageing population and the concomitant health issues this brings. There is also much more competition within the global labour market now, including both competition for health workers from other labour markets experiencing their own shortages, and competition from other sectors within the labour market. The third factor identified as impacting on workforce numbers is the capacity within Australia to educate students to replace those leaving the profession. Changes to Australian Government requirements for subsidised student places at universities from 2012 will allow universities to choose the number of nursing and

midwifery students they wish to take. However, the current dearth of available, quality clinical placements for nursing and midwifery students and the impact their placement has on an already stressed workplace, has yet to be resolved (National Health Workforce Taskforce, 2009).

The Nursing and Midwifery Labour Force Report (Australian Institute of Health and Welfare, 2009) noted that the number of nurses had increased by 7.6% over the period from 2003 to 2007. Interestingly this report also noted that nurses were working an increased average number of hours across an average week. The report also pointed out that the nursing workforce was continuing to age, with the percentage of nurses over fifty years increasing from 28.2% to 33%. Similarly, data collected by the Workforce Analysis Research Unit in Queensland highlighted that over 75% of nurses in 2007 were aged over forty (Workforce Analysis and Research Unit, 2007). This is an alarming statistic for Queensland health services to manage.

The importance of recruitment and retention strategies to counteract shortages has been widely discussed in the literature (Buchan & Aiken, 2008; Hayes, et al., 2006; Jackson & Daly, 2004; World Health Organisation, 2002). Shortages in specialty areas, such as mental health, aged care or midwifery, has been identified as causing further stress for those remaining in the profession (Jackson & Daly, 2004). Similarly, expectations for staff in specialty areas such as mental health or midwifery to be multi-skilled in order to address shortages across the workplace has a significant and direct impact on job satisfaction, a known influencing factor for retention (Duffield & O'Brien-Pallas, 2002; Jackson, et al., 2001). The expectation of health professionals in rural and remote locations to be multi-skilled is highly significant due

to the fact that these areas are where staffing shortages are most acutely experienced. As a result, nurses and midwives who work in rural and remote locations face mounting pressure to be multi-skilled in order to perform multiple roles within the organisation. Segal and Bolton (2009) however remind us that it is important to focus on an analysis of the actual demands put on the health workforce, rather than focussing predominately on recruitment and retention. Hence, these authors call for an evidence based approach to estimating demand for the health workforce (Segal & Bolton, 2009).

The rural health, nursing and midwifery workforce

As discussed above, there is significant evidence in the literature to support a claim for actual and impending shortages in the health workforce worldwide. These shortages are known to be exacerbated in rural areas where recruitment and retention is of greatest concern (Bushy, 2002; Hegney & McCarthy, 2000; Hunsberger, et al., 2009; Mills, et al., 2010; Smith, 2004; Wakerman & Humphreys, 2008). Additionally, concerns have been raised about an identified shortage of nurses appropriately prepared to work in rural and/or remote communities (Usher, Miller, & Turale, 2005). Similarly, there appears to be a perception that nurses working in small rural hospitals and communities in Australia should be able to provide both nursing and midwifery care in the facility depending on the need at that particular time (Kildea, et al., 2010; Wilkinson, 2002). This raises two main concerns: firstly, it requires nurses who have not been educated as midwives to provide care for birthing women, and secondly, it requires midwives to alternate in roles between midwife and nurse. These concerns may be partly addressed in the future as increasing shortages

of midwives become the impetus to develop alternate models of care where midwives are employed only to provide midwifery care to women (McKenna & Rolls, 2007).

In Australia, and more specifically in Queensland, issues facing the rural health workforce are compounded by an ageing population and corresponding ageing nursing workforce. This problem has been noted not only in Australia (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002a), but also in Canada (Montour, Baumann, Blythe, & Hunsberger, 2009), and Scotland (Richards, Farmer, & Selvaraj, 2005), which intensifies the pressures on the current rural and remote workforce (Richards, et al., 2005; Wakerman & Humphreys, 2008). A Canadian study of eighty eight nurses and nineteen nurse administrators working in rural and remote settings confirmed the increasing age of the rural and remote nursing workforce and argued that workforce planning in the future must focus on attracting younger nurses as a way to ensure future workforce sustainability (Hunsberger, et al., 2009). Although the terms 'rural' and 'remote' were used in this study, and in some parts of Canada the remoteness would be comparable to rural and remote areas of Australia, the facilities featured in the study were only 50-160 miles from a metropolitan hospital.

Common themes have been identified in research on rural health workforce populations. Rural health professionals tend to have a more diverse role at an advanced practice level, provide care to an overall less healthy population with less access to resources than their urban counterparts, while the remoteness of practice is linked to an increase in the average hours worked (Australian Institute of Health and Welfare, 2008a; Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007; Hunsberger, et al., 2009; Lea & Cruickshank, 2005; Mills, et al., 2010; Smith, 2004; Wakerman &

Humphreys, 2008). Other factors commonly identified in the rural health workforce are professional isolation and reduced opportunity to access professional development opportunities (Price, 2000; Richards, et al., 2005). Midwives, pressured to be multi-skilled in rural locations, may have an even greater demand for CPD to assist them to meet the needs of their patients (Fahey & Monaghan, 2005).

Recruiting and retaining the health workforce in rural and remote areas has been identified as an area of concern internationally. Factors identified as having a significant impact on recruitment to rural and remote locations include job satisfaction, professional satisfaction, opportunities for professional development, wages, and the particular location (Shen, Cox, & McBride, 2004). Family or social reasons have also been cited as a major impediment to recruitment of nurses to rural areas (Hegney & McCarthy, 2000). Wakerman and Humphreys (2008) however, claim that retention requires a different perspective to that of recruitment. They explain that the health worker makes a decision to move to a rural area from outside the perspective of that setting whereas decisions to remain are made within the context of the rural setting. Research specifically focussing on the recruitment and retention of nurses in rural and remote Queensland found that management practices, including lack of recognition of work well done, family responsibilities and emotional demands of the work, all had a significant contribution to staff turnover (Hegney, et al., 2002a).

While there has obviously been a significant amount of research conducted that has investigated the issues related to the nursing workforce in rural and remote locales, much less research has focused on the specific issues of midwives in rural areas and

for this reason, most of the literature cited in this chapter relates to nurses. Hegney et al. (2002a), in their study of the issues around attracting and retaining nurses in rural areas, commented on the high turnover rate of nurses and warned of the potential crises that could occur as a result. They highlighted the common requirement for rural nurses to work as an advanced practitioner and identified how that has the potential to place the nurse at risk of practising outside their scope of practice. This issue, they add, is compounded as the population of rural areas often has a lower level of overall health than the general population, with less access to medical, nursing, midwifery, and allied health services (Hegney, et al., 2002a). This study was conducted with participants from rural Queensland, therefore making the findings particularly relevant to the context of the current study.

Many rural nurses have expressed concerns that their urban counterparts underestimate the difficulties they face in being required to work across a wide range of clinical practice areas, as well as being frequently called upon to provide services outside of nursing, such as housekeeping, physiotherapy, or pharmacy (MacKinnon, 2008; Mills, Francis, & Bonner, 2005). Further, a perceived lack of understanding by staff in tertiary referral centres of the challenges related to transporting unstable patients and the tendency of the staff in the referral centre to question the clinical decisions to transport made by the rural nurse, is reported to lead to rural nurses feeling demeaned by their urban counterparts (Hunsberger, et al., 2009). The implications of working in a rural unit and the influence this has on the decision to transfer a person for further care, was also found to be misunderstood by staff in larger referral units, who may have little or no understanding of the impact of time and geography on decisions to transfer ill patients (Tucker, et al., 2005).

Research on rural nurses highlights differences in rural nursing practice to that of the urban nurse, however the majority of nursing workforce studies are carried out in urban areas due to the ready availability of a larger population size (Molinari & Monserud, 2008). The context of rural nursing is different to that of urban nursing and the factors that attract rural nurses to move to and remain in rural areas are often different. Exposure to the rural life, either through living in rural areas or participating in a rural placement as a student, is noted to be an important factor that attracts nurses to rural areas (Daniels, et al., 2007; Kaye, Mwanika, & Sewankambo, 2010; Killam & Carter, 2010). The increased level of autonomous practice as well as the variety of practice, have been noted as positive factors that encourage the retention of nurses in rural areas (Hegney, McCarthy, Rogers-Clark, & Gorman, 2002b) as has knowledge of the rural context and the work environment (Kaye, et al., 2010).

The Australian midwifery workforce

A number of Australian reports and studies have highlighted the difficulties in accurately estimating the current midwifery workforce (Australian Health Workforce Advisory Committee, 2002; Department of Health and Ageing, 2008; Hirst, 2005; McLelland & McKenna, 2008). The historical development of midwifery in Australia has led to midwifery being subsumed within the nursing workforce with the result that most midwifery data is contained within the overall nursing data. This has made it very difficult to accurately identify the numbers of midwives currently practising midwifery in Australia, as opposed to identifying those whose names appear on a register as having acquired a midwifery qualification. In fact, midwives whose names appear as having qualified as such may in fact be working in other areas of nursing, or outside of nursing and midwifery all together, and thus not working as midwives in

any capacity (Australian Health Workforce Advisory Committee, 2002; Hirst, 2005; McLelland & McKenna, 2008). The Department of Health and Ageing, in their audit of the Australian health workforce, highlighted the difficulty in identifying midwifery numbers, but noted an anecdotal shortage in rural and remote areas (Department of Health and Ageing, 2008). As with the nursing workforce, an ageing midwifery workforce, coupled with insufficient numbers of students being educated to replace those currently in midwife positions, is of huge concern to employers and midwifery service providers (Hirst, 2005; McLelland & McKenna, 2008; O'Connor, 2006).

One strategy proposed as a way to help address the shortage of midwives in Australia is the development of dual or double degrees in nursing and midwifery. Upon successful completion of the course, the student is awarded a Bachelor of Nursing and a Bachelor of Midwifery. This qualification is regarded as advantageous for employment in rural and remote areas as these graduates are considered to be more flexible and able to work across different areas within the same setting in contrast to graduates with only one qualification (Preston, 2009). In 2007, more than one third of students who embarked on pre-registration nursing courses were enrolled in a double degree program, with one sixth of those undertaking both nursing and midwifery degrees (Preston, 2009).

Another strategy introduced in an attempt to increase the number of midwifery graduates more rapidly, is the introduction of an undergraduate or direct entry Bachelor of Midwifery program (Australian Health Workforce Advisory Committee, 2002; Brodie, 2003; Bryant, 2009). The rationale behind this strategy is that a student will qualify as a midwife after three years of education rather than the four years

required completing a double degree in nursing and midwifery. The direct entry program is also faster than the five year program of study where the student undertakes a three year undergraduate entry level nursing degree followed by a two year postgraduate midwifery degree leading to endorsement as a midwife. It is important to note that in most cases the nursing graduate is required to have a minimum of at least one year of post graduate experience as a nurse prior to being considered eligible to enrol in a postgraduate midwifery course (Tracy, et al., 2000). Motivation to develop a direct entry midwifery course was the result of changes within the midwifery profession and philosophy that aimed to promote midwifery as a separate profession, removed from and distinct to the biomedical orientation of nursing (Carolan, Kruger, & Brown, 2007).

Concern has been raised in some arenas that the direct entry midwife education strategy will not be a viable and sustainable solution in rural and remote areas where there is a need for nurses to be able to perform both general nursing and midwifery in the current model of care (Australian Health Workforce Advisory Committee, 2002). This may be the case in very small rural settings, particularly those without birthing services and where maternity work is not sufficient to occupy and sustain a full time position. A number of Australian midwifery researchers, however, have proposed that appropriate re-structuring of the provision of maternity care, including the implementation of midwife-led, continuity of care models, will address the current under-utilisation of midwives in rural areas and match midwifery activity to need (Brodie, 2002; Kildea, 2003; Kildea, et al., 2010; Tracy, et al., 2006). In their opinion, strategies should be developed and implemented to reduce the need for midwives to work in dual roles as midwife and nurse. McKenna and Rolls (2007)

argue it may be the more urgent issue of workforce, rather than the philosophical debate on professional identity, that prompts the development of sustainable midwifery models of care best suited to rural settings.

Reiger (2000) also commented on the preference, particularly in rural areas, for the employment of midwives with a nursing background as a way to address staffing shortages. As most midwives currently working in Australia were first educated as nurses prior to becoming midwives, they have tended to acquire a dual professional identity; one of both a nurse and a midwife. This dual identity is further reinforced through the inclusion of midwifery as part of nursing by organisations such as nursing unions. This results in the potential to lead to underutilisation of midwifery skills in rural settings already experiencing midwifery shortages. This dual identity has also been identified as a cause of job dissatisfaction (Brodie, 2002; Reiger, 2000).

Therefore, the requirement to work as a multi-skilled generalist in both nursing and midwifery is a significant issue that causes great concern to many rural and remote midwives in Australia, as well as to the midwifery profession overall. As discussed previously, this fragmentation of the midwifery role has been linked to job dissatisfaction, a factor prominent in discussions regarding retention of the workforce. Brodie (2003) highlighted the increased autonomy that midwife-led models of care bring to midwives as an important aspect of job satisfaction. Kirkham (2007), in her research on why midwives stay, also emphasised the importance midwives place on autonomy and flexibility in their role, and reveals how they resent being used to fill gaps in the overall service provision.

Kirkham's (2007) research, cited above, formed part of a larger study on why midwives leave the profession and was conducted in response to concerns about shortages of midwives in many parts of the United Kingdom (Curtis, Ball & Kirkham, 2006). Almost 2000 midwives, who were not renewing their registration to practice as a midwife, were sent questionnaires to elicit the reasons for their decision to leave the profession. Analysis of the questionnaires returned (n=1000 or 50%), indicated five major reasons for midwives leaving the profession in the United Kingdom. The largest single reason reported was that midwives had become dissatisfied with how they had to practice midwifery in the current health system (Curtis et al., 2006). Staff shortages, either perceived or real, was also indicated as a reason the midwives chose to leave midwifery, usually due to an increase in stress levels.

Another issue that has been raised by midwives in rural areas is that they feel they are being underutilised in regards to the provision of maternity care when there are already noted shortages of midwives in other areas of the country. Further, the lower volume of services in rural areas has been identified as causing an actual or potential skill loss which may have a negative impact on the midwives' confidence to practise midwifery (Brodie, 2002; Fahey & Monaghan, 2005; McLelland & McKenna, 2008; Price, 2000;World Health Organisation, 2004). In contrast, a survey of midwives working in urban, rural and remote locations of Scotland, found that midwives working in rural and remote locations felt more confident managing a breech birth than their urban counterparts. Overall, issues of competence and confidence were similar between the groups in this study. The authors claim that the issue of competency is much more complex and thus deserves more attention. When considering the results of this study, it is important to note that rural and remote

locations in Scotland are much closer to regional and urban locations in distance than is the case in Australia. However, the issues identified in previously cited research studies related to professional isolation, reduction in exposure to clinical midwifery, and perceived loss of skills, remain a concern and have the potential to threaten the sustained provision of maternity services in rural and remote areas and thus pose a greater risk of closure of small rural birthing facilities.

Brodie's (2002) survey of midwives identified barriers to the effective provision of midwifery care in Australia, reporting that one of the concerns highlighted by midwives was inappropriate staff skill mix which was identified as frequently resulting in situations where one or two midwives were supervising registered and enrolled nurses in the delivery of midwifery care. Conversely, rural midwives are also concerned that the requirement to provide both midwifery and general nursing care to rural clients; increases the risk of sub-optimal or unsafe care, to one or both groups of patients. An example of where this becomes problematic is where the midwife is called upon to assist a birthing woman which conflicts with the simultaneous need for the midwife to supervise, coordinate, or actually deliver care to general patients (MacKinnon, 2008).

Midwifery shortages and the loss of midwifery specific skills as a result of reduced exposure and opportunities to deliver care to women in labour and birthing, were identified as contributing to adverse events and 'near misses' in an observational study of midwifery practice in England (Ashcroft, Elstein, Boreham, & Holm, 2003). A shortage of midwives, which led to an increase in working hours in rural settings,

was also linked to the potential for errors and low staff morale which resulted in higher staff turnover (Smith et al. 2010).

Ashcroft et al. (2003) also revealed the difficulty rural midwives reported in accessing training and opportunities to update knowledge because of staff shortages leading to an inability to be released for course attendance. In rural areas of Australia, midwives often have to contend with the difficulty of being released for training as well as the additional burden imposed because of the time required to travel to access CPD courses. Lack of access to CPD and maintenance of specialty skills has been identified as a contributory factor in the reduction of GP numbers in rural areas in Australia. In response to this the Australian Government established Rural Workforce Agencies in all Australian states and territories in 1998 (White, Willett, Mitchell, & Constantine, 2007). Functions of these Agencies included the establishment of continuing medical education and locum programs to support ongoing education and rural incentive funds to support the GP workforce. Access to continuing medical education that is relevant to rural practise is seen as an incentive to retain GPs in rural settings (White, et al., 2007). In 2004 the Australian Government also introduced financial incentives to assist rural doctors to continue to provide procedural services. As part of a revised Medicare package, rural doctors can access financial support to undertake CPD activities, including funding locums to backfill, to a maximum of $15,000 per year (Glazebrook & Harrison, 2006). Nurses and midwives in rural areas have substantially less financial assistance to access CPD. Queensland Health offers midwives and nurses working in remote areas an additional two weeks leave for CPD per year and annual cash bonuses of between $3000 and $9000, depending on length of service (Queensland Health, 2010).

The role of the midwife in Australia

The role of the midwife in Australia, as in most countries around the world, uses a 'wellness' model of care, where pregnancy, birth and the postpartum period are viewed as normal life events. This is in direct contrast to the common nursing model of care, particularly the case in acute care facilities, which is situated in the medical or 'illness' model (Lane, 2002). While this may be contested in areas where nurses work in primary care and other new and emerging roles, the midwife's role is firmly centred within a framework where pregnancy and birth is conceived as part of the normal developmental processes of the woman. The midwife's role in this case is to offer support and partnership to the woman while promoting the normality of the birthing process (Larsson et al, 2007). Lane (2002) acknowledges the importance of the midwife establishing a partnership relationship with the woman, which emphasises that the woman is not expected to be a 'compliant patient' but rather is perceived as an equal participant in the normal processes of pregnancy and birth.

Midwives, as well as attending at the time of birth, also provide primary care for women throughout the antenatal and postpartum period (Sandall, Hatem, Devane, Soltani, & Gates, 2009). Midwives may refer to secondary or tertiary level health care providers when required; however they may still provide midwifery care using a collaborative arrangement (Australian College of Midwives, 2008). The World Health Organisation (2004) also notes that midwives are the most appropriate providers of primary maternity care to women with normal pregnancies and births, and midwives are also identified as capable of conducting appropriate risk assessments and recognising complications that require consultation or referral (Boon, 2004). Walsh and Steen (2007) identified four defining characteristics of what it

means to be a midwife. These characteristics are autonomy, normality, holism and women-centeredness.

Over time, the historical development of midwifery in Australia has resulted in confusion between the midwife role and role of a nurse. In some Nursing Acts, midwifery is defined as a 'restricted practice area of nursing' (Brodie, 2003) and this can lead to a critical lack of understanding of what constitutes the role of the midwife. Hunter (2008) reported that midwives have difficulty practising a model of care that is medically dominant because ways of knowing which are essential to women-centred midwifery care are not valued. Both Reiger (2000) and Brodie (2003) observe that it is important for the professions of midwifery and nursing to have distinctly separate identities. These authors explain that for midwifery to assert its influence, it is essential that the different professional roles be recognised.

Recent attempts to recognise the midwifery profession as separate to nursing in Australia has resulted in much debate (Homer, et al., 2009). Historically, in Australia as in much of Europe, midwives were regarded as a separate profession to nurses (Fahy, 2007). Until the 1920s, it was openly accepted by both doctors and nurses that midwifery and nursing were separate professions, however, efforts by medical officers to gain status by regulated practice led to the subordination of nursing under doctors (Summers, 1998). At this point midwives were still a separate entity and as medicine could not create the same control over midwives as nurses, by regulating their education, without affording them greater autonomy, they supported nursing bodies in the notion that midwives must first qualify as registered nurses (Fahy, 2007; Summers, 1998). This has led to the eroding of the midwife identity as separate to

nursing until recent years, when midwives are again striving to be recognised as a profession in their own right (Homer, et al., 2009).

In a comparison of midwifery care in eight industrialised countries, it was noted that midwives in Denmark, the Netherlands, Canada and Sweden are generally self employed, they are autonomous practitioners who are considered independent practitioners with hospital admitting privileges (Malott, Davis, McDonald, & Hutton, 2009). Midwives in Australia, however, are predominately employed by hospitals and therefore they have limited autonomy, they do not have admitting privileges and although they are the primary carer in labour for most women, they are not ultimately responsible for this care (Malott et al. 2009).

In identifying midwifery as a separate profession to nursing, this is not to say that there are not some synergies within both roles and that prior education as a nurse allows the midwife to bring skills to their practice as a midwife (Spence, 2007) that they might not otherwise. It has been identified that although a midwife is not the same as a nurse, due to a distinctly specialised skill set that she has and a general nurse does not, the vast majority of midwives in Australia have been part of the nursing profession, if not still so (Kinnane, 2008). Though many midwives would like to assume the professional role as midwife and would easily relinquish a previously attained nursing identity, there are those that gladly maintain both (Kinnane, 2008).

The advanced practice midwife – mythical or essential?

Changes to Australian legislation, as referred to in the previous chapter, that enable eligible midwives to access the Medical Benefits Scheme and Pharmaceutical Benefits Scheme have rekindled the discussion on the concept of advanced practice in midwifery (Smith, et al., 2010). This discussion is not new, and reflects inherent difficulties within the midwifery profession. The development of the Nurse Practitioner[4] role in South Australia over ten years ago prompted much debate about the concept of advanced practice (Byrne, 2000) in midwifery. At that time, it was identified that much of what was promoted as part of the role of the Nurse Practitioner were examples of practice already demonstrated by midwives, such as autonomous practice and collaboration with other health professionals, including obstetricians (Byrne, 2000).

The advanced practice debate primarily revolves around recognising midwives as practitioners in their own right, who at the point of registration are able to work to the full scope of practice as a midwife, according to the International Definition of the Midwife (Byrne 2000). The Australian College of Midwives (ACM) released a position paper in 2005 explicitly outlining that the role of a midwife was not an advanced or extended one. Instead, they argued that the autonomous nature of the role of a midwife was only impeded by legislative restrictions that did not allow midwives to prescribe and order certain tests and medications to support their role (Australian College of Midwives, 2005). The concept of an 'extended' midwifery role was reflected inaccurately in a project in the Northern Territory early in the debate, that allowed midwives access to limited diagnostic tests and medications (Watson,

[4] A Nurse Practitioner is a registered nurse who is educated and authorised to function in an advanced and extended clinical role (S. Smith, et al., 2010)

Turnbull, & Mills, 2002). Watson et al. (2002) commented that this part of the role was not considered 'extended' by midwives in other jurisdictions such as the United Kingdom and New Zealand, but part and parcel of the role of the midwife.

A continuing problem in the debate over advanced midwifery practice is that there is no clear articulation as to what would constitute advanced practice over the full scope of normal midwifery practice (Smith, et al., 2010). The same debate and discussion occurred in England and Ireland where the concept of 'Higher Level Practice' (HLP) was mooted for nursing and midwifery (Begley, Oboyle, Carroll, & Devane, 2007; Smith, et al., 2010). In an attempt to map what competencies would be required for HLP it was noted that these were already present in midwifery through a well defined scope of practice and that the idea of advanced practice, though of merit in nursing, was unnecessary in midwifery. Midwives in Ireland expressed unease regarding the creation of specialty areas in midwifery that would potentially lead to further fragmentation of midwifery care. These midwives stated that role fragmentation would increase the medicalised view of pregnancy and birth and lead to potential loss of expertise and de-skilling of midwives who could otherwise work to their full scope of practice (Begley, et al., 2007).

Midwives in Australia are moving closer towards models of care that allow them to work to their full scope of practice as identified in the International Definition of the Midwife with recent amendments to legislation regarding prescribing rights. It needs to be made clear, however, that midwives working in these models are not working at an advanced level, but rather fulfilling the recognised role to its full scope (Smith et al., 2010). Recent comments by Haxton and Fahy (2009) that midwives who provide

independent midwifery care in birth centres or at home births are practising at an advanced level are erroneous and their claim that the midwifery literature is silent on the concept of advanced practice is misleading (Haxton & Fahy, 2009). It is the opinion of Smith et al. (2010) that the midwifery profession work towards resolving the barriers in Australia that prevent midwives from working to their full scope. Ensuring midwives can be educated and supported to work in that full scope is more deserving of the energy put into debates about concepts of 'advanced practice'.

As previously noted, the historical development of midwifery in Australia is such that it has been considered by some a sub-specialty of nursing rather than a profession in its own right. Most midwives in Australia still provide care to women in service models that are dominated by the biomedical model of care (Hunter, 2008; Walker, Moore, & Eaton, 2004) and this places considerable limitations on midwives being able to work to their full scope of practice as autonomous professionals (Kildea, et al., 2010; Watson, et al., 2002). There is discussion in the literature which outlines the role of the midwife and a greater discussion of the nurse's role as well as discussion around the potential for role conflict or role conceptualisation that can result when nurses are required to work in multiple roles. However, to my knowledge, there has been no research to date focussed on what it is like to work in the dual role of midwife and nurse in a rural area. Further, there has been no work to identify the implications the requirement to work in a dual role may have for the future recruitment and retention of midwives, particularly in rural settings. To examine the experience of the midwife in a dual role in rural settings, it is important to first explain some of the concepts of role theory and how these may influence a midwife's perception of her/his role.

Role theory

Role theory is used to explain behavioural characteristics of people in certain contexts and assumes that people behave in certain ways with specific expectations based on the context of their role (Biddle, 1979). Earlier writings by Biddle and Thomas in 1966 noted that role theory was a newly developing field of study and that no one particular person or group was responsible for its development (Biddle & Thomas, 1966). Various contributors to early work on role theory were observed by Biddle and Thomas (1966) to be philosophers, psychologists, sociologists and anthropologists, as role theory is thought to be of importance to all these professions. It has also been reported to be popular and useful to the so-called helping professions, such as social work, education, and the clinical health care fields (Biddle, 1979).

In 1979, Biddle described role theory to that date, as being at the initial pre-cursive stage, where terms around role were gradually being formed. This is a conceptual development stage used to formalise early concepts to enable them to be applied to a variety of settings as well as where the concepts are applied in research (Biddle, 1979). Biddle (1979) documents five propositions that form the basis of role theory and these are:

> "1. role theorists assert that 'some' behaviours are patterned and are characteristic of persons within contexts (i.e. form *roles*)
> 2. roles are often associated with sets of persons who share a common identity (i.e. who constitute *social positions*)
> 3. persons are often aware of roles, and to some extent roles are governed by the fact of their awareness (i.e. by *expectations)*
> 4. roles persist, in part, because of their consequences (*functions*) and because they are often embedded within larger social systems
> 5. persons must be taught roles (i.e. must be *socialised*) and may find either joy or sorrow in the performances thereof." (Biddle, 1979, p. 8).

Biddle (1979) notes that the term 'role' has come to mean "a behavioural repertoire characteristic of a person or a position; a set of standards, descriptions or norms, or concepts held for the behaviours of a person or social position" (p.9). Role, therefore, can refer to a single person or a particular group of people, within a certain context. In defining roles, it is important to note that only those behaviours that can be observed and characterise that role, can be considered part of the role (Biddle, 1979). Non- behavioural characteristics such as race, sex or nationality cannot be considered part of the role as they are not behavioural. Biddle (1979) asserts that while roles may be defined by their context or limited by certain contextual boundaries, they may change radically if the context changes.

Conway's later definition of role theory, cited by Brookes, Davidson, Daly and Halcomb (2007), similarly described role as "a collection of concepts and a variety of hypothetical formulations that predict how actors will perform in a given role, or under what circumstances certain types of behaviours can be expected" (p.149). They report that the general nursing role includes a number of distinct tasks such as carer, clinician, educator and manager (Brookes, Davidson, Daly, & Halcomb, 2007). These tasks could also be reflective of the role of the midwife, although in the role of carer and clinician, the woman and her family are central to the decision making due to the partnership developed between the woman and midwife. Midwifery models of care reflect that pregnancy and birth is a normal life event as opposed to the common nursing illness model (Hyde & Roche-Reid, 2004).

Ewens (2003) writes that it is a normal progression for role identity to change and evolve and that in nursing this may lead to frustration and disappointment if the nurse

is not adequately supported by management as they progress into a new role. This frustration and disappointment can lead to what is known as role strain which has been described as a disparity between what a person perceives of as their role and what they can actually achieve in carrying out of that role (Lambert & Lambert, 2001). Thus professional identity is built up and created through the sense of unity within a profession and if the role of the profession changes, this can affect the role identity of members of the profession (Larsson, Aldegarmann, & Aarts, 2007).

Role Stress, role conflict and role ambiguity

Role stress, or *role strain*, as defined earlier, results from incongruity between what an individual perceives is required of a role and what they can actually achieve when performing that role (Chang, Hancock, Johnson, Daly, & Jackson, 2005). In the short term, role strain may create embarrassment as a person struggles to meet the perceived demands of the role, but in the longer term may result in the person removing themselves from the role (Biddle, 1979). There are a number of factors known to contribute to role stress and these include shortages of resources, both human and material; little control over one's job; being moved among different clinical areas, and unfamiliarity with situations (Bartram, Joiner, & Stanton, 2004; Chang, et al., 2005; Lambert & Lambert, 2001). The implications of prolonged role stress are significant in an environment of workforce shortages as the end result of roles stress is exhaustion, cynicism, and reduced personal accomplishment, commonly known as 'burnout' (Leiter & Maslach, 2009). Burnout is a significant contributor to nurses leaving the profession (Aiken, et al., 2001; Daly, Chang, & Jackson, 2006; Fereday & Oster, 2010).

The concept of burnout, first described in the 1970s, contributes to organisational turnover due to the impact it has on employees' psychological well-being (Leiter & Maslach, 2009; Schaufeli, Leiter, & Maslach, 2009). Leiter and Maslach (2009) surveyed over 600 nurses in Canada on their work life, burnout and intention to leave their position, and observed a clear correlation between burnout and turnover. Schaufeli et al. (2009), in their investigation of the concept of burnout, linked a number of factors as contributing to burnout. These included a continuing disparity between demands and resources, and a differing set of personal values between an employee and their employer or organisation (Schaufeli, et al., 2009).

Role ambiguity, however, exists when there is uncertainty as to what should be achieved in the role (Biddle, 1979; Tunc & Kutanis, 2009). Role ambiguity has been reported to result in unhappiness with a role (Biddle, 1979). When there is a lack of clear information about how a role should be performed, the resultant role ambiguity can lead to role stress (Brookes, et al., 2007; Chang & Hancock, 2003). The multi-skilled role of the rural midwife and nurse may contribute to role ambiguity, particularly in those nurses and midwives new to rural practice who may be used to the specialised practice of working in one clinical area only.

Role conflict is defined as "the stress felt when an employee perceives the role or job expectations as being contradictory or mutually exclusive" (Brumels & Beach, 2008, p. 374). Role conflict is reported to occur when different expectations or demands are inflicted on the person which in turn has the potential to lead to job dissatisfaction, poor performance, decreased commitment to an organisation, and impact negatively on retention of staff (Biddle, 1986; Brookes, et al., 2007; Corey, 2008). The

possibility of role conflict is increased when a person takes on multiple roles (Biddle, 1986). In the case of nurses, this may be due to a number of competing demands or changes in the work place over which the nurse may perceive she or he has little control. Again, this factor has been cited as a major influence on nurse retention (Piko, 2006; Tunc & Kutanis, 2009).

Midwives working in a dual role of midwife and nurse may thus find themselves faced with role conflict between the two models of wellness and illness and the impact on their approach to the delivery of patient care. Further, the partnership model of care espoused in current midwifery philosophy may be constrained by competing demands on the midwife's time and the limitations placed on the provision of midwifery care due to the simultaneous requirement to care for general nursing patients (Corey, 2008). If midwives working in rural areas are required to develop other clinical skills for when they are not working in a midwifery situation, this may put more demands or stress on the midwife. This additional stress may lead to an even greater sense of disillusionment as they believe they are unable to fulfil what they perceive to be the role of a midwife in rural areas using a wellness model.

As previously documented, high levels of role conflict have been associated with decreased job satisfaction which has a negative impact on retention of staff (Brookes, et al., 2007; Piko, 2006). Curtis et al. (2006) conducted a study with almost 1000 midwives leaving the profession and found that there was an increased likelihood of midwives leaving their jobs when they were dissatisfied with their role and when they perceived they were not able to work to their full scope of practice. Conversely, Buchan and Aiken (2008), in their paper on the implications of nursing shortages and

strategies to address them, noted that when nurses felt they were being acknowledged, had autonomy, and perceived they had the opportunity for professional development, they were more likely to stay (Buchan & Aiken, 2008).

Conclusion

This chapter has outlined pertinent research related to the acknowledged global shortage of health workers and identified how this is particularly pertinent to midwives and nurses, as they comprise the largest proportion of the health workforce. Health workforce shortages were described as exacerbated in rural areas where recruitment and retention of staff is difficult due to a variety of reasons. The problem of an ageing workforce, which is a national problem in Australia, is known to be more pronounced in rural areas. Data on the midwifery workforce in Australia is difficult to obtain and that which is currently available is contained mostly within the overall nursing workforce data.

Midwives in rural areas, like their nursing colleagues, have been highlighted as being multi-skilled generalists who work across many areas of clinical practice. As a result of this demand, there is a possibility that midwives may experience role stress or role conflict because of the expectation that they work both as a nurse and a midwife in rural areas. This chapter has identified that the opportunity to work across the two roles may in fact be what actually attracts some midwives to work in a rural area. To date, there is nothing in the literature that specifically explores the experience of midwives required to work in this dual role in rural areas which led to the conception of the current study. The following chapter discusses phenomenology, the

methodology chosen to conduct the study. This chapter sets out the historical development of the methodology and important components of the approach.

Chapter 3

Methodology

Introduction

Phenomenology was chosen as a suitable standpoint from which to understand the experience of midwives who work in a dual role of midwife and nurse in rural areas of far north Queensland. Searching the related literature identified nothing on the experience of working in dual roles, in particular those of midwife and nurse, so phenomenology which has been noted to be particularly useful when a phenomenon is poorly defined or conceptualised (Polit & Beck, 2008), was selected as appropriate to guide the study. In particular, phenomenology based on the philosophy of Martin Heidegger was chosen as most suitable for the study. The six methodological themes of van Manen's (1990) phenomenological approach were used to assist with the analysis of the data.

In addition to phenomenology being identified in the literature as an appropriate methodology to investigate experience, it is also a methodology that resonates with my world view. As a midwife I subscribe to the partnership philosophy of midwifery and the belief that people make choices in the context of their own life experiences. The concept I wanted to investigate is best understood by those experiencing it or living it in their everyday world which relates to Heidegger's concept of Dasein or 'being-in-the-world'.

Methodology, or the "theory behind the method" (van Manen, 1990, p27) is important to the development and conduct of any study. As phenomenology is the philosophical framework underpinning this study, it will be outlined in this chapter. To begin, this

chapter will first give an overview of phenomenology and why it is an appropriate methodology to underpin the study. It will then examine the work of Edmund Husserl and his student Martin Heidegger in relation to how their philosophies underpin the development of phenomenology. The use of the hermeneutic circle and its necessity in the Heideggarian tradition, especially as a way to aid the interpretation of the data derived from participants' discussion of their experience, will then be discussed. A comparison of 'traditional' versus 'new' phenomenology from the perspectives of scholars such as Crotty (1996) and Caelli (2000) will also be provided. The tenets of van Manen's (1990) approach to phenomenology, which was used to inform the analysis of the data, will also be discussed. A brief overview of phenomenology in nursing and midwifery will then be presented.

Phenomenology

Pearson, Robertson-Malt, Walsh and Fitzgerald (2001) identify phenomenology as the methodology of choice when the aim of a study is to reveal participants' experiences. The goal of a phenomenological study is to fully describe a lived experience and so the participants are invited to describe 'what it is like' so that the researcher may make sense of that experience (Koch, 1999). The use of a phenomenological approach permits the researcher to explore the experiences of a few individuals in order to come to some understanding of this common experience, in this case to understand the experience of [a midwife] undertaking the dual role of midwife and nurse in a rural facility in far north Queensland. This makes phenomenology an extremely appropriate way to research human experience because it offers an approach where the experience of the participant is pivotal.

Phenomenology is a methodology used to describe experiences of the world as lived. The aim of a phenomenological study is to obtain experiences of a phenomenon of interest and gain an understanding of the meaning of that experience for the individual (Higginbottom, 2004). Heidegger, one of the central figures in the development of the phenomenological movement, espoused phenomenology as a way of challenging us to look beyond what is taken for granted and see things from a fresh viewpoint (Heidegger, 1962). However, Spiegelberg (1982) acknowledged the difficulty in stating exactly what constitutes phenomenology. This is said to be due to the continuing reinterpretation of the philosophy and the changing nature of what is considered phenomenology. Although phenomenology is difficult to define it is seen as a way to systematically uncover the meaning of an experience through analysis of the descriptions provided by those encountering or living the phenomenon (van Manen, 1990; Dowling, 2005).

Phenomenology seeks to obtain descriptions of experiences. This is usually undertaken through interviews conducted in an informal one-to-one basis. These interviews are then transcribed and analysed to seek meaning in the description (Mapp, 2008). The aim of the analysis is to grasp the essential meaning of the experience in an attempt to uncover the internal meaning of the lived experience (van Manen, 1990). Phenomenology has many perspectives and the underlying philosophy used will direct how the particular study is conducted. However the aim remains the same, the interpretation of the nature of a particular human experience.

Historical Development of Phenomenology: From Husserl to Heidegger

Phenomenology was characterised by Spiegelberg (1982) as an early twentieth century movement and Edmund Husserl was noted to be central to its development. Spiegelberg (1982) used the term 'movement' to denote the changing philosophy of phenomenology over time. Husserl was influenced by the earlier work of Franz Brentano and it was this influence that led to him taking the term 'phenomenology' for his descriptive psychology (Dowling, 2007). Husserl sought to expound the 'general essence' of a phenomena being investigated through a descriptive analysis of participants' experience of a phenomena (Cohen & Omery, 1994).

Husserl, initially educated as a mathematician, first attempted to use psychological acts to derive fundamental concepts of mathematics (Spiegelberg, 1982). Thought of as the father of phenomenology (McConnell-Henry, Chapman & Francis, 2009), Husserl's thinking underwent many shifts in the development of phenomenology but his main purpose was to identify a basis for all human knowledge (Barkway, 2001). In Husserl's view, phenomenology was the "basic science of philosophy" (Bernet, Kern & Marbach, 1993, p 59).

Husserl posited a number of concepts necessary for conducting his descriptive or eidetic form of phenomenology. The concept of the 'life world' or 'lived experience' was introduced by Husserl (Koch, 1995) for the purpose of using reflective intuition to describe and clarify an experience as it is lived, with the goal being to describe the meaning of an experience from the perspective of those that have experienced it. People were seen by Husserl as detached subjects that existed in an objective world (Walters, 1995). Husserl's position was that this 'life-world' was always more

complex than anything that could be said about it as the lived is greater than the known (Todres & Wheeler, 2001).

This life-world, or Lebenswelt (Dowling, 2005), was thought by Husserl to be what individuals experience pre-reflexively, that is without interpretation. This is also what the researcher who follows Husserlian principles asks about the meaning of human experience (Koch, 1995). By questioning the life-world Husserl proposes that the 'taken-for-granted' becomes a phenomenon and that the task of phenomenology is to clarify this 'life-world' (Todres & Wheeler, 2001). This clarification requires that the researcher maintain an open-minded attitude and that pre-conceptions are set aside so as to allow descriptions to reveal meaning. This setting aside of preconceptions, or bracketing as discussed below, requires the researcher to suspend their own beliefs about a phenomena so as to see it clearly (Laverty, 2003).

In clarifying this 'life-world' the researcher is required to adopt the concept of intentionality. This concept requires the researcher to direct their mind towards objects and this conscious awareness helps toward the building of knowledge of a reality (Koch, 1995). These objects, or essential structures, of an experience are seen to be what constitute that experience (Cohen & Omery, 1994). Husserl saw that there was a relationship between the world and consciousness and that the two were interconnected. He proposed that developing knowledge of what is real should start with awareness of one's own consciousness. Crotty (1996) noted that intentionality should not be taken to mean 'purposive' as defined by a dictionary but rather that it is a concept that has to do with the union of object and subject, a rejection of the Cartesian idea of separation of subject and object.

An essential component of Husserlian phenomenology is thus the concept of 'bracketing'. This concept requires the researcher to set aside all assumptions about the phenomenon of interest including any conceptions of causation, consequences or of wider significances (Koch, 1995). The setting aside of any preconceptions allows the researcher to reflect on the experience as described by the participant and determine the essential structures of the experience. This pre-suppositionless approach was seen by Husserl as an essential way of defending the validity or objectivity of the research by preventing the self-interest of the researcher from colouring the interpretation (Koch, 1995).

Mapp (2008) outlines the need for the researcher to suspend their personal beliefs about the phenomena of interest so that participants' experiences can be clearly described. In other words, the researcher will set aside their own experience so that the data generated from the participants remains uncontaminated by the researcher's experience (Koch, 1999). This means that the study examines meanings produced and describes the life world of the participant in terms of 'essences', which Husserl saw as the ultimate structures of consciousness (Koch, 1999). It is the search for these essences in Husserlian phenomenology that makes it objective (Koch, 1995). These essences were considered by Husserl to be the fundamental nature of reality and they remained unchanging and universal over time (Walters, 1995). They are taken to mean the most essential meaning for a particular context (Kleiman, 2004). The fundamental emphasis of Husserlian phenomenology then is description. The term phenomenological reduction was seen by Husserl to be the foremost methodological principle, achieved through the principle of bracketing and Husserl believed necessary to provide a rigorous foundation for the research.

Martin Heidegger, a student of Husserl, endeavoured to answer the question of 'being' rather than that of 'consciousness' as sought by Husserl. He succeeded Husserl as Professor of Philosophy at Freiberg University in Germany (Walters, 1995) and was seen by some as deserting the orthodox methodology of phenomenology as developed by Husserl, rather than a rightful developer of his work (Spiegelberg, 1982). Heidegger (1962) scrutinised the origins of the original Greek word for 'phenomenon' and stated "The concept of phenomenon signifies that which shows itself, the manifest" (Heidegger, 1962, p. 52).

In his seminal work 'Being and Time' (Heidegger, 1962) Heidegger was concerned with the essential philosophical (and existential) question 'What is it to be?' and he saw phenomenology as a methodological conception to guide research. An essential component of this is for the researcher to acknowledge that they are in the world and that it is not possible to set aside, or 'bracket' their pre-understandings of the phenomenon and that these should form part of the interpretation as the researcher can only interpret things in keeping with their own experiences (Heidegger, 1962).

Heidegger used the word 'Dasein', or being-there which emphasized the notion that human existence was always in the world. This concept refers to the fact that there is an aspect of human-ness which is capable of wondering on its own existence and inquiring into its own being (Heidegger, 1962). Indeed, this is what separates us from all other animals. Heidegger felt that this state of Dasein allowed humans to exist 'authentically' as they had awareness of their own Being (Mackey, 2005). This idea that humans are existing in the world and not able to be separated from this led to Heidegger's rejection of Husserl's concept of bracketing (Draucker, 1999).

Heidegger proposed that for the researcher to develop an understanding of a phenomenon it was essential that that the interpretation occurs through the researcher's own knowledge and experience (Mapp, 2008).

Heidegger, in 'Being and Time' (1962) describes the concept of Dasein as:

> *Thus to work out the question of Being adequately, we must make an entity –the enquirer – transparent in his own Being. The very asking of this question is an entity's mode of Being; and as such gets its essential character from what is enquired about namely, Being. This entity which each of us is himself and which includes enquiring and the possibilities of Being, we shall denote by the term Dasein (*p 27).

This concept emphasised the 'situatedness' of humans in the world, that they are in and of the world rather than subjects in a world of objects (Walters, 1995) and this term written as hyphenated, being-in-the-world symbolised unified nature of how humans exist in the world. Heidegger said that this concept of Being was not something that could be objectively measured but that Dasein was what allowed humans to question and wonder about their own existence (McConnell-Henry et al, 2009). The aim of a phenomenological inquiry, according to Heidegger was to discover meaning and that the researcher was a legitimate part of the research as they were Being-in-the-world of the participant (McConnell-Henry et al, 2009). The researcher, in using the methodology espoused by Heidegger, is required to utilise both descriptive and interpretive activities in order to achieve understanding (Mackey, 2005).

Heidegger believes that hermeneutic phenomenology was not a special process to be conducted separate from our every day lives but is actually a process of people making sense of their everyday lives and that it applies to all understanding and interpretation. "An understanding that is to contribute to understanding, must already have been understood what is to be interpreted" (Heidegger, 1962, p 194). This follows that research that is guided by the philosophy of Heidegger means that understanding is a manner in which possibilities of life as experienced are disclosed.

The concepts of time and space were both pivotal to Heidegger's philosophy of phenomenology. Time, or temporality is argued by Heidegger to be central to being but it was not in reference to time as a linear or chronological sense, rather that time was fluid and that past experience of humans affects both their present and future dealings (McConnell-Henry et al, 2009). This temporality allows a person to experience past, present and future as a concurrent unity. Time was considered by Heidegger to be a fundamental structure of human existence and he considered that all human experience is grounded in time (Mackey, 2005). The researcher engaging in Heideggerian phenomenology notes those things that the participant describes that situate their experience in a particular time to increase understanding of the experience.

Heidegger also said that space could not be measured in a quantitative way either, rather space reflected qualities of human presence and that these needed to be also described on their own terms. His concept of Being-in-the-world means that this spatiality grounds the person in a location (Mackey, 2005). Heidegger believed that

this grounding in the world created significant impact on the experience and existence of the person (McConnell-Henry et al, 2009).

There are then a number of key distinctions between the phenomenology of Husserl and Heidegger. Heidegger rejects the notion that presuppositions can be suspended and that nothing is able to be encountered without reference to a person's background. This 'historicality', or interpretation based on a person's background and history, means that data generated by the participant becomes fused with that of the researcher's experience to guide interpretation (Koch, 1996).

McConnell-Henry et al (2009) argues that phenomenology based on the philosophy of Heidegger requires the researcher to recognise and address the pre-suppositions or 'fore-structure' as they augment the interpretation that follows. This means that the researcher becomes as much a part of the research as the participant as their ability to interpret the data is heavily reliant on their previous knowledge and understanding and that it is not something we can eliminate or bracket (Koch, 1995). The underlying principle of Husserlian phenomenology then is description so that the primary focus is on the nature of knowing, or epistemology whereas the fundamental emphasis for Heidegger is on understanding so that the primary focus becomes the nature of existence, or ontology (Dowling, 2005).

The Hermeneutic circle.

Heidegger described the ongoing process of seeking clarity and the ways that the world and experience can be interpreted and understood as a circular process (Heidegger, 1962). He posited that the detection of unknown truths must be based on

known truths and this hermeneutic circle is a metaphor for describing the action of moving between parts and whole in the interpretation of experience (Koch, 1996).

Entering into the hermeneutic circle allows the researcher to constantly acquire new knowledge although for understanding to take place there must be constant movement between the parts and whole of the text (Debesay, Naden & Slettebo, 2007). Koch (1999) also recognises the importance of this continual movement between parts and whole to help gain understanding in interpretation and the importance of prejudices or fore-understandings in gaining new knowledge. Heidegger also acknowledged the importance of fore-knowledge and the fact that it cannot be eliminated, only corrected and modified within the hermeneutic circle.

'Traditional' versus 'American' Phenomenology

Michael Crotty, in his text 'Phenomenology and Nursing Research' (1996), criticised much nursing research that purported to be conducted using phenomenology as a philosophical basis. His critical analysis of thirty published research studies highlighted what he saw as the development of a 'new' phenomenology. The phenomenological movement birthed by Husserl and further developed by the likes of Heidegger was termed mainstream phenomenology by Crotty and he posited the 'new' phenomenology as developed by North American researchers. Crotty felt that the goal of mainstream phenomenology was to objectively study what people experience whereas 'new' phenomenology seeks to subjectively analyse what sense people make of the experience (Crotty, 1996).

Crotty's (1996) critique of phenomenology as used in nursing research concluded that 'new' phenomenology was not true to the intent of the traditional European phenomenologists, and that it tended to provide an illustration of a phenomena rather than a critical examination. He noted that the phenomenology studies he critiqued did not embrace the epistemological position that Husserl regarded as essential to phenomenology and so therefore could not be truly called phenomenology. He also noted that the subjective focus of American phenomenology was incompatible with the traditional, task of objective phenomenology as developed by Husserl (Crotty, 1996).

Caelli (2000) posits that although Crotty (1996) and Paley (1997) argue the way traditional phenomenology was interpreted by nursing researchers was flawed there is a counter argument that the 'new' phenomenology utilised by nursing researchers was not a misinterpretation of the traditional, European philosophers but rather a new way of applying the principles of phenomenological philosophy to enquiry. Caelli (2000) acknowledges and outlines two major differences between what she terms American and European phenomenology. In traditional, or European, phenomenology the emphasis is on pre-reflective analysis of the experience, whereas, American phenomenology allows for exploration of the experience. The role of culture is also dealt with differently in each tradition. Traditional phenomenology sees a universal meaning or essence of the phenomena outside the context of the culture of the participants, whereas, in the newer American phenomenology the role of culture plays an important part in describing participant's experience as situated within the context of their culture (Caelli, 2000).

Different approaches to phenomenology espoused by the traditional European philosophers and American phenomenologists both are of value in nursing research according to Caelli (1998). The human science approach, such as that put forward by van Manen and used in his research on pedagogical experience, addresses the need of nursing researchers to understand the human condition rather than the phenomena as a stand alone entity (Caelli, 1998). Caelli, supports research designs that combine traditional approaches with aspects of the American approach. This allows nurse researchers to understand the lived experience from the perspective of the participants.

The importance of using a philosophical underpinning that supports the research question is clearly articulated by Caelli (2001) however she notes that in the case of phenomenology, the lack of clearly described methods for undertaking research using this methodology, and the difficulties inherent in understanding the philosophical underpinnings both create challenges for the researcher. She notes that despite large volumes of literature published about phenomenology, there are few sources that guide the novice researcher by providing specific directions on how to conduct phenomenological research. This lack of information or guidance on how to actually carry out a phenomenological study creates difficulties for the inexperienced researcher (Caelli, 2001).

van Manen

van Manen was influenced by the phenomenology of European philosophers such as Heidegger and Husserl, but also by North American scholars, stating that phenomenology is the study of the life-world as we live it proclaiming that

hermeneutic phenomenology is essentially a writing activity (van Manen, 1990). van Manen combines aspects of descriptive and traditional interpretive phenomenology but concurs with Heidegger's position that it is not possible to 'bracket', or set aside, what we already know (Dowling, 2007). In fact, van Manen encourages the use of personal experience as a starting point to identify how the researcher's own experience links to that of the participants (van Manen, 1990).

van Manen (1990) discusses the principle of 'intentionality', or our inter-connectedness with the world, as a retrospective concept in that we cannot reflect on an experience while undergoing that experience. Hermeneutic phenomenology was described by van Manen (1990) as a fundamental writing activity that allows us to interpret an experience via the text. van Manen uses the term 'phenomenological nod' to indicate that a written description provides a clear link to an experience. This experience might be something that we recognise as having experienced in the past, or something we believe we could experience in the future. He notes that if a phenomenological description resonates with the sense of lived life, then this is a good phenomenological description (van Manen, 1990).

The four life world existentials provide guidance for researchers using a phenomenological method (Dowling, 2007). van Manen (1990) considers the four existentials as the fundamental themes that all humans experience regardless of history or context (van Manen, 1990). He posits that each life world existential provides a useful guide to the reflective process. These existentials are those of lived space or spatiality; lived body or corporeality; lived time or temporality and lived

human relation or relationality, and reflect Heidegger's concepts of 'temporality' and 'spaciality' as previously discussed.

The concept of spatiality, or lived space, can refer to the world in which humans find themselves at home or elsewhere. An exploration of lived space allows the researcher to assign meaning to a particular experience. How lived space is experienced by people, and what it means to them, can help uncover more fundamental dimensions of the meaning of lived life (van Manen, 1990). The second of van Manen's life world existentials is that of corporeality or lived body. This concept refers to how the physical body can reveal or conceal aspects of the person. The fact that people are always bodily in the world means that their bodily presence may unconsciously reveal and conceal things at the same time (van Manen, 1990). The third concept of lived temporality, or lived time, refers to time that is subjective as opposed to objective, or clock time (van Manen, 1990). A person's perception of time appears to speed up or slow down depending on what may be occurring in their life. What has happened in the past to a person, referred to by van Manen (1990) as historical time, may also influence present time as what has happened before can influence the future. The fourth concept, that of relationality, or lived human relation, is the relation we maintain with others in the space that we share with them, or how we relate to others in the world (van Manen, 1990).

Phenomenology and nursing

Phenomenology has been used for some decades in nursing research. Todres and Wheeler (2001) noted that there was a cautious use of phenomenological methods in the 1970s followed by quite widespread use and acceptance by nursing scholars in the

1980s. Benner's seminal work *From Novice to Expert* (1984) was strongly influenced by the phenomenology of Martin Heidegger. Phenomenology has been noted as an appropriate philosophical grounding for nursing research as research using this approach reflects the reality of the complex and situational reality of nursing practice (Dowling, 2007).

Though many contemporary nurse researchers have used phenomenology as a methodological approach to their study, there are multiple papers highlighting inconsistencies in application and philosophical underpinnings. Koch (1995) and Walters (1995) both note that although much nursing research has been conducted under the banner of phenomenology, many studies have been inconsistent in the application of methodology or have used terms interchangeably in a way that does not always refer to the same philosophical underpinnings; both of which lead to the concern that many nurse researchers may lack a strong philosophical understanding of phenomenology (Ray, 1994).

Koch (1995) notes that many nurses who have written about phenomenological methods, such as Omery, Parse et al, Davis, Cohen and Morse, have used core descriptions of techniques or methods that were developed by psychologists such as Colaizzi or Giorgi, and that what is not stated is that these techniques are underpinned by Husserlian principles. Walters (1995) also notes the misconception created in some papers that there is a single phenomenological method. Both authors highlight the importance of selecting the appropriate methodology based on the research question and that the various philosophical underpinnings will create different methodological implications.

Draucker (1999) conducted a critique of the use of Heideggerian hermeneutics as a basis for nursing research identifying a wide variation in how Heidegger's principles were incorporated in various studies leading to a concern for the level of rigour. Several authors have sought to address the question of rigour in phenomenological research (Koch, 1994; 1998; Whitehead, 2004) with Koch (1994) expounding the use of a 'decision trail', multiple data sources and a reflective journal to aid in the establishment of rigorous phenomenological research. Whitehead (2004) also documents the importance of providing the reader of the research with a decision trail to increase the trustworthiness of a study.

In using a Heideggerian approach to research requires careful number of key essential elements to ensure consistency in methodology and approach. Draucker (1999) identified co-constitution of data as a cornerstone of a hermeneutic approach and in her review of Heideggerian nursing research notes that many authors fail to reflect this. Also crucial to research based on Heideggerian principles is the need for the researcher to make clear their pre-suppositions or fore structures are and how these were identified and influenced their interpretation of the data (Todres & Wheeler, 2001).

van Manen's elucidation of phenomenology as a human science allows the exploration of a lived experience from the perspective of those that experience it and this is seen as valuable in nursing research. An inquiry which aims to explore the lived experience of the dual role of midwife and nurse in rural areas is 'human science' according to van Manen, in that it studies " beings that have 'consciousness' and 'act purposefully' in and on the world" (van Manen, 1990, p 4).

Conclusion

This chapter discussed the use of phenomenology as an appropriate methodology to describe and interpret the lived experience of midwives who work in a dual role of midwife and nurse in rural Far North Queensland. The philosophical underpinnings of the phenomenology of Edmund Husserl and Martin Heidegger were discussed and concepts key to each, described. The identification of 'traditional' and 'new' phenomenology as used by nurses and discussed by Crotty and Caelli was summarised for the reader. Phenomenology developed by van Manen, was also outlined including description of the six methodological steps proposed by van Manen (1990) as a means to guide phenomenological analysis. These steps will be discussed further in the following methods chapter. A brief summary of phenomenology and its appropriateness for midwifery and nursing research was also provided.

The following chapter introduces the steps outlined by van Manen (1990), describes the study participants, and provides an overview of the data collection and analysis techniques employed in the study. Issues of rigor and ethics are then addressed.

Chapter 4

Methods

Introduction

The aim of this study was to investigate the experience of midwives working in a dual role of midwife and nurse in a rural area of North Queensland, Australia. Phenomenology was chosen as an appropriate methodology to bring these experiences to light these experiences as discussed in the last chapter. The purpose of this chapter is to describe the methods employed to address the aim of the research. van Manen (1990) noted that the aim of phenomenology is to transform lived experience into textual expression and he describes six methodological themes to guide a phenomenological study.

This chapter will outline the six methodological steps or stages described by van Manen (1990) and how they were applied to this study. The research design used in the study will be discussed including ethical considerations, selection criteria for participants and recruitment strategy. The method of data collection and analysis will be outlined and also the steps taken to ensure methodological rigour in the study. A distinct lack of specific methods in phenomenology, identified as problematic particularly for novice researchers by Caelli (2001), is also noted by van Manen (1990) who says "the method of phenomenology and hermeneutics is that there is no method" (p. 30). Therefore, the methodological steps outlined by van Manen as a way to assist the researcher, were used in this study.

van Manen (1990) did not intend his methodological steps to be a prescriptive, linear procedure for conducting phenomenological research, but rather a way to provide

researchers with some structure. The intent was to move back and forwards between the themes at differing times in the research process and that these themes would serve to "animate inventiveness and stimulate insight" (van Manen, 1990, p. 30). This iterative and reflective process is also congruent with Butler-Kisber's (2010) description of the analytic process in phenomenological studies. The six steps or stages outlined by van Manen are:

1. Turning to a phenomenon of interest
2. Investigating experience as we live it rather than as we conceptualise it
3. Reflecting on the essential themes which characterise the phenomenon
4. Describing the phenomenon through the art of writing and re-writing
5. Maintaining a strong and oriented relation to the phenomenon
6. Balancing the research context by considering the parts and the whole

(van Manen, 1990, pp. 30-31).

1. Turning to a phenomenon of interest

van Manen (1990) wrote that a lived experience has a quality or essence that we recognise in retrospect and this first step, to make sense of that experience, requires us to identify what deeply interests us so that we may explore this. When orienting to a certain phenomenon it is approached with specific interest. In my case as a midwife of over twenty years experience and recently working closely with midwives working in rural facilities I was deeply interested in how they work, their experiences and how this might impact on work force issues of recruitment and retention.

Turning to a phenomenon of interest then leads to the formulation of a research question. van Manen (1990) says that phenomenological research requires the

researcher to ask ‘what is this thing really like?’ or what is the nature of this particular experience? In asking “What is the experience of midwives working in a dual role as midwife and nurse in rural Far North Queensland?” I sought to discover the ‘essence’ or meaning of this experience from the perspective of those living it. The result of this phenomenological inquiry is ‘one interpretation’ of the experience realising that no interpretation is ever complete, though each adds to the meaning of what this experience is like (van Manen, 2002).

It is important that I identify my pre-understandings and how they may influence interpretation (van Manen, 1990). As discussed in Chapter One, my interest in this topic was prompted by both my experience as a midwife and my interest in issues affecting the midwifery workforce in rural areas. My interest in these issues increased since commencing in the role of Regional Maternity Services Coordinator, and became the major impetus for my doctoral studies. My background will influence my interpretation of the participants’ stories and so it is important that during the process of data analysis and presentation, I make my assumptions and pre-understandings explicit placing myself within the hermeneutic circle (Smith, Flowers, & Larkin, 2009).

I used a number of strategies to identify and overcome my pre-understandings. These included the use of a reflective journal, where I could document my personal views and impressions of the phenomena of interest. The use of this journal is discussed further on in this chapter. I have also included a comprehensive account of my personal and professional background and how that brought me to this study, in Chapter One, as means of making clear my influence on interpretation.

2. Investigating the experience

In order to understand a phenomenon it is necessary to 'see' it from the life world of those experiencing it. van Manen (1990) noted that the "best way to enter a person's life world is to participate in it" (p69). This required me to conduct unstructured interviews with midwives who were working in this dual role of midwife and nurse in a rural facility, allowing them to describe their experiences in this role as fully as possible.

I asked the participants to tell me about their everyday working life in the facilities that they worked in. I asked them to give examples of situations where they felt working in this dual role had possibly challenged their midwifery practice and also whether there were examples of situations that they felt had enhanced their practice. The interview process was guided by the research question so it was important to allow the midwives to tell stories of their own experience (van Manen, 1990).

3. Reflecting on essential themes

van Manen (1990) discusses how phenomenological research requires a "thoughtful, reflective grasping of what it is that renders this or that particular experience its special significance" (p32). The researcher reflects on the text to find those words that provide the essence of the experience. In trying to determine what the essential meaning of an experience is, the researcher identifies themes that arise from the reflective process that bring into focus what the meaning of that experience is.

In my desire to bring into focus the experience of midwives working in dual roles as midwife and nurse in rural hospitals of FNQ I utilised van Manen's suggested three

approaches to begin to identify themes or sub-themes. Initially this involved the wholistic or sententious approach where text is regarded as a whole and is searched for a phrase that may "capture the fundamental meaning or main significance of the text as a whole" (van Manen, 1990, p. 39). The sententious approach then followed whereby phrases or sentences particularly revealing about the phenomenon of interest are highlighted (van Manen, 1990). I listened to the tapes during the process of transcribing and made reflective notes of statements that seemed particularly telling about the experience to me in the first instance. Reading and re-reading of the transcripts in conjunction with my reflective notes enabled me to highlight whether these statements did indeed seem to be an essential part of the phenomenon. Finally, a detailed or line-by-line approach, where every single sentence is scrutinised to see what, if anything, this sentence reveals about the experience (van Manen, 1990) is used. This process is discussed in more depth later in this chapter under the heading 'Data analysis'.

4. Describing the phenomenon through the art of writing and re-writing

Writing is an important part of the phenomenological research process and in fact according to van Manen (1990), it is the object of phenomenological research. Writing "fixes thoughts on paper" (van Manen, 1990, p. 125) and is closely aligned with the both the research and the reflective process. Through the process of writing the researcher aims to make visible to the reader the experience described, in this case that of working in a dual role as midwife and nurse in a rural setting. Writing commences well before any formal analysis begins, in that diary notations in preparing the research question and proposal, immediately after interviews and after meetings with my supervisor all contributed to the whole.

Writing and re-writing provides a process through which interpretation of the data can occur. In writing we are attempting to make that which is internal to participants become external (van Manen, 1990) by distilling meaning from the text. Reflecting on the text may make meanings explicit in the descriptions. Themes can be interpreted through drafts and re-drafts. Continual revision and re-writing of drafts increases understanding through identification of consistency of meanings or themes (Debesay, Naden, & Slettebo, 2008). I also continued to move between the text of transcripts, notations made in my reflective diary and on the transcripts and drafts of emergent themes, moving between the parts and the whole, to enhance understanding (Smith, et al., 2009).

5. Maintaining a strong and oriented relation to the phenomenon

van Manen (1990) highlighted the need for a researcher to retain a strong and oriented relationship to the phenomenon being investigated throughout the process of the research process. It is therefore important that throughout the process I remain sensitive to the question "What is the experience of midwives working in a dual role of midwife and nurse in rural far North Queensland?" but also equally important that I remained aware of my own preconceived opinions and experiences. The use of a reflective journal throughout the process helped me to be aware of the difference between the thoughts of the participants and my own ideas. I noted down my perceptions and thoughts, not only about the content of interviews but also reflections on how the interview went, such as what went well or what might have been better, for future interviews.

6. Balancing the research context by considering the parts and the whole

It is important for the researcher to continuously measure the parts of the research study process or text against the whole to see how each contributes. van Manen (1990) recommends this back and forth movement between the parts and whole as a way to avoid getting so "buried in writing that one no longer knows where to go" (p. 33). As previously noted, I continued this back and forth movement between parts and whole during the process of writing and re-writing. Sometimes it becomes necessary to take a step back to consider the experience as a whole or the 'big picture' view and then back to the parts to help create an understanding of how each midwife's story contributed to the themes and essences identified.

Smith et al. (2009) describe the circularity of this process, in that the researcher is working at a number of different levels when moving between the parts and whole. They cite the examples that considering a single word is a part and the sentence that contains the word is the whole just as a single extract of a transcript is a part of the whole transcript. This movement back and forth between various levels when interpreting the text is influenced by the history of what I have previously read and constructs different ways to think about the information read and is not a linear, step-by-step process (Smith, et al., 2009).

Participants

A purposive sampling method was used to recruit participants which is appropriate in phenomenological studies where participants experiencing the phenomena are required (Schneider, Elliott, LoBiondo-Wood, & Haber, 2005). Midwives working in rural facilities who hold dual roles as both registered nurses and midwives were

invited to participate. Participants were approached through a variety of means, such as flyers placed within the facility of interest and direct approach by inviting participants at in-service or conference venues. The flyers contained information about the research aim and noted that a one-on-one interview would be required for those who participated. My contact details were on the flyer and potential participants were encouraged to contact me if they had any questions about the research. Flyers were initially distributed to each maternity unit selected and left in staff tea rooms and notice boards. I also distributed the flyers to the Unit Managers of each maternity unit as I considered them to be key contact people in each facility.

An initial response from the flyers, I arranged three interviews. Flyers were redistributed to encourage further participation and I also displayed flyers at other venues such as midwifery conferences and midwifery work shops where rural midwives were registered. I also made direct approaches to a number of midwives at the above venues and gave flyers to them for their consideration. In order to avoid possible undue pressure on midwives to feel obligated to participate, I asked each to take the flyer away and think about whether they would like to participate and to call or email me at a later date if they were interested or had further questions. I reassured each of these that I would not re-contact them if I heard nothing further as I would assume that they were not interested in participating.

The inclusion criteria for the participation in the study were:

i. Over eighteen years of age and able to speak English
ii. Working in one of the four nominated rural hospitals in the district as both a midwife and nurse

iii. Willing to participate in the study and give written consent after receiving written explanation of the study aims

Though there are no defined rules for establishing sample size in qualitative studies (Tuckett, 2004), due to the in-depth nature of the data collection and the need for participants to experience the phenomena, a small sample size of participants is usually selected in phenomenological research studies. A total of eight participants were interviewed as after this number, the same information was being heard during interview.

The midwives that participated in the study worked in facilities that provide a birthing service as well as facilities that no longer provide birthing, except in unplanned or emergency situations, but do provide antenatal and/or postnatal care. I wanted to include midwives who worked in a variety of midwifery roles in rural locations to ensure a rich description of the experience of working in a dual role of midwife and nurse was forthcoming. A more detailed outline of each participant is included in Chapter Five.

Data collection

Data was collected through the use of unstructured in-depth interviews with the participants. Using of open-ended questions allows participants to describe their lived experiences. As unstructured interviews do not reflect preconceived ideas they are often lengthy but useful when significant depth is required about the subject, such as with a phenomenological inquiry (Gill, Stewart, Treasure & Chadwick, 2008). The use of unstructured interviews also prevents the researcher making assumptions about

the important aspects of the phenomenon, rather allowing the participants to reveal what they consider to be the significant or essential aspects (Pearson, Robertson-Malt, Walsh, & Fitzgerald, 2001). Unstructured interviewing is in keeping with van Manen's (1990) approach of investigating the experience as lived rather than as we as researchers conceptualize it. van Manen (2002) also describes the importance of the interviewer keeping both themselves and the interviewee oriented to the meaning of the phenomenon throughout the process of the interview.

It is important to develop a sense of rapport during interviews so that the participant is encouraged to provide sufficient depth of data to enable valid interpretations to be made by the researcher (McConnell-Henry, James, Chapman, & Francis, 2009-10). I had previously met all but two of the participants through a variety of work related activities and McConnell et al. (2009-10) note that the building of rapport can be enhanced and accelerated when participants know the researcher but there is also potential for mistrust if the participant suspects the researcher has a hidden agenda. It was important, therefore, that I reinforce the concepts of confidentiality and my role as researcher in this process, not Regional Maternity Coordinator. I am not in a line management role to any of the participants and I reassured them that nothing discussed in the interview would be discussed outside of that forum and that the data would be reported in such a way that the source would not be identifiable.

I also needed to ensure that participants did not leave out information that they may assume I already knew about their role through previous contact. To address this possibility, I again reinforced confidentiality and that I could only use information given to me in the interview. Where I was aware of certain aspects of a person's role

that may have not been raised, I used prompting questions when related information was discussed, for example “You mentioned how working as a midwife was different where you used to work, can you tell me more about this?”.

Interviews were conducted at a time and place convenient for the participants. The length of time of interviews varied between fifty minutes and two hours, with the average being about one hour long. Allowing the participants to choose time and venue for the interview may help them feel more relaxed and result in a more productive interview (Gill, Stewart, Treasure, & Chadwick, 2008; McConnell-Henry, et al., 2009-10). A variety of venues were selected by the participants and these included coffee shops, their own home, my home and work place offices.

Interviews were tape-recorded with the permission of the participants to allow for full engagement of the researcher with the participants. Gill et al (2008) note the importance of listening attentively and engaging with the participants in order to derive the most from the interview process and the taping of interviews allowed me to fully engage with what was being said. I had originally planned to take brief notes during interviews as well, but found I could not remain as engaged with the participants and this impacted on me being able to demonstrate I was really listening. Instead, I made reflective notes about each interview immediately afterwards.

Verbatim transcripts of the interviews were combined with the use of a critically reflective diary to assist the methodological process of the study. The reflective diary was used after each interview to document my thoughts about the interview, any obviously dominating subjects that emerged, how non-verbal language may have

impacted on the words uttered and how subsequent interviews might be conducted. I made notes on the interview environment, the demeanour of the participant, how this may have changed throughout the interview and what I felt went well and not so well about each interview. Reflecting on each interview as it was conducted gave me opportunity to develop skills as an interviewer and also identify that sometimes, when an interview was not as productive as I expected that there are numerous facets that might contribute to this. The diary was also used during play back of the tape soon after each interview to allow for documentation of pertinent points that stood out while the interview was still fresh in my mind.

The researcher's role in this process is to facilitate the interview without leading the discussion with the participants and to provide an environment that will help the participants feel relaxed and comfortable (Gill et al, 2008). Participants were asked to talk about their every day experience as a midwife and nurse in a rural facility and asked whether they thought working in this dual role had enhanced or challenged their practice. They were asked to provide examples if they did think working this way had enhanced and or challenged their practice. At the end of each interview I encouraged the participants to ask any questions they wished and explained how I would feedback results of the study to them. A number took the opportunity to question me on district protocols to ensure they were using current guidelines..

Data analysis

Much analysis of phenomenological data in nursing studies utilizes methods developed by psychologists such as Colaizzi and Giorgi (Koch, 1995). These are structured methods based on the philosophy of Husserl and require the researcher to

'bracket' or eliminate all preconceived ideas about the phenomenon of interest. The beliefs and experiences of the researcher are seen as an important part of the research process in Heideggerian phenomenology and contribute to the interpretation and analysis of the data (Walters, 1995). Koch referred to this fusion of the researcher's experience with the data provided by the participant as "co-constitution" (1996, p. 176) and recommends the researcher keep a reflexive journal to describe their experience as a researcher and how this informs their interpretation.

As noted previously, I maintained such a journal throughout the research process. It initially served as a way for me to express how I felt the whole research process was progressing from the early days of writing a proposal and considering appropriate approaches to analysis in consultation with my supervisor. Often, at this point, it served more as a way to note questions to my supervisor or diarise meetings related to the study. During the period of interviews, as noted, I used the diary to reflect on the content and impressions I had of each interview and how I might use this information in subsequent interviews. During the analysis phase I made multiple diary entries as I read and re-read the transcripts. These entries were invaluable in the process of early identification of concepts and thematic analysis.

I chose to transcribe the interviews myself so as to immerse myself in the data from the beginning and although very time consuming I could not imagine relating so closely to the transcripts had they been transcribed by someone else. I used personal codes to help identify things such as particular emphasis on words, pauses in conversation or laughter so that as I read and re-read the transcripts. As previously stated, the transcripts were read as a whole and in combination with the reflective

journal to assist in identification of themes. van Manen (1990) suggests that reading and re-reading while identifying themes provides a method of giving meaning to the experience. Reflection on these themes helps to distinguish the phenomenon of interest (Barreca & Wilkins, 2008). Analysing themes helps to uncover meaning and promotes understanding of the lived experience (Whitehead, 2002). The act of describing the phenomenon through writing and re-writing, as described by van Manen (1990), assists in distilling meaning from the text and this helps in identifying themes and essential meaning and interpretation of those themes.

Interpreting the data and identifying themes required me to acknowledge that my own experiences in the world are a part of this process of analysis and that these experiences provide an important contribution to the interpretation (Carolan, 2003; Walters, 1995). The use of a reflective journal, as previously noted, helps contextualize the data and provides a strategy to identify differences in interpretation that my experience brought to the analysis. The use of the journal also helps to maintain the strongly oriented relation to the phenomenon as suggested by van Manen (1990).

Interpretation and analysis of the text began during the conduct of interviews and continued throughout the process of transcription and thematic analysis. The process of writing and re-writing allowed for the use of direct quotes of the experience and helped to provide rich examples of the emerging meaning. I used a variety of methods when writing and identifying themes. These included compiling tables of what seemed connected meanings, using post it notes as I read and re-read the data, reflecting on what I had written, and incorporating reflective comments made

throughout the process. After examining the transcripts, it was essential to return to the literature and reflexive notes to expand on the themes.

Thematic analysis

As previously stated, van Manen's (1990) analytic approach was utilised in the study. The phenomenological process of thematic analysis is designed to uncover meanings of human experience as they are represented in a text (van Manen, 2002). The first of van Manen's approaches is the wholistic approach (van Manen, 1990). As the first part of the analytical process, I read each of the transcripts individually and in their entirety. I read each transcript several times searched for patterns or recurring ideas that stood out from the transcript as a whole. While doing this, I made notes in the margins of the transcripts of key phrases or words that seemed to me to reflect the experience of the concept of dual role of midwife and nurse.

As part of the wholistic approach I was looking for phrases that "capture the fundamental meaning" (van Manen, 1990, p. 93) of the text in an attempt to isolate core meanings of the phenomenon. van Manen (1990) then suggests the researcher tries to develop a phrase that reflects the text as a whole. This 'sententious' phrase is not fully formed at this stage but it contributes to further development of themes and sub-themes as the process of reading, writing and reflection continue. Again, this is a circular process, rather than a linear one, moving back and forth between themes and sub-themes.

The selective or highlighting approach asks the researcher to identify which statements or phrases assist in portraying meaning about the phenomenon of interest

(Roulston, 2010). In this process I read and reread transcripts to identify phrases or sentences that seemed particular to the phenomenon of working in a dual role as midwife and nurse and then highlighted these phrases. These phrases were then transcribed into a table and this enabled me to first distinguish key words that seemed to reflect the meaning of each statement. I then compared these key words between transcripts to develop concepts that eventually linked to create sub-themes. Much time was spent moving concepts around to determine a best 'fit' with various sub-themes. Table 2 is an example of part of the table used to link quotes and concepts.

Table 2: Developing meaning from text

Line	Quote	Concept /Meaning
6	General, midwifery was separated	Midwifery unique to general
30	you know they're, it's all in together it's just, I find its not, its not ethical, I feel its not the right thing because me being an older midwife I've grown up with the fact that you know you don't mix the general and maternity	How it used to be? Or longing for the way it was?
9	I found it from the very beginning extremely difficult	Difficult/stressful
14	We haven't worked in general for 35 years, we've only worked in maternity.	"quite stressful"
102	Not just concentrating on maternity, you have to concentrate on general stuff	
270	I find it quite stressful… you haven't got that other extra person to bounce things off	
22	I'm very flexible, I can work in any area they put me in	Multi-skilled
70	I am very multi-skilled and very flexible	Need to be able to do it all
93	well I certainly have to know a lot more because you're not just working in one area, you know you're working in maybe 2 or 3	

The third approach was the detailed or line-by-line approach where van Manen suggests reading every sentence or cluster of sentences to ask 'what does this sentence reveal about the phenomenon?'. As I read through the transcripts again, and reviewed each sentence I looked for confirmation of concepts already identified and also looked for any new ideas that might reveal themselves. The process of line by line reading may identify some conflicts or tensions among identified themes that reflect the

phenomenon of interest, but these should not be contradictory to each other (Butler-Kisber, 2010).

While conducting line by line reading I continually asked myself ‘is this concept essential to the meaning of this experience?’ and ‘if I remove this concept, is this phenomenon still the same?’, a method suggested by van Manen (1990) to determine the “universal or essential quality of a theme” (p. 107). Throughout each of these steps, as words or phrases stood out to me, notations were made in the margins of individual transcripts and I looked between the transcripts for evidence of shared meanings and so moved between the parts and the whole. This creates the process of entering the hermeneutic circle to acquire new knowledge (Debesay, Naden, & Slettebo, 2008).

The process above led to the identification of three themes from the data with each theme reflecting an essential aspect of the experience of a midwife who works in a dual role of midwife and nurse in a rural area of far North Queensland. Each theme is comprised of a number of sub-themes. Table 3 lists each theme and the related sub-themes that exemplify the experience of these midwives. Although each theme is discussed separately, in Chapters Six-Eight, they interweave to represent the experience or phenomenon of a midwife working in a dual role as midwife and nurse in rural far north Queensland.

Table 3: The themes and sub-themes that explain the experience of working in a dual role of midwife and nurse in rural areas

Themes	Sub-themes
Making choices between professional role and lifestyle: "Because I choose to live here"	- Nothing you can do about it (no choice) - Choosing to live rural (choice) - you're a nurse first
Integration of maternity and general nursing: "All in together this fine weather"	- Stress due to working across roles - It's not right, conflict with integration - Enjoy the variety
Shaped by location: "That's part of working in a small place"	- Sense of belonging to a community - You deal with what comes through the door - Limitations of working in a rural hospital.

Methodological rigour

Using the processes of hermeneutical phenomenology, it is impossible and undesirable for the researcher to set aside prejudice and own interests. The use of an ongoing, critical reflexive mindset characterises phenomenological research (Koch, 1998). Providing the reader with an ongoing narrative of the researcher's reflexive account enables the reader to follow the decision trail that the researcher has used (Koch, 1994b). Decisions made by the researcher about methodology, theory and analysis are made clear for the reader then, though interpretation is influenced by the reader's own prejudices or background, clarity is provided as to how the researcher came to these interpretations.

Koch (1994) suggests the use of a field journal to aid the researcher to increase self-awareness by recording the contexts, processes and interactions of the study so that these may be incorporated in the analysis or text. This journal, as an additional data source, can also contribute to increasing trustworthiness of the study (Koch, 1996).

The use of vivid, thick descriptions of the phenomenon, taken from the transcripts also helps to assure rigour of the findings (Barreca & Wilkins, 2008).

A number of other strategies were adopted to ensure rigour or validity of the study. These included a purposive sampling method to ensure appropriate participants were selected and the continuation of recruitment and interviewing until saturation was achieved, or in other words no new themes were emerging. Interviews were first transcribed by the interviewer to increase reliability in that it was then clear how nuances of conversation were documented. Transcripts were then re-checked with the recordings to ensure accuracy of content.

Ethics

The conduct of this research met the values set out in the National Health and Medical Research Council (NHMRC) National Statement on Ethical Conduct in Human Research (NHMRC, 2007). The first of these guidelines states that the research has merit and integrity. This research aims to contribute to the body of knowledge about professional role and in relation to rural midwives in particular, there is little published in the literature in this area. As the aim of the research was to understand the meaning of what it is to be a midwife in a dual role in rural areas, the choice of phenomenology was an appropriate method to investigate the issue (Walker, 2007).

The second value is that of justice. Inclusion of participants was through purposive sampling as this an appropriate method for phenomenological research. Participants were fully informed about the purpose of the research and participation was entirely voluntary. The researcher is not in a line management role to any participants and so this helped to reduce any power differential in the research process. Participants were

each offered access to findings of the research. The principles of informed consent were followed in that participants were provided with written information about the aims of the research (Appendix 3), had opportunity to ask questions, had the choice of whether to participate or not and an option to withdraw consent at any time with no negative consequences. Participants were requested to sign a consent form (Appendix 4) when they agreed to participate.

The third value of beneficence requires that the research design minimize the risk of any potential harm or discomfort. The use of open ended interview technique allowed the participants to control the information provided and it was not anticipated that talking about their role should cause distress. Should this have been the case, however, as employees of Queensland Health all were be eligible for the Employee Assistance Program if required and this fact was provided in the information sheet given prior to consenting to participate. Participants were informed that interviews would be tape recorded as this is essential to the research process.

The fourth value of respect requires the researcher to have due regard for the welfare, beliefs and customs of those involved in research. Participants were given an assurance that their confidentiality and anonymity would be maintained. Any reporting of data from the study will be done in such a way that sources will not be able to be identified. Data storage was on a password protected memory stick that was kept with the researcher at all times and tape recordings were erased/destroyed after transcription. Participants were able to choose the venue for the interviews as they may not have wanted to do this at their place of employment. The researcher sought and received ethical approval to conduct the study from the Human Research

Ethics Committees of both James Cook University and Cairns and Hinterland Health Service District (Appendices 1 & 2).

Conclusion

This chapter has identified the methods used to conduct this interpretive phenomenological study of the experience of midwives who work in a dual role as midwife and nurse in rural Far North Queensland. The six analytic stages outlined by van Manen (1990) were described in detail and applied to the study. Methods of data collection, thematic analysis and ethical issues were all discussed. The next chapter introduces in detail, the participants of the study.

Chapter 5

Introducing the participants

This chapter introduces the study participants and provides an overview of each participant's acquisition of nursing and midwifery qualifications and the length of time each has worked both as a midwife and in a dual role. The context of the interview location and preliminary reflections in my reflective journal made immediately after each interview, are outlined here. The use of the journal, as suggested by Koch (1994a), assists the researcher to increase their awareness of the contexts and interactions in the study, which in turn contributes to the rigour or trustworthiness of the analysis (Koch, 1996). In this study, the journal provided a medium to reflect on the participants' reactions during the interview, to note preliminary concerns and issues that arose as a result of the interview content, and a site to describe early analytical notions.

Overview of the participants

Participants were recruited, using a purposive sampling method, from four targeted rural facilities that provided maternity services. The facilities chosen are all within the Cairns and Hinterland Health Service District and Cairns Base Hospital is the referral hospital for each of them. Each of the towns where the facilities are located is classified as outer regional in the ASGC Rural and Remoteness classification system. They were selected as the distance to travel to each town was realistic for the purpose of interviewing local participants, and in my role as Regional Maternity Services Coordinator I am/was responsible for supporting maternity services at these hospitals. Information flyers about the study were distributed to the targeted facilities. These flyers invited midwives, who worked as both a midwife and nurse in these rural

hospitals, to participate in research that sought to identify if a link or links existed between recruitment and retention strategies and the experience of working in a dual role. The flyer explained that all that was required of the midwives who took part was participation in a one on one interview at a time and place of their choosing.

Three of the facilities chosen for the study provide antenatal, birthing and postnatal services. There is only one other facility in the district that provides a full maternity service, however as the midwives at this facility use a caseload model of midwifery care, they were not working in a dual role and so were excluded from the study. The fourth facility provided antenatal and limited postnatal services, but no planned birthing services, although unplanned births did occur at that facility from time to time. This hospital was included because I believed it was important to take account of the experiences of midwives who were not involved in providing planned birthing services, or did so only in emergency situations.

A total of eight participants were interviewed, two from each of the four targeted facilities. All participants were assigned a pseudonym to maintain anonymity and to help preserve confidentiality. Seven out of the eight participants had been a midwife for fifteen years or longer with only one participant graduating two years prior to being interviewed. All but one of the participants had worked in rural locations for five years or longer, with four living and working in rural towns for over eighteen years. One participant had only re-located to a rural area in the previous six months. Seven of the eight participants had acquired their nursing and midwifery qualifications through the hospital-based system of education, and the majority had pursued some form of post-registration tertiary education. Most mentioned their

rationale for pursuing further education was to keep them on an even footing with tertiary educated nurses and midwives. The participants are described below in the order they were interviewed.

Participant 1: Margaret

Margaret is a 61 year old registered midwife and nurse, and has been a midwife since 1984. She obtained her initial nursing and midwifery qualifications through hospital based training but has since completed a post registration Bachelor of Nursing and is currently undertaking a Master of Midwifery degree. She believes it is essential that she complete university education as she feels this puts her in equal position with the university educated nurses and midwives with whom she now works. Margaret has always worked in a dual role where she has been required to work as both midwife and nurse in the same facility. She has worked at her current workplace for 19 years. Margaret is married and lives with her husband. Her children are all grown and no longer live at home. She is also a grandmother.

Margaret had previously talked to me in my substantive role, as Regional Maternity Service Coordinator, about concerns she had with the model of maternity care where she worked and the effect she believed this had on her midwifery colleagues. I had previously met Margaret through the process of talking to midwives in the region about issues with maternity services. We had also both been on the team investigating a sentinel event at one of the hospitals in the District. As previously noted in Chapter Four, I am not in a line management or supervisory role to any of the midwives in the study and I emphasised both the voluntary nature of participating and the maintenance of confidentiality for all participants. I think having met before and

having had discussions about rural maternity issues, Margaret felt comfortable talking to me and was open and comfortable relaying her thoughts as the interview progressed.

Although Margaret expressed a preference for working in a dual role, she worried about other midwives who expressed a preference to work as a midwife only, but were unable to do so in their current position. Margaret was the first participant I interviewed and she responded quickly to the first flyer sent out to recruit participants. She said that as we had had previous discussions about her concerns about the issue of working in dual roles so felt she 'should follow up' by volunteering to be interviewed. At Margaret's request, the interview was conducted in my home because she expressed concerns that her participation might be obvious if she was interviewed in her home town. We discussed the confidentiality of her comments and that responses would be de-identified in any published findings and she was reassured by this.

At first she seemed quite nervous about what to disclose, however she appeared to relax and communicate more freely as the interview progressed. Although she stated that her post-registration education was for continuing professional development and to keep current, she often seemed at odds with her own history and experience of nursing and midwifery and the current situation. This was evidenced by a number of comments such as *"I've grown up with the fact you don't mix the general and the maternity" (1:32-33)* and *"that's just not how I was taught as a midwife… in my day they had it totally separate" (1:301-304).* There appeared to be some conflict for Margaret between accepted clinical practice today and what she had learnt previously, despite further tertiary studies.

Participant 2: Lesley

Lesley is a 54 year old registered midwife and nurse and like Margaret, followed up hospital based nursing and midwifery training with tertiary studies, though her post-graduate studies were not in nursing or midwifery but rather in education. Lesley has had a number of roles in her career, including nursing and midwifery management, education and clinical roles. She qualified as a midwife in 1974 and for most of that time has worked solely as a midwife. However, she had been in a dual role for six months prior to the time of the interview, due to relocating to a rural area. Lesley lives with her husband and their relocation to their current town was as a result of a career progression for her husband. She has grown up children who live in the city where she re-located from and also interstate, but has no grandchildren as yet. Lesley hopes that they will be in a position to move back to the city in a few years when her daughter decides to have a family so that they can be near their grandchildren.

Lesley and I had known each other for some years, through previous positions that we had both been in and though not close friends, we are colleagues with an amiable relationship and a shared interest in midwifery research. Lesley was keen to participate in the research as she was quite new to the experience of working in a dual role and initially felt quite conflicted by this requirement. Her preference was to work as a midwife as that is what she had concentrated on for the previous 35 years. Lesley was happy to meet in her home town and we met at a coffee shop of her choosing. She was quite relaxed from the outset and eager to contribute. I was initially concerned that the background noise would be distracting during the interview, however this proved not to be the case.

A number of times Lesley expressed her desire to work only as a midwife, though as the interview progressed she also indicated that she was actually enjoying the dual role she worked in currently. However, she also acknowledged the necessity of working in such a role in the current model of care in the facility, as a result of low staffing numbers and expertise. Lesley is aware that there are other ways to structure models of care to enable midwives, even in small facilities, to work solely as midwives as evidenced by her comment *"unless we move to caseload midwifery there's no option" (2:57-58)*(to working in the dual role). She also realises that change is often difficult for those who have not been exposed to these alternate ways of working. Lesley also acknowledged change itself can be challenging: *"changing the model of care is really challenging… the midwives on one hand whinge and grumble about having to work in general, but on the other hand, when you talk to them about caseload it's the great unknown and we don't wanna go there" (2:103-107).*

Participant 3: Christine

Christine is a 45 year old registered midwife and nurse with qualifications or endorsements in Child and Family Health, Immunisation and as a Lactation Consultant. Christine obtained her nursing and midwifery qualifications through the hospital based system and had not followed those courses up with any tertiary studies. She has been a midwife since 1988. She moved to her current rural location soon after obtaining her midwifery qualification and not long after gaining midwifery registration. She reported that she had always worked in a dual role. Christine lives with her husband and teenage children on acreage some distance from the town. She

and her husband were attracted to the rural area many years ago as it appealed to them as a good place to raise children.

Christine originally arranged to meet me for the interview at her home but decided at the last minute to meet at a café in her home town. We have met a number of times previously through my role as Regional Maternity Services Coordinator and at a number of in-service presentations. Christine had also spent two weeks at the hospital where I am based as part of a rural midwifery up-skilling program some years ago and this was where we had first met. Christine said she was keen to participate in the research but wondered whether her input would be as valuable as other participants, as the facility she worked at no longer provided a birthing service. She was initially quite nervous about the interview being taped but it transpired that this was only because she worried about how she sounded when recorded. The interview progressed in a relaxed, conversational mode.

Christine saw participation in this research study good opportunity to ensure that clinical practice guidelines at the facility in which she worked were current. It appeared that she was motivated to participate in the interview, in part, to enable this exchange of information that was otherwise difficult for her to access. She said she was happy to take part as long as she could 'pick your brains after this' on current maternity care protocols. It was clear that Christine wanted to ensure that the women she cared for were provided with the most current and up to date evidence-based practice and she noted that she felt the reduction in maternity services provided in her home town made it more difficult for midwives to keep up to date. A lack of access to CPD for midwives in rural areas is a recognised problem (Fahey & Monaghan,

2005; Kildea, Barclay, & Brodie, 2006) that can have serious implications for the quality and safety of care provided to women in rural areas.

Participant 4: Alison

Alison is a 60 year old registered midwife and nurse who, as noted with previous participants, completed her nursing and midwifery through a hospital based program. Alison has also completed a post-registration Bachelor of Nursing degree. A midwife for 26 years, Alison completed her midwifery education in 1983, and has always worked in rural areas which required her to function in a dual role. Working almost continuously at the same facility for 40 years with some short secondments to other nearby communities (or towns) to provide opportunities to up-skill or provide leave relief, Alison lives with her husband, with her grown up children and grandchildren close by.

Alison wished to conduct the interview at her place of work, in her office. I discussed the potential for loss of confidentiality due to the choice of this location and outlined my preference to conduct the interview away from her workplace but Alison was comfortable to use her office. As a way of ensuring privacy for the interview in this location, the door to the office was closed and Alison notified staff that she was unavailable for the next hour or so. Unlike the previous three interviews, I found it difficult to get Alison to relax into the interview and expand on her answers initially. I believe this would have been quite discouraging if this had been the first interview I conducted for the project. Alison did not appear anxious or in a hurry to conclude the interview, however, and though she indicated that she was keen to participate, she did not give a lot of information when questioned or prompted. On reflection after the

interview, I believe Alison was keen to contribute to the study and that the succinctness of her responses were a personal attribute of her speech pattern.

Similar to Christine, Alison also saw a reciprocal benefit in participating in that she wanted to confirm the use of up to date maternity protocols in her unit. She commented that while she had me there, she could ensure that any recent changes that may have occurred in maternity practice were being implemented in her hospital. As Cairns is the referral hospital for this facility, as with others in the study, protocols and clinical guidelines developed in Cairns are followed by the staff in the rural hospitals. This ensures consistency of practice and supports the smaller facilities who have limited resources to develop individual guidelines. As noted previously, a lack of access to CPD is a significant issue for midwives in rural areas. No onsite education opportunities, coupled with declining midwife numbers, has prompted Alison to hold education sessions on midwifery issues with non-midwifery staff. *"it's a bit of a struggle for us here with midwives and in fact I'm doing some teaching with the non-midwives to show them how to assist with an unplanned birth" (4:79-81).* This hospital does not have any planned births but has, on average, ten to twelve unplanned births per year. Small numbers of unplanned births, always in an unintended and potentially crisis situation, have implications for maintenance of skills and safety. These implications are discussed further in Chapters One and Two.

Participant 5: Lauren

Lauren is a 59 year old registered midwife and nurse who obtained her qualifications through a hospital based training program. Since then Lauren has completed a post-registration Bachelor of Nursing and has also obtained a Rural and Isolated Practice

Nurse endorsement. She has been a midwife for 15 years and has worked in a dual role for five years after relocating from interstate with her husband. Her daughter recently gave birth to Lauren's first grandchild and lives interstate. Lauren and I met for the first time about two months prior to the interview at a maternity emergency skills workshop and I approached her at that time to tell her about my research and invite her to participate. I gave her a copy of the flyer and my contact details and encouraged her to call me if she was interested in taking part in the study. She contacted me some weeks later to arrange time for an interview.

At Lauren's request, the interview was conducted in her home. Lauren's husband was home at the time although he absented himself during the interview. He returned at one point and Lauren was anxious at this interruption as she thought this would ruin the recording. I reassured her that this was not a problem. Initially, Lauren also seemed anxious about what was the right thing to say and felt that she would not say the 'correct things' which would render the information unsuitable for the study. As the interview progressed, however, she relaxed and information flowed more freely. Lauren expressed a number of times that she was passionate about midwifery and worked in the dual role as it was her only option at the current work place. As a result, she indicated that she had been actively pursuing alternate places of work, even if this meant intermittent separations from her husband or a long commute. She said her husband was supportive of this as he knew of, and respected her passion for midwifery.

Participant 6: Heather

Heather is a 54 year old registered midwife and nurse who gained these qualifications through hospital-based training. Heather has worked as a midwife since 1980 and has worked at her current workplace for two years. In total, she has worked in a dual role for eleven years over two separate periods of employment at the same facility, most recently for just over two years. Although Heather stated that she had previously worked at the same facility in a dual role, she outlined how previously this was more satisfying as midwifery was now a much smaller component of her role than when she last worked there, due to the reducing numbers of women birthing at the facility. Heather and I met at a midwifery conference and I invited her to participate in the study when I found out where she worked. Heather lives with her husband and they returned to this country town just over two years ago due to her husband's work.

Heather requested to be interviewed in my office as she was in town for the day on business and did not want me to travel unnecessarily to her home town. This seemed to be the in keeping with other participants who did not want to inconvenience me with travelling to them, although I assured them I was happy to do so as it was for my benefit. I closed the door and diverted the phone for the duration of the interview to prevent interruptions. This interview was similar to that with Alison, in that it was difficult to encourage Heather to expand on many points. I am not sure whether this was because of the interview location or Heather's nervousness as she stated she had not ever participated in a research interview before.

Similar to Lauren, Heather was worried about the 'usefulness' of her responses and expressed concern a number of times about giving 'correct' responses. I feel that this

concern to provide the 'right' answer may have influenced Heather's responses and resulted in her succinct responses to my questions. It is quite possible that Heather was intimidated by my position, both substantive and that I was acting as Nursing Director at the time of the interview. In addition to my position, the perception of me as someone pursuing a higher research degree and the connotations of academic links are potentially significant contributors to perceptions of power. The concern to be useful, provide 'correct information' and the desire of many of the participants to not inconvenience me through travelling to them may reflect attributes identified as characteristic of nurses. Characteristics such as compassion, commitment, motivation to help and a sense of responsibility have all been noted as innate attributes of the personal and professional self of the nurse (Sumner, 2001).

Participant 7: Helen

Helen is a 52 year old registered as a midwife and nurse. In keeping with many of the other participants, Helen had also followed up her hospital-acquired qualifications in nursing and midwifery with a Bachelor of Nursing degree. Helen has been a midwife since 1987 and has worked in a dual role for 18 years, the last 17 of these at her current workplace. Helen and I also met at the same maternity emergency skills workshop where I had met Lauren and I invited her to participate in the study. Helen lives with her husband and school age children, and has always lived in far north Queensland, mostly in rural areas, while moving to regional or larger centres to obtain her nursing and midwifery qualifications.

Helen chose a coffee shop close to her home for the interview. This venue was particularly noisy and I was initially concerned that the tape of the interview may be

difficult to transcribe due to high background noise. We recorded a short test piece to hear the play back and this proved not to be the case. Helen said she had been keen to participate and apologised that it had taken some time to arrange the interview. I reassured her that I was appreciative of her participation. Helen was also keen to give what she perceived as the 'right' responses so that her information would be useful to the study. I reassured her that I was interested in her experience working in a dual role and that there were no right or wrong responses. Helen quickly relaxed in the interview and I feel the environment encouraged a conversational tone to the interview.

Participant 8: Sandra

Sandra is a 44 year old registered midwife and nurse. Unlike the other participants, Sandra commenced midwifery as an older student and acquired her qualifications though a university based program. She has been a midwife for two years working in a dual role since qualifying as a midwife. Sandra has worked at her current location for five years, except for one year during the clinical placement of her midwifery education, first as a registered nurse and then as a midwife and nurse. Sandra lives with her partner and teenage children in the town where she grew up. She loves the rural life but is frustrated by her dual role and has contemplated giving up nursing and midwifery all together as she feels compromised working in the dual role, but does not wish to leave the town. She stated she would almost rather do a completely different job that she could totally commit to, rather than moving between nursing and midwifery, even though she said she was passionate about midwifery.

The interview took place at my home, at Sandra's request. Sandra was extremely enthusiastic and very keen to launch into discussion on the topic, even before signing the consent form and before I could commence taping the interview. I did attempt to keep the conversation away from the topic until I had been able to start the tape to ensure I captured all of the information. Sandra expressed interest in participating quite early in the study but it had taken some time to organise a mutually convenient time to conduct the interview. Sandra stated she was very interested in the potential outcomes of this research study. She was the only participant who had acquired a midwifery qualification through a tertiary program, and had only completed her midwifery degree recently. Her responses and comments seemed to reflect the more recent philosophy of midwifery as a separate profession to nursing. It was evident that she has been exposed to the philosophy of the continuity of midwifery care model, and was aware of the desire of many midwives to work to their full scope of practice. She therefore conceptualised her involuntary return to nursing work, after completing a midwifery qualification, as a backward step.

Conclusion

This chapter has provided an introduction to the participants of the study, described the length of time each participant has been a midwife and outlined how long each had worked in a dual role of midwife and nurse in a rural hospital. The context of each interview was briefly described, including location and participant level of interaction, and included some reflective comments included in my journal notes written immediately after each interview. The following chapters discuss the phenomenological themes that were identified during the analysis of the participants'

interviews, together with excerpts from the journal notes made throughout the interview process.

Chapter Six

Making choices between professional role and lifestyle:

'Because I choose to live here'

Introduction

The process of data analysis identified three core themes that elicited the experiential essence of working in a dual role as midwife and nurse in rural Far North Queensland, Australia. A number of sub-themes were identified, that woven together became core aspects of each theme; together they reflect the phenomenon. The themes reveal that rural midwives experience their choices in how they work as limited by location and by being re-deployed to general areas of nursing. Conflict arises because of the need to work between two models of care: the biomedical model that tends to dominate generalist nursing and medicine, and the partnership-wellness model of midwifery. While the midwives express a preference to work as midwives only, they do acknowledge that they enjoy the variety offered by working in a dual role of midwife and nurse. While working across dual roles may assist midwives to become multi-skilled generalists, it also raises concerns about the potential for deskilling rural midwives who often spend more time performing a generalist rather than midwifery role.

This chapter, 'Making choices between professional role and lifestyle', discusses the concept of choice, and a lack of choice in relation to participants' professional and personal lives and how this impacts on the experience of the dual role of midwife and nurse.

Theme One: 'Because I choose to live here.'

This theme reflects the notion of choice, or lack of choice, that the midwives related to their reasons for working in a rural area and in a dual role, a concept illustrated by Christine's quote:

> *I'd prefer to just do midwifery but because I chose to live here that was what was on offer* (3:21-22).

There were three sub-themes that contributed to the main theme. These were 'Nothing you can do about it' which was characterised by the concept of no choice; 'Choosing to live rural' where the midwives express that the desire to reside in the rural area overtook the desire to be able to work as a midwife solely or, alternatively, that working in a rural facility across two roles is the deciding factor in living in the rural area. The third sub theme was 'You're a nurse first' which participants indicate impacts on choice due to the nature of the workload in a rural facility.

Sub-theme: 'Nothing you can do about it'

The lack of choice in how or where the midwife worked is reflected in this theme. In some instances restructuring or redevelopment of facilities or downsizing of services had increased the likelihood of midwives also caring for general patients and there was little or no consultation as to how this might work. Margaret already works in a dual role by choice, working some shifts in maternity and others in a surgical area, but feels that the midwives who usually only worked in maternity were given no choice as to how they now work:

> *…and they still had you know, a good few years working life to contribute and they would've done, but they were kind of told if you don't like it sort of thing then leave (1:16-19) …so they got their finances in order and went…they did*

say that they would have done maybe three days antenatal clinic…they still would have worked and they had all the experience (1: 62-66).

There is an attitude amongst most of the participants that there is no choice in what they do because of where they work. They accept that as they work in a small, rural facility with limited staff then it can be expected that they provide care for whoever requires it. Lesley notes that although she was recruited to a 'midwifery' position it was soon apparent that she was expected to care for general patients as well*:*

right, OK, this is not your choice but you're here and these people need looking after and what you don't know you ask (2:460-462).

Sandra also expresses a desire to just work as a midwife but concedes that:

I really don't mind because somebody's got to do it, I understand that somebody's got to do the job (8:13-14)… but you know, we do what we have to do because it's a small hospital and we've gotta do it(8:39-40).

This sentiment is echoed by Heather, who remarks:

I mean you just, you just get in and do it (6:48-49)

Similarly Lauren states:

I mean there's nothing you can do about it if, if you've got no choice (5:257-258).

Lesley is also accepting of having no option in her place of work, even though she believed she was recruited to work as a midwife only. She states:

I haven't got too hot under the collar about having to do general nursing… when I have to do it, I do it (2:255-256).

The conflict between the work of a midwife and that of a nurse is also apparent in many of the interviews. A majority of participants express a preference to work solely as a midwife but note that choice is not available to them due to where they work. Lesley sums up this feeling as:

> *…on the one hand, philosophically I totally object to it, but with the model of care as it currently stands, I don't think there's any option (2:368-370)…in summary my heart says no but my head says this is the way it is (2:854-855).*

Lauren also comments that:

> *if I was living closer to Cairns I would just opt for midwifery (5:211-212)… given the choice I would prefer to be in the one role (5:250-252).*

Participants comment that a lack of choice in where they worked, although accepted as part of working where they were, did impact on their job satisfaction. Christine was frustrated by the limitations put on her opportunities to work in midwifery due to her other roles as evidenced by the following quote:

> *I'm not **allowed** to be on call when I have a child health day the next day because if I'm out on call and I can't come in for 10 hours or whatever the break is and so I, I'm not on call that much because it's too hard fit in… I find that restricting, frustrating, 'cause I want to be on call because it's keeping my practice up"(3:308-314).*

Margaret explains:

> *I like that better* [being rostered to an area in advance] *rather than coming on and not knowing where I'm going to be, which has happened in the past and then going 'Oh, you gotta go to HDU' or 'you gotta go to A&E…(1:359-363).*

Sandra also resents this lack of choice when she perceived redeployment to other areas was

to fill someone else's gap then it, it's a bit difficult, I take offence at that (8:17-18).

Sub-theme: Choosing to live rural

The second sub-theme exemplifies the concept of making a choice, rather than having no choice. In this case the participants, though in the majority were not happy with working in a dual role and expressing a preference to work as a midwife only, accept the dual role as a necessary concession to living where they chose. This sub-theme was typified by the comments of Alison who states:

It's because where I live, where my family live and kids live and I've never sort of, I've worked in a couple of larger hospitals and I prefer the small country… (4:115-118).

In Alison's case, she enjoys her dual role and has always worked in that capacity as the desire to live and work in a rural community is stronger than a desire to work as a midwife only. It was not problematic for Alison because her work in the rural hospital fulfils both her desire to live in a rural location while giving her the opportunity to work in a dual role. She acknowledges that this need to work in a dual role did, however, impact on recruiting midwives to rural areas:

We have had a few midwives come through here and they haven't done clinical… general ward work for years. They're very reluctant to take on the position for that reason (4:89-93).

Most of the other participants, however, regard working in a dual role as more of a sacrifice they make that enables them to reside in a rural community. Christine remarks:

> *I'd prefer to do just midwifery but because I chose to live here that was what was on offer (3:21-22).*

This feeling is echoed by Lauren and Heather. Although Lauren states that if she lived somewhere where she could work only in midwifery this would be her preference, she appears rather pragmatic explaining:

> *I knew I was here to stay and I would learn to love it… to like it (5:262-264).*

Heather also comments:

> *... because I want to live where I live. I must and I need to work, so I work at X (6:6-8).*

Lesley admits that although her heart is in midwifery and she previously would have happily relinquished her general registration if she could, she accepts the change in her role as a necessity because of her location. Her relocation to a rural area was to support her husband's career:

> *my major role here, in coming to X is to support David and I've had to constantly not lose sight of that, didn't come for me, didn't come for a career move for me (2:245-248).*

Lauren also relocated to a rural area as she and her husband were looking for a lifestyle change and although her preference is for midwifery only she acknowledges the limitations of where she lives and the work opportunities available. In saying this Lauren is frustrated with a dual role and is seriously considering alternate options that may involve commuting or temporary separations from her husband, with his support:

Evan wants me to do midwifery because he knows that I'm not terribly happy, I mean, I can fit in anywhere and, you know, I do… I'm not as happy as I would be if I was doing mid… straight midwifery (5:216-220).

Sub-theme: 'You're a nurse first.'

This final sub-theme that contributes to the theme of 'Because I chose to live here', or the concept of choice/no choice relates to the acknowledgement by most participants that their first qualification was in nursing. They accept that because they have a nursing qualification they are required to work in that role due to staffing constraints even if that is not their choice. Sandra, the most recently qualified midwife, feels that going back to nursing was a negative experience:

...because I have done extra training to be a midwife and I think I've put a lot of extra effort in, I feel really as though I'm taking a backward step when they put me in, back into the nursing role because I feel that I'm a midwife now, not a nurse and I keep getting told 'but you're a nurse first' (8:4-8).

She does admit that there may be some advantages, in her current role, even as a midwife, to having been a nurse first:

I don't know that it's an advantage me being a midwife when I'm out on the ward but when I'm a midwife I suppose having been a nurse is an advantage(8:58-60).

For Lesley, acknowledging to herself that she feels first and foremost a midwife was important; it is also important to maintain her nursing identity when caring for general patients and reassure them that she was qualified to care for them:

I still feel like a midwife and I even say to the general patients, I say 'look I'm one of the midwives in the maternity unit but I'm working here tonight and so I'll be

looking after you and don't worry, I'm actually a nurse as well' (2:763-766).

Lesley concedes that she had come to terms with the conflicting ideologies because of what she felt she had achieved, returning to a general nursing role after so many years as a midwife only:

your heart's where your heart is and, like I really do still identify as a midwife and I think I probably always will but I'm quite sort of proud of myself a little bit, for accepting the challenges that I have accepted (2: 828-832).

For some participants, the necessity of working in a nursing role when maternity work was scarce conflicts with their preference to work as a midwife, even though they accepted the necessity to do so. Sandra commented that she found returning to general nursing difficult due to the different perspective on health and illness that her midwifery education had given her:

it's actually pretty hard going back to a ward after being in maternity and doing, looking at people differently. You look at people as well women, not sick people, so um, and it's really hard to get in the knack… (8:35-38).

Sandra also believed that her additional education and skills were devalued when not used and this would not be expected in other fields:

we are quite, as midwives I see us as specialists, and you know, you wouldn't get a specialist, I don't know, um, orthopod or something, delivering babies or you know, you wouldn't expect someone working in that section to just pick up and go to a general ward (8:144-148).

All but one of the participants states their preference would be to work as a midwife only:

> *I mean, I enjoy it most of the time but I would much prefer to just work as a midwife (6:5-6)… I don't really like it because my passion is for midwifery (5: 39)… I prefer to work in maternity, you know, just work as a midwife (6:72-74)… I really don't like working anywhere else now, it's just what I've chosen to be and… I prefer to just be doing midwifery" (8:130-134).*

Although admitting their preference to work solely as a midwife, most participants recognise that there are positive aspects to being a nurse as well as a midwife and having opportunities to use their general nursing skills. Christine comments that doing both nursing and midwifery:

> *keeps your...keeps you in touch with just general stuff whether it be you know, wounds, diabetes, blood pressures, heart attacks, things like that (3: 188-190).*

Helen also considered the benefits of working in both roles in that:

> *you see a whole broad perspective of the whole community and you.... It keeps up your skills, it gives you other opportunities to look to say, 'do you wanna do other things?' (7: 26-28).*

Conclusion

This chapter has provided an interpretation of excerpts from the participant's narratives and described the first of three themes that emerged from the analysis, that of 'Making choices between professional role and lifestyle': "because I choose to live here". This is one theme that contributes to the experience of working in a dual role of midwife and nurse in a rural setting. The sub-themes identified as contributing to this theme were 'nothing you can do about it' (no choice), 'choosing to live rural'

(choice) and ‘you’re a nurse first’. The next chapter discusses the second theme identified, ‘Integration of maternity and general nursing’: “All in together this fine weather”.

Chapter Seven
Integration of maternity and general nursing:

"All in together this fine weather"

Introduction

The second theme identified during analysis of the data is discussed in this chapter. This is the theme of integration, a mixing of maternity and general clients/patients within one area and the impact this has on the midwives. For some facilities this had been a long standing practice but for others it was a more recent phenomenon as maternity activity decreased or staff distribution was rationalised due to redevelopment of facilities. The sub-themes that contribute to this theme are discussed and supported by quotes from the participants.

Theme Two: Integration of maternity and general nursing

This theme was reflected by the quote from Margaret "All in together, this fine weather" where general and maternity patients are cared for in the same ward, in this case due to a hospital redevelopment, and the resultant disharmony and stress this created for many of the midwives. The three sub-themes that contribute to this theme are: Stress due to working across roles; 'it's not right', conflict with integration; and enjoying the variety.

Sub-theme: Stress due to working across roles

Many of the midwives stated that they found it stressful to care for both maternity clients and general patients. Lauren has worked in a dual role for the last five years but for fifteen years prior to that she worked as a midwife only and she comments that:

After fifteen years of working as a straight out midwife I found it very difficult to

adjust to combining the two, of being a general nurse and a midwife (5:5-7).

Margaret also expresses how difficult she found caring for both general and maternity clients when the maternity ward was integrated with a general ward after a hospital redevelopment. Although she voluntarily worked in two different areas of the hospital, she felt that when she was in maternity previously, she could focus on just caring for maternity clients. She was more concerned for colleagues who previously had not been required to work across roles:

…staff who were older midwives and had been there, had only been nursing in midwifery say for 35 years or something and there was really no in-service offered to them, to do both, they said, 'look we haven't worked in general for um 35 years, we've only worked in maternity', so they found it very difficult. And they still had, you know, a few good years working life to contribute and they would've done, but they were kind of told 'if you don't like it sort of thing, then leave' (1: 10-19).

Margaret is concerned about this impact on these midwives and the possible effect it had on retention of existing staff. She comments:

I just know the girls who are, want to, dedicate themselves just to maternity are ***not*** *happy working in general and maternity (1:443-445).*

Helen found that working across both roles could be quite stressful as she was often not sure what she would be doing or where she might be working from one shift to the next. She says:

…it varies from being stimulating to stressful, depending on the workload that you've got (7:4-5).

Her method of dealing with this stress was to try and enjoy what she did as a coping strategy. She relates:

I think the best bit, to enjoy what you're doing and doing both roles, you've gotta deal with what you feel capable of doing, otherwise it becomes too stressful (7:141-144).

Alison also notes the difficulties faced when having to work across various areas. She expresses similar thoughts to a number of the participants in relation to the likelihood of being required to be in a number of different places across the facility, caring for either maternity or general nursing patients within the one shift. She states:

…in the rural area you can be called any minute from the ward to A&E to um, a birth, so you're all over the place and it makes it, especially on shifts like night shift and that makes it difficult (4:105-108).

Another aspect of the integration of patients and requirement to work across areas that contribute to the midwives' stress was the perceived lack of support from the general nursing staff at times. They comment on the expectation in most places of work that they were required to assist in general areas when it was busy but this assistance was not reciprocated when they were busy. Margaret, for instance, describes what usually happens when midwives are busy:

…you were kind of just left there and if you had a delivery or whatever was happening, no-one seemed to bother with you and no-one would come and sort of say 'how are you today?' You know, 'are you OK with everything, is everything OK here?' (1:51-55).

She expands on this further in the interview, disclosing what she sees as an inequity in workload distribution at times, which had happened at more than one rural facility she had worked at:

…so the same kind of thing's happening in X, where they're having you know,

they're integrating the midwifery with the general, because if somebody arrests you're expected to go there and help, you know, on the general side and yet there's not too many, like if there's not enough people to help you in maternity (1:179-184).

Sandra also describes what she sees as a lack of support from general staff when the midwives are busy. She comments on the expectation that the midwives would assist the general staff but that this assistance was not given in return, whether as a matter of rostering or in busy or emergency times:

…if we got all postnates or something like that on the ward, but you know, if they haven't got someone to fill that role, we're the first people they will take from… and yet, you know, when we're flat tack and there's only two of us and we've got the ability to have two women in labour and three, four, five postnates, that's a lot of people to look after, just two people. So you know, nobody comes running to help us (8:23-31).

Margaret does acknowledge, however, that part of the reason for this lack of assistance could be fear or lack of knowledge on the part of the general staff:

They don't want to do it because it's too stressful and you know, they're sort of saying 'you're responsible for the mother and baby and we don't. We don't know enough to be able to do this, we don't want to do this' (1: 193-197).

This raises the potential stress that placing maternity clients amongst general patients has on the non-midwifery staff as well. Nurses who are not educationally prepared to care for antenatal or postnatal women may be fearful and avoid these women to prevent potential errors and are put in the position of working outside their scope of

practice. Midwives, in proclaiming their role as appropriate carers for these women, may exacerbate this fear or reluctance.

Sub-theme: 'It's not right', conflict with integration

A number of participants describe feelings of conflict between midwifery philosophy and the biomedical model of general nursing care that having to care for both maternity clients and general patients creates. For some, it also creates conflict with how they were previously educated as nurses and midwives and some of the principles that they had abided by for many years seemed compromised. This was particularly noticeable in Margaret's comments:

I still found that working in, on the general side was difficult because when we're really busy in maternity we've gotta find room on the general end to put patients from maternity so they. They're in with geriatrics. They're in with ah, and you know, if you've got people in there with infections… you know, they're, it's all in together it's just, I find it's not ethical. I feel it's not the right thing because me being an older midwife, I've grown up with the fact that you know, you don't mix the general and maternity and so I found that was, you know, I couldn't get used to that idea (1:25-34).

Margaret comes back to this concern a number of times throughout the interview and it seems particularly problematic for her to accept. She reiterates:

…you can be there looking after somebody that might have an infectious wound or something and then you've got to leave that person and go to maternity and deliver a baby. You don't have, you don't have, you know, a shower or change of clothes or anything like that. I find that's not, that's just not how I was taught as a midwife.

In my day they had it totally separate and there wasn't any way that they were going to have it together… I don't think it's right and I know a lot of the other midwives that work down there don't like it (1:297-310).

Lesley also expresses feelings of conflict between her philosophical beliefs about her role as a midwife and what she was required to do in her working role. She says:

I mean, I thought I'd hate it, I thought I'd really hate it and I, and the philosophy is not to do it (2:242-244).

Although there was this philosophical objection from Lesley, she accepts that this was the reality of how she would have to work in this facility within current models of care and staffing constraints:

…as I said, I'd rather not have to do it, you know, from a, um 'I'm a midwife' perspective but that, that's one side of the argument I've always leaned towards for many, many years and I mean, there's going to be a time it, it will have to change eventually 'cause there's gonna be a time with direct entry when they won't be employing anything but midwives (2:450-456).

Conflict with patient/client integration also caused frustration for the midwives, impacting on how they worked and on their perception of appropriate care for women, particularly those who were in labour. Both Sandra and Margaret work in facilities where maternity used to be a separate unit but after redevelopments, both had been combined with general wards. This creates frustration and stress in their role as a midwife, caring for women in labour who were in close proximity to medical or surgical patients. For Sandra, who was the most recent graduate of midwifery and had been used to caring for labouring women in a defined birthing suite area this was

particularly frustrating and though she hadn't previously worked as a midwife in the facility she now worked in prior to its redevelopment, she had worked there as a nurse and had experienced how it used to be.

> *The women had privacy, you know, they had, they could make as much noise as they wished and it wasn't bothering… and now our birth suite borders like, back to back with surgical ward, like their, their closest ward, closest to the nurses' station. So the sickest patients are in there putting up with, you know, what goes on in maternity wards (8:213-218).*

Margaret also finds it difficult to care for women and babies in close proximity to people who are sick. The noise in particular creates stresses for her, working in that environment:

> *There's two rooms there that we use for maternity patients **but** then the rest of it's general, so those crying babies can be heard right up there, right…**and** when we have to integrate them throughout the ward (1:489-492).*

Margaret also is concerned about lack of privacy for labouring women and how this impacts on sicker patients. She describes it as:

> *…if the lady's labouring and they're screaming and you know, some of them **are** screaming, they're literally screaming. Well, it's kinda heard everywhere (1:462-465).*

Additionally, Margaret is frustrated about the changes in practice that integration has brought about in the routine ways of working since the facility was redeveloped. The Nurse Unit Manager of the ward, in an attempt to encourage integration and reduce the sense of difference or exclusivity between the previously two separate areas,

insists on all staff participating in one handover report at each shift change. Margaret is frustrated by this practice and sees it as less than useful for both groups of staff. She says:

> *You've got to have **one** report, so all those girls who are getting report about the general patients have also to be listening about what's happening in maternity. Even when we are extremely busy in maternity we are still there, having to listen to the general report, which we **know** we're not going to be general for that day. We are **gonna** be in maternity 'cause it's busy… our NUMs adamant that we **have** to get this handover and that we can't have our, a mid handover in our, in you know, in the mid section 'cause that's dividing it. Its one ward, regarded as one ward (1: 389-407).*

She also feels this would be frustrating for the general ward staff as well:

> *They're not understanding what's going on with maternity but they've gotta sit there and listen to the mid handover that they don't understand anyway (1:409-412).*

Sub-theme: Enjoy the variety

Only one of the participants expressed a preference for working in a dual role, as opposed to midwifery only, if this was an option where they worked. Though all others said that given the chance they would prefer midwifery only, most commented on the fact that they enjoyed the variety that the dual role offered. Alison, the midwife who had always worked in a dual role and expressed a desire to continue to do so and made several comments about the role and why she preferred it:

> *It's the only thing I've ever done so I, I just enjoyed it was a nice, um, you know, variable work, it was never the same thing…(4:23-25). I've never stuck in one*

stream. I've always worked in rural areas and it's always been a mixture. What comes through the door! (4:40-42). I've always done it and I've always enjoyed it, I've always enjoyed the diversity of the rural area (4:52-54). I think I would prefer to have the dual role (4:123-124).

Christine initially said that given the choice she would prefer to work as a midwife only but early on commented as well that:

Well I like doing the dual role in some ways, in other ways, because you keep your skills up with other things (3:29-31).

As the interview progressed she explains that aspects of the dual role such as the variety of the work and the potential for a more holistic view of patients also appeals to her:

I think of just working in one particular area, I think I'd get very bored. I actually like working across the board (3:232-233). I'm just lucky that I've got a role where I can do everything (3:264-265). I think that having worked in all the different departments and still doing that now, I like that because it does every now and then open my eyes up to other things and, relating to people (3:357-360).

Other participants find that although the role is not something they had planned to do, they see it as a necessary aspect to working in a rural area and over time have come to enjoy it. Lesley, although saying early on in the interview that her heart was not in general nursing, then states:

I've actually learnt to really enjoy it (2:77-78).

Margaret also expresses that the variety of the dual role had become appealing to her:

I quite enjoy the variety, I do quite enjoy that (1:373-374).

Helen also explains that working in a dual role gave staff an opportunity to expand their knowledge and horizons. She says:

> *…gives you other opportunities to look and say do you wanna do other things (7:27).*

Helen also sees the variety in the role as a positive contributor to teamwork within a small hospital. The chance to work in various areas gives staff a better insight into what the roles are in each area. She said:

> *…it can be really good on quiet days 'cause you've got, you see the other people, you help out the other nurses, it's the networking as well and it's…they feel, I think they feel valued if you go down and help them when you're quiet, it's good team working I believe, good team building (7:10-15).*

Helen also expresses the belief that working across different areas in one rural hospital helps with team work as it increases staff skills in a variety of areas, but also gives an understanding of individual preferences or strengths and weaknesses. She says:

> *They know what you can do and when you say 'I can't do A&E but I'll do surgical while you go out 'cause I can do that', then we give and take a bit (7:148-150).*

Conclusion

This chapter has discussed the second theme identified through the analysis of the data, that of 'Integration of Maternity and General Nursing. This theme was comprised of three sub-themes: stress due to working across roles; conflict with integration; and enjoying the variety. The next chapter will discuss the third theme identified, that of Shaped by Location: "that's part of working in a small place"

Chapter Eight

Shaped by location:

"That's part of working in a small place"

Introduction

This final theme highlights the positive and negative aspects of living and working in rural areas, as described by the participants. All participants made frequent references to how working in a rural hospital impacted on the way they provided care, the resources they had, or more often lacked, and the benefits of belongingness and continuity, that is seeing families throughout the life span, afforded by being part of the local community.

Theme three: Shaped by location

The quote by Christine "that's part of working in a small place" typified the characteristics of this theme. The Participants spoke of limited resources, both human and material, and how they managed in this situation. The theme also makes reference to the broad skills and knowledge base required to work in such an environment as well as the collective community involvement experienced by the participants. The three sub-themes reflect these attributes and contribute to the theme. The sub-themes are: sense of belonging to a community; "you deal with what comes through the door"; and limitations of working in a rural hospital.

Sub-theme: Sense of belonging to a community

The concept of community was represented by a number of aspects of the midwives' narratives. Continuity of care and carer is a central concept of current midwifery philosophy, and refers to the idea that a woman has a known carer throughout

pregnancy and birth as well as the early postnatal period. Continuity of care is thought to assist the development of a partnership between a woman and the care provider which helps to enhance choice and communication (Pairman, 2006). Participants in this study took the continuity of care concept further talking of the continuity of care throughout the lifespan, which they attributed to living in a small rural town and working at a small rural hospital. Continuity of care was therefore linked to being both a midwife and a general nurse, as described by Christine:

> *…having been the midwife and then seeing people after they've had their children and say they bring their child into emergency that, I think has been handy because they know you, you know them, but that's part of working in a small place, isn't it? (3:63-67).*

Christine expands further on this idea and explains how providing continuity of care afforded her better insight into a person's background and history:

> *When you get someone in emergency and you've already seen them and you know what their home situation's like or you know… people can sometimes make judgements about people and you might know that person better to say, 'well, you know this is what's happening' or 'actually they're, they **are** a good parent', that this is a good mother, the situation she's in may not be good but the mother herself does care for her children (3:79-86).*

She also thinks providing continuity of care enables her to be more holistic in her assessment of someone presenting to the hospital for care compared with someone who worked in only one area or capacity. She says:

> *On the wards or emergency, I don't know, they seem to hone in on just what they've come in with whereas you might know a bit more of a holistic picture because you know what the home situation is (3:70-73).*

Seeing a woman through both the continuum of her pregnancy experience and then providing ongoing care to her children, was also described as a positive experience that enhanced the practice of the midwives working in a dual role. Christine describes:

Someone that's got four children and I've seen her through every one of her four children. I haven't been there for any of her births but, you know, I've seen her before, I've done antenatal, I've seen them afterwards and I follow the children up now, do immunisations and growth assessments (3:94-98).

Alison also enjoys her involvement throughout the lifespan of a family and says:

I think the continuum of care through all the stage of pregnancy, including the birth and the after care and then the after care of the baby and as the baby's growing up it just gives you that sense of community involvement in a rural area (4:47-51).

Due to the length of time Alison had lived in the one community she had not only experienced continuity of families but also generational continuity in care provision, an aspect of her working life that she enjoyed:

I'm birthing second and third generations now which is really nice (4:12).

Helen notes that being able to follow up children as they grow is a rewarding aspect of her role to which she would not have been exposed if she worked only in a midwifery capacity. Continuity of care provision helps to answer questions about long term outcomes for children that otherwise may have remained unknown. She says:

I've come across some of the little children that we know have been delivered and have had, you know, problems at birth, a very flat CTG and where you wonder, I

wondered as a midwife, whatever became of that baby and what was their…? I could see that, being out there now (7:62-67).

Margaret works in both the operating theatres and maternity on a regular basis and this allows her greater continuity of care across an admission than if she worked in only one area. She comments:

I like it too because if there's a patient in maternity that's gotta have a Caesarean then I can sort of follow through that patient, it's the same patient that's coming through theatre, so for me it's a bit of a follow on (1:376-379).

Another element of this sub-theme is the expectations of women in relation to their pregnancy, when living in rural towns, and their desire to birth locally. Even when local birthing may be discouraged for clinical or risk assessment reasons, it does still occur. A number of midwives commented on women who were determined to remain in their home town to birth and how they used a number of strategies to achieve this. Lauren works in a facility that supports very low numbers of low risk births. In response to women desiring a birth in their home town who don't 'qualify' to do so, she comments:

Most of them are pretty clued up, the women. They know not to come in with their first contraction, too early, … even the hard, the ones that should be going, you know like the Gravida 8's and things like that, you know, they will, they ***want*** *to have their baby in X and so they do and things go alright you know, you prepare for them to go wrong and they go right so it's good (5:117-124).*

Alison also describes the issue of women having to relocate to birth as the hospital she works in no longer has a birthing service. However, she explains that some women in the community do not accept this policy and still prefer to remain at home for the birth of their baby. She says:

People, the community of X has always…you have your babies in the X Hospital, why should we have to go to Cairns? (4:175-177).

Earlier in the morning that I conducted the interview with Alison, a woman had turned up in advanced labour, too late to transfer. Alison acknowledges that this would have been a deliberate decision on the part of the woman. She says:

*Like Vanessa, who delivered this morning, she wouldn't **think** of going to Cairns. She's had all her babies here and that's it (4:203-205).*

Margaret also has similar experience from a previous job in a small rural hospital that only conducted small numbers of low risk births. In the case of a woman who presented too late for transfer, she comments:

…she had a good experience with her first baby and wanted to come back to X Hospital for her second baby (1:165-166).

The notion of support also contributes to this sub-theme in that there is a 'community' amongst the rural staff that creates a network of support for each other. Lack of staff, particularly in the case of emergencies or unplanned leave, is a chronic problem for many rural facilities and a reliance on staff goodwill to 'fill the gaps' was described. Lesley speaks of an emergency situation that required additional staff to manage, saying:

I had to spend a bit of time but I had no trouble getting staff to come in… people were very, are very willing to drop their lives and just come… they've been there

themselves and they know that, you know, you actually have to rely on people to come in (2:648-658).

Lesley also felt that the staff support for each other, and teamwork was enhanced in the rural areas by virtue of the limitations they all faced. She described it as:

…from a collegial midwifery point of view it's a very tight little team and the midwives support each other, you know in big city hospitals there's always the back stabbing, there's always the 'oh she shouldn't have done that'… that doesn't happen in X. There's an attitude of 'she did her best with what she had at the time with the decisions she had to make'. The midwives are all very supportive of each other (2:662-669).

Sub-theme: 'You deal with what comes through the door'

'You deal with what comes through the door' is a sub-theme that describes the skills and knowledge required both to work in a rural hospital and across dual roles. The acquisition and maintenance of the broad range of required skills and knowledge were discussed in both a positive light, as in the attributes of being multi-skilled, as well as from a negative perspective, where sometimes a loss of confidence ensued from trying to be all things, to all people, at all times. Flexibility or versatility was viewed as a key attribute to working across roles in this environment. Margaret comments that:

…although I'm very flexible I can work in any area that they put me in, they call it multi-skilled (1:21-22).

She added that this ability to be multi-skilled could have negative consequences for her as well:

I know I am multi-skilled and very flexible, and I, and I do it and it doesn't concern

me greatly but I don't like it because I know I've been to all, some, all departments in the hospital like, in my eight hour shift (1:69-73).

The ability to be multi-skilled was actively fostered by many participants as they saw it as a necessary requirement of their roles. Christine describes her various roles to demonstrate how she maintains a broad skill base. She says:

…so I do child health for three days a week and I do the antenatal clinic and classes one day a week but I alternate that with working in the emergency department when the other midwife is doing it so I'm still keeping my skills in, um that sort of nursing, general nursing area, plus putting drips in and taking blood (3:33-38).

Strategies are also employed to facilitate the development of multi-skilling rather than responding in a reactionary manner to staffing issues. Lesley details the rationale for rotating staff to a number of different areas in the hospital where she worked to ensure appropriately qualified staff were available. She said:

…when maternity is quiet you've gotta utilise the staff. When the general ward is, and you need people to be multi-skilled so you can't just have it like 'Oh my god, suddenly we gotta put midwives in Ward 2'. You've gotta have the midwives rostered regularly to Ward 2 so they get their skills up (2:58-62).

Being multi-skilled and working across roles also influences the perception of how busy a shift might be. Alison describes a time when she worked only as a midwife for a period as less challenging, because she was in the one role:

I worked as a midwife in Cairns Base, I took myself down there for three months a couple of years back just to keep up my skills and I found that it was very, very, it was extremely busy, Cairns Base Hospital maternity ward but it wasn't such a, it

wasn't as busy as the rural area because it was all the same thing (4:99-104).

A number of midwives commented on the variety of their work and how this required them to be multi-skilled as it is often difficult to plan exactly what might occur in the facility and what staff you may have available. Margaret recalls a situation one night duty shift when there was only she and an enrolled nurse in the hospital and a woman arrived in labour.

…she wasn't there long, just long enough to get the paperwork sort of sorted out and she wanted to push and I was faced with this breech! And, anyway it all turned out OK but it certainly was, I had my heart thumping for a while, yeah and then to get it all sorted out and then have these two chest pains come in and the guy arrest (1:167-173).

Alison has also experienced similar situations that required her to manage a number of different clinical scenarios with limited support. She says:

You're conducting a birth or going through a birth and it's night shift and there's only three people on. All of a sudden you get the phone call to say that the ambulance is coming in with a motor vehicle accident (4:63-67).

Midwives often allocate workloads depending on both skill mix of available staff and clinical requirements of a variety of patients or clients. Patient allocation was often revised over the course of a shift as the needs of differing client groups dictated. Heather describes strategies she uses to deal with a busy shift:

There'd be busy days when the, like the mid girl needs stuff done and the general side is very busy and… yeah I still try and sort of manage to get it all done, but then, like a lot of times, like the ENs there can do a lot of stuff as well. So they'll help me with the general stuff so that I can look after the, do what I have to do (6:59-64).

Alison also recalled times when she was required to change focus and hand over care of one group of patients to deal with a new admission. She said:

So if you had a, a mid patient came in, in labour, then you would drop all your work onto the other staff who were on the floor and you'd go and concentrate on your birth (4:15-17).

Many of the participants comment on the need to have a broad knowledge base across both nursing and midwifery. Margaret concedes:

Well I certainly have to know a lot more because you're not just working in one area, you know, you're working in maybe two or three… you know you have to be aware of a lot more and have a lot more knowledge I feel, because you've gotta perform in some other departments (1:91-96).

There was an acknowledged necessity to maintain continuing professional development (CPD) across both nursing and midwifery. Both Lauren and Heather expressed the need undertake continuing professional development activities focused on general nursing even though both would prefer to work solely as midwives:

I've done my RIPRN [Rural and Isolated Practice Registered Nurse] ***only*** *to help me with my general training and because I look after A&E as well (5:46-47).*

…and I've as well gotta learn about, like cardiac stuff and all that, everything else… most of the in-services that I tend to go to are, or that I can, tend to choose are pretty much midwifery based, but I've got to go to other ones as well. So you sort of, I think you probably having to go to a lot more in-services (6:103-109).

One of the main concerns for a number of participants was the potential to lose skills or confidence, particularly in relation to midwifery, through the reduced exposure to the actual provision of midwifery care. Several participants note that due to maternity services being reduced in some places, or their ability to work with maternity clientele was reduced, maintaining skills and confidence was threatened. Heather works in a small facility that has a low number of births, a smaller number than in past times. She expresses her concern:

> *…because at the moment we don't have many maternity patients, I feel like I'm losing my skills 'cause I'm not doing it all the time, every day (6:102-103).*

Helen has less opportunity to care for midwifery clients now and she also comments on her concern for her potential loss of skills:

> *I think you, for me as a midwife, I feel I've lost a bit of the **real,** the confident in my skills because you don't just do that only… I do more of the nursing than I do midwifery at this stage, so where before I was focused only on midwifery and that was my, my real joy and love, I find now because I do more of the other I'm a bit less confident in my midwifery practice (7:34-40).*

Helen also thinks that the multi-skilled nature of rural practice could potentially contribute to a loss of her skills as a midwife. She describes a practice of rotation of most staff so that they are able to function across a variety of areas at the hospital but thinks this may be at the cost of losing expertise. She says:

> *…well you then lose your experts in your field as well in a rural area, so there's some, you now level 2s and that can stop in their own areas so they become the expert and the rest all move around…doing the dual role, you lose that expertise in your field (7:197-202).*

Sandra commented that this was also a potential problem for general nursing knowledge and skills when she first returned to the dual role after completing her midwifery. She says:

I found it's amazing how quickly you forget things, when you're working in maternity rather than the wards (8:116-117).

Sandra acknowledges the reverse once she was back in the dual role, with regard to midwifery skills:

You kind of lose it if you're not doing that all the time, you lose a certain amount of your skills (8:123-124).

Sub-theme: Limitations of working in a rural hospital

The limitations of working in a rural hospital is the next sub-theme described by participants. There were a number of recurrent topics raised throughout the interviews that typify this sub-theme, the most frequent being staffing limitations. All participants made mention of the fact that staffing is often an issue where they worked. There are issues with both the number of available staff and the staff skill mix, particularly in relation to providing maternity services.

Lack of midwives in all of the facilities where this study was undertaken, was an issue for those interviewed. Lesley comments that:

...like if you get two midwives on a shift you're lucky. You usually get a midwife and an EN (2:47-48).

The situation was the same for Lauren, who says:

One midwife, one registered nurse, this is me working at night and an enrolled nurse (5:11-13).

In the facilities where both Heather and Alison work, the shortage of midwives is such that on some occasions there is no midwife rostered on duty, and one of the strategies that has been implemented to address this is putting a midwife on call. As Heather says:

> *Hopefully, but not always* [response to the question 'is there always a midwife on?']. *And then sometimes someone has to do call, yeah (6:145-146).*

The increasing need to be on call to cover service was also noted by Alison:

> *...if need be we'd have to call other people in. That's definitely the case now because we're really short on midwives (4:18-20).*

Christine worked at the same facility as Alison and the shortage of midwives was also a concern for her. She said:

> *...the other midwives are all a little bit older than me, except one who does night shifts. I don't know quite what's going to happen once those people retire (3: 270-272).*

This shortage of midwives has implications for the staff working in the hospitals and the service they can offer to their local community. Lesley talks about having to structure certain tasks around staff availability. She related a case of a baby that had a congenital anomaly requiring a naso-gastric tube and said:

> *Changing the tube, you **really** needed two midwives to do it and you just don't have two midwives unless you wait to changeover of shift or, or whatever (2:317-319).*

Alison has implemented education for the non-midwifery staff as a strategy to try and address the shortage of midwives in her hospital. She relates:

> *It's a bit of a struggle for us here with midwives... I'm doing some teaching with the non-midwives to show them how to assist with an unplanned birth (4:79-81).*

The hospital that Alison works at no longer provides a birthing service and this has contributed to difficulties in recruiting midwives, but also impacts on those still working and the community as a whole. As Alison tells it:

You explain to the community why they can't birth here, but they don't see that and they won't see it until after something goes wrong... it takes up a lot of our resources if we have to send a midwife down in an ambulance with these people (4:179-183).

Though women who live in the same town as Helen can still access a local birthing service, at times this is sporadic due to availability of staff. Helen is aware of the implications of reduced services and says:

It'll get worse too 'cause they keep taking all the regional stuff away. We've got... we had trouble a couple of years... oh last year, because the people that did the, the doctors doing obstetric cover were from the hospital only and so if they were away, you know, like the two that were doing midwifery, they were away, then you didn't have any cover for a weekend, and everything, doesn't matter who come in, unless they were like Gravida 3 Para 2 and had nice normal deliveries, were sent away (7:265-273).

Helen feels for the women of her community when this happens. She says:

And that's really devastating when you get these poor people that come in and expecting to deliver and they've done all their antenatal, done everything right, seen the birth suite, and you come in and say 'look, we've got no cover, we'll have to send you to Cairns' (7:283-287).

Lauren is also reluctant to have to transfer women when she feels there is no clinical need. At the hospital where she works, small numbers of planned low risk births occur but this is highly dependent on available medical coverage. Lauren discloses:

If there's no obstetric trained doctor, you, I usually do keep them [whispered], *but a lot of people will, a lot of the staff will say 'Oh, Dr So and So doesn't know any obstetrics, you'll have to transfer your patients to X (5:114-117).*

Medical support varies as discussed above; however a number of participants voice concern that without medical back up, services could not continue and therefore were further threatened. Margaret expresses concern at possible doctor fatigue. There being only one available, she was hesitant to call him, possibly even unnecessarily. She states:

You gotta know, you know, when to get the doctor and the same thing happened in X, like 'cause there's only one, at that time there's only one doctor so he's on call 24 hours a day (1:207-210).

Helen feels that the presence of a 'good' doctor enhances the safety of the service provided. She conveys her feelings thus:

But the main thing with obstetrics is having a good doctor. A good person that you know will... knows what's going on and will cover you and that and watch and be there when you want him and then you don't have any worry, you could, you can risk a few things 'cause you know they're smart and they know when to step in. 'Cause you're only as safe as your doctors and how often do you feel unsafe and think 'oh, Lordy...' (7:305-317).

Lesley concedes that she felt the practice of the doctor where she worked was not current and evidenced based, but that she weighs up the risks of following his orders with the potential loss of service and says:

But then you kind of realise, this is X, if we didn't have Larry...Larry's very committed to obstetrics, he gets you out of many a scrape. He's not perfect, but if we didn't have him, we wouldn't have a service (2:524-528).

The issue of available support or back up in rural areas is also discussed by a number of participants. Margaret talks of how she missed having two midwives on a shift to be able to discuss things or get a second opinion. She comments:

Yeah, it's support too, for you like, you can't, sometimes you just want another midwife to say 'Oh, what do you think?' you know, 'what do you feel on that vaginal examination? What do you think of this CTG?' (1:235-238).

Margaret feels this lack of on-site support adds to the pressure she experiences as the only midwife on a shift. She says:

Yeah, so I think there's a lot extra, you know, that you have to have, you know – stress that you are having because you don't have that other midwife to help you, or to... bounce things off (1;248-251).

For Lauren, working night shifts in a facility that is staffed only by herself and an enrolled nurse, the availability of back up is particularly important. She feels confident that there is sufficient staff she could call on if required. She comments:

But if we got into strife and had a 28 weeker in labour, we can easily call the DON or NUM in to help, oh and the doctor, the superintendent, depending on who the doctor is (5:33-36).

As a referral hospital for these rural sites,, Cairns Base provides some outreach services and telephone advice to practitioners in the rural areas. Midwives in the rural hospitals had asked me in the past to try and set up some sort of avenue for phone advice, for example ringing the Birth Suite in Cairns for advice if needed. This has been difficult to establish as workloads at Cairns means that there is not necessarily anyone available to give advice over the phone if the Birth suite is busy. Medical staff or midwives do ring and refer or seek advice for situations that may be outside the scope of their practice, but midwives are reluctant to ring to 'bounce things off' someone as they are aware of the business of the unit.

A number of participants comment on the differences between working in a small rural hospital and a larger regional or city hospital. Margaret says:

> *That's different in a bigger hospital, where you got a lot more at your fingertips, you know? You can just call somebody to come... (1:508-510).*

Lesley also compares what is was like working at a large city hospital, her previous location before moving to this rural town and how she works now. She describes it as:

> *In Brisbane, you had a problem, you walked out the door, there was a doctor in the corridor, say 'I want you in here to have a look at this' or 'come and see this patient' or whatever. Two o'clock in the morning in X, you're by yourself, you've got a problem, you've gotta think 'OK, I've gotta ring a doctor, I'm gonna wake him up' (2:613-619).*

For Christine, it is frustrating at times that staff at the referral hospital do not seem to understand the implications of what she is dealing with when she calls for advice or to organise transfer of a patient. She relates an occasion where she transferred a woman

in labour and the reception given to her by the Birth Suite staff in the referral centre was not supportive. She says:

> *...when people work in one particular area, that's it, they think that's it, they think they know everything. I have to say when you're up here with an emergency or you've been given a situation to deal with, we just have us sometimes, we have to* ***wait*** *for the doctors to come in and they don't realise the responsibility you have up here, you know, you've got all your doctors running around you down there. I get a bit upset with that really (3:317-324).*

Christine also recounts a scenario where she had transferred a woman with seriously high blood pressure to the referral centre. The time required to transfer from where she lived to Cairns was over one hour; by the time she arrived the woman's blood pressure had settled somewhat. She details the response she received as:

> *I got called in and I had a woman with high blood pressure... did all the things I had to do... transferred her down there. When she got down there her blood pressure had settled and they're going 'well, was it really up?' This is what they said to her and I felt like saying 'Were you up there at the time?' (3:332-338).*

Conclusion

This chapter has described the third theme identified in the experience of midwives working in dual roles as midwife and nurse, that of 'Shaped by location'. This theme is comprised of the three sub-themes: sense of community, 'you deal with what comes through the door', and limitations of working rural. The following chapter discusses the findings outlined in the three preceding chapters in relation to the current literature and policies. The chapter then describes the study limitations and identifies the implications for further research, education and practice.

Chapter Nine

Discussion

Introduction

The aim of this study was to investigate the experience of midwives working in a dual role of midwife and nurse in a rural area of Far North Queensland, Australia. The research question, "What is the experience of working in a dual role of midwife and nurse in rural Far North Queensland?" was explored using a hermeneutic phenomenological approach guided by van Manen's (1990) methods of analysis and interpretation. The themes reveal that rural midwives experience their choices in how they work, as limited by location, and by being re-deployed to general areas of nursing. Conflict arises because of the need to work between two models of care: the biomedical model that tends to dominate generalist nursing and medicine, and the partnership-wellness model of midwifery. While the midwives express a preference to work as midwives only, they do acknowledge that they enjoy the variety offered by working in a dual role of midwife and nurse. While working across dual roles may assist midwives to become multi-skilled generalists, it also raises concerns about the potential for deskilling rural midwives who often spend more time performing a generalist rather than midwifery role. This chapter discusses the themes that emerged in relation to past research and scholarly literature where available.

In conducting a phenomenological research study guided by the tenets of Heideggerian phenomenology it was not possible to put aside my own beliefs and background, or 'historicality', in total. Hence, I reveal that my own background and experiences have influenced the interpretation of the data (Koch, 1996) to some degree. Interpretation of the data required engagement with the hermeneutic circle

which included not only moving between the parts and the whole of the data but also incorporating my reflective notes. Using this cyclical reflection allowed me to identify where my personal philosophy of midwifery could potentially influence how I interpreted the words of the participants. Furthermore, it was important for me to acknowledge my passion, and preference, for midwifery over nursing so that it did not mislead my interpretation. I attempted this task during the analytic phase of the research. Importantly, acknowledging my being in the world links to van Manen's existential concept of relationality, or how I related to the participants and how their stories influenced the perspective of my interpretation.

Overview of themes identified

There were three main themes identified in this study, each comprised of a number of sub-themes. The themes cannot be considered individually or in isolation as each is intertwined with the others to provide an overall interpretation of what it is like for rural midwives to work in dual roles as midwife and nurse. The three major themes that emerged from the data were "Because I choose to live here", "All in together this fine weather", and "That's part of working in a small place". Each of these themes reveals participants' experiences, an aspect of what it is like to work in the dual role of midwife and nurse in a rural area.

Making choices between professional role and lifestyle: "Because I choose to live here"

This theme comprised the sub-themes of choice, lack of choice, and being a nurse first. The first sub-theme, choice, was characterised by quotes from participants Alison and Heather when they comment that they choose to live in rural areas because

they prefer it, or their families live there. They chose to live in a rural area but need to work, so accepted the work available. These statements typify the concept of making concessions in the type of work in which the participant engaged, even if it was not a preferred option, because the desire to live rurally was stronger than the need to work as a midwife only. In other words, in making a decision to live in a rural area, lifestyle and /or social factors were valued over the type of employment available. Hegney and McCarthy (2000), in their survey of the job satisfaction of nurses in rural areas comment that family or social reasons often influence recruitment to rural areas. As outlined by Hegney et al. (2002b) and Molinari and Monserud (2008), a rural lifestyle is something that is generally appreciated by nurses that live in rural areas, and it is often the rural lifestyle that serves to lure nurses to the area rather than the opportunity to work at the health service itself.

Although there is nothing specific in the literature that explains why midwives choose to work in rural areas, other than because of family relocation, one could presume that factors that are appealing to nurses, such as those identified in a research study by Hegney et al. (2002b), and nursing and medical students in the research conducted by Kaye et al. (2010), may also apply to midwives. These researchers identify that in general, nurses are more likely to be attracted to rural areas if they have a rural background or experience a rural placement as a student where they are exposed to the positive lifestyle often afforded by rural settings. Previous exposure to 'living rural' is observed by Daniels et al. (2007), Robinson et al. (2010) and Kaye et al. (2010), to enhance recruitment and retention of health professionals to rural areas. The importance of nurses' rural background was also identified in a study of rural nurse job satisfaction by Molinari and Monserud (2008). In this study, however, the

majority of participants had not come from a rural background yet sought out the rural lifestyle for various other reasons such as family relocation. Robinson et al. (2010) in their study of procedural GPs in rural Victoria also identify that the desire for a rural lifestyle, more holistic patient care and the challenges of procedural medicine in rural areas serve to attract GPs to rural areas.

However, it is clear that for participants in this study, decisions about working in a rural area were also linked to the need to relocate or remain because of partners' work commitments. Supporting partners or other family members was thus identified as a reason for relocating to a rural town, which Lesley illustrates when she states that she had made the move to the rural town to support her husband's career. Family or social reasons for relocation were also found to influence nurses' recruitment to rural areas in the study of job satisfaction in Australian rural nurses by Hegney and McCarthy (2000). Conversely, it may be the case that a midwife's relocation or decision to remain in small rural towns could be reversed if their partner's employment situation `changed.

The second sub-theme identified indicated lack of choice or the notion that there was 'nothing you can do about it', referring to the majority of the study participants' preference not to work in a dual role as a nurse and midwife. Rather, participants believed they were faced with a situation where they had no choice in assuming a dual role by virtue of their place of work. Although participants primarily expressed a desire to work solely as midwives, they were also quite accepting of the need to work as nurses as well because they worked in a small rural hospital.

The literature contains multiple references to the requirement for midwives to work as nurses in rural areas, reflecting the generalist nature of rural nursing (Mills, et al., 2010; Montour, et al., 2009; Reiger, 2000; Wilkinson, 2002), yet to date there has been no attempt to unravel and describe what it is like for midwives when they are required to work in generalist roles or how it makes them feel. This study has highlighted that for most rural midwives, a dual role is not something they would choose if they did in fact have a choice. However, it is clear these midwives recognise the need to work in a generalist rather than a specialist role as part of the reality of working in small rural hospitals. Lesley describes herself as having a strong midwifery philosophy but acknowledged that the dual role of nurse and midwife was an inevitable result of current models of care. It is possible that health care professionals' roles may become even more blurred in the future as a way of meeting the shrinking rural health workforce. If that becomes the case, the need for midwives to work across roles and to be prepared to accept a generic role may become a more common occurrence. A multi-skilled workforce may in fact be the reality of the future, as health care in rural areas is moving more towards a situation which tends to favour generalist roles over specialists (Hegney 2000; Henwood et al. 2009).

The third sub-theme under the choice theme is between professional role and lifestyle or, 'you're a nurse first'. This sub-theme is an acknowledgement by participants that they had first been nurses before they were midwives and they could see the requirement for their nursing expertise to be used, even if ultimately they would prefer not to *be* nurses. The creation of a dual nurse/midwife identity through the traditional education pathway where a nursing qualification was necessary prior to going on to undertake a specialist qualification in midwifery, has been noted by both

Reiger (2000) and Brodie (2002) as a potential source of job dissatisfaction for midwives. Job dissatisfaction is clearly linked in the literature to issues of retention of nurses, and is a particular problem in rural areas (Aiken, et al., 2001; Bartram, et al., 2004; Hayes, et al., 2006; Hegney & McCarthy, 2000; Hegney, Plank, & Parker, 2006). However, lower job dissatisfaction in rural areas in Australia may also be linked to the requirement of high working hours for rural nurses. Recent data suggests that nurses in rural areas work considerably longer hours than their urban counterparts (Australian Institute of Health and Welfare, 2009). This was reflected in my data in some facilities where the burden of being on call to support services is increasing. In addition, opportunities for specialisation and career advancement may be minimised in rural and remote communities, which can negatively affect job satisfaction (Penz, Stewart, D'Arcy & Morgan 2008).

Some of the participants in this study express concerns that their skills as a midwife are not being fully utilised or appreciated. This sentiment is echoed by Duffield and O'Brien-Pallas (2002) in their comparison of issues facing the nursing workforce in Australia and Canada. The authors comment that the expectation of specialised nurses to be multi-skilled compounded workforce shortages through its effect on job satisfaction and query whether there would be the same expectation of medical staff. They ask the question: "In the year 2001, would we ask cardiothoracic surgeons to undertake neurosurgery?" (Duffield & O'Brien-Pallas, 2002, p. 140). Conversely, effective utilisation of the midwifery workforce through the implementation of midwife-led models of care that allow midwives to work only as midwives, has also been linked with increased job satisfaction (McLelland & McKenna, 2008). Importantly, this indicates that midwives' satisfaction is closely linked to their ability

to work in their preferred area of expertise which is an important consideration when planning ways to retain a rural health workforce for the future.

Most participants express a desire to work as midwives only and indicate they would gladly forgo the nursing component of their work if they had a choice. The literature on identity and role in relation to midwifery links purely to the various aspects of the midwifery role (Blaaka & Schauer Eri, 2008; Corey, 2008; Curtis, Ball, & Kirkham, 2006; Hunter, 2004; Scoggin, 1996), rather than a dual nursing/midwifery role. Scoggin (1996), in her study of how certified nurse-midwives in the United States defined their occupational identity, comments on the potential dilemma caused by an occupation that carries a dual name, but again only focused on nurse-midwives when they worked in the midwifery role. Much maternity care in the United States is provided by nurses under the direction and supervision of doctors with nurse-midwives only attending about ten percent of births in 2000 (Scoggin, 1996); in Australia virtually all births are attended by midwives (Malott, et al., 2009).

Midwives working in a dual role of nurse and midwife in this study identify a desire to maintain their midwifery identity with most preferring to practise only as midwives if given the opportunity. This position has not been reflected in the literature on rural midwifery practice to date, as the literature available focuses primarily on the varying aspects of the midwife role or competence, rather than the dual nurse/midwife role per se (Hundley & Ryan, 2004; Ireland, et al., 2007; Tucker, et al., 2005). Lack of opportunity to maintain specific skills and competencies presents a huge problem for nurses and midwives in rural and remote areas. As a result of the newly established Nursing and Midwifery Board of Australia, a division of the Australian Health

Practitioners Regulatory Authority, nurses and midwives are expected to come under greater levels of surveillance with regard to their recency of practice. For rural nurses and midwives, this requirement may be problematic when opportunities to work across both areas are not available. Further, the lack of continuing professional development opportunities for nurses and midwives in rural and remote areas is regularly cited as a cause of dissatisfaction (Hegney 2000; Henwood et al. 2009) and this too will need to be given due consideration now that there is a mandatory annual CPD requirement for all nurses and midwives (Mills, 2009).

Integration of maternity and general nursing: "All in together this fine weather"

This theme includes the sub-themes, stress due to working across roles; conflict with integration ('it's not right'); and enjoying the variety. The first sub-theme, stress due to working across roles was commented on by a number of participants who found working in multiple areas, often without fore-knowledge of where they would be working, was quite stressful. A number of participants describe how having to work across roles, often within the one shift, created stress or was difficult for them. Another factor that contributed to participant stress in this study was that although they were expected to be multi-skilled and work as both midwives and nurses where required, they felt that the collegial support was not reciprocal from general nursing staff. Participant Margaret describes a common occurrence when the midwife is busy but receives no help from general nursing staff. She also sees this lack of support as impacting further on a midwife's workload, compared to those working in nursing areas.

Stress is recognised in the literature as a factor linked to the requirement for rural nurses to be multi-skilled. Pinikahana and Happell (2004) comment that the fact that rural nurses are usually multi-skilled and required to work in extended roles can be either stressful or rewarding, depending on the context and the individual. The level of professional responsibility rural nurses face due to reduced access to the/a multidisciplinary team and workforce shortages has also been noted as a leading cause of stress in rural nurses (Krebs, Madigan, & Tullai-McGuinness, 2008).

High levels of stress in the workplace have been linked to job dissatisfaction, which in turn increases the likelihood of staff leaving (Hayes, et al., 2006). Outcomes of dissatisfaction and attrition ultimately lead to increased workloads for those who remain, which contributes further to the stress levels for those left behind. (Jackson & Daly, 2004; Mackin & Sinclair, 1998). In rural areas where workforce shortages are already an issue, factors that contribute to stress and potentially increase workloads further is a significant concern. The discourse relating to stress in the rural nursing workforce to date however tends to be limited to generic comments related to the need to be multi-skilled and the requirement to work across different areas (Pinikahana and Happell 2004). However, the literature does not explicitly make mention of the potential for stress to be created for midwives working in a dual nurse/midwife role.

The second sub-theme is conflict with integration, where the participants identify philosophical conflict between what is perceived as the biomedical model of nursing and the wellness model of midwifery care. Combining maternity and general nursing patients in the one ward creates further conflict for the participants. In addition to this issue, the midwives are concerned with what they perceive as lack of privacy for

birthing women when combined with a general nursing area. Maternity Unit ward design, particularly birthing areas, are often very different to general ward areas.

MacKinnon (2008), in a study of nurses providing maternity care in rural Canada, identified the conflicts created for nurses required to care for a woman in labour while simultaneously having to provide nursing care to other patients. A number of studies that investigate differing belief systems within the provision of midwifery care and how that leads to conflict and stress, have previously been published (Blaaka & Schauer Eri, 2008; Deery, 2005; Mackin & Sinclair, 1998). These studies highlight potential change in a midwife's focus when affected by competing belief systems (Blaaka & Schauer Eri, 2008), cultural conflict through not being able to work to a personal philosophy (Deery, 2005), and the effect that role conflict and physical environment have on the creation of stress (Mackin & Sinclair, 1998). There is little in the literature that documents the increased likelihood of these effects when midwives work between differing belief systems in providing maternity care and general nursing care, which was the experience of participants in this study. The potential results of these conflicts, however, are detrimental to retention of staff and levels of job satisfaction. It is possible that being required to work across two philosophical belief systems, that is the medical model and the midwifery model of care, has the potential to cause role conflict, identified as a major influence on retention (Brookes, et al., 2007; Piko, 2006).

The third sub-theme that constitutes the theme of integration is that of 'enjoying the variety'. All but one of the participants in this study expressed a preference to work as a midwife only if possible, yet most commented on the benefits that working across

the dual nurse/midwife roles conferred. In particular, they commented on enjoying the variety of work at times, and the opportunity to maintain skills across a broader range of clinical areas.

Increased autonomy and variety in practice have been stated as positive factors that increase satisfaction with work and encourage retention of nurses in rural areas (Chaboyer, Williams, Corkill, & Creamer, 1999; Hegney, et al., 2002b; Ingersoll, Olsan, Drew-Cates, DeVinney, & Davies, 2002). Hegney and McCarthy (2000), in their study of job satisfaction in rural nurses in Australia, note high levels of satisfaction in nurses who 'floated' amongst a variety of areas in small health services but that the opposite effect was found in larger rural or metropolitan areas where there was an adverse outcome on satisfaction. Hegney and McCarthy, (2000) study, however, only refers to nursing and not to a situation where there is a combination of nursing and midwifery duties. Despite this, as it was conducted in Australia, midwifery duties may have been part of the variety but this has not been explicitly stated. In other studies, it has also been found that some nurses appreciated the variety offered in rural hospitals while others report being unhappy about being moved around during a shift (Hunsberger, et al., 2009; Molinari & Monserud, 2008). Again, these were studies of nurses only and did not include midwives. As these studies were conducted in Canada and North America it is unlikely that midwifery was part of the duties due to the differing models of midwifery care evident in these countries.

Shaped by location: "That's part of working in a small place"

This third theme was comprised of the sub-themes: sense of belonging to a community; "you deal with what comes through the door" (being multi-skilled); and limitations of working in a rural hospital. The first sub-theme was the sense of belonging to a community, where the participants valued the holistic nature of rural practice, where knowing previous history gave a broader picture. The Participants identified that being part of the community and knowing a family's history gave them greater insight into individual's needs.

Rural nurses' ability to provide holistic care across the life span is also identified in other Australian and international studies, as factors that contribute to attracting and retaining nurses in rural areas (Hegney, McCarthy, & Pearson, 1999; Lauder, et al., 2006; Lenthall, et al., 2009; Molinari & Monserud, 2009). Similarly, the opportunity to provide holistic patient care has also been cited as a contributory factor in attracting procedural GPs to rural areas (Robinson, et al., 2010). In addition to this holistic view of the patient or client, the sense of belonging to a community and being both a provider and consumer of health services have all been identified as positive aspects for attracting and retaining nurses to rural locations (Hegney, et al., 2002a; Sutherns, 2003). Conversely, this close link with the community and the fact that the community may consider the nurse to be on duty at all times due to the fact that they 'are' nurses and don't just 'work' as nurses, can have detrimental effects on the health professional and potentially be a source of stress (Mills, Francis, & Bonner, 2007; Molinari & Monserud, 2009).

Another aspect of the sub-theme of community is that of community expectations of their health service and women's desire to birth in their local community, particularly Indigenous women. Lauren, like a number of the participants, spoke of women remaining to birth locally, even after being advised to relocate for perceived safety reasons. A number of the midwives acknowledge this was always going to happen, despite advice to the contrary and so they did their best to prepare for it. A number express disappointment that services had been reduced in their home towns and voice an understanding of why women choose to stay, often expressing tacit support of this decision.

There is a multitude of publications on the implications of women having to relocate for some or all of their pregnancy and or birth care. Financial implications (Hirst, 2005; Kildea, 2003; Kornelsen & Grzybowski, 2006), stress and anxiety (Hirst, 2005; Kildea, 2003; Kruske, et al., 2006; Moffitt & Vollman, 2006) and issues of cultural safety and culturally inappropriate care (Arnold, et al., 2009; Kruske, et al., 2006; Van Wagner, et al., 2007), have all been identified as key issues. There have been some studies published on the implications for maternity workforce when services are downgraded or ceased, particularly in relation to maintenance of midwifery competence (Hundley, et al., 2007; Monaghan & Walker, 2001; Tucker, et al., 2005) but most of the literature details the implications for birthing women and their families with little on how midwives are affected directly.

The second sub-theme was "you deal with what comes through the door" which relates to both the concept of being multi-skilled but also that of a potential loss of skills and or confidence due to less exposure, to maternity care. The concept of rural

nurses being multi-skilled is a facet of rural nurses in particular has been clearly explored in contemporary literature (Daniels, et al., 2007; Hunsberger, et al., 2009; Mills, et al., 2010; Wakerman & Humphreys, 2008). The broad range of skills a rural nurse requires is well documented, including a role expansion due to lack of multidisciplinary teams such as allied health and on site medical support in rural areas (Hegney, et al., 1999; Lea & Cruickshank, 2005; Molinari & Monserud, 2009) and the autonomous nature of the practice, making the rural nurse a specialist with a generalist focus (Molinari & Monserud, 2009; Montour, et al., 2009). Again, each of these studies focused on the nursing workforce without specific discussion of the role of midwives in rural areas. This expectation to be multi-skilled, as a strategy to address workforce shortages, has also been shown to impact on job satisfaction and therefore retention (Duffield & O'Brien-Pallas, 2002; Jackson, et al., 2001).

The risk to the rural workforce, particularly in the provision of maternity care, is that midwives may lose skills and confidence due to services being reduced or closed and this was a concern voiced by some of the participants in this study. Relocating women to birth and consequent reduction in birth numbers has a negative impact on midwives' skills and confidence (Brodie, 2002; Fahey & Monaghan, 2005; McLelland & McKenna, 2008; World Health Organisation, 2004). A number of Australian authors also highlight that changes to models of care in rural areas may be one solution to workforce shortages through better utilisation of the midwifery workforce and potential increased satisfaction with the role (Brodie, 2002; Kildea, 2003; McKenna & Rolls, 2007; Tracy, et al., 2006). All but one of the midwives in this study expressed a preference for being able to work solely as a midwife if this was possible within their current location.

The third sub-theme that constituted part of the theme "That's part of working in a small place" was that of the limitations faced by working in a rural area, particularly staffing limitations, but also service limitations. From the perspective of maternity service provision, lack of sufficient midwives was a concern voiced by all of the participants. Closures of maternity services, both in Australia and overseas have been linked to workforce shortages (Brodie, 2003; Hirst, 2005; Kornelsen, et al., 2009). The implications of midwife shortages in rural areas are the increased likelihood of adverse events or 'near miss' events (Ashcroft, et al., 2003; Smith, et al., 2010), professional isolation (Richards, et al., 2005), increased intervention (Lavender & Chapple, 2004) and difficulty accessing professional development (Ashcroft, et al., 2003; Richards, et al., 2005). Lack of midwives also results in the use of non-midwives to provide maternity care which is also a threat to safety and quality (Brodie, 2002).

In this study, lack of available midwives was found to contribute to increased on-call for participants, and hours worked. Shortages of staff and the resultant increased hours worked by others are both known to contribute to fatigue, which can lead to burnout and staff leaving (Leiter & Maslach, 2009; Shen, et al., 2004). Another factor identified by the participants in this study was that a lack of midwives meant that there was often little or no on-site support for decision making or just for confirmation of assessment and management decisions. The literature on rural nursing describes rural nurses often working in isolation from a multidisciplinary team with minimal support or resources (Henwood, Eley, Parker, Tuckett, & Hegney, 2009; Hunsberger, et al., 2009; Lea & Cruickshank, 2005; Mills, et al., 2010). Usually however, except for very remote areas, there are generally other nurses with which to confer. In

contrast, where there is only one midwife, who may be reluctant to ring an on call doctor too frequently, there may be little or no collegial support. Unfortunately there seems to be little documented about this issue specifically relating to midwives.

What does this mean for the rural midwifery workforce?

In areas currently facing workforce shortages, it is critical to examine the most effective use of the currently available workforce and develop strategies to support existing workforce numbers, as well as strategies to encourage recruitment to these areas. In Lavender and Chapple's (2004) exploration of midwives' views of maternity care in England, they note little research into what is important to midwives in their work. Much of the research conducted since then continues to focus on models of midwifery care or midwives' relationships with women. Research conducted on the rural nursing workforce does consider midwives, and tends to bundle midwives in together with nurses. Furthermore, rural nursing research studies do not focus on the issues specific to midwives or research issues from the perspective of the midwives.

The study reported here demonstrates the importance of undertaking workforce research that explores issues of importance to midwives from their perspective. Midwives working in rural areas have described their disquiet with the current system which requires them, because of their location and the generalist nature of rural healthcare, to work as a generalist nurse as well as a midwife. This problem, while not a new one to the Australian nursing and midwifery workforce, often results in dissatisfaction with the role and could affect retention of midwives in rural areas. Midwives have also expressed concerns about the lack of opportunities to work to

their full scope of practice (Brodie, 2002). In the future this may be a serious concern. The new system of national registration requires midwives to have practiced a minimum equivalent to three months full time in the preceding five years (Nursing and Midwifery Board of Australia, 2010), an amount of time that may be difficult to accrue in areas where maternity care is continually reducing and where midwives spend a considerable amount of their time delivering general nursing care. In addition to this, if midwife-led models of primary maternity care are to be considered in rural areas, midwives will need to meet criteria for endorsement as an eligible midwife. This criteria includes having worked across all areas of scope of midwifery practice for three of the previous five years (Nursing and Midwifery Board of Australia, 2010), which may be difficult to achieve for rural midwives working in fragmented models of care. As a result, opportunities for midwives to be able to work to the full scope of practice of a midwife, as well as opportunities for CPD, will need to be addressed. National registration requirements for CPD will require at least 20 hours annually of CPD relevant to nursing and 20 hours of CPD annually relevant to midwifery (Nursing and Midwifery Board of Australia, 2010). Some of this CPD may meet criteria for both roles, but as has been previously stated, access to CPD is inherently difficult for health professionals in rural areas anyway. It will no longer be good enough to allow midwives to become de-skilled as a result of their location or because of a lack of sufficient clinical exposure to midwifery care.

Importantly, the issue that must be considered in light of the generalist notion of rural nurses and midwives is the existing division between nursing and midwifery in Australia. Many midwives support the position that nursing and midwifery should be recognised as separate disciplines or entities (Brodie, 2002; Homer, et al., 2009) and

as a result of changes to national registration, midwives who first qualified as nurses will have the option to relinquish their nursing registration and register as a midwife only. In this case, midwives may resist the idea of working as a generalist nurse in rural areas or in fact in any non-midwifery area of work, which will have serious implications for the midwifery workforce in rural areas. Though so far resisted in rural areas, the development of direct entry midwifery courses are supported by proponents of primary maternity care models as a much more efficient utilisation of midwifery workforce in rural areas and in line with Federal Government reforms for maternity care (Bryant, 2009; Kildea, et al., 2010; Leap, n.d.; McKenna & Rolls, 2007). However, there are others who favour the development of joint nursing and midwifery undergraduate degrees as more relevant for a sustainable rural nursing workforce (Preston, 2009).

As outlined by Mills (2009), it is now well over twenty years since the Australian Government decided that all nursing and midwifery education would be conducted in tertiary settings. Education of midwives in Australia now follows one of three separate pathways. These pathways include a direct entry Bachelor of Midwifery degree, a post-graduate midwifery qualification at either Graduate Diploma or Masters level, or a double degree that provides combined undergraduate Nursing and Midwifery degrees. The first of these pathways, as noted above, is restricted to urban and regional areas if the current generalist belief about the workforce suited to rural areas continues. If that case is perpetuated, midwifery only prepared graduates will be deemed unsuitable for employment in rural areas. However, planning for midwifery only service delivery models has the potential to attract rural women not interested in becoming nurses to enter midwifery directly, and hence qualify as midwives. Such a

strategy has been identified as a potential solution to the current shortages of midwives in rural areas (Brodie, 2002; Kildea, 2003; McKenna & Rolls, 2007; Tracy, et al., 2000). These opposing views and strategies need further consideration, with proponents of each needing to consider the outcomes of their position on not just the future of midwifery in Australia, but also as it relates to the future delivery of midwifery services in rural areas.

Job satisfaction is recognised as a key component of staff retention (Jackson, et al., 2001) and the findings of this study suggest that midwives are willing to explore alternate ways of working in rural areas, that allow them to work to their full scope of practice as a midwife. Although findings from this study are not necessarily generalisable to all rural midwives, it would seem possible that implementation of midwife led models of care would enhance job satisfaction and support midwives to provide holistic midwifery care, and so assist in addressing the current shortages of midwives in rural areas. There is evidence that newly graduated midwives in urban areas have some difficulty obtaining permanent positions (B. Maier, personal communication, July 1, 2010) and that there will be increasing percentages of midwifery graduates from the direct entry midwifery route in the near future (Leap, Barclay and Sheehan 2003). Facilitating the employment of these midwives in rural areas would help address current workforce shortages and provide graduates with the option of working in models of care for which they have been prepared.

Conclusion

Findings from this study have reinforced and supported published findings on issues in relation to the rural nursing workforce. The attraction of a rural lifestyle as an aid

to the retention of staff (Hegney & McCarthy, 2000; Molinari & Monserud, 2008) is supported by participants in this study who have chosen the rural lifestyle even though this choice limits their practice as midwives. The sense of community belonging experienced by rural nurses (Hegney, et al., 1999; Lauder, et al., 2006; Lenthall, et al., 2009) was also described by the participants in this study as a factor that contributed to enhanced job satisfaction.

The multi-skilled nature of the current rural nursing and midwifery workforce that includes a broad range of extended roles (Daniels, et al., 2007; Hunsberger, et al., 2009; Mills, et al., 2010) was also clearly identified and supported by the participants in this study. All participants described their role as much more diverse and varied than if they worked in a metropolitan area and focused only on one field of practice even though the necessity to be multi-skilled has the potential to cause stress (Krebs, et al., 2008; Pinikahana & Happell, 2004) Experiencing high stress levels as a result of multitasking was also borne out in this study and as described previously in the literature, was often linked to high workload as well as the variety of work undertaken.

This study has examined the experiences of rural midwives who are required to work as a nurse as well as a midwife. Previous literature has focused on either the role of the rural nurse, incorporating midwives into the general mix, as a generalist and what this may mean for them, or the role of the midwife in different practice settings of midwifery only. There is scant reference in the literature to the lack of support midwives feel in rural areas when there are no other midwives readily available to confer with or even from whom to seek reassurance.

This chapter has discussed the findings of this study, and has compared and contrasted these with the literature identifying new knowledge in relation to the work of midwives in rural areas who also work as general nurses. The final chapter will discuss the limitations of this study and make recommendations for further research based on these findings to contribute to appropriate workforce and service delivery planning for maternity services in rural Australia.

Chapter Ten

Limitations and Recommendations

Introduction

This study outlined three themes identified through phenomenological analysis of transcribed interviews guided by the approach proposed by van Manen (1990). The study investigated the lived experience of midwives who work in dual roles as midwives and nurses in Far North Queensland. In this chapter, I will outline the limitations of the study in order to aid the reader in evaluating the findings presented in the thesis. Recommendations for policy and further research will also be provided.

Limitations

Phenomenological researchers obtain descriptions of individuals' experiences of a phenomenon of interest and develop an interpretation that aims to understand the meaning of that experience for the individual (Higginbottom, 2004). The intention of a hermeneutic phenomenological study is to generate an understanding of a phenomenon, rather than generate theory or produce results that are generalisable to large populations (Spencer, 2008). The generation of understanding is undertaken by turning to people who can offer insights into the experience under investigation. In this study participants were selected using a purposive sampling method, a technique appropriate to phenomenological studies where participants experiencing the phenomena are required (Schneider, et al., 2005), and where the intention is to find a deeper meaning of the phenomenon under investigation.

While there are no defined rules for establishing sample size in phenomenological studies (Tuckett, 2004), a sample of 6 to 12 participants is usually considered a reasonable sample size (Ray, 1994) due to the in-depth nature of the data collection process. Furthermore, most qualitative studies, including phenomenological studies, cease data collection when the same information begins to appear during analysis or when the data presented by participants appear to be repetitive (Laverty, 2003). Eight participants from four facilities in far north Queensland were interviewed in this study before information being collected began to produce this repetitive analysis. A possible limitation of the study is that these eight participants were from a single geographical area, Far North Queensland. While constraining the data collection sites, necessary due to time and travel constraints, it may have had an impact on the experiences of the participants. It is therefore possible, that midwives from a different rural location may have described different experiences, however, phenomenological studies do not claim to be generalisable (Spencer, 2008), so it is accepted that different participants or a different researcher may lead to other findings and interpretations.

The aim of the study was to investigate the experience of midwives working in a dual role of midwife and nurse in rural Far North Queensland, Australia. As I am also a midwife and involved in a management position in the District, this may be perceived by some as a limitation as my world view will have influenced the interpretation of the data, however, being aware of the potential for bias helps to alleviate the potential problem to some degree. I recognise that my interpretation of the data will be framed by my professional background and hence what I see in the data will be different from a non-midwife or someone who does not have experience in this context. Importantly

I also acknowledge and recognise that my own experience in the world is considered an asset to the use of this type of methodology, as my experiences provide an important contribution that assists with the interpretation of the data (Carolan, 2003; Walters, 1995). In addition, the use of direct quotes taken from the transcripts to support the interpretation helps to assure the rigour of the findings and assist the reader to connect the voice of the participants with my interpretation.

My experience as a midwife has inevitably had an impact on my beliefs about the current divide between nursing and midwifery. For some time now midwives in Australia have sought to disconnect themselves from nursing and seek recognition as a distinct profession (Brodie, 2003). I am aware that the reader may be suspicious that my opinion about this issue may have overly influenced my interpretations, however, Heidegger insists that the only way that a hermeneutic inquiry can truly be conducted is if the researcher acknowledges fore-knowledge and is situated in the context to enable the right choice of questions (McConnell-Henry, Chapman, & Francis, 2009). Importantly, if my interpretation resonates with others, even though each experience is unique, this adds to the trustworthiness of the interpretation (McConnell-Henry, et al., 2009).

Recommendations

The study identified rural midwives' strong desire to work as a midwife in a rural environment. Participants' preference for living in a rural area appears to override the desire to work in a facility where they could work as a midwife without the need to also work as a nurse. It is possible however, that while some midwives may be prepared to accept the need to work across the dual roles if they wish to reside in a

rural area, others may be turned away from moving to rural areas because of the issue of a dual role as a midwife and nurse. Though considerable research has been conducted on what attracts nurses to rural areas, as well as what helps to keep them there (Hegney, et al., 2002a, 2002b; Kaye, et al., 2010; Molinari & Monserud, 2008), very little if any research has been conducted with rural midwives, particularly in relation to the necessity to work in a dual role of midwife and nurse. Further research on whether this is an impediment to the recruitment and retention of midwives in rural areas is recommended.

While a number of authors moot the development of midwife-led models of maternity care in rural areas, a desire echoed by most participants (Brodie, 2002; Kildea, et al., 2010; Tracy, et al., 2000), there is strong opposition to such a proposal in many rural health care facilities in this district. This opposition is due mainly to the perception that rural midwives require a general nursing background to allow greater flexibility in the allocation of the available workforce, and this issue currently appears to determine workforce policy. While both policy and perception hinder the development of rural midwifery in many areas, a small number of midwife led models of care have been developed in rural areas of Queensland, such as in Goondiwindi. It is important that these midwifery models are evaluated rigorously and findings published to add to the data available to support the effectiveness of midwifery models of care in rural areas. It is also important to reassess the reliance on a general nursing qualification as a primary requirement for the recruitment of midwives to rural areas. High numbers of applications for direct entry midwifery courses is evidence that there are many students who wish to become midwives but not nurses, while many of these students are potentially living in rural areas.

The difficulty that nurses and midwives in rural areas have in accessing CPD requires the development of innovative strategies that would help overcome this problem. Midwives who work in dual roles of nurse and midwife require CPD and up-skilling in both areas of practice to continue as safe practitioners who are eligible for continued registration. Expansion of locum relief programs to facilitate placements at regional or metropolitan facilities is one way that rural midwives and nurses could better access CPD and up-skilling. Development of more on-line education and mentoring programs would also help support rural nurses and midwives in their own workplace.

Conclusion

The closure of rural maternity units around Australia has significant implications for both the people living in those communities and the rural midwifery workforce. Closure of maternity units may lead to midwives re-locating to continue to practice as a midwife, or alternatively being required to work as both a midwife and nurse to maintain employment in a rural hospital. This study used a hermeneutic phenomenological approach to understand what the experience was for midwives required to work across dual roles as midwife and nurse in rural far north Queensland. Phenomenology is an appropriate approach when trying to develop understanding of a phenomenon where little is known.

This study reveals three main themes that reflect the experience of working in a dual role as midwife and nurse. These themes are: Making choices between professional role and lifestyle: “Because I choose to live here”; Integration of maternity and general nursing: “All in together this fine weather”; and Shaped by location: “That’s

part of working in a small place". These findings reveal that the midwives experience their choices in how they work as limited by location and being re-deployed to general areas of nursing. Conflict is experienced because of the need to work between two models of care: the biomedical model that tends to dominate generalist nursing and medicine, and the partnership-wellness model of midwifery. While the midwives express a preference to work as midwives only, they did acknowledge that they enjoyed the variety offered by working in a dual role. The midwives also express that while working across dual roles they had become multi-skilled generalists, but raised concerns that midwifery skills could be lost with diminishing amounts of midwifery work.

These findings have indicated further research should be conducted on the workforce implications of the necessity for midwives to work in dual roles in rural areas. In a time of increasing global health workforce shortages, and in particular in rural areas, it is important to identify the factors that might encourage recruitment to, and support retention in, rural health services. Effective utilisation of the midwifery workforce in rural environments is essential to provide safe and sustainable maternity services to these communities.

References

Aiken, L., Clarke, S., Sloane, D., Sochalski, J., Busse, R., Clarke, H., et al. (2001). Nurses' reports on hospital care in five countries. *Health Affairs, 20*(3), 43-53.

Aiken, L., Clarke, S., Sloane, D., Sochalski, J., & Silber, J. (2002). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *Journal of the American Medical Association, 288*(16), 1987-1993.

Arnold, J., deCosta, C., & Howat, P. (2009). Timing of transfer for pregnant women from Queensland Cape York communities to Cairns for birthing. *Medical Journal of Australia, 190*(10), 594-596.

Ashcroft, B., Elstein, M., Boreham, N., & Holm, S. (2003). Prospective semistructured observational study to identify risk attributable to staff deployment, training, and updating opportunities for midwives. *British Medical Journal, 327 (7415).* Retrieved 2/4/2010, from www.bmj.com

Australian College of Midwives (2005). Midwifery and the Nurse Practitioner. Retrieved 2/4/2010, from www.midwives.org.au/AboutUs/ACMPositionStatements/MidwiferyandtheNursePractitioner/tabid/263/Default.aspx

Australian Health Workforce Advisory Committee (2002). *The Midwifery Workforce in Australia 2002-2012, AHWAC Report 2002.2*. Sydney: Australian Health Workforce Advisory Committee

Australian Institute of Health and Welfare (2006). Indigenous Health Retrieved 4/9/2009, from www.aihw.gov.au/indigenous/health/index.cfm

Australian Institute of Health and Welfare (2008a). Demography. Retrieved 4/9/2009, from www.aihw.gov.au/ruralhealth/demography.cfm

Australian Institute of Health and Welfare (2008b). Rurality Risk. Retrieved 4/9/2009, from www.aihw.gov.au/ruralhealth/ruralityrisk.cfm

Australian Institute of Health and Welfare (2009). Nursing and midwifery labour force 2007. Retrieved from http://www.aihw.gov.au/publications/index.cfm/title/10724

Barclay, L., & Tracy, S. (2010). Legally binding midwives to doctors is not collaboration. *Women and Birth, 23*(1), 1-2.

Barreca, S., & Wilkins, S. (2008). Experiences of nurses working in a stroke rehabilitation unit. *Journal of Advanced Nursing, 63*(1), 36-44.

Bartram, T., Joiner, T., & Stanton, P. (2004). Factors affecting the job stress and job satisfaction of Australian nurses: implications for recruitment and retention. *Contemporary Nurse, 17*(4), 293-304.

Begley, C., Oboyle, C., Carroll, M., & Devane, D. (2007). Educating advanced midwife practitioners: a collaborative approach. *Journal of Nursing Management, 15*, 574-584.

Biddle, B. (1979). *Role Theory. Expectations, Identities, and Behaviours.* New York: Academic Press.

Biddle, B. (1986). Recent developments in role theory. *Annual Review of Sociology., 12*, 67-92.

Biddle, B., & Thomas, E. (Eds.). (1966). *Role Theory: Concepts and Research.* New York: John Wiley & Sons.

Blaaka, G., & Schauer Eri, T. (2008). Doing midwifery between different belief systems. *Midwifery, 24*(3), 344-352.

Boon, C. (2004). Primigravidas' perception of the role of a midwife. *Australian Midwifery, 17*(2), 26-31.

Brodie, P. (2002). Addressing the barriers to midwifery - Australian midwives speaking out. *Australian Journal of Midwifery, 15*(3), 5-14.

Brodie, P. (2003). *The invisibility of midwifery - will developing professional capital make a difference (D.Mid).* University of Technology, Sydney., Sydney.

Brookes, K., Davidson, P., Daly, J., & Halcomb, E. (2007). Role theory: A framework to investigate the community nurse role in contemporary health care systems. *Contemporary Nurse, 25*(1-2), 146-155.

Brumels, K., & Beach, A. (2008). Professional role complexity and job satisfaction of collegiate certified athletic trainers. *Journal of Athletic Training, 43*(4), 373-378.

Bryant, R. (2009). *Improving maternity services in Australia. The report of the Maternity services review.* Canberra: Department of Health and Ageing.

Buchan, J., & Aiken, L. (2008). Solving nursing shortages: a common priority. *Journal of Clinical Nursing, 17*(24), 3262-3268.

Bushy, A. (2002). International perspectives on rural nursing: Australia, Canada, USA. *Australian Journal of Rural Health., 10*(2), 104-111.

Butler-Kisber, L. (2010). *Qualitative Inquiry. Thematic, Narrative and Arts-Informed Perspectives.* London: Sage Publications.

Byrne, J. (2000). The South Australian Nurse Practitioner Project: A midwife's perspective on a new initiative. *Collegian, 7*(3), 37-39.

Carolan, M. (2003). Reflexivity: A personal journey during data collection. *Nurse Researcher, 10*(3), 7-14.

Carolan, M., Kruger, G., & Brown, V. (2007). Out of the Ashes: the new bachelor of midwifery curriculum at Victoria University. *Women and Birth, 20*(3), 127-130.

Chaboyer, W., Williams, G., Corkill, W., & Creamer, J. (1999). Predictors of job satisfaction in remote hospital nursing. *Canadian Journal of Nursing Leadership., 12*(2), 30-40.

Chang, E., & Hancock, K. (2003). Role stress and role ambiguity in new nursing graduates in Australia. *Nursing and Health Sciences, 5*(2), 155-163.

Chang, E., Hancock, K., Johnson, A., Daly, J., & Jackson, D. (2005). Role stress in nurses: review of related factors and strategies for moving forward. *Nursing and Health Sciences, 7*(1), 57-65.

Commonwealth of Australia (2010). *National Health (Collaborative arrangements for midwives) Determination 2010*. Retrieved 7/3/2011. from http://www.comlaw.gov.au/Details/F2010L02105.

Corey, J. (2008). Who do we serve? Role conflict in Ontario midwifery. *Canadian Journal of Midwifery Research and Practice., 7*(2), 31-35.

Council of Australian Governments (2008). *Communique*. Canberra: COAG.

Curtis, P., Ball, L., & Kirkham, M. (2006). Why do midwives leave? (Not) being the kind of midwife you want to be. *British Journal of Midwifery, 14*(1), 27-31.

Dahlen, H. (2006). Midwifery: "At the edge of history". *Women and Birth, 19*(1), 3-10.

Daly, A., & Smith, D. (2005). Indicators of risk to the wellbeing of Australian Indigenous children. *Australian Review of Public Affairs, 6*(1), 39-57.

Daly, J., Chang, E., & Jackson, D. (2006). Quality of work life in nursing: some issues and challenges. *Collegian, 13*(4), 2.

Daniels, Z., VanLeit, B., Skipper, B., Sanders, M., & Rhyne, R. (2007). Factors in recruiting and retaining health professionals for rural practice. *The Journal of Rural Health, 23*(1), 62-71.

Debesay, J., Naden, D., & Slettebo, A. (2008). How do we close the hermeneutic circle? A Gadamerian approach to justification in interpretation in qualitative studies. *Nursing Inquiry., 15*(1), 57-66.

Deery, R. (2005). An action-research study exploring midwives' support needs and the effects of group clinical supervision. *Midwifery*, *21*(2), 161-176.

Department of Health and Ageing (2008). *Report on the Audit of Health Workforce in Rural and Regional Australia.* Canberra: DoHA.

Duffield, C., & O'Brien-Pallas, L. (2002). The nursing workforce in Canada and Australia: two sides of the same coin. *Australian Health Review, 25*(2), 136-144.

Ewens, A. (2003). Changes in nursing identities: supporting a successful transition. *Journal of Nursing Management, 11*(4), 224-228.

Fahey, C. M., & Monaghan, J. S. (2005). Australian rural midwives: perspectives on continuing professional development. *Rural and Remote Heath., 5*(468). Retrieved from www.rrh.org.au

Fahy, K. (2007). An Australian history of the subordination of midwifery. *Women and Birth, 20*(1), 25-29.

Farmer, J., Lauder, W., Richards, H., & Sharkey, S. (2003). Dr John has gone: assessing health professionals' contribution to remote rural community sustainability in the UK. *Social Science and Medicine, 57*(4), 673-686.

Fereday, J., & Oster, C. (2010). Managing a work-life balance: the experience of midwives working in a group practice setting. *Midwifery, 26*(3), 311-318.

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: interviews and focus groups. *British Dental Journal, 204*(6), 291-295.

Glazebrook, R., & Harrison, S. (2006). Obstacles to maintenance of advanced procedural skills for rural and remote medical practitioners in Australia. *Rural and Remote Heath., 6*(502). Retrieved from www.rrh.org.au

Harris, M., Gavel, P., & Conn, W. (2002). Planning Australia's hospital workforce. *Australian Health Review, 25*(2), 61-77.

Haxton, J., & Fahy, K. (2009). Reducing length of stay for women who present as outpatients to delivery suite: A clinical practice improvement project. *Women and Birth, 22*(4), 119-127.

Hayes, L., O'Brien-Pallas, L., Duffield, C., Shamian, J., Buchan, J., Hughes, F., et al. (2006). Nurse turnover: A literature review. *International Journal of Nursing Studies., 43*(2), 237-263.

Hegney, D., Eley, R., Plank, A., Buikstra, E., & Parker, V. (2006). Workforce issues in nursing in Queensland: 2001 and 2004. *Journal of Clinical Nursing, 15*(12), 1521-1530.

Hegney, D., & McCarthy, A. (2000). Job satisfaction and nurses in rural Australia. *Journal of Nursing Administration., 30*(7/8), 347-350.

Hegney, D., McCarthy, A., & Pearson, A. (1999). Effects of size of health service on scope of rural nursing practice. *Collegian, 6*(4), 21-26.

Hegney, D., McCarthy, A., Rogers-Clark, C., & Gorman, D. (2002a). Retaining rural and remote area health nurses. *Journal of Nursing Administration., 32*(3), 128-135.

Hegney, D., McCarthy, A., Rogers-Clark, C., & Gorman, D. (2002b). Why nurses are attracted to rural and remote practice. *Australian Journal of Rural Health, 10*(3), 178-186.

Hegney, D., Plank, A., & Parker, V. (2006). Extrinsic and intrinsic work values: their importance on job satisfaction in nursing. *Journal of Nursing Management, 14*(4), 271-281.

Henwood, T., Eley, R., Parker, D., Tuckett, A., & Hegney, D. (2009). Regional differences among employed nurses: a Queensland study. *Australian Journal of Rural Health, 17*, 201-207.

Higginbottom, G. (2004). Sampling issues in qualitative research. *Nurse Researcher, 12*(1), 7-19.

Hirst, C. (2005). *Re-Birthing. Report of the review of maternity services in Queensland.*

Homer, C., Passant, L., Brodie, P., Kildea, S., Leap, N., Pincombe, J., et al. (2009). The role of the midwife in Australia: views of women and midwives. *Midwifery, 25*(6), 673-681.

Humphreys, J., Wakerman, J., Wells, R., Kuipers, P., Jones, J., & Entwistle, P. (2008). "Beyond workforce": a systemic solution for health service provision in small rural and remote communities. *Medical Journal of Australia, 188*(8), 77-80.

Hundley, V., & Ryan, M. (2004). Are women's expectations and preferences for intrapartum care affected by the model of care on offer? *British Journal of Obstetrics and Gynaecology, 111*(6), 550-560.

Hundley, V., Tucker, J., Teijlingen, E., Kiger, A., Ireland, J., Harris, F., et al. (2007). Midwives' competence: is it affected by working in a rural location? *Rural and Remote Heath., 7*(764). Retrieved from www.rrh.org.au

Hunsberger, M., Baumann, A., Blythe, J., & Crea, M. (2009). Sustaining the rural workforce: Nursing perspectives of worklife challenges. *The Journal of Rural Health, 25*(1), 17-25.

Hunter, B. (2004). Conflicting ideologies as a source of emotion work in midwifery. *Midwifery, 20*(3), 261-272.

Hunter, L. (2008). A hermeneutic phenomenological analysis of midwives' ways of knowing during childbirth. *Midwifery, 24*(4), 405-415.

Hyde, A., & Roche-Reid, B. (2004). Midwifery practice and the crisis of modernity: implications for the role of the midwife. *Social Science and Medicine, 58*(12), 2613-2623.

Ingersoll, G., Olsan, T., Drew-Cates, J., DeVinney, B., & Davies, J. (2002). Nurses' job satisfaction, organizational commitment, and career intent. *Journal of Nursing Administration., 35*(2), 250-263.

International Council of Nurses (2006). *The global nursing shortage: Priority areas for intervention.* Geneva: International Council of Nurses.

Ireland, J., Bryers, H., Teijlingen, E., Hundley, V., Farmer, J., & Harris, F. (2007). Competencies and skills for remote and rural maternity care: a review of the literature. *Journal of Advanced Nursing, 58*(2), 105-115.

Jackson, D., & Daly, J. (2004). Current challenges and issues facing nursing in Australia. *Nursing Science Quarterly, 17*(4), 352-355.

Jackson, D., Mannix, J., & Daly, J. (2001). Retaining a viable workforce: a critical challenge for nursing. *Contemporary Nurse, 11*(2-3), 163-172.

Janiszewski Goodin, H. (2003). The nursing shortage in the United States of America: an integrative review of the literature. *Journal of Advanced Nursing, 43*(4), 335-350.

Johnston, T., Wills, R., & Coory, M. (2008). *Indigenous trends in population-based indicators of perinatal health in Queensland.* Brisbane: Queensland Health.

Kaye, D., Mwanika, A., & Sewankambo, S. (2010). Influence of the training experience of Makerere University medical and nursing graduates on willingness and competence to work in rural health facilities. *Rural and Remote Health, 10*(1372). Retrieved from www.rrh.org.au

Kildea, S. (2003). *Risk and childbirth in rural and remote Australia.* Paper presented at the 'The art of science and community - sharing country know-how'. 7th National Rural Health Conference.

Kildea, S. (2006). Risky business: contested knowledge over safe birthing services for Aboriginal women. *Health Sociology Review, 15*(4), 387-396.

Kildea, S., Barclay, L., & Brodie, P. (2006). Maternity care in the bush: using the internet to provide educational resources to isolated practitioners. *Rural and Remote Heath., 6*, 1-12. Retrieved from www.rrh.org.au

Kildea, S., Kruske, S., Barclay, L., & Tracy, S. (2010). Closing the gap: how maternity services contribute to reducing poor maternal infant outcomes for

Aboriginal and Torres Strait Islander women. *Rural and Remote Health, 10*(1383). Retrieved from www.rrh.org.au

Killam, L., & Carter, L. (2010). Challenges to the student nurse on clinical placement in the rural setting: a review of the literature. *Rural and Remote Health, 10*(1523). Retrieved from www.rrh.org.au

Kinnane, J. (2008). *Everyday Encounters of Everyday Midwives: Tribulation and Triumph for Ethical Practitioners.*, Queensland University of Technology, Carseldine.

Kirkham, M. (2007). Retention and return in the NHS in England. *RCM Midwives, 10*(5), 224-226.

Klein, M., Christilaw, J., & Johnston, S. (2002). Loss of maternity care: the cascade of unforeseen dangers. *Canadian Journal of Rural Medicine., 7*(2), 120-121.

Koch, T. (1994a). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing, 19*(5), 976-986.

Koch, T. (1994b). Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing, 19*, 976-986.

Koch, T. (1995). Interpretive approaches in nursing research: the influence of Husserl and Heidegger. *Journal of Advanced Nursing, 21*(5), 827-836.

Koch, T. (1996). Implementation of a hermeneutic inquiry in nursing: philosophy, rigour and representation. *Journal of Advanced Nursing, 24*(1), 174-184.

Koch, T. (1998). Reconceptualizing rigour: the case for reflexivity. *Journal of Advanced Nursing, 28*(4), 882-890.

Koch, T. (1999). An interpretive research process: revisiting phenomenological and hermeneutical approaches. *Nursing Researcher., 6*(3), 20-34.

Kornelsen, J. (2009). Rural midwifery: Overcoming barriers to practice. *Canadian Journal of Midwifery Research and Practice., 8*(3), 6-11.

Kornelsen, J., & Grzybowski, S. (2006). The reality of resistance: the experiences of rural parturient women. *Journal of Midwifery and Women's Health., 51*(4), 260-265.

Kornelsen, J., & Grzybowski, S. (2008). Obstetric services in small rural communities: what are the risks to care providers. *Rural and Remote Heath., 8*(943). Retrieved from www.rrh.org.au

Kornelsen, J., Moola, S., & Grzybowski, S. (2009). Does distance matter? Increased induction rates for rural women who have to travel for intrapartum care. *Journal of Obstetrics and Gynaecology of Canada, 31*(1), 21-27.

Krebs, J., Madigan, E., & Tullai-McGuinness, S. (2008). The rural nurse work environment and structural empowerment. *Policy, Politics and Nursing Practice., 9*(1), 28-39.

Kruske, S., Kildea, S., & Barclay, L. (2006). Cultural safety and maternity care for Aboriginal and Torres Strait Islander Australians. *Women and Birth, 19*(3), 73-77.

Lambert, V., & Lambert, C. (2001). Literature review of role stress/strain on nurses: an international perspective. *Nursing and Health Sciences, 3*(3), 161-172.

Lane, K. (2002). Midwifery: A profession in transition. *Australian Journal of Midwifery, 15*(2), 26-31.

Larsson, M., Aldegarmann, U., & Aarts, C. (2007). Professional role identity in a changing society: three paradoxes in Swedish midwives experience. *Midwifery, 10*.

Lauder, W., Reel, S., Farmer, J., & Griggs, H. (2006). Social capital, rural nursing and nursing theory. *Nursing Inquiry., 13*(1), 73-79.

Lavender, T., & Chapple, J. (2004). An exploration of midwives' views of the current systen of maternity care in England. *Midwifery, 20*(4), 324-334.

Laverty, S. (2003). Hermeneutic phenomenology and phenomenology: a comparison of historical and methodological considerations. *International Journal of Qualitative Methods., 2*(3), 1-29.

Lea, J., & Cruickshank, M. (2005). Factors that influence the recruitment and retention of graduate nurses in rural health care facilities. *Collegian, 12*(2), 22-27.

Leap, N. (n.d.). Educating Australian midwives: current debates and concerns. Retrieved from www.nmh.uts.edu.au/cmcfh/products/monographnleap.pdf

Leeman, L., & Leeman, R. (2002). Do all hospitals need cesarean delivery capability? An outcomes study of maternity care in a rural hospital without on-site cesarean capability. *Journal of Family Practice, 51*(2), 129-135.

Leiter, M., & Maslach, C. (2009). Nurse turnover: the mediating role of burnout. *Journal of Nursing Management, 17*(3), 331-339.

Lenthall, S., Wakerman, J., Opie, T., Dollard, M., Dunn, S., Knight, S., et al. (2009). What stresses remote area nurses? Current knowledge and future action. *Australian Journal of Rural Health, 17*(4), 208-213.

Mackin, P., & Sinclair, M. (1998). Labour ward midwives' perceptions of stress. *Journal of Advanced Nursing, 27*(5), 986-991.

MacKinnon, K. (2008). Labouring to nurse: the work of rural nurses who provide maternity care. *Rural and Remote Heath., 8*(1047). Retrieved from www.rrh.org.au

Malott, A., Davis, B. M., McDonald, H., & Hutton, E. (2009). Midwifery care in eight industrialised countries: how does Canadian midwifery compare? *Journal of Obstetrics and Gynaecology of Canada, 31*(10), 974-979.

McConnell-Henry, T., Chapman, Y., & Francis, K. (2009). Husserl and Heidegger: Exploring the disparity. *International Journal of Nursing Practice., 15*(1), 7-15.

McConnell-Henry, T., James, A., Chapman, Y., & Francis, K. (2009-10). Researching with people you know: issues in interviewing. *Contemporary Nurse, 34*(1), 2-9.

McGrail, M. R., Jones, R., Robinson, A., Rickard, C. M., Burley, M., & Drysdale, M. (2005). The planning of rural health research: rurality and rural population issues. *Rural and Remote Health, 5*(426). Retrieved from www.rrh.org.au

McKenna, L., & Rolls, C. (2007). Bachelor of Midwifery: Reflections on the first 5 years from two Victorian universities. *Women and Birth, 20*(2), 81-84.

McLelland, G., & McKenna, L. (2008). A demographic snapshot of midwives in Victoria. *Contemporary Nurse, 31*(1), 71-79.

Mills, J. (2009). Professional portfolios and Australian registered nurses' requirements for licensure: developing an essential tool. *Nursing and Health Sciences, 11*(2), 206-210.

Mills, J., Birks, M., & Hegney, D. (2010). The status of rural nursing in Australia: 12 years on. *Collegian, 17*(1), 30-37.

Mills, J., Francis, K., & Bonner, A. (2005). Mentoring, clinical supervision and preceptoring: clarifying the conceptual defintions for Australian rural nurses: a literature review. *Rural and Remote Heath., 5*(410). Retrieved from www.rrh.org.au

Mills, J., Francis, K., & Bonner, A. (2007). Live my work: rural nurses and their multiple perspectives of self. *Journal of Advanced Nursing, 59*(6), 583-590.

Moffitt, P., & Vollman, A. (2006). At what cost to health? Tlicho women's medical travel for childbirth. *Contemporary Nurse, 22*(2), 228-239.

Molinari, D., & Monserud, M. (2008). Rural nurse job satisfaction. *Rural and Remote Heath., 8*(1055). Retrieved from www.rrh.org.au

Molinari, D., & Monserud, M. (2009). Rural nurse cultural self-efficacy and job satisfaction. *Journal of Transcultural Nursing., 20*(2), 211-218.

Monaghan, J. S., & Walker, J. (2001). *Delivery in the Bush: Maintaining a skilled Midwifery workforce in rural and remote Tasmania.* Paper presented at the Good health-Good country: 6th National Rural Health conference.

Montour, A., Baumann, A., Blythe, J., & Hunsberger, M. (2009). The changing nature of nursing work in rural and small community hospitals. *Rural and Remote Heath., 9*(1089). Retrieved from www.rrh.org.au

Muula, A. S. (2007). How do we define 'rurality' in the teaching on medical demography? *Rural and Remote Health, 7*(653). Retrieved from www.rrh.org.au

National Health Workforce Taskforce (2009). *Health Workforce in Australia and Factors for Current Shortages*. Canberra.

Nursing and Midwifery Board of Australia (2010). Fact Sheet: New obligations for Nurses and Midwives Retrieved 20/8/2010, from www.nursingmidwiferyboard.gov.au/FAQ-and-Fact-sheets.aspx

Nursing Council of New Zealand (2009). Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice. Retrieved from www.nursingcouncil.org.nz/download/97/cultural-safety09.pdf

O'Connor, T. (2006). Midwifery. *Kai Tiaki Nursing New Zealand., April,* 18-19.

Pairman, S. (2006). Midwifery partnership: working 'with' women. In L. Page & R. McCandlish (Eds.), *The New Midwifery: Science and Sensitivity in Practice.* (2nd ed., pp. 73-96). Philadephia: Elsevier.

Pearson, A. (2008). Claims, contradictions and country life in Australia: the evidence on rural nursing and midwifery. *International Journal of Nursing Practice., 14*(6), 409-410.

Pearson, A., Robertson-Malt, S., Walsh, K., & Fitzgerald, M. (2001). Intensive care nurses' experience of caring for brain dead organ donor patients. *Journal of Clinical Nursing, 10*, 132-139.

Phillips, A. (2009). Health status differentials across rural and remote Australia. *Australian Journal of Rural Health, 17*(1), 2-9.

Phiri, J., Dietsch, E., & Bonner, A. (in press). Cultural safety and its importance for Australian midwifery practice. *Collegian*.

Piko, B. (2006). Burnout, role conflict, job satisfaction and psychosocial health among Hungarian health care staff: A questionnaire survey. *International Journal of Nursing Studies., 43*(3), 311-318.

Pinikahana, J., & Happell, B. (2004). Stress, burnout and job satisfaction in rural psychiatric nurses: a Victorian study. *Australian Journal of Rural Health, 12*(2), 120-125.

Preston, B. (2006). *Nurse workforce futures.* Melbourne: Council of Deans of Nursing and Midwifery.

Preston, B. (2009). The Australian nurse and midwifery workforce: issues, developments and the future. *Collegian, 16*(1), 25-34.

Price, K. (2000). *Recruitment and retention of midwives across a rural region: defining needs and framing problems.* Paper presented at the Infront Outback Conference, Toowoomba, Queensland.

Productivity Commission (2005). *Australia's Health Workforce*. Canberra: Australian Government.

Queensland Health (2005). *Clinical Services Capability Framework*. Brisbane: Queensland Health.

Queensland Health (2010). *Remote Area Nursing Incentive Package (RANIP) Human Resources Policy*. from http://www.health.qld.gov.au/hrpolicies/benefits/c_2.pdf.

Ramsden, I. (1990). Cultural safety. *New Zealand Nursing Journal, 83*(11), 18-19.

Ray, M. (1994). The Richness of Phenomenology: Philosophic, Theoretic and Methodological Concerns. In J. M. Morse (Ed.), *Critical Issues in Qualtiative Research Methods.* Thousand Oaks: Sage Publications Inc.

Reiger, K. (2000). The politics of midwifery in Australia. *Annual Review of Health Social Sciences., 10,* 53-64.

Reiger, K. (2006). A neoliberal quickstep: Contradictions in Australian maternity policy. *Health Sociology Review, 15*(4), 330-340.

Richards, H., Farmer, J., & Selvaraj, S. (2005). Sustaining the rural primary healthcare workforce: survey of healthcare professionals in the Scottish Highlands. *Rural and Remote Heath., 5*(365). Retrieved from www.rrh.org.au

Robinson, M., Slaney, G., Jones, G., & Robinson, J. (2010). GP Proceduralists: 'the hidden heart' of rural and regional health in Australia. *Rural and Remote Health, 10*(1402). Retrieved from www.rrh.org.au

Rogers, J. (2003). Sustainability and collaboration in maternity care in Canada. *Canadian Journal of Rural Medicine., 8*(3), 193-198.

Roulston, K. (2010). *Reflective Interviewing; A Guide to Theory and Practice*. London: Sage Publications.

Rural Health Workforce Australia, National Rural Faculty Royal Australian College General Practitioners, Rural Doctors Association of Australia, Australian College of Midwives, Australian College of Rural and Remote Medicine, & Royal Australian and New Zealand College of Obstetricians and

Gynaecologists (2008). *National Consensus Framework for Rural Maternity Services*. Melbourne, Victoria.

Sandall, J., Hatem, M., Devane, D., Soltani, H., & Gates, S. (2009). Discussions of findings from a Cochrane review of midwife-led versus other models of care for childbearing women: continuity, normality and safety. *Midwifery, 25*(1), 8-13.

Schaufeli, W., Leiter, M., & Maslach, C. (2009). Burnout: 35 years of research and practice. *Career Development International, 14*(3), 204-220.

Schneider, Z., Elliott, D., LoBiondo-Wood, G., & Haber, J. (2005). *Nursing Research: Methods, Critical Appraisal and Utilisation* (2nd ed.). Marrickville: Elsevier.

Scoggin, J. (1996). How nurse-midwives define themselves in relation to nursing, medicine and midwifery. *Journal of Nurse-Midwifery, 41*(1), 36-42.

Segal, L., & Bolton, T. (2009). Issues facing the future health care workforce: the importance of demand modelling. *Australia and New Zealand Health Policy, 6*(12). Retrieved from http://www.anzhealthpolicy.com/content/6/1/12

Shen, J., Cox, A., & McBride, A. (2004). Factors influencing turnover and retention of midwives and consultants. *Health Services Management Research, 17*(4), 249-262.

Smith, J. (2004). *Australia's Rural and Remote Health. A Social Justice Perspective.* Croydon: Tertiary Press.

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretive Phenomenological Analysis: Theory, Method and Research.* London: Sage Publications.

Smith, S., Leap, N., & Homer, C. (2010). Advanced midwifery practice or advancing midwifery practice? *Women and Birth, 23*(3), 117-120.

Spence, N. (2007). From nurse to student midwife: do they have the advantage? *British Journal of Midwifery, 15*(6), 352.

Spencer, R. L. (2008). Research methodologies to investigate the experience of breastfeeding: a discussion paper. *International Journal of Nursing Studies., 45*(12), 1823-1830.

Summers, A. (1998). The lost voice of midwifery: Midwives, nurses and the Nurses Registration Act of South Australia. *Collegian, 5*(3), 16-22.

Sumner, J. (2001). Caring in nursing: a different interpretation. *Journal of Advanced Nursing, 35*(6), 926-932.

Sutherns, R. (2003). In praise and search of midwifery well-suited to rural women. *Canadian Journal of Midwifery Research and Practice., 2*(2), 13-21.

Toohill, J., Pilcher, J., & Edwards, H. (2009). *A clinical services capability framework for statewide maternity care.* Paper presented at the ABC - Access, boundaries, collaboration in midwifery Conference., Townsville.

Tracy, S., Barclay, L., & Brodie, P. (2000). Contemporary issues in the workforce and education of Australian midwives. *Australian Health Review, 23*(4), 78-88.

Tracy, S., Sullivan, E., Dahlen, H., Black, D., Wang, T., & Tracy, M. (2006). Does size matter? A population-based study of birth in lower volume maternity hospitals for low risk women. *British Journal of Obstetrics and Gynaecology, 113*(1), 86-96.

Tucker, J., Hundley, V., Kiger, A., Bryers, H., Caldow, J., & Farmer, J. (2005). Sustainable maternity services in remote and rural Scotland? A qualitative survey of staff views on required skills, competencies and training. *Quality and Safety in Health Care., 14*(1), 34-40.

Tuckett, A. (2004). Qualitative research sampling: the very real complexities. *Nurse Researcher, 12*(1), 47-61.

Tunc, T., & Kutanis, R. (2009). Role conflict, role ambiguity, and burnout in nurses and physicians at a university hospital in Turkey. *Nursing and Health Sciences, 11*(4), 410-416.

Usher, K., Miller, M., & Turale, S. (2005). Meeting the challenges of recruitment and retention of Indigenous people into nursing: outcomes of the Indigenous Nurse Education Working Group. *Collegian, 12*(3), 27-31.

van Manen, M. (1990). *Researching Lived Experience.* London, Ontario: State University of New York Press.

van Manen, M. (2002). Phenomenological Inquiry. Retrieved 3/5/2009, from www.phenomenologyonline.com

Van Roo, S., & Houweling, H. (2008). *Indigenous infant mortality - the denominator dilemma.* Brisbane: Queensland Health.

Van Wagner, V., Epoo, B., Nastapoka, J., & Harney, E. (2007). Reclaiming birth, health and community: midwifery in the Inuit villages of Nunavik, Canada. *Journal of Midwifery and Women's Health., 52*(4), 384-391.

Vernon, B. (2009). *A new chapter in Australian midwifery.* Paper presented at the ABC- Access, boundaries, collaboration in midiwfery Conference., Townsville.

Wakerman, J., & Humphreys, J. (2008). Rural and remote health - definitions, policy and priorities. In S. Liaw & S. Kilpatrick (Eds.), *A Textbook of Australian Rural Health.* (pp. 13-30). Canberra: Australian Rural Health Education Network.

Walker, S., Moore, H., & Eaton, A. (2004). North Queensland midwives' experience with a team model of midwifery care. *Australian Journal of Midwifery, 17*(1), 17-22.

Walker, W. (2007). Ethical considerations in phenomenological research. *Nurse Researcher, 14*(3), 36-45.

Walters, A. J. (1995). The phenomenological movement: implications for nursing research. *Journal of Advanced Nursing, 22*, 791-799.

Watson, J., Turnbull, B., & Mills, A. (2002). Evaluation of the extended role of the midwife: the voices of midwives. *International Journal of Nursing Practice., 8*, 257-264.

Watson, L., Potter, A., & Donaghue, L. (1999). Midwives in Victoria, Australia: a survey of current issues and job satisfaction. . *Midwifery, 15*(4), 216-231.

White, C., Willett, K., Mitchell, C., & Constantine, S. (2007). Making a difference: education and training retains and supports rural and remote doctors in Queensland. *Rural and Remote Health, 7*(700). Retrieved from www.rrh.org.au

Whitehead, D. (2002). The academic writing experiences of a group of student nurses: a phenomenological study. *Journal of Advanced Nursing, 38*(5), 498-506.

WHO (2004). *Making Pregnany Safer: the critical role of the skilled attendant.* Geneva: WHO.

Wilkinson, D. (2002). Issues and challenges facing rural hospitals. *Australian Health Review, 25*(5), 94-105.

World Health Organisation (2002). *Strategic Directions for Strengthening Nursing and Midwifery Services*. Geneva: WHO.

World Health Organisation (2004). *Making Pregnancy Safer: the critical role of the skilled attendant.* Geneva: WHO.

World Health Organisation (2006). *The World Health Report 2006: Working together for health*. Geneva: WHO.

Appendix 1

JAMES COOK UNIVERSITY
Townsville Qld 4811 Australia

Tina Langford, Ethics Officer, Research Office. Ph: 07 4781 4342; Fax: 07 4781 5521

ETHICS REVIEW COMMITTEE
Human Research Ethics Committee
APPROVAL FOR RESEARCH OR TEACHING INVOLVING HUMAN SUBJECTS

PRINCIPAL INVESTIGATOR	**Mrs Karen Yates**				
SUPERVISOR(S)	Prof Kim Usher & A/Prof David Lindsay (Nursing, Midwifery and Nutrition)				
SCHOOL	Nursing, Midwifery and Nutrition				
PROJECT TITLE	**Experience of midwives working in dual roles as nurse and midwife in FNQ**				
APPROVAL DATE	8 Jan 2009	**EXPIRY DATE**	1 Dec 2010	**CATEGORY**	**1**
This project has been allocated Ethics Approval Number with the **following conditions**:				**H**	**3199**

1. All subsequent records and correspondence relating to this project must refer to this number.
2. That there is **NO** departure from the approved protocols unless prior approval has been sought from the Human Research Ethics Committee.
3. The Principal Investigator **must advise** the responsible Ethics Monitor appointed by the Ethics Review Committee:
   - periodically of the progress of the project;
   - when the project is completed, suspended or prematurely terminated for any reason;
   - if serious or adverse effects on participants occur; and if any
   - unforeseen events occur that might affect continued ethical acceptability of the project.
4. In compliance with the National Health and Medical Research Council (NHMRC) *"National Statement on Ethical Conduct in Human Research"* (2007), it is **MANDATORY** that you provide an annual report on the progress and conduct of your project. This report must detail compliance with approvals granted and any unexpected events or serious adverse effects that may have occurred during the study.

NAME OF RESPONSIBLE MONITOR	Leicht, Dr Anthony
EMAIL ADDRESS:	anthony.leicht@jcu.edu.au
ASSESSED AT MEETING **APPROVED** **Professor Peter Leggat** **Chair, Human Research Ethics Committee**	***Date:*** 8 Jan 2009 ***Date:*** 8 Jan 2009
Tina Langford Ethics Officer **Research Office** Tina.Langford@jcu.edu.au	Date: 8 January 2009

Appendix 2

Queensland Government

Queensland Health
Enquires: Ethics Committee
Direct Telephone: (07) 40 508 012
Direct Facsimile: (07) 40 506 331
Our Reference: MDH/mg 15.10
Your Reference: #534

PRIVATE & CONFIDENTIAL

Ms Karen Yates
31 Banning Avenue
BRINSMEAD Qld 4870

Dear Ms Yates

Re: Experience of midwives working in dual roles as nurse midwife in FNQ
Protocol: #534

I refer to your letter of 21st October 2008 in which you addressed issues of concern raised at the HREC meeting held 9th October 2008. I am pleased to advise that final approval is now granted.

The HREC Cairns and Hinterland Health Service District is both duly constituted and operates in accordance with the National Statement on Ethical Conduct in Research Involving Humans and Supplementary Notes, (2007).

During the conduct of the study you are required to adhere to the following conditions:

- The National Statement on Ethical Conduct in Research Involving Humans requires a Human Research Ethics Committee to nominate a person to whom complaints from participants, researchers, or other interested person can be directed. This HREC has nominated The Chairperson Professor Michael Humphrey (Phone: 07-40 508012). This information must be included in the Information Sheet provided to participants.

- The protocol number should be quoted on all correspondence relating to the application.

- You are required to provide a report on the outcome of the study at the completion of the study or annually if the study continues for more than 12 months.

Office	Postal	Phone	Fax
HREC Administrator Cairns Base Hospital The Esplanade CAIRNS Q 4870	PO Box 902 CAIRNS Q 4870	(07) 40 508012	(07) 4050 6331

- You must immediately report to this HREC any serious or unexpected adverse effects on participants, and any unforseen events that might affect continued ethical acceptability of the project. In addition, the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected casualty and whether changes are required to the Patient Information and Consent Form.

- If any subsequent change/amendment is made to the protocol it will be necessary for you to obtain approval from this HREC. The amended documents must be accompanied by the letter, signed by the Principal Investigator, providing a brief description of the changes, the rationale for them and their implications for the ongoing conduct of the study. All amended documents must contain revised version numbers, version dates and page numbers. Changes must be highlighted using Microsoft Word "Track Changes" or similar.

- If relevant to your project, your attention is drawn to standards for clinical trials reporting as enunciated in the CONSORT statement *(http://www.consort-statement.ort/?o=1001)* and a requirement by many journals for certain categories of clinical trials to be registered (see: *http://www.actr.org.au*)

- Copies of all publications resulting from the study should be submitted to this HREC. Please also ensure that a copy is also forwarded to the Cairns Base Hospital Medical Library.

Your protocol number for the above application for all future correspondence is **#534.**

Yours sincerely

Professor Michael Humphrey
Chairperson
Human Research Ethics Committee
Cairns & Hinterland Health Services District

23rd October 2008

Appendix 3

Queensland Government

INFORMATION TO THE PARTICIPANT Queensland Health

Midwives' experience of working in dual roles of midwife and nurse in rural FNQ.

Chief Investigator:
Karen Yates, Regional Maternity Services Coordinator, Cairns Base Hospital

You are invited to take part in research to uncover and describe the experience of midwives working in a dual role as nurse and midwife in facilities in rural Far North Queensland.

1. PURPOSE AND BACKGROUND OF THE RESEARCH

The purpose of this research is to provide midwives the opportunity to describe their experiences working as both a midwife and a nurse in rural facilities. Your participation in this research is anticipated to provide understanding about the experiences of this situation. Smaller birth numbers in many rural facilities mean that midwives provide care for both maternity clients and general nursing patients. Recruitment of midwives to rural facilities is difficult and developing an understanding of the role may help develop recruitment strategies to address this or help with the development of models of care that attract midwives to these regions.

2. PROCEDURE/RESEARCH

If you agree to participate in this research you will be you will be asked to take part in an informal interview process where you will be asked to talk about your daily work as a nurse and midwife. The interview will be with the Chief Investigator and yourself only. The time and place for the interview will be up to you to choose.

3. BENEFITS

In conducting this project, the researcher hopes to describe and interpret what it means to work as a midwife and nurse in rural areas of Far North Queensland. Little or no research has been carried out to examine the role in which you work and this research aims to describe your experiences.

4. RISKS/DISCOMFORTS

It is not envisaged that you will experience any discomfort while participating in the research. If you do not wish to discuss anything that is perfectly acceptable and as there will be no specific questions to answer, you may disclose whatever you feel is appropriate to describe your working role.

Support for the research will be sought from the Directors of Nursing at each facility and also the Unit Managers of the wards where you work. At all times during the study your identity will be protected and remain confidential. Only the researcher will have access to these details.

Your participation in the study is entirely voluntary and you have the right to withdraw from the research project at any time. If you decide not to participate or if you withdraw, you may do this freely. All information will be treated with absolute confidentiality.

Results from this study will be presented at relevant conferences and submitted for publication in refereed journals. There will be no identifying information in any results disseminated. The researcher will also contact you if you desire at the end of the study to provide you with a copy of the results.

5. **QUERIES OR COUNSELLING**

If you have any questions regarding the project, please contact Karen Yates on 40407475.

It is not anticipated that participating in this study should cause you any distress but if this is so a Counsellor is available to you through the Employee Assistance Scheme by contacting the HRM department in your facility.

Thank you for considering participation in this project.

Appendix 4

Queensland Government

Queensland Health

CONSENT TO PARTICIPATE IN RESEARCH PROJECT

Midwives' experience of working in dual roles of midwife and nurse in rural FNQ.

Are you an adult ie. 18 years or over?	YES ____ NO_____
Do you consent to take part in this research project?	YES ____ NO_____
Have you read and/or had read and explained to you the information sheet which explains the nature, object and possible risks of the research project?	YES ____ NO_____
Do you understand the contents of the information sheet?	YES ____ NO_____
Do you understand that:	
1) your responses, the results and any report arising from this project will remain confidential?	YES ____ NO_____
2) only persons carrying out the research project will have access to the information?	YES ____ NO_____
3) you will not be identified or named in the publication of the results and findings of the research?	YES ____ NO_____
Do you understand that you may withdraw from this research project at any stage?	YES ____ NO_____
Do you voluntarily agree to take part in the research?	YES ____ NO_____
Do you acknowledge that you have signed this Consent Form of your own free will and that you have not relied upon any verbal, written or visual representation or statements by the person conducting the research?	YES ____ NO_____
Have you received a copy of this consent form?	YES ____ NO_____

Queensland Government

Queensland Health

SIGNED this day of 2008

.....

Participant: Name: .....

Signature: .....

Witness: Name: .....

Signature: .....

RESEARCHER'S STATEMENT

I have explained to the Participant .....
The nature and purpose of the research project and the procedures used and any risks which may result from participation.

.....
signature of the Researcher.