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Sadie Margaret Geraghty
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'FIGHTING A LOSING BATTLE': A Glaserian Grounded Theory of Midwives' Workplace Stress

SADIE MARGARET GERAGHTY

BA (Hons), BSc (Hons), MMid, MEdRM

This thesis is presented for the degree of Doctor of Philosophy (Nursing)

School of Nursing and Midwifery

Edith Cowan University 2017

ABSTRACT

The development of the midwifery profession and the culture of childbirth are inevitably entwined from an historical perspective through to current day practice. Early written accounts describe the fifteenth century midwife as dealing with high maternal and child mortality rates, the invention of forceps, the rise of male obstetric practitioners, and the complex social and cultural changes of that era. The twenty-first century midwife faces challenges in Australia and worldwide, which are not dissimilar to our midwifery predecessors.

Midwifery clinical practice has become more complex due to the medicalisation of childbirth and 21st century lifestyles, which have contributed to a rise in critical incidents and emergency situations amongst labouring, birthing and postpartum women. Therefore, the purpose of this study was to examine whether clinical midwifery practice causes midwives work-related stress which may have implications for the emotional well-being and career decisions from the perspective of Western Australian midwives. Work-related stress has been extensively researched amongst other health professionals, but relatively little is known about Western Australian midwives and work-related stress, therefore this required further exploration. A classic grounded theory study design was used, which included 21 in-depth individual face-to-face interviews with Western Australian registered midwives from May 2014 to December 2015. 'Midwifery is Stressful but it is not the Job Itself', was the core problem to emerge from the collected data, with three major sub-categories emerging which included workloads, coordinators and traumatic incidents. These factors were identified as causing stress. The sub-categories are explored in relation to the consequences, context and process that affected, influenced and constrained the participants. Emotional distress, commitment to midwifery and future career decisions are the final sub-categories identified that provide an understanding of the relationship between the categories. A new substantive theory of work-related stress in midwifery is presented entitled 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress.

Keywords: midwifery, stress, work-related, emotional well-being, classic grounded theory, midwives, career decisions.

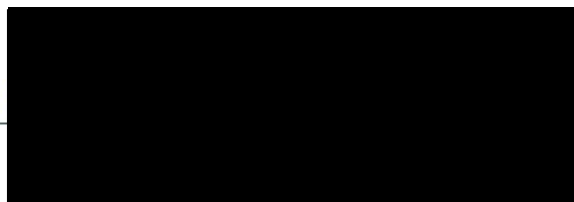
DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

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A special thank-you to my friends and colleagues who were also on their own PhD journeys at the same time but provided me with space and time when I needed it.

I am forever grateful to the midwives who participated in this study, and freely gave me their thoughts and time. Without their participation there would not be a study to report.

PRESENTATIONS AND PUBLICATIONS

Geraghty, S., & Bayes, S. (2015). Winners of the Research Photography Competition 2015, in the Digital category at Edith Cowan University Culture Week. (Appendix D)

Geraghty, S., & Oliver, K. (2015). Is work-related stress affecting nurses and midwives? *Australian Nursing and Midwifery Journal*, 23(3), 32.

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**'The ultimate act of service is to acknowledge and honour the integrity
of another being as they, like us, pass through the beauty
and the pain of a human birth'**

(Unknown)

TABLE OF CONTENTS

ABSTRACT	I
DECLARATION	II
ACKNOWLEDGEMENTS.....	III
PRESENTATIONS AND PUBLICATIONS.....	IV
LIST OF FIGURES.....	X
LIST OF TABLES.....	XI
CHAPTER ONE: BACKGROUND TO THE STUDY	1
1.1 INTRODUCTION.....	1
1.2 HISTORICAL BACKGROUND TO THE STUDY.....	2
1.2.1 Contemporary Background to the Study	3
1.3 ORGANISATION OF THE THESIS	4
1.4 SUMMARY.....	5
CHAPTER TWO: THE RESEARCH DEFINED	6
2.1 INTRODUCTION.....	6
2.2 USE OF THE LITERATURE.....	6
2.2.1 Literature Search Strategy	7
2.3 WORK-RELATED STRESS IN MIDWIFERY	8
2.4 WORK-RELATED STRESS AND WORKFORCE ISSUES	13
2.5 WORK-RELATED STRESS AND THE MIDWIFERY ROLE.....	14
2.6 STRESS IN MIDWIVES	16
2.7 COPING WITH STRESS.....	18
2.7.1 Compassion Fatigue	19
2.7.2 Emotional Well-being	20
SUMMARY	21

CHAPTER THREE: METHODOLOGY	23
3.1 INTRODUCTION.....	23
3.2 QUALITATIVE RESEARCH.....	23
3.2.1 Symbolic Interactionism	25
3.3 GROUNDED THEORY METHOD	27
3.3.1 Paradigm.....	30
3.3.2 Glaserian or Classical Grounded Theory	30
3.3.3 Use of the Literature.....	31
3.3.4 Strength and Weaknesses of Grounded Theory	32
3.4 RESEARCH DESIGN	33
3.4.1 Ethical Considerations	33
3.4.2 Theoretical Sensitivity and Bias.....	34
3.4.3 Sample Size.....	36
3.4.4 Recruitment of Participants.....	36
3.4.5 Profile of Participants.....	37
3.4.6 Purposive Sampling.....	38
3.4.7 Theoretical Sampling	38
3.5 DATA COLLECTION.....	39
3.5.1 Interviews.....	39
3.5.2 Iteration	43
3.5.3 Transcribing	43
3.5.4 Constant Comparative Method.....	43
3.5.5 Open Coding	47
3.5.6 Theoretical Coding.....	48
3.5.7 The Definition of the Major Categories	50
3.5.8 Memoing	50
3.5.9 Theoretical Saturation of Categories.....	52
3.6 WRITING THE THEORY.....	53
3.6.1 Trustworthiness	54
3.6.2 Extended Engagement	54
3.6.3 Audit Trail	54
3.6.4 Peer Group Debrief and Review Sessions.....	55
3.6.5 Triangulation of Data	56
3.6.6 Negative Cases	56
3.6.7 Transferability.....	56
3.7 LIMITATIONS OF THIS STUDY	57
SUMMARY	58

CHAPTER FOUR: RESEARCH FINDINGS.....	59
4.1 INTRODUCTION.....	59
4.2 ‘FIGHTING A LOSING BATTLE’: A GLASERIAN GROUNDED THEORY OF MIDWIVES’ WORKPLACE STRESS.....	60
4.3 ‘MIDWIFERY IS STRESSFUL BUT IT IS NOT THE JOB ITSELF’	62
4.3.1 ‘Having to be 150% on Your Game all the Time’	63
4.3.2 ‘Being Between a Rock and a Hard Place Whether You are Coordinating or Not’	72
4.3.3 ‘Going Pear-Shaped in Four Rooms at Once’	77
4.3.4 ‘People do not have any Understanding of What Midwives go Through Emotionally’	81
4.3.5 ‘Being an Advocate in the Face of Medical Disrespect is Tough’	88
4.3.6 ‘Toeing the Line and Giving our Pound of Flesh’	91
4.4 MATESHIP HELPS BUT IT’S NOT ENOUGH’	93
4.4.1 ‘Having Each Other’s Backs’	93
4.4.2 ‘Knowing Other Midwives Understand’	94
4.4.3 ‘Thinking Very Seriously About Getting Out’	101
4.5 FIGHTING A LOSING BATTLE.....	105
4.6 SUMMARY.....	109
 CHAPTER FIVE: DISCUSSION	 110
5.1 INTRODUCTION.....	110
5.2 FIGHTING A LOSING BATTLE: OVERVIEW OF A MIDDLE-RANGE THEORY TO EXPLAIN MIDWIVES’ EXPERIENCES OF AND RESPONSE TO WORKPLACE STRESS.....	112
5.3 MAKING MEANING OF THE KEY FINDINGS.....	114
5.3.1 The Effects of Being Physically and Emotionally Stressed at Work	121
5.3.2 The Value of ‘Mateship’ in Stressful Workplaces.....	130
5.3.3 Midwifery Practice Workplaces as War Zones.....	132
5.4 FIGHTING A LOSING BATTLE: A NEW THEORY OF WORK-RELATED STRESS	136
SUMMARY	139
 CHAPER SIX: LIMITATIONS, RECOMMENDATIONS AND CONCLUSION.....	 140
6.1 INTRODUCTION.....	140
6.2 SUMMARY OF THE STUDY	141
6.3 SIGNIFICANCE OF THE STUDY.....	144
6.4 LIMITATIONS.....	145
6.5 RECOMMENDATIONS.....	148
6.5.1 Recommendations for Preparation of New Coordinators.....	148

6.5.2	Recommendations for Further Research.....	150
6.5.3	Implications for Education Regarding Work-related Stress Pre and Post Registration.....	150
6.5.4	Support in Clinical Practice.....	151
6.6	AUTOBIOGRAPHICAL REFLECTION	151
	FINAL WORDS	152
	REFERENCES	154
	APPENDIX A	178
	APPENDIX B	180
	APPENDIX C	181
	APPENDIX D	182
	APPENDIX E	183

LIST OF FIGURES

Figure 1:	Categories Being Formed	48
Figure 2:	Examples of my Memos Kept After Interviews	52
Figure 3:	Examples of my Memos Kept After Interviews	52
Figure 4:	Examples of my Memos Kept After Interviews	52
Figure 5:	Examples of Trustworthiness / Audit Trail.....	54
Figure 6:	Examples of Trustworthiness / Audit Trail.....	54
Figure 7:	Example of the Audit Trail.....	55
Figure 8:	Fighting a Losing Battle: A Grounded Theory of Midwives' Experience of and Response to Workplace Stress	108

LIST OF TABLES

Table 1:	Examples of Line-by-Line Coding.....	45
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CHAPTER ONE: BACKGROUND TO THE STUDY

“You are a birth servant. Do good without show or fuss. If you must take the lead, lead so that the mother is helped, yet still free and in charge. When the baby is born, they will rightly say: We did it ourselves!”

(Tao Te Ching)

1.1 INTRODUCTION

Chapter One introduces the study and presents the aim of the research. It also presents the conceptual elements of this research study: midwives’ workplace stress and its implications for their emotional well-being and career decisions, within the contemporary Western Australian midwifery clinical working environments. An overview of the processes is also provided, and the chapter ends with a description of how the thesis is organised.

Occupational stress is known to be a primary cause of job dissatisfaction amongst healthcare workers, for example nurses, social workers, care workers and doctors, and a factor in the retention of health professionals in the professions (Antoniou, Cooper, & Davidson, 2016; Nowrouzi et al., 2015; Qiao et al., 2016; Ruotsalainen, Verbeek, Mariné, & Serra, 2015). Recent studies suggest that workloads and fear of making mistakes because of exhaustion are causing midwives stress (Foureur, Besley, Burton, Yu, & Crisp, 2013; Hildingsson, Westlund, & Wiklund, 2013; Mander, 2016; Mollart, Skinner, Newing, & Foureur, 2013; Sato & Adachi, 2013). This has led to studies reporting on adversity in the midwifery environments and midwives’ emotional well-being (Drach-Zahavy, Buchnic, & Granot, 2016; McDonald, Jackson, Vickers, & Wilkes, 2016), as well as coping strategies (Warriner, Hunter, & Dymond, 2016) and the development of personal resilience (Crowther et al., 2016; Rice & Liu, 2016).

Stress in clinical environments can have significant consequences for midwives, the women and babies they care for and the organisations who employ midwives; this can include psychological and physical health deterioration and impaired professional practice (Suresh, Matthews, & Coyne, 2013). Stress and burnout in midwives have been

identified as factors impacting on retention of midwives in the workforce (Hildingsson et al., 2013; Mollart et al., 2013; Rouleau, Fournier, Philibert, Mbengue, & Dumont, 2012; Sheen, Spiby, & Slade, 2015; Sidebotham, Gamble, Creedy, Kinnear, & Fenwick, 2015). Therefore, it is important to identify stress and stressors, and understand the impact and consequences these have on midwives working in the clinical environments.

There have been no studies that have investigated midwives' workplace stress and the implications for their well-being and future career decisions in Western Australia. This thesis adds to the body of research literature that explores midwives and work-related stress globally, and offers a substantive theory to provide understanding and improve outcomes for the midwifery profession.

1.2 HISTORICAL BACKGROUND TO THE STUDY

Put in simple terms, the word midwife means 'being with woman' (Hunter, 2002). Midwives and the practice of midwifery has an ancient and rich history, and evolved before medicine, with women who were known as 'healers' or 'wise' women (van Teijlingen, 2004) assisting each other within small clans or communities, as they gave birth (Wall, 2014). The development of the midwifery profession and the culture of childbirth are inevitably entwined from a historical perspective through to current day practice. Midwifery has been identified as an ancient tradition that is present in almost every culture globally (Todman, 2007).

From the earliest recorded written accounts up to the fifteenth century in Europe, almost all births were conducted by midwives, who used and understood herbs and were often the only health care providers for a village, clan or community (Drife, 2002). During this time frame, midwives were often targets for accusations of witchcraft because of their knowledge of healing and the mystery of birth (Ehrenreich & English, 2010). The Inquisition, which persecuted midwives, was the primary political presence in Europe, and strong minded women (as midwives tend to be), were often called witches to silence them. According to Anderson (1992), during this period in history many wise-women who used herbs for birth control, to manage postpartum bleeding or assist with abortion, were denounced as a witch, although some authorities dispute how widespread this phenomenon actually was. Thousands of midwives accused of witchcraft were discredited, disgraced and arrested; many midwives were tortured or put to death by burning at the stake, hanging or drowning (Anderson, 1992). The fifteenth century midwife was also dealing with high maternal and child mortality rates

(Wrigley & Schofield, 1983), the invention of forceps and the rise of male obstetric practitioners (Jeffcoate, 1953), and the complex social and cultural changes of that era (Braudel, 1992).

1.2.1 Contemporary Background to the Study

The twenty-first century midwife faces challenges in Australia and worldwide, which are not dissimilar to our midwifery predecessors. Midwifery clinical practice has become more complex due to the medicalisation of childbirth (Healy, Humphreys, & Kennedy, 2016) and 21st century lifestyles (O'Brien, Grivell, & Dodd, 2016), which have contributed to a rise in critical incidents and emergency situations amongst labouring, birthing and postpartum women (Adriaenssens, de Gucht, & Maes, 2012). These changing circumstances have exposed midwives to work-related stress and compassion fatigue which impact upon emotional well-being. Therefore, the purpose of this research was to explore whether work-related stress from clinical midwifery practice has implications for the emotional well-being and career decisions of midwives.

The role of the midwife has always involved being with the woman through her childbirth journey; more recently, midwifery has evolved to encompass 'woman-centred care' and 'partnerships with women' as the focus of providing care (Berg, Ólafsdóttir, & Lundgren, 2012; Davison, Hauck, Bayes, Kuliukas, & Wood, 2015; Giarratano, 2016; Miles, Chapman, Francis, & Taylor, 2014). Research has shown that midwifery models of care result in optimal outcomes for childbearing women (Sandall, Soltani, Gates, Shennan, & Devane, 2016), whilst providing midwives with motivation and job satisfaction (Gu, Zhang, & Ding, 2011; Sullivan, Lock, & Homer, 2011; Warmelink et al., 2015). However, there is little evidence of how providing midwifery care in stressful circumstances can impact emotionally on midwives.

This research study uses classic grounded theory methodology, with the aim to understand midwives' workplace stress, and to theorise ways to better support this under-threat workforce and maintain midwives' emotional well-being so they remain effective in their roles. Understanding midwives' experiences and personal perspectives of work-related stress is important to the future development of the midwifery profession and the continued recruitment and retention of midwives to be of service to childbearing women.

My selection of classic grounded theory methodology enabled the generation of a substantive theory which reflects how the midwifery participants of this study

understand work-related stress. The study contextualises the experiences of midwives through in-depth, face-to-face interviews that were recorded and transcribed. The every-day practises and situations the midwives found themselves in were described and how this made them feel, and the impact it had on them was discovered. These experiences became the data for this study that is described by Glaser and Strauss (1967) as "theory developed from data systematically collected through social research" (p.1).

It is therefore an important point that any theories regarding work-related stress in midwives, should be grounded in the clinical practises and experiences of midwives. The midwifery participants who took part in this study worked in public and private maternity units, a birth centre, a midwifery group practice, rural / remote maternity services, independently practising midwifery and the only tertiary maternity hospital – all in Western Australia.

1.3 ORGANISATION OF THE THESIS

This thesis consists of six chapters, the first of which has been used to present an overview of the research study, an historical and contemporaneous background to the study, and the aim and significance of this study. In Chapter Two, the current and past literature relating to work-related stress in midwives in both Australia and the international context is reviewed, thus providing the justification for under-taking this study. In Chapter Three, the methodology used in development of a substantive theory in this study is described in depth and justified; the theoretical framework underpinning the study is examined therein, and explanation and justification of the participant recruitment process, data collection methods and how the analysis of the data was conducted is discussed. Additionally, the considerations taken for ethical research practice and rigor are provided in Chapter Three. In Chapter Four, the findings which emerged from the data are presented, along with an explanation of the core, major and sub categories. In Chapter Five the substantive theory is presented and discussed, and the key findings are discussed in detail with a link made to the existing literature. The thesis concludes with Chapter Six in which the limitations, recommendations and conclusions of this study in relation to midwives, work-related stress and its implications for the well-being of midwives, the impact of midwives' career decisions and the overall impact on the midwifery profession are outlined.

1.4 SUMMARY

This chapter has contextualised the midwifery role for the main premise of this research study and has introduced the study and presented the aim of the research. The conceptual elements of the study: midwives' workplace stress and its implications for their emotional well-being and career decisions, within the contemporary Western Australian midwifery clinical working environments has been presented. The substantive theory that emerged from the analysed data collected for this study, is intended to contribute to the existing knowledge regarding work-related stress, emotional well-being and career decisions of midwives. Work-related stress is a major concern for the twenty-first century midwife and the future of the midwifery profession, and this study has highlighted the issues associated with work-related stress and provides a helpful insight into the reduction of this problem. Chapter Two now follows, in which the issues relevant to the phenomenon of interest in this thesis are identified, and the existing knowledge surrounding this topic is explored.

CHAPTER TWO: THE RESEARCH DEFINED

**“Becoming a midwife isn’t just choosing a profession,
It is answering a calling that has chosen you,
And will be you”**

(Jan Jutter)

2.1 INTRODUCTION

Following the background to the study, I now discuss the problem and the existing literature related to the problem. The issues relevant to the phenomenon of interest in this thesis are identified, and current knowledge pertaining to those issues are explored. In keeping with the grounded theory methodology, a limited review of the literature was conducted at the proposal writing stage of this study, and this chapter provides an in-depth discussion concerning the use of literature when using the grounded theory methodology for a study. I identify that minimal attention has been paid to date on Western Australian midwives’ workplace stress and the implications for their emotional well-being and career decisions, and it is this gap that this research is aimed at addressing.

2.2 USE OF THE LITERATURE

This study was conducted using Grounded Theory (GT) methodology, wherein particular rules apply to the pre-investigation review of the extant literature. Grounded theory has been described as a “general inductive method possessed by no discipline or theoretical perspective or data type” (Glaser, 2005, p. 14). This suggests that concepts are generated from the data collected from the study as opposed to being generated from the extant literature.

When undertaking a grounded theory data collection, the analysis is commenced without a specific pre-conceived theoretical framework or hypothesis. This is achieved without conducting an exhaustive literature search in the substantive area prior to commencing the study because grounded theory is for the discovery of hypotheses. According to Glaser (1978), the first step in grounded theory is:

"to enter the substantive field for research without knowing the problem. This requires suspending your knowledge, especially of the literature, and your experience. The researcher must take a 'no preconceived interest' approach and not ask questions that might be on his mind" (p. 122).

In other words, the grounded theory process is not required to test or replicate, and the researcher must avoid contamination of perception that might arise from conscious and unconscious assumptions of what should be found in the data prior to commencing research. This facilitates the researcher to enter into the study as a 'tabula rasa' or 'clean slate' (Glaser & Strauss, 1967, p. 45), and this term refers to the mind in its hypothetical primary blank or empty state before receiving outside impressions (Merriam-Webster, 2016).

Glaser (1978) makes it clear that a researcher cannot approach reality completely 'tabula rasa' (p.7), and concedes that at least a theoretical perspective, in relation to the phenomenon of interest, is required to enable a grounded theory about it to emerge. Therefore, the researcher is acknowledged to begin with a general theoretical perspective and an understanding of 'local' concepts from their experience of the environment under investigation. Glaser's argument, though, is that a researcher should pose a research question with an aim to explore what might be happening in a particular substantive area without proposing a hypothesis based on an 'argument' derived from a literature search. The literature search therefore becomes more like setting the scene within which the research will be conducted without any presumption of what might be going on or what might emerge from the research.

The literature review also serves to verify that there is a gap in knowledge around the topic and that the current study is necessary to add knowledge not previously known in the field of interest.

2.2.1 Literature Search Strategy

Several literature searches were conducted in July and August of 2016 for this thesis. In order to obtain a wide scope of research covering the subject of midwives and work-related stress, databases including CINAHL PLUS, Medline, ProQuest, Psych Info, Scopus and the Cochrane Library of Systematic Reviews were accessed. Depending on the database, the keywords used in differing combinations included 'midwives', 'stress', 'emotional well-being', 'compassion fatigue', 'retention' and 'work-related stress'. Truncations were applied to the key search words to expand search

results. Filters applied to the search review included peer/scholarly reviewed, English language, and year of publication. The dates of research searched for was initially limited to 2012 - 2016 as to only include the latest research, but then broadened to 2000 - 2016. The initial search yielded no research regarding studies conducted with Western Australian midwives and work-related stress. Therefore, I adapted the search to include literature related to nurses, first responders and other healthcare professionals and work-related stress in Australia and globally. The databases yielded 2,651 studies, which I explored for papers concerning 'midwives' and 'emotional well-being' and 'work-related stress'. I selected articles from the searches based on the relevance of the article from the abstract. In addition, I conducted a manual search of reference lists from selected journal articles. This resulted in nine relevant studies, which focus on the reasons, sources, manifestations and implications of stress within midwifery, beginning with the contemporary issues associated with being responsible for 'managing' the wayward and unpredictable nature of birthing have been discussed in this review of the literature. These nine studies are discussed in the next section, and contextualised in other work on this topic in the remainder of this chapter.

To reiterate, consistent with the grounded theory methodology used for the current study, this literature review was conducted only to confirm the need for further work in this area.

2.3 WORK-RELATED STRESS IN MIDWIFERY

A midwife working in a clinical environment routinely experiences the dilemma of being unsure of how each particular shift will unfold. Birth is a normal physiological process however it can become complicated and progress into an emergency situation in a short space of time. Emergencies in a clinical environment are stressful (Adriaenssens et al., 2012; Bragard, Dupuis, & Fleet, 2015), and although midwives are trained to manage obstetric emergencies, they are not the norm in midwifery. As a profession, midwifery is centred on the woman and the relationship that evolves between the woman and their midwife (Davison et al., 2015); a midwife employs an array of interpersonal skills to facilitate the unexpected aspects of this role (Cooper & Lavender, 2013). Exposure to uncertain obstetric situations, and the potential for catastrophe, increases stress within the midwifery clinical environments (Sheen et al., 2016).

The body of literature relating to stress and working environments amongst health professionals, other than midwives, is substantive, however there are few research studies relating specifically to midwives' emotional well-being and working clinically (Drach-Zahavy et al., 2016; Halperin et al., 2011; Hunter, 2004; Knezevic et al., 2011; Leinweber & Rowe, 2010; Mollart et al., 2013; Sheen et al., 2015).

An early study undertaken by Hunter (2004) explored how midwifery students and midwives experienced and managed emotion in their work. An ethnographic approach used focus groups, observations and interviews to collect data from British participants. The key findings from this study centred on how the participant's main focus for emotional stress were the conflicting ideologies of midwifery practice.

Participants who worked within the woman-centred philosophy of midwifery found their job emotionally rewarding, whereas those working with the medicalised, institution-centred care found their work emotionally difficult. The findings from this study were important as it was identified that midwifery was deemed as highly emotional work, with participants experiencing many work-related conflicts and dilemmas. What was unique with this study was the recognition that the organisation and interactions with colleagues were sources that created dissonance and conflict within the midwifery philosophy. This study concluded that understanding the causes that impact upon emotion within the midwifery working role would improve the quality of midwives' lives.

Subsequent to Hunter's (2004) study, Turkish researchers conducted an investigation into Turkish midwives' levels of work-related stress, burnout and job satisfaction in midwifery (Oncel, Ozer, & Efe, 2007). The descriptive and cross-sectional data were collected via survey, and the sample numbered 325 midwives. The study could not determine whether burnout was a causal factor in job dissatisfaction among the midwives, or whether job dissatisfaction caused burnout. The participants were not asked about other factors that may have contributed to both job dissatisfaction and burnout; for example, working conditions, relationships with other midwives and members of the multidisciplinary team and critical incidents that occur in clinical practice were important factors that were over-looked. The emphasis of the study was determining the level of burnout and job dissatisfaction of the participants, which contributed to work strain and emotional exhaustion. The authors concluded that those midwives with high levels of job satisfaction had moderate levels of burnout and work-

related stress and required minimal support, although a recommendation of an ongoing educational program could be introduced regarding coping with stress.

A paper by Leinweber and Rowe (2010) followed wherein they reported a review of literature on traumatic stress in midwifery; these authors found that midwives, who are involved in providing care for others, experience compassion fatigue, post-traumatic stress, secondary traumatic stress and emotional suffering. The authors suggested that the woman-midwife relationship within midwifery clinical practice evokes empathy and exposes midwives to the risk of experiencing secondary traumatic stress when caring for women who experience a traumatic birth. This in turn can impact upon the midwife's own mental health and her/his capacity to provide care to women as befits the midwifery philosophy of care. Therefore, the authors recommended that midwifery should acknowledge secondary trauma caused by clinical situations as a professional risk, and investigate it within midwifery.

Leinweber and Rowe's (2010) recommendations were supported by a study that was published soon after by Halperin, Goldblatt, Noble, Raz, Zvulunov and Liebergall Wischnitzer (2011), that investigated how midwives coped with life-threatening clinical situations. Individual semi-structured, in-depth interviews were conducted with eighteen midwives, who were asked to recall an extremely stressful clinical situation they had witnessed or been involved with, and what coping strategies or support systems they had used after the event. Two themes emerged: the first one focused on reactions to stressful childbirth situations and their impact on midwives, and the second related to coping with stressful situations, focusing on coping difficulties, and suggestions for change. The authors concluded that stressful clinical situations had a long-term impact on midwives' personal and professional identities, and suggested that a supportive framework managed by experienced midwives should be in place for other midwives. This is something that has yet to be implemented in clinical practice in Australia.

Published in the same year as Halperin and team's (2011) work was published, a study conducted in Croatia that explored the sources and levels of work-related stress and work ability amongst Croatian midwives (Knezevic et al., 2011). The participants included 105 registered midwives and 195 paediatric nurses, who were surveyed using an Occupational Stress Assessment Questionnaire (OSAQ) in a cross-sectional design study. The midwifery participants represented 14.7% of all hospital-based midwives in Zagreb hospitals, with 76.7% of midwives believing that although their job was

stressful, they cited insufficient work resources caused the most stress. Over 50% of the midwives identified factors such as an insufficient number of co-workers, unexpected situations, inadequate income, night work and poor organisation at work, with a higher level of stress. Insufficient work resources and poor organisation at work were more common stressors among midwives than for the paediatric nurses in the sample. The conclusion from this study was that midwives' work ability, in relation to the demands of their job, was good. Dissatisfaction and emotional well-being were not explored, however, burnout was not mentioned or discussed by the participants or researchers.

In a more recent study reported by Mollart, Skinner, Newing and Foureur (2013), 152 midwives were surveyed using a demographic survey that asked the participants about the model of care they worked in, shift work, lifestyle data and exercise level. All the participants worked in two public hospitals in New South Wales, Australia. Over 60% of the midwives reported experiencing moderate to high levels of emotional exhaustion. One point that the researchers highlighted in this study was that a midwife participant's level of exercise significantly affected how these midwives dealt with burnout. Therefore, this study highlighted an incidental association that demonstrates a learning point to be drawn from this finding, that exercise as burnout management/prophylaxis should be investigated as a matter of urgency. The authors concluded that length of service in the profession, number of shifts worked, including the complexity of the women being cared for, and heavy workloads, affected how midwives dealt with stress and burnout.

Two years after Mollart et al., (2013) study was published, Sheen, Spiiby and Slade (2015) reported on a postal survey, in which 421 British midwives responded to, who had experienced a clinical incident involving a perceived risk to the mother or baby, and which elicited feelings of fear, helplessness or horror. This was the first large-scale investigation conducted in the United Kingdom to explore midwives' experiences and responses to traumatic perinatal events. The results from this study revealed that 33% of the midwifery participants showed clinical symptoms of posttraumatic stress disorder. Midwives who provided empathy and had experienced previous traumatic incidents in practice whilst providing care to women, were associated with more severe posttraumatic stress responses. These findings suggest that midwives' emotional well-being is affected by incidents that occur in the clinical environments, and that this may have important implications for both midwives' personal and professional wellbeing.

However, the study did not address or make any recommendations of effective ways of preparing and supporting midwives following traumatic perinatal events.

The most current reported studies on the topic of midwives' workplace stress at the time of writing were published the year this thesis was submitted. One was conducted by Drach-Zahavy, Buchnic and Granot (2016), who examined the antecedents and consequences of emotional work experienced by midwives. This study was located in Israel and involved 104 births and 24 midwives. The data was collected via survey after a labour had finished and then again 48 hours post the woman giving birth. The researchers wanted to understand the specific factors involved in a midwife / birthing woman encounter, which included aspects of parity, use of epidural analgesia, induction of labour, and instrumental birth that may impact on the emotions of the midwife. It emerged that epidural analgesia and instrumental birth had negative connotations for the midwife emotionally, and the researchers concluded from this study that the findings offered empirical support for the importance of the midwife's expression of authenticity.

Authenticity was defined in this study as displaying emotions that he/she actually experienced toward birthing women in improving the woman's childbirth experience. The researchers suggested that this could only be achieved if the midwife was emotionally engaged and not experiencing stress caused from work or workforce issues.

Another study published this year had a more serious outcome to report upon, linking female health professionals in Australia, who experienced high levels of work-related stress with a greater risk of suicide (Doran, Ling, Gullestrup, Swannell, & Milner, 2016). This study conducted a national analysis of suicide by health professionals and in a period of eleven years, from 2001 – 2012, health professionals accounted for 3.8% of all suicides by employed Australians. The study revealed health professionals were exposed to higher levels of stress than other professions, due to extended working hours, non-family friendly work conflicts and fears of making mistakes. Doran et al. (2016) discovered that these stressors were associated with the development of mental health disorders, which included anxiety and depression that tended to increase when the health professional was exposed to medical emergencies and trauma. Interestingly, the study found that female health professionals had the additional stressors of gender, which involved child-care, household issues, and bullying and harassment in the workplace. This study indicates that female health professionals have additional

pressures, both inside and outside of the work environment that impact upon their working role.

As health professionals have a ready access to prescriptive medication, this study found that female health professionals were more likely to commit suicide via a drug overdose. Of all the health professionals included in the study, male nurses and midwives were attributed a disproportionately high rate of suicide.

The authors of this study suggest occupational gender pressures were contributing factors, as the midwifery profession is:

“organised to reinforce traditionally feminine characteristics of caring and support” (Doran et al., 2016, p. 121).

A third study, that was published as the writing up of this thesis was being conducted, was undertaken by the National Health Service (NHS) in the United Kingdom. The data was collected via an online survey, with 300,000 NHS staff responding during 2015 (National Health Service, 2016). There were responses from 5,268 midwives, who reported that stress in the work-place was a problem, with 46% saying they had suffered from stress in the past year. This result was higher than other health professionals, with findings showing 36% of health visitors and 33% of paramedics reported suffering from stress in the past year. The findings also revealed that 69% of midwives had felt pressure in the last three months to attend work when they were feeling unwell, and 43% of midwives had witnessed potentially harmful errors, near misses or incidents in the last month in clinical practice. One third (32%) of midwives had experienced bullying, abuse or harassment from NHS staff in the previous 12 months, with respondents stating that this was largely unreported, with only 37% saying that they reported the most recent experience. This study suggests that UK midwives are currently facing pressure due to understaffing, and an increased birth rate, that appears to be causing work-related stress in almost 4000 midwives, and concludes with concern over the current shortage of approximately 2600 midwives in England (National Health Service, 2016).

2.4 WORK-RELATED STRESS AND WORKFORCE ISSUES

There is evidence to confirm the unpredictable nature of midwifery makes the job stressful (Skinner & Maude, 2016); there is also research to suggest work-related stress is associated with a declining midwifery workforce (Hildingsson et al., 2013; Mollart et

al., 2013; Schluter, Turner, Huntington, Bain, & McClure, 2011). Workforce issues, including the suboptimal retention and recruitment of midwives, are a real threat to the profession and the midwifery organisation as a whole (Hildingsson et al., 2016; Pugh, Twigg, Martin, & Rai, 2013; Scott, Witt, Duffield, & Kalb, 2015). There are over 32,651 registered midwives in Australia (Nursing and Midwifery Board of Australia (NMBA), 2016), to serve an annual birth rate of over 317,000 live births (Australian Bureau of Statistics, 2015), however, only 15,523 midwives of these are reported as working principally in midwifery (Australian Bureau of Statistics, 2015). The profession is dominated by females (98.6%) and the average age of the midwife is 47.9 years old and 52.3% are aged 50 and over (Australian Bureau of Statistics, 2015). Similar to the national picture, there are currently 3,279 registered midwives in Western Australia (Australian College of Midwives, 2015), and 3,098 of this number are actually working in midwifery (NMBA, 2016). Research suggests midwives are describing their working environments as becoming increasingly stressful and being permeated by a culture of fear (Dahlen & Caplice, 2014; Hood, Fenwick, & Butt, 2010), which has been acknowledged as another attrition factor. The term 'culture of fear' has been used to describe the emerging sense of a crisis around childbirth in western culture, and centres on the decline of women's confidence in birth without medical intervention (Adams, Eberhard-Gran, & Eskild, 2012; Nieminen, Andersson, Wijma, Ryding, & Wijma, 2016; Rouhe et al., 2015; Ryding et al., 2015).

Midwifery workforce attrition is at a critical rate in Australia (Hildingsson et al., 2016), with a predicted shortfall in Western Australia in the next five years (Pugh et al., 2013); this is due to the threat of losing midwives to retirement in unprecedented numbers and falling recruitment of new midwives to the profession. Currently in Western Australia, of the 3,098 midwives working clinically, 830 midwives are aged 50 years plus (NMBA, 2016). Therefore, support of midwives is essential for those who stay in clinical practice, particularly with the increase in complex childbirth and the changing midwifery role.

2.5 WORK-RELATED STRESS AND THE MIDWIFERY ROLE

A source of work-related stress for midwives is the fact that the midwifery role has become multifaceted due to the increased complexity of pregnancies (Kelly, Alderdice, Lohan, & Spence, 2013), insufficient work resources (McDermott, Keating, Freeney, & Fellenz, 2013), poor skill mix amongst staff (Freund et al., 2015), and heavy workloads (Bailey, Wilson, & Yoong, 2015). Midwives have also described how they lack

time in providing non-medical or non-urgent care during their working day (Shaban, Barclay, Lock, & Homer, 2012), for example supporting a labouring woman and educating her with newborn care such as breastfeeding. Years of working in the profession under these conditions leads to burnout (Mollart et al., 2013). Therefore, the role of the contemporary midwife has undergone major change during the last century (Sidebotham, Fenwick, Rath & Gamble, 2015), with normal birth becoming increasingly medicalised in conjunction with the health challenges resulting from 21st century lifestyles (Healy et al., 2016; O'Brien et al., 2016). This has had an impact on the midwifery role, which has become more demanding and complex.

Complex pregnancy and birth has been directly affected by the adopted lifestyles of some pregnant women; increasingly the childbearing episode is complicated by smoking (Yerushalmy, 2014), alcohol (O'Keeffe et al., 2015), illicit drugs (Lindsay & Burnett, 2013), obesity (Lim & Mahmood, 2015), low physical activity (Currie et al., 2013), advanced maternal age (Kenny et al., 2013), poverty (Hamad & Rehkopf, 2015) and the misuse of prescribed medication (Martin, Longinaker, & Terplan, 2015). These factors have direct implications for maternal and fetal morbidity and mortality.

The rise of medical conditions attributed to lifestyle factors takes pregnancy and birth out of the realms of 'normal' and midwife-led care, and into 'high-risk' obstetrician-led care. As a consequence, midwives are exposed to a rise in critical incidents and emergency situations amongst pregnant, labouring, birthing and postpartum women (Sheen et al., 2015). One example is postpartum haemorrhage, which is defined as a blood loss after giving birth of 500 mls or more (Mousa, Blum, Abou El Senoun, Shakur, & Alfirevic, 2014); until relatively recently a recorded blood loss of one litre was a rare occasion. However, women are increasingly having postpartum haemorrhages of up to four litres (Le Bas, Chandrachan, Addei, & Arulkumaran, 2014), and requiring blood transfusions and at least 24 hours of care in the adult special care unit post birth (Patterson et al., 2014).

Gestational diabetes has risen in Western Australia (WA), and is now the most common antenatal condition affecting pregnancy (Hutchinson & Joyce, 2014), and the number of people classed as overweight to obese has risen by 70 – 79% amongst the population of WA (Western Australian Mothers and Babies, 2015). These statistics are associated with an increased incidence of shoulder dystocia (Young & Ecker, 2013) and Caesarean births (Ovesen, Jensen, Damm, Rasmussen, & Kesmodel, 2015), amongst

childbearing women, as is the growth in the number of substance misusing women who present with placental abruptions (McLaurin & Geraghty, 2013).

Women with compromised health are at risk of birthing a compromised newborn due to adverse antenatal and intrapartum complications, and may require admission to the special care nursery for treatment for addiction, premature birth and life support (Harrison & Goodman, 2015). These births can be stressful, as the midwife could be involved in a life-threatening situation not just for the woman, but for the neonate also. As discussed in the next section this cultural shift appears to have coincided with the dominance of the medicalisation of childbirth and societal changes to lifestyle factors.

Birth moved from the home to the hospital in the 20th century (Cameron, 2009; Davis & Hunter, 2015), and since then midwives have battled to keep birth normal and care led by a midwife. Midwives have always held the inherent belief that childbirth is a normal part of the female life-cycle, and that the practice of midwifery was an integral part of healthcare and family life. The midwifery role has, however, become fragmented and midwives have become marginalised and somewhat dissatisfied professionally because of the medicalisation of birth (McIntosh & Hunter, 2014; Monk, Tracy, Foureur, & Barclay, 2013; Papoutsis, Labiris, & Niakas, 2014).

2.6 STRESS IN MIDWIVES

Midwifery is widely acknowledged as a caring profession (Chokwe & Wright, 2013; Simwaka, De Kok, & Chilemba, 2014), in that it meets the physical and emotional needs of the woman. Meeting these needs requires personal emotional involvement, which has the potential to cause emotional stress in health-care professionals (Sey, Scott, Wu, Van Gerven, Vleugels, Euwema, Panella, Conway, Sermeus, & Vanhaecht, 2013). There has been research conducted within the health professional clinical environments that supports the notion that caring for others who suffer pain and trauma can cause traumatic stress reactions in staff (Adriaenssens, De Gucht, & Maes, 2015; Fiabane, Giorgi, Sguazzin, & Argentero, 2013; Rushton, Kaszniak, & Halifax, 2013).

These stress reactions manifest various responses from those affected, which emerge as coping reactions and can impact upon the mental health and their capacity to continue to provide optimal care (Drury, Craigie, Francis, Aoun, & Hegney, 2014; Ruotsalainen et al., 2015). Research suggests that health care professionals have been experiencing increasing levels of work-related stress in recent years (Jones, Wells, Gao, Cassidy, & Davie, 2013; Karimi, Leggat, Donohue, Farrell, & Couper, 2014; Ruotsalainen

et al., 2015), which implies that work-related stress is influenced by the clinical environment and the ensuing workload.

Stress was first defined and described as a physiological response to stimuli by Selye (1956), who stated that "stress occurs within an individual as a bodily adaption to restore homeostasis" (p.53). This definition suggests that individuals' attempt to adapt to the external environment, specifically when the external environment affects an individual's internal and social environment. However later work by Selye (1977) suggested that stress is "a normal and useful response of the body" (p.35), and later research suggested that it could be viewed as providing motivation within the working environment (Wheeler, 1996). More recent research suggests stress impacts negatively on healthcare individuals, resulting in stress-related disorders (Iliceto et al., 2013; Khojamli, Habibi, Hossein, & Kazemiyan, 2014; Spielberger & Sarason, 2013), especially those healthcare individuals subject to work-related traumatic events (Khamisa, Oldenburg, Peltzer, & Ilic, 2015; Lin, Liao, Chen, & Fan, 2014). In brief, the mammalian bodily response to stress negatively affects the hypothalamic pituitary adrenal (HPA) axis, and those working in stressful environments often cope with stressors by engaging in unhealthy behaviours that may contribute to morbidity and mortality (Happell et al., 2010).

Research has been conducted with first responders and work-related stress; which includes nurses (Svensson, Fridlund, Wångmar, & Elmqvist, 2016), fire-fighters and police officers (Wilson, 2015), soldiers (Hoge, 2015), and doctors (Healy & Tyrrell, 2013). These studies recognise that compassion fatigue and exposure to frequent emergency situations or traumatic events manifests as stress, and affects those involved in caring and compassionate professions. Therefore, as midwives witness emergency situations and traumatic events, it can be assumed that they may also suffer work-related stress.

The Diagnostic and Statistical Manual of Mental Disorders [DSM, V] (Hacking, 2013), defines work-related stress and post-traumatic stress as experiencing, witnessing or being confronted by serious injury or a threatened death (American Psychiatric Association, 2013), which for midwives could be seen as thinking that the woman or baby may die. This is listed under Criterion A of the DSM V (Hacking, 2013), and as the midwifery role involves 'being with woman', it exposes them to witnessing and being confronted with life-threatening events, which may lead to fear, powerlessness and helplessness (Kendall-Tackett, 2014). This in turn can lead to midwives suffering with

post-traumatic stress which is known to impact upon personal life and occupational dysfunction (Sheen et al., 2015). Post-traumatic stress, and its progression to depression if left untreated, has been well-researched in relation to birthing women (Ayers, Bond, Bertullies, & Wijma, 2016; Cunen, McNeill, & Murray, 2014; Garthus-Niegel, Ayers, von Soest, Torgersen, & Eberhard-Gran, 2015; Grekin & O'Hara, 2014), police officers (Husain, 2014; Marchand, Nadeau, Beaulieu-Prévost, Boyer, & Martin, 2015; McCanlies, Sarkisian, Andrew, Burchfiel, & Violanti, 2014), patients (Davydow, Zatzick, Hough, & Katon, 2013; Jackson et al., 2014; Slavich & Irwin, 2014), military healthcare professionals (Engel et al., 2014; Engel et al., 2016; Gibbons, Hickling, & Watts, 2012), nurses (Cavanaugh, Campbell, & Messing, 2014; Drury et al., 2014; Mealer & Jones, 2013), and to a lesser extent midwives (Leinweber & Rowe, 2010; Sidebotham, Gamble et al., 2015).

The study by Leinweber and Rowe (2010) found that the main component of the midwife-woman relationship involves a high degree of empathic identification within clinical midwifery practice, and therefore places midwives at risk of experiencing secondary traumatic stress when caring for women experiencing traumatic birth. This finding was reinforced by a study which discovered that midwives suffered emotional distress when they were unable to practice according to their midwifery philosophy (Rice & Warland, 2013).

This study was the first published research that examined the phenomenon of midwives witnessing traumatic birth, however it did not explore how witnessing traumatic birth impacts on midwives. Given the wealth of evidence about the impact of work-related stress on wellbeing and our lack of understanding about how midwives respond to it, the importance of knowing how midwives cope with work-related stress is clearly significant.

2.7 COPING WITH STRESS

Coping with stress has been defined as "the cognitive and behavioural efforts to manage specific external and internal demands that are appraised as taxing or exceeding the resources of the person" (Folkman & Lazarus, 1986, p. 141). Therefore, coping can be viewed as being applied to situations in order to reduce factors impacting on someone, and helps to deal with the conflict this causes. Coping strategies used by midwives dealing with grief and loss within clinical practice have been described as maintaining a professional mask to hide feelings of devastation and

culpability, yet re-living trauma experienced in private when away from the clinical environment (Kenworthy & Kirkham, 2011). An earlier study identified two modes of coping; problem-focused coping and emotion-focused coping (Folkman & Lazarus, 1980). These two modes of coping could be applied to midwifery clinical practice; where problem-based coping may relate to work-related stress, and emotion-focused coping could relate to relationships formed with the women the midwives care for, and the multidisciplinary team they work with.

Coping with stress is a major concern amongst midwives (Muliira & Bezuidenhout, 2015), with work overload (Banovcinova & Baskova, 2014), and midwife shortages and high turnover rates (Edwards et al., 2016) contributing to the overall impact upon a profession that principally provides care for others. More recent research suggests that coping strategies employed by midwives are dependent on certain factors (Mollart et al., 2013), and these factors are reported by others to include resilience accumulated working in the profession (Hunter & Warren, 2013), number of shifts worked and amount of sleep (Tremaine et al., 2013), how many women with multiple psychosocial issues were included in their workload (de Groot, Venekamp, Torij, Lambregtse-Van den Berg, & Bonsel, 2016) and the midwife's level of exercise (Hood et al., 2010). According to the afore-mentioned studies, these factors significantly affect how midwives cope with stress and burnout and how they provide care for women. Providing care for increasingly complex pregnancies in conjunction with work-related stress have together been described as leading to compassion fatigue.

2.7.1 Compassion Fatigue

The term 'compassion fatigue' was first discussed in the literature by Joinson (1992), who found nurses were experiencing chronic fatigue, irritability, decreased life enjoyment and a lack of desire to attend their place of work (Joinson, 1992, p. 334), following the cumulative effect of providing physical and emotional care to patients. Compassion fatigue is thought to occur alongside the symptoms described by Joinson (1992) and the lack of ability to empathise and express compassion to the people being cared for (Romano, Trotta, & Rich, 2012). According to Coetzee and Kloppe (2010), who completed a concept analysis on the subject, compassion fatigue was defined as:

"a process caused by prolonged, continuous and intense contact with patients, the use of self and exposure to stress, with compassion fatigue"

being a state where the compassionate energy that is expended by nurses has surpassed their restorative processes, with recovery power being lost” (Coetzee & Kloppe, 2010, p. 237).

A group of American researchers conducted a literature search, guided by search terms related to compassion fatigue and healthcare workers (which included midwives), using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and PubMed encompassing publications between 2005 and 2015 (Sorenson, Bolick, Wright, & Hamilton, 2016). Three hundred and seven articles were retrieved and systematically reviewed and synthesised, and it was concluded that the term ‘compassion fatigue’ appears to have evolved, and that there is a need for a better-developed concept analysis to be devised. This review suggested that further research was required amongst a variety of settings to better understand the degree to which compassion fatigue affects personal and professional well-being, including how healthcare workers interact with patients, how this impacts upon patient outcomes, and the quality of healthcare worker’s professional lives.

One of the major findings from a primary research study on this topic linked midwives’ compassion fatigue with witnessing traumatic birth (Rice & Warland, 2013). The study was conducted to investigate midwives’ experiences of witnessing traumatic birth, using in-depth interviews and thematic analysis. This study was undertaken because of the gap in the literature regarding midwives’ experiences as opposed to women’s experiences of traumatic birth. This study concluded that posttraumatic stress disorder, secondary traumatic stress, vicarious traumatisation and compassion fatigue were the result of midwives being ‘stuck’ between opposing philosophies. Midwives described wanting to practice within their midwifery philosophy of ‘being with woman’ (as discussed in Chapter One), but working within the medical model of care caused a clash of philosophy that caused emotional distress to the midwives. Therefore, the model of midwifery care and the emotional contribution midwives provide to childbearing women whilst providing care may affect midwives’ own emotional well-being.

2.7.2 Emotional Well-being

As previously discussed, there are very few studies specifically examining midwives’ emotional well-being. Midwives facilitate childbirth and provide care that involves meeting the physical and emotional needs of women, which in turn has the

potential to impact upon the midwife's emotional stress (Foureur et al., 2013; Leinweber & Rowe, 2010). This possible consequence is supported by numerous studies that have examined caring generally and how the cost of caring impacts upon health professionals other than midwives (Hayes, Bonner, & Douglas, 2013; Schaufeli, Maassen, Bakker, & Sixma, 2011; Slocum-Gori, Hemsworth, Chan, Carson, & Kazanjian, 2013; Walker, 2011). This was also demonstrated in a study investigating emotional well-being and intention to leave work conducted amongst Australian nurses (Bartram, Casimir, Djurkovic, Leggat, & Stanton, 2012). Bartram and team concluded that emotional burn-out was closely associated with nurses leaving the profession; this finding is supported by a more recent study that also discovered employee well-being and job-stress to be linked to decreasing retention rates amongst Australian community nurses (Karimi et al., 2014).

The subject of emotional well-being is a relatively new area of research within the midwifery profession and currently how midwives experience and cope with workplace stress, and by extension the implications for their practice, is unknown. The literature makes it clear that, like other caring professionals, midwives are subject to work-related stress (Mollart et al., 2013), and there is evidence from other professions such as the Police Force and other First Responders that work-related stress is directly attributable to leaving employment, and given the similar nature of the work, there is every chance that the impact on midwifery could be the same. The purpose of the current study therefore was to understand midwives' workplace stress and its implications for their overall emotional wellbeing and career decisions, and to theorise ways to better support this under-threat workforce and maintain midwives' emotional wellbeing so they remain effective in their roles.

SUMMARY

The medicalisation of childbirth, work-force issues, work-related stress and compassion fatigue have been revealed by the literature as driving forces affecting the emotional well-being of health care staff. Stress has been associated with a declining midwifery workforce and impacts upon midwives being able to provide optimal care. Stress in the midwifery environments appears to have become common-place within the culture of the clinical environments. Exploring midwives' emotional well-being is a relatively new phenomenon in the research literature, and current research is examining specifically how midwives cope with stressful work-related incidents and the new occurrence of a greater risk of suicide. However, there is a gap in the literature

regarding how midwives understand work-related stress and its implications for emotional well-being and the impact on career decisions. Therefore, this study addresses the gap that exists in the literature regarding Western Australian midwives' work-related stress and the impact it may have on emotional well-being and career decisions; in doing so it reveals the significance of the study in portraying the factors affecting the 21st century midwifery role. Chapter Three will describe and rationalise the methodology used in development of a substantive theory related to midwives' workplace stress and its implications for their emotional wellbeing and career decisions in Western Australia.

CHAPTER THREE: METHODOLOGY

**“The future of grounded theory is in the hands of the beginning
PhD researcher”**

(Barney Glaser)

3.1 INTRODUCTION

The review of the literature presented in Chapter Two was conducted in order to determine the contemporary knowledge available, and provide the justification for under-taking this study. In this chapter I explain, describe and rationalise the methodology used in development of a substantive theory related to midwives' workplace stress and its implications for their emotional wellbeing and career decisions in Western Australia. The chapter begins with a brief discussion of qualitative research in an effort to position the researcher's choice of Grounded Theory (GT) methodology. Symbolic Interactionism, which is the theoretical framework that underpins grounded theory, is explained and is followed by a description of grounded theory methods and processes. How these methods and processes have been applied to this study are described, with accounts of how data were collected, analysed and managed. The strengths and weaknesses of the grounded theory method are examined followed by a discussion of the limitations of this study. Validity and reliability issues are aspects of qualitative research that are presented in terms of trustworthiness, along with the ethical considerations relevant to this study. In summary, this chapter describes a qualitative study using data collected from semi-structured in-depth interviews using classical Glaserian grounded theory methodology.

3.2 QUALITATIVE RESEARCH

Scientific research is always conducted within a scientific paradigm or philosophical worldview of enquiry. The range of paradigms within which research might be situated include the positivist or post-positivist, naturalist interpretivist or constructivist, transformative and the pragmatic worldviews (Mackenzie & Knipe, 2006); the respective research approaches within these are quantitative or qualitative. Qualitative research is associated with a range of methodologies and approaches that

do not use the quantitative research methods of experiments, measurements or statistical analysis. The qualitative method has been criticised by some researchers as being inferior and less meaningful, and historically researchers have asserted that if a phenomenon could not be measured then it was not scientific and not recognised by the social sciences (Glaser & Strauss, 1967).

More recently it has been recognised that qualitative research is central in discovering people's experiences or their experience of their social worlds and from qualitative data models and theories are developed (Creswell, 2012). From this process new knowledge can be gained, or an old theory can be revised, which makes this an ideal methodological approach for use in health care disciplines. This is because qualitative research aims to determine the meaning of a phenomenon through description and to "develop concepts that aid in the understanding of natural phenomena with emphasis on the meaning, experiences and views of the participants" (Al-Busaidi, 2008, p. 11). Qualitative research and its way of exploring subjective human experience has become increasingly popular within midwifery research as the aim of illuminating people's experiences and examining understanding leads to new meanings and theory (Osborne & Schneider, 2013). Midwives, like nurses, are fundamentally interested in how people feel, or in their experiences within the health care system; this is likely to be because both disciplines are seen as being highly engaged holistic professions.

Choice of methodology by qualitative researchers is influenced by the research question that is produced from the research problem that is to be explored. There are many qualitative methodological approaches that can be used including case study, phenomenology, grounded theory, historical research, discourse analysis, ethnography and feminist research to name a few. The aim of the study reported in this thesis was to provide an insight into midwives' workplace stress and its implications for their emotional wellbeing and career decisions, and I wanted to examine and understand the experience within the Western Australian context. It was imperative therefore to select a methodology that enabled me to both describe and explain the phenomenon of interest.

I did have limited experience with qualitative research, as I had previously used ethnography as a methodology, but I decided that grounded theory may be a better choice to allow a greater depth of investigation to understand the midwives' experiences from their different cultural backgrounds and perspectives. As a novice

researcher the understanding of grounded theory methodology and its many different versions was complicated by my exploration of my own research philosophy, and by learning to recognise and understand the differences between the grounded theory methodological variants. I was drawn to grounded theory methodology because a substantive theory would be created by the data produced by the participant midwives' experiences. As I had identified a gap in the literature regarding midwives' workplace stress and its implications for their emotional wellbeing and career decisions, I thought that grounded theory would enable me to focus on these experiences and reveal how the midwives dealt with the main issues of concern.

The theoretical framework used most commonly with grounded theory is symbolic interactionism; however, Glaser asserts that grounded theory can be conducted outside of the symbolic interactionism framework. Glaser suggests that the fields of nursing and health related areas of research have aligned grounded theory with the symbolic interactionism to "continually reinforce mutually held perceptions" (Glaser, 2005, p. 11).

3.2.1 Symbolic Interactionism

Despite Glaser's view that grounded theory studies can be conducted with reference to symbolic interactionism, this study was conducted within the interpretivist theoretical framework of symbolic interactionism, using grounded theory methods as the means for describing, analysing and theorising whether and how stress experienced from midwifery practice has implications for midwives' emotional well-being and career decisions. The founding fathers of symbolic interactionism were Charles Cooley and George Herbert Mead who started to develop the theory in the 19th century through to the early 20th century (Goulding, 1999). Cooley, whilst exploring personal conduct and the influence of societal norms, first used the phrase 'looking glass self' (Cooley, 1902, p. 126), to describe how people arrived at the perception of self through social intercourse with others. Mead added to the concept of self by suggesting that human conduct is symbolism (Mead & Mind, 1934).

Herbert Blumer continued to build the symbolic interactionism concept in the 20th century by suggesting that to understand someone's situation one has to put themselves in the position of others (Blumer, 1969, p. 1). This requires the researcher to engage in the participant's world using observation in order to interpret what occurs. By using a symbolic interactionism framework, actions can be interpreted to provide

rich description and develop a theory which includes "self, language, social setting and social object" (Schwandt, 1994, p. 124). Therefore, symbolic interactionism can be seen as describing a social theory coupled with an approach to the study of human behaviour.

Symbolic interactionism arose from the seminal work by Herbert Blumer (1969), and this theoretical construct is based on three principles. The first symbolic interactionism principle suggests that human beings act towards things on the basis of their meaning; the second principle suggests that meanings of things are derived in the process of social interaction and the third principle suggests that these meanings are handled and modified via an interpretive process used by the person dealing with the things encountered (Blumer, 1969, p. 2). Therefore, the participant's definition of self, as interpreted in the symbolic interactionism theoretical approach can be viewed as an ongoing process, which is continually formed and reformed by the participants as they interact with others.

The importance of social meanings that people attach to the world around themselves and how they respond to them is highlighted by using this approach in the 21st century (Cohen, 2013). Symbolic interactionism has been described as having the ability to "orient questions, inform design options and refine analytic questions" (Handberg, Thorne, Midtgaard, Nielsen, & Lomborg, 2014, p. 1), which is helpful in conducting research in the subjective world of midwives. A research approach based upon symbolic interactionism can be concerned mainly with identifying patterns over time in the relationships between participants' meanings and actions, and changes in these patterns. The concepts (and relationships between them) generated with regard to the nature of these patterns and changes within them, constitute the answer to the question of how people deal with a phenomenon (O'Donoghue, 2007). In this study, the participants are midwives and the phenomenon is how work-related stress impacts upon midwives' emotional well-being and career decisions.

Historically, symbolic interactionism and grounded theory have been linked in qualitative research to such an extent that researchers have often combined them in their theoretical justifications for research design decisions (Chamberlain-Salaun, Mills, & Usher, 2013). In this study, the symbiotic relationship of grounded theory and symbolic interactionism are ideally suited to the generation of concepts and relationships regarding whether midwifery practice has implications for midwives' emotional well-being and their career decisions. Grounded theory is concerned with

situations resulting from the interaction of individuals and society; it also enables the discovery of patterns of "action and interaction between and among various types of social units" or actors (Strauss & Corbin, 1994, p. 278). Symbolic interactionism is thus ideally suited to underpin this study and the methods used for data gathering, data analysis, and the generation of substantive theory that emerged from these processes.

3.3 GROUNDED THEORY METHOD

The grounded theory methodology was conceived and developed by Barney Glaser and Anselm Strauss in the 1960's, whilst working on a research project entitled 'Awareness of Dying' (Glaser & Strauss, 1966). Glaser was a sociologist who had been influenced by the work of Paul Lazarsfeld within quantitative science; Lazarsfeld was a mathematician who developed a way of quantifying social data that forms the basis of the early grounded theory approach (Christensen, 2015). Strauss was a social psychologist and had been influenced by the philosophy of symbolic interactionism (Fernández, 2004). Within the 'Awareness of Dying' project, Glaser and Strauss used an inductive and also a deductive process concurrently, in order to establish a theory based upon observational data alone, instead of beginning the process with an hypothesis (Handberg et al., 2014).

This induction process aims to generate theories that are "fully grounded in data rather than speculation or ideology" (Simmons, 2010, p. 15), thus reducing the gap between theory and empirical research (Glaser & Strauss, 1967, p. 16). Therefore, Glaser and Strauss were finding a way of bridging the gap between "theoretically uninformed empirical research and empirically uninformed theory by grounding theory in data" (Goulding, 1999, p. 6). The development of grounded theory was to provide verification within qualitative research when developing theoretical analysis; "In social research generating theory goes hand in hand with verifying it" (Glaser & Strauss, 1967, p. 2).

From the 'Awareness of Dying' (1966) study, a constant comparative inductive technique was devised and implemented; this was a new process and the one which formed the basis of Glaser and Strauss's seminal text entitled 'The Discovery of Grounded Theory' (Glaser & Strauss, 1967). The constant comparative method evolves as the research gets underway and is formed through the data collection and the analysis of that data. Essentially, this process involves the constant comparison of newly and previously collected data in order to discern the common problem participants experience and the common process they use to address, or resolve that problem. This

method allows a theory to be generated about a subject or topic not previously explored or to examine known knowledge from a different perspective.

However, as the methodology became popular with other researchers, Glaser and Strauss began having differing opinions on the principles, aims and methods associated with conducting grounded theory (Evans, 2013). At this point, Strauss diverged from the original methodology and in collaboration with a nursing researcher produced a piece of work entitled 'Basics of Qualitative Research: Grounded Theory Procedures and Techniques' (Strauss & Corbin, 1990). In this version of the methodology, researchers were guided to use a defined framework within which to consider their data.

Glaser maintained that Strauss and Corbin had diverged from the original grounded theory methodology because data was being analysed with an imposed paradigm as opposed to concepts naturally emerging from the data. This diverging from the original Classical grounded theory method resulted in a change of design, terminology and also involved a restricted and complex process of systematic coding (Goulding, 1999); which resulted in the dissolution of the Glaser / Strauss partnership and the formation of a number of variations of the grounded theory methodology; these include Straussian Grounded Theory, Constructivist Grounded Theory and Feminist Grounded Theory (Creswell, 2012).

Glaser went on to build upon the definition of the original version of grounded theory as "a general methodology of analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area" (Glaser, 1992, p. 16). Therefore the emphasis of a grounded theory approach focuses on the use of a "general method of comparative analysis" (Glaser & Strauss, 1967, p. 1), which in turn aims to discover rather than verify theory. Glaser believed that category saturation would provide verification, and the researcher should continue to collect data until no new evidence emerges.

Grounded theory has been a popular choice of methodology in health care research during the last few years (Urquhart, Lehmann, & Myers, 2010); and has enabled a large contribution in areas where little research has previously been undertaken. The methodological path chosen for the study reported in this thesis was the classic (or Glaserian) grounded theory approach which is focused on discovering latent patterns of behaviour within the data (Breckenridge, Jones, Elliot, & Nicol, 2012).

The objective is that the grounded theory method does not simply relate participants' narratives, but instead identifies and explains participants' behaviour and how that impacts upon the issues being explored. This is achieved by investigating "patterns of action and interaction between individuals and their situations, rather than creating theory about individuals" (Glaser & Strauss, 1964, p. 671).

Grounded theory is therefore ideally suited to this study about the implications of midwifery practice for midwives' emotional well-being and job-related decision making. Grounded theory comprises a systematic process to develop a theory through induction (Glaser & Strauss, 1967). However, it also has a deductive aspect to it, because the researcher must work iteratively by moving backwards and forwards in their thinking to examine the generalisations and give them specific meaning throughout the analytic process (Punch, 2005).

The grounded theory researcher attempts to explain the main concern of participants in a specific environment or area, and explores how they resolve or process this main concern. The results that emerge from the research are presented either as a hypothesis, a model or as an abstract conceptual theory (Hallberg, 2010). The theory itself is created from a core category and other categories relating to the core category. The aim of grounded theory is to "generate a theory that accounts for a pattern of behaviour which is relevant and significant for those involved" (Glaser, 1978, p. 93). Therefore, grounded theory is a theory-generating method as opposed to a descriptive method.

Due to the fact that grounded theory is the term used for both the research process and its product, it can be a misleading name; others have, for example, discussed ways of 'doing grounded theory' (Charmaz, 2014; Glaser & Strauss, 2009). It is this characteristic that meant grounded theory was an appropriate methodology for the current study; it enabled me to both explore and explain midwives' experiences of workplace stress and the implications for their emotional wellbeing and career decisions. The role of the researcher is to apply grounded theory methodology in order to discover and theorise the main problem experienced and any processes participants may use to deal with it.

Grounded theory is a method of data analysis that results in a new theory that bears a direct relationship to the data, which is termed as being grounded in the data, but is at the same time abstracted from the data. Using the grounded theory

methodology does not reveal how to collect data or what type of data is required, even though interviews are used frequently in the literature.

3.3.1 Paradigm

Thomas Kuhn is thought to have been the first person within the scientific community to suggest the definition of a paradigm as "a set of recurrent and quasi-standard illustrations of various theories in their conceptual, which a particular scientific community acknowledges for a time as supplying the foundation for its further practice" (Kuhn, 1970, p. 10). Therefore, a paradigm could be viewed as a matrix of beliefs and perceptions which are time and context specific, and seen as perhaps social as opposed to being individual. A simpler explanation could be described as a mindset. A brief description of the main different paradigms within grounded theory explored below, and the rationale for the choice of classical grounded theory chosen by the researcher is discussed.

3.3.2 Glaserian or Classical Grounded Theory

As previously noted, there are now several variants of the grounded theory methodology. The differences between the varying philosophies and methodologies used within grounded theory have been explored and identified (Fernandez, 2012). Four main models / paradigms have emerged as the most popular. These are: Glaserian or classical grounded theory (CGT), which is the original version of the methodology; Straussian grounded theory, which encourages the use of literature to provide a framework for collecting data and also referred to as qualitative data analysis; feminist grounded theory, and constructivist grounded theory, which "places an emphasis on social constructivism and includes the subjective and reflexive stance of the researcher" (Claxton, 2014, p. 191).

When Glaser and Strauss diverged on how grounded theory should be conducted, the main difference in their views was around how data should be treated and thus how understanding of the phenomenon of interest is developed. Glaser was convinced that data emerges, revealing facts in the form of objective truth to a researcher; Strauss, in contrast, maintained that a researcher should actively obtain the theory from the data (Glaser & Holton, 2004). This implies that the researcher's own beliefs, norms, values and cultural background will greatly influence the interpretation of the collected data.

I considered the other philosophies within the grounded theory methodology, but could not reconcile that as a researcher, my own beliefs and values should influence the interpretation of the data. Having confirmed my affiliation with Glaser's view of the aims and outcomes of using classical grounded theory, which are the "discovery and emergence followed by development of theory without preconceived ideas" (Claxton, 2014, p. 192), and thus my subscription to the objectivity of the researcher in collecting and interpreting data, I chose to use classical grounded theory for this study. The classical grounded theory approach was the most appropriate paradigm in order to discover the participants' underlying process for dealing with the problem they faced, and to conceptualise it through the production of a substantive theory. The classical grounded theory approach to me, ensures rigour in the methodology and is more likely than other variants to produce credible results.

Glaser was firm in his belief that classical grounded theory generates a parsimonious theory (succinct hypothesis), that "fits the real world, works in predictions and explanations, is relevant to the people concerned and is readily modifiable" (Glaser, 1978, p. 142). This makes classical grounded theory an optimal and trustworthy approach when examining subjects or topics about which little is already known. One of the challenges to investigators using classic grounded theory research is that its tenets and processes make it very difficult to determine exactly what is known about a topic of interest in advance.

This is because we are, as I explain in more depth shortly, steered away from examining the extant literature in any depth prior to the collection and analysis of our own data.

3.3.3 Use of the Literature

Classical grounded theory methodology relies on the researcher to develop concepts from the data as opposed to being influenced or being subject to bias from the literature. Glaser has stated that "there is a need not to review any of the literature in the substantive area under study" (Glaser, 1992, p. 31). The researcher of this study did not conduct an in-depth literature review before undertaking the data collection and relied upon themes and concepts emerging naturally from the collected data. This is in line with Glaser's belief that "grounded theory is for the discovery of concepts and hypotheses, not for testing or replicating them" (Glaser, 1992, p. 32). Glaser and Strauss identified a concept requiring the need for the researcher to be, as far as possible, a

'tabula rasa' (Glaser & Strauss, 1967, p. 3), meaning a blank slate. This can be achieved by the use of theoretical sensitivity measures (in the form of bracketing, which is discussed in more detail later), as well as not looking at the literature before collecting data.

Once major categories were identified and a substantive theory had emerged, I searched the databases, read and linked the corresponding literature to this study (Glaser & Strauss, 1967), as described in Chapter Two. I used the literature as data and as a comparison with the findings that emerged from the data of this study to integrate and enrich the emerging theory (Dunne, 2011). This is in keeping with the classical grounded theory methodology that there should be no review of the literature before data collection is completed, except in a cursory manner to establish the need for the research. Glaser and Strauss (1967) both advocated not reviewing the literature before data collection commences, stating that "an effective strategy is, at first, literally to ignore the literature of theory and fact on the area under study" (p.37).

However, as discussed in the literature review chapter, I did have some current knowledge of midwives and stress in the clinical environments but was unaware of any established theoretical frameworks in this area. This made both access to potential participants and the faithful implementation of the research design easier.

3.3.4 Strength and Weaknesses of Grounded Theory

One of the biggest strengths of grounded theory methodology is that it has been used extensively in the disciplines of sociology, behavioural sciences, nursing and midwifery (Walsh et al., 2015), because of its applicability in understanding the world from the participant's perspective. By using grounded theory, the researcher is attempting to view the issues under study from the participant's perspective. This allows the researcher to conduct a theoretical interpretation of data analysis while remaining grounded in the data. Therefore this systematic process of data analysis is an important strength as the data is carefully ordered and can be easily traced between the developing categories (Goldkuhl & Cronholm, 2010). The researcher is required to remain open-minded throughout the whole grounded theory process which allows for an unprejudiced approach to be used. This is an important feature as data analysis within grounded theory methodology is not routine but a creative and iterative process that encompasses categorisation and validation of properties within categories. The methodology is further strengthened in the analysis process by theoretical sampling

that uses new data to enhance the emerging theory. This leads to an additional strength of the grounded theory method in that theory is built at the substantive level by the researcher, as opposed to adopting an already existing theory, which may not adequately fit a researcher's own study. The main benefit of this aspect of the grounded theory methodology is that providing the researcher observes or follows the process, core categories will appear and develop. This in turn allows the substantive theory to develop and emerge.

One of the weaknesses of grounded theory is that it is time consuming, as discussed previously, to not only the researcher through conducting and transcribing interviews but also participants who consent to being interviewed (Coast et al., 2012). Another perceived weakness is the large volumes of data produced and of the sometimes chaotic nature of the data retrieved (Grbich, 2012), which again impacts upon time constraints. Certainly in this study I did not always recognise the importance of some data collected which later became important in the developing theory. I, as a novice researcher, also found it difficult to decide when the categories were saturated, and probably conducted more interviews than were necessary (Francis et al., 2010).

3.4 RESEARCH DESIGN

Constructing a robust and comprehensive research design for a study helps to ensure that credible findings will be produced; and that participant's responses and experiences are clearly recorded and analysed. The methodological approach is therefore integral to the research design, and choice of paradigm equally important, as these components influence the preparation and implementation of the study.

3.4.1 Ethical Considerations

Ethics approval was sought and granted by the Edith Cowan University Human Research Ethics Committee prior to the commencement of data collection (Appendix E). This was a process which was achieved by firstly having the study's proposal reviewed by senior academics; secondly defending the proposed study before the academic staff in Edith Cowan University, and finally providing a detailed description of the planned study for the ethics committee. This description included informing all potential participants that privacy and confidentiality would be maintained throughout and after the study was completed and published, and that participants could withdraw from the study at any time without penalty. Data storage and security requirements

were described as being kept in the researcher's University office and a locked filing cabinet, and that the researcher held the keys.

The computer in the office was used only by myself and was password protected. The Ethics Committee required further assurance that I had taken adequate precaution in protecting participants from psychological and emotional distress/harm. I was also required to describe the measures that were to be undertaken if participants became distressed during or after interviews, and I also detailed steps to ensure my own safety and emotional well-being whilst conducting the study.

Each potential participant was provided with an information sheet (Appendix A), that outlined the focus of the research project and explained the participant's role. I asked each participant if they had read and understood the information, and if they objected to having their interview audio-recorded. I also reminded the participant that they could stop the interview at any time or that I would stop the recording of the interview if asked. Participants were also reminded that they could request data not be used and that any confidential information inadvertently given, for example names of people and places, would be omitted from the transcript. An informed consent document (Appendix B) was read and signed by each participant, and participants gave their time freely as no inducements were offered to participate in the study. I telephoned the participant the day after the interview to thank them for their time and participation and none of the participants expressed any dissatisfaction with being interviewed; none asked for data to be removed from the interview and none of the participants withdrew from the study.

3.4.2 Theoretical Sensitivity and Bias

Theoretical sensitivity has been described as an ability the researcher learns to develop whilst conducting research to conceptualize and formulate a theory by constant comparison of the data (Glaser & Strauss, 1967). It requires the researcher to think in theoretical terms about what he or she already knows about a given subject. The term theoretical sensitivity describes a sensitive approach used when conducting research in a chosen area that is known to the researcher (Glaser & Strauss, 1967), and is often associated with grounded theory research studies.

The process involves the researcher developing sensitivity to the chosen research area through having professional knowledge or experience, which may help the researcher to make sense of connections in the data. As Glaser explains "The researcher

does not go blank or give up his knowledge. He goes sensitive with learning which makes him alert to [the] possibility of emergence and how to formulate it conceptually" (Glaser 1998, p. 123). However, it could be noted that sensitivity could allow the researcher to make meanings because of prior knowledge or cause bias instead and this is a challenge to the investigator's capacity to approach the research as the *tabula rasa* described earlier. I came to this study as a midwife, and although I had not worked recently in the clinical area, I had made notes about my own experiences of work related stress before I collected any data. Glaser states that different researchers bring different theoretical sensitivities to a study (Glaser, 2007), which suggests that the researcher should approach any study with an open mind, but it would be naïve to imagine that a researcher could approach a study without any preconceived notions or conceptions. Glaser has stated that if data was approached with preconceived ideas it would more than likely result in data being forced to "reflect the analyst's preoccupation" (Glaser, 2005, p. 16). This is supported by Glaser's later writings where he suggests "When using grounded theory, forget what you are supposed to find and just see what you are finding" (Glaser, 2012, p. 142). Therefore, I acknowledged that I possessed pre-existing knowledge regarding midwives and could not change this factor but chose to remain open-minded to the findings. Many other researchers use this self-reflective process and refer to it as 'bracketing' (Hamill & Sinclair, 2010; Oiler, 1982; Tufford & Newman, 2012), which allows prior knowledge and assumptions to be put aside but not abandoned and encourages the researcher to remain open-minded (Sorsa, Kiikkala, & Åstedt-Kurki, 2015).

As mentioned previously, as well as bracketing my prior assumptions and experience before collecting any data, I also wrote down my thoughts following interviews and during the analysis in a journal in an effort to avoid own presumptions and views from influencing interviews or analysis. I was able to revert back to these memos / journal entries in order to maintain neutrality (Thornberg, 2012); however some of my bias was exposed through some incidents discussed by the participants where I could empathise with the feelings expressed. Occasionally though I was surprised to hear revelations which clearly disputed my perceived knowledge and preconceived ideas regarding the study topic, and highlighted how much knowledge there was to be learned from the participants.

The literature pertaining to stress and midwives was not accessed prior to data collection; therefore, the emerging themes from the data were not subject to bias by

the researcher. For example, I had not previously considered the idea that a coordinator of a shift added to work-related stress, or that midwives conscientiously employed self-care strategies directly related to work-related stress, both of which were themes that emerged during data analysis.

3.4.3 Sample Size

The sample size for this study was twenty-one participants, which may appear to be a small number for some methodological approaches, but not for a classical grounded theory study, which is not dependent upon a set number of participants. This is because classical grounded theory aims to develop a conceptual theory founded in a deep understanding of participants' experiences and behaviour as opposed to being concerned with statistical power, and does not rely upon a fixed sample size to achieve this aim. Rather, it is 'saturation' of the data that is pursued, and the process of data collection and analysis determines the sampling sequence selection which continues until saturation occurs (Glaser, 1992).

Saturation is not dependent on sample size; it is achieved when no new concepts are produced from the collected data, and the emerging substantive theory is verified as being grounded in the data (Glaser & Strauss, 1967). In some classical grounded theory studies saturation has been reached after in-depth interviews with twelve purposively sampled participants (Emmel, 2015; O'Reilly & Parker, 2012). This is possible because the researcher will continually return and re-analyse the collected data when new concepts or themes are identified in newly collected data through the process of constant comparison, which was described earlier. To reiterate, the main emphasis is not placed on the sample size but is guided by the principle of the concept of saturation of the categories (Mason, 2010). The literature on this topic suggests that smaller studies using theoretical sampling and the constant comparison approach achieve saturation sooner than larger studies generating greater amounts of data (Guest, Bunce, & Johnson, 2006). There is the potential for dispute in relation to the reaching or not of saturation, therefore the onus is on the researcher to demonstrate how saturation was achieved through a detailed research design and report outlining sampling strategies, participant recruitment, data collection and data analysis.

3.4.4 Recruitment of Participants

Participant selection within grounded theory studies usually occurs through purposive sampling, followed by theoretical sampling. Purposive sampling involves the

researcher making decisions about the participants to be included in the sample “based upon a variety of criteria which may include specialist knowledge of the research issue, or capacity and willingness to participate in the research” (Palys, 2008, p. 697). Theoretical sampling comes later, when participant’s experiences’ enrich the investigator’s understanding of particular aspects of the phenomenon of interest (Glaser, 1978).

Western Australia (WA) is geographically large, with a small metropolitan area and a vast rural and remote area, and has a growing population of sub-immigrants. Some of these immigrants are midwives working within the Australian health care system, who have experienced working within midwifery in different health-care systems, therefore the collective experience of the midwives who participated in this study is unique. The participants recruited to this study came to working in WA with a range of backgrounds and were employed in a variety of midwifery clinical environments including the main public tertiary maternity hospital in Western Australia; a rural public hospital, two private maternity units, one midwifery Group Practice, and two were independent midwives not attached to any single maternity service.

Participants were recruited via posters made and displayed in public areas by the researcher and through advertising for participants via social media (Facebook). Some participants ‘shared’ through their own Facebook page the researcher’s study and call for participants in a form of snowballing strategy. Snowballing is used in populations that may be difficult for a researcher to approach, and where one participant tells a researcher about other possible participants (Goodman, 1961), but in this case participants were spreading the information about the study amongst their midwifery friends and colleagues.

3.4.5 Profile of Participants

Midwives recruited as participants of this study had to be registered with the Nursing and Midwifery Board of Australia and working clinically in the midwifery environments. Being a midwife currently working in clinical practice in WA was the only criterion for inclusion in the study as a participant. Participants were not asked any demographic information, and participants varied in age and midwifery experience. I was interested in midwives’ workplace stress and its implications for their emotional wellbeing and career decisions.

Although some participants did reveal how long they had been midwives in the course of the interview, the researcher wanted to concentrate on individuals' experiences and not exclude participants based on age or experience. Twenty of the participants were female midwives, and one was a male midwife; all of the participants lived and worked in Western Australia. I commenced interviews in May 2014 and had conducted all of the interviews by December 2015.

3.4.6 Purposive Sampling

Purposive sampling was initially described as the preferred method for "selecting the best informant who is able to meet the informational needs of the study" (Morse, 1994, p. 225). Purposive sampling has also been described as a method of non-probability sampling that is "most effective when one needs to study a certain cultural domain with knowledgeable experts within" (Tongco, 2007, p. 147). The first 10 participants were purposively sampled, after which a further 11 midwives were theoretically sampled for their capacity to enhance my understanding of the phenomenon of interest and to confirm the theory emerging.

3.4.7 Theoretical Sampling

Theoretical sampling is concerned with deciding what data to collect next and where to find the data required. The term theoretical sampling "means sampling for development of a theoretical category, not sampling for population representation" (Charmaz, 2012, p. 3), and by conducting the data collection this way, the data is led by the emergent theory. Theoretical sampling saturates categories and establishes relations between categories in the later phase of data collection (Glaser & Strauss, 1967). Theoretical sampling is used to further refine a key pattern or theme that has emerged from the data. One concept that emerged in the developing theory in this study was the reference to how a shift coordinator could increase or decrease workload stress for midwives.

It became clear that I would need to recruit and interview midwives who coordinated shifts in the various midwifery environments, but particularly the labour and birth suite, to fully understand this aspect of midwives' work-engendered stress. By implementing theoretical sampling after conducting, transcribing and analysing ten participant's interviews, the next ten interviews were conducted with the aim of identifying an understanding of the key aspects required to achieve saturation of the data. Glaser defined theoretical sampling as:

"The process of data collection for generating theory whereby the analyst jointly collects, codes and analyses the data and decides what data to collect next and where to find it, in order to develop the theory as it emerges; this process of data collection is 'controlled' by the emerging theory" (Glaser, 1978, p. 36).

Therefore, theoretical sampling allows the researcher to narrow the focus of the emerging data to show insight into a particular area or effectively close off an avenue of inquiry. By using these two sampling strategies, I gained access to participants with whom semi-structured interviews were conducted. All the participants were midwives working in midwifery environments in both the public and private clinical settings. There were twenty-one participants in the sample in this study, which was directly attributed to saturation of categories, where no new data revealed new concepts.

3.5 DATA COLLECTION

It has been suggested that Glaserian classic grounded theory "can adopt any epistemological perspective appropriate to the data and the ontological stance of the researcher" (Holton, 2009, p. 38). Data collection of grounded theory begins with purposive sampling leading to theoretical sampling, which bases sampling on theoretically relevant constructs. It enables the researcher to select subjects that maximize the potential to discover as many dimensions and conditions related to the phenomenon as possible (Corbin & Strauss, 2014).

Data collection methods can range from interviews, research journals, focus groups, conversations, observations or any activity which produces data (Leitner, Hayes, & Imai, 2015). However, the only form of data deemed necessary to collect for this study was interview data from the key informants' and memos made by the researcher during interviews. At the beginning of the study, I did not pre-determine who would be interviewed first amongst the participants, but recruited willing midwives through midwifery networks. I was able to access a large network of prospective participants for interview for this study.

3.5.1 Interviews

Two major historical professional developments influenced the formation of the central aim of this study: the role of the contemporary midwife undergoing major change during the last century with normal birth becoming medicalised due to the

challenges of 21st century lifestyles; and the current under-recruitment and shortage of midwives, as discussed in the previous chapter. Guiding questions were developed from the central aim in preparation for initial data collection. These guiding questions in turn, assisted in the development of a semi-structured guide for use in the interviews that were conducted with participants.

The term 'interview' used in a research context has been defined as a two-person conversation conducted to obtain information data for research (Holstein & Gubrium, 2011). Within midwifery research, research interviews have become a popular method of collecting qualitative data (Fadyl & Nicholls, 2013); which has led to the use of postmodern interviewing techniques to approach questions about people's reality of their experiences. Postmodern interviewing techniques include the historical, cultural and environmental factors that surround and influence the interview process, and the researcher uses passive listening as opposed to actively questioning the participants which encourages the participants to be the focus of the interview (Gubrium & Holstein, 2003).

This way of conducting interviews reduces the interviewer's influence by recording participants' responses with minimal input from the interviewer, and focuses on obtaining, understanding and analysing what participants describe as meaningful and important (Fadyl & Nicholls, 2013). I knew, from experience in clinical practice and from the literature on the matter, that the quality and content of my interviews depended on the rapport developed between myself and the participants (Gemignani, 2011, p. 704); therefore I needed to show skill and sensitivity in asking questions, and to focus on the dynamics in the interaction between us. In order to provide a relaxed beginning to the audio interviews, I began with a brief personal introduction about the study which included signing the consent form, and then I encouraged the participant to discuss a little about themselves, such as their midwifery background and working history. I encouraged participants to state where they currently worked and asked some simple demographic questions to help put participants at ease, (e.g. how many years' experience did they have as a midwife).

Throughout the interviews I felt it was important to establish an open atmosphere of trust so that the participants would feel free to share their experiences, thoughts, and feelings as well as balance it with their need for emotional protection by not dwelling too deeply on any clinical traumatic incidents that may have occurred. I trusted my judgment in being sensitive to gestures, silences, facial expressions,

weeping, and any changes in the atmosphere between the participant and myself. I began the interview by asking introductory questions, and then followed through by probing the participant's answers, which helps circumvent the exploration of non-emergent issues. This process seemed to encourage the participants to discuss issues that were relevant or important to them. Focusing on the participant's perspective ensures that the substantive theory that emerges remains grounded.

Twenty-one participants were recruited and interviewed, and all the interviews were audio recorded and transcribed verbatim. I decided to audio-record the interviews as I found note taking whilst talking and interviewing was distracting for both the participant and the interviewer. This is contrary to Glaser's belief that taping interviews "delays theoretical sampling" (Glaser, 1998, p. 147); however I transcribed and analysed each audio-recorded interview as it was completed, not waiting to collect and complete them in a group. I found it very useful to listen to the interviews and hear pauses and laughs, which added to the richness of what participants were saying. I felt that all data was collected accurately by audio-recording the interview, nothing was missed, and the stored recordings and analysed transcriptions provide an audit trail showing how the substantive theory was developed.

The interviews were conducted in participants' homes at times that were convenient for the participants, which also allowed for privacy and confidentiality for the participant. As mentioned previously, each participant had received an information sheet informing them of the aims of the study, and had completed a consent form prior to the interview commencing. This gave the participants time to read the information sheet and consent form and I could answer any questions the participants had or clarify any points that arose. Participants were also reminded that they could withdraw from the study at any time without any penalty, and that neither they nor the hospital / setting where they worked would be identified.

I found it easy to build a rapport with participants, as I am also a registered midwife, and understood jargon and abbreviations used by the participants. Interviews were semi-structured and lasted between forty and seventy minutes, and were all transcribed by myself and coded afterwards with an alpha-numeric code that was known only to the researcher. All recorded interviews were stored on an external hard drive and stored in a locked filing cabinet in the University.

The participants were willing to discuss their experiences of work-related stress and their future career plans, however at times I found it difficult to keep the participants on the topic of the study. The participants were keen to discuss many different topics within the midwifery 'umbrella', and so I would begin the interview with a simple chat session that served as an ice-breaker and also helped me become familiar with individual regional, sometimes quite strong, accents. This chat session before the interview began also helped me to build a rapport with the participants, especially as the participants did not have to explain midwifery and obstetric complications and the interview evolved naturally.

In the first 10 interviews participants were asked questions similar to the following: "how long have you been a midwife", followed by "that's quite a long time; do you think your job has become more stressful or do you think it has been at the same sort of level" or "do you think stress is part of the midwifery role". I also used probes to encourage the participants for examples of their experiences, such as "have you had a childbirth incident that has caused you stress" or "I would like to hear about a specific example of a work-related incident that caused you stress" or "can you describe a particular situation that might have caused you some emotional distress at work"? Sometimes I had to rephrase a question and ask it from a different perspective if the probe was not properly understood, however as more interviews were conducted, my questions became more focused.

The next 11 (theoretically sampled) interviews were used to build on the collected data by focusing questions pertinent to the developing concepts and themes, which in turn allowed me to compare, clarify or verify these concepts and themes. For example, initially data collected regarding midwives witnessing traumatic incidents were coded as 'stressors', but as data was added during the process, it was revealed that traumatic incidents compounded stress as opposed to being the driver of stress. This aspect is discussed in detail in the Discussion chapter.

There were several occasions when the participant would recall a particular work-related incident that would make them appear tearful, however, when I asked if the participant wanted a break, none wanted the interview to stop or the audio recorder to be switched off. I gave a participant time to compose themselves and all participants said that it was good to be able to talk about an incident and that someone was able to listen independently from the working environment. One participant did discuss a particularly traumatic birth event that did not appear to distress the participant;

however, I debriefed with one of my supervisors the next day. I found the use of memos and notes were particularly useful in situations like this and for remembering important points after an interview.

3.5.2 Iteration

As briefly noted earlier, three main features of grounded theory that differentiate it from other qualitative methodologies are iteration, constant comparison and theoretical sampling (Watling & Lingard, 2012). In this study the researcher used iteration, which is the process of analysing new data once it has been collected and transcribed so that subsequent collected data can be refined (Kelle, 2007), in the constant comparison process described previously. Therefore, this study needed to be designed and implemented so that each interview could be conducted, transcribed and analysed before the next interview occurred. This was an important consideration when planning the timeframe of the study.

3.5.3 Transcribing

All interviews were conducted and transcribed verbatim by the researcher; this was because I wanted to immerse myself in the data and although it was time consuming it enabled familiarity with the interview content and ensuing data. The data for this study was collected from participants who were registered midwives working in Western Australia in a variety of midwifery clinical environments. The midwives were from culturally diverse backgrounds, but all spoke English fluently.

Some of the participants had very strong accents that slowed the transcribing process, as some sections of an interview had to be replayed several times so accurate transcribing could occur. I listened to the recorded interviews and typed out each sentence directly into the computer, which in some cases took many hours to complete. Once the interviews were transcribed, I immediately began data analysis and interpretive analysis continued throughout and until completion of the study (Bickman & Rog, 2008).

3.5.4 Constant Comparative Method

As mentioned earlier, constant comparison is the main feature of analysis within grounded theory methodology. The transcribed words from each interview are reviewed line-by-line and theme-by-theme (Charmaz, 2014), and the constant comparative method is then used to search for emerging patterns and themes. This

involves formulating the data into ideas and then continuing to match these emergent ideas with other emergent ideas (Simmons, 2011). This process allows for the identification of concepts that describe what is emerging from the data to provide information of what is actually occurring according to participants. For example, during data collection in this study it became apparent that after stressful incidents occurring in the workplace, midwives preferred to debrief with other midwives as opposed to spouses, friends or family members. The constant comparison process helped me to identify emerging patterns, reveal any inconsistencies and formulate preliminary conclusions about the phenomenon of interest See Table 1).

Table 1: Examples of Line-by-Line Coding

Initial Coding from transcribed interview	Sub categories
<p>I feel that <u>during my employment I have had probably different levels of stress but right now I feel that I am under the most stress I've ever been. Before I came here I did community midwife, I was a community midwife, and that was a completely different stress but very, very enjoyable. The stress I feel we are under at the minute is not overly enjoyable – and I don't feel a lot of it should be part of our job.</u></p> <p>Because <u>we are knowledgeable midwives with lots of experience and I find we get it in all directions. You know we get it from the organisation – you know trying to increase their productivity I suppose, I find that we have got students we are trying to teach;– we've got RMO's who we are trying to teach, we've got registrars who think they know everything, that we are trying to teach and yeah – and at the minute I feel that we've got a lot of senior midwives and we've got a lot of junior midwives – but the beef in the middle is not there. At the minute. I don't know what has happened to that bit in the middle – but it's not there. We've got loads of midwives that are under 5 years trained.</u></p> <p>So you've got things like – <u>you may be coordinating in birth suite and you've got – you know – a grad or well you know one of your last year's grads and you might have 2 of your last year's grads – and you know a new grad. And you know the thing is as well that you know we in the culture of now – especially when you've got a lot of the mums and dads are very, very opinionated and you can be called some really flowery words. so you know sometimes I feel when I am working on birth suite – it's more so on birth suite – not only am I looking after my own registration but I'm looking after say 3 other junior midwives registration as well. You know ensuring they follow policy, ensuring</u></p>	<p><u>Always had stress in my job, not always bad</u> during my employment I have had different levels of stress community midwife(ry) ... was stress(ful) but very, very enjoyable</p> <p><u>Never been as stressed as I am now</u> right now ... I am under the most stress I've ever been The stress ... we are under at the minute is not overly enjoyable</p> <p><u>Stress comes from all directions</u></p> <ul style="list-style-type: none"> • we get it in all directions • we have got (stress) because we are knowledgeable midwives with lots of experience • we get it from the organisation ... trying to increase their productivity • we have got ... different kinds of students we are trying to teach • we've got a lot of senior midwives and we've got a lot of junior midwives but the beef in the middle is not there • we've got loads of midwives that are under 5 years trained • you may be coordinating in birth suite and you've got ... a grad(uate midwife) or well you know one of your last year's grads and you might have 2 of your last year's grads and ... a new grad – and it's just ... (a lot of responsibility) • a lot of ... mums and dads are very, very opinionated • you can be called some really flowery words (by parents) • not only am I looking after my own registration but I'm looking after say 3 other junior midwives' registrations as well • (I'm) ensuring (junior midwives) follow policy

Glaser and Strauss (1967) stated that this technique moves the abstraction process onto a theoretical level. The researcher applied the constant comparative method of analysis meticulously to this study, comparing each piece of data with all other data collected. This was achieved by physically grouping data that referred to the same subject, and by moving data around to ensure their 'fit' with a particular grouping; categories and sub-categories were constructed and revised as new data was collected and added.

There is software available to aid researchers' grouping of qualitative data, but I chose the more visual and tactile approach of physically cutting up and grouping the collected data. I used large pieces of card to collate the data into categories which facilitated coding of like data together (Glaser, 1992), and attached the card to the walls of my lounge so that I became immersed in the research. This allowed me to compare previously collected data with newly collected data, and became wall-mounted storyboards.

This aligns with Glaser and Strauss (1967) who identified a four stage process consisting of the comparison of incidents applicable to each category; the integration of categories and their properties, delimiting the theory, and finally the writing up of the theory. As the data collection and analysis progressed in this study, statements and incidents were compared to properties within the categories, or as suggested by Glaser and Strauss (1967), "accumulated knowledge" (p.106). This is in keeping with the grounded theory philosophy that constant comparison is a "meaning making activity" (Glaser, 1992, p. 140). The process allowed me to pinpoint other aspects within categories, which included the formation of memos to document these aspects as they emerged during the constant comparison phase.

By implementing this four stage process of the constant comparative method, the data collection was assessed, analysed and the information coded which encouraged theory generation during the process of theoretical sampling (Kolb, 2012). Categories began to become repetitive and some required collapsing as the theory emerged through conceptual analysis of the categories and their related links (Glaser, 1992). This method began with the raw data and by making constant comparisons, a substantive theory emerged.

This process allows for categories to either collapse or be integrated and the resulting data encourages the researcher to "make some related theoretical sense of

each comparison" (Glaser & Strauss, 1967, p. 109). I found the grounded theory process labour-intensive with the processes of analysis and data coding requiring many hours.

3.5.5 Open Coding

Open coding has been described as a process where the data is divided and categorised into clusters of meaning, and the sampling is purposeful and systematic (Kolb, 2012); and is conducted after data transcription. In this study, I transcribed interviews conducted and then analysed each line of text to identify key words or phrases that would connect what the participant revealed about the subject being investigated. Open coding was achieved by extracting concepts from the raw data and beginning to develop them in terms of properties and aspects. I found that the recorded interviews were integral to the analysis process as all nuances were identified and noted. For example, emphasis of certain words or significant pauses could be quite significant to what was being said. This is in keeping with the open coding process as it shows that the researcher has identified what was occurring from the data. The recordings could also be re-listened to at any point of the analysis process. As the data begins to be coded, the researcher seeks similar concepts and begins to group them together under one classification or description.

This leads to the researcher asking the question "What category or property of a category does this incident indicate?" (Glaser, 1992, p. 39). In this study, my questions centred on: What was happening in the data? What meaning does it have for the midwives? What consequences do work-related stress issues have on the midwives? What effects are there on midwives' career decisions? Therefore, the researcher seeks answers from the data to the questions that arise during the open coding process, which ensures that open coding remains grounded and that concepts that emerge from the collected data come directly from the participant's view-point.

I used this process for all of the subsequent transcripts in this study; all collected data were examined and disseminated into concepts. Concepts were coded together comparing like with like and already coded data. New categories were established when dissimilar data were identified. I felt it was important to be immersed in the data, and so all the transcribing was completed by myself, and the categories were fixed to one wall in my lounge room (Fig. 1). It allowed me to think about the data and position myself with the midwives' perspectives in order to understand the meanings they had

attached to their responses. Again, this was time-consuming but an essential process as it aided me in conceptualising the study.



Figure 1: Categories Being Formed

Through comparing the coded data, I was able to identify emerging patterns and group them into categories that appeared to be related to incidents, behaviours, traumatic events, and consequences. The categories were labelled in terms of short sentences describing the category; for example, 'stress is part of the job' where participants had stated in different ways that stress was an inevitable part of the midwifery role. This is in keeping with grounded theory which recommends using the words "that have been abstracted from the language of the research situation" (Glaser & Strauss, 1967, p. 106). By identifying the categories through a naming process, the research findings become accessible and can be replicated in future studies and the named categories "provide a bridge between theoretical thinking and practical thinking of the people concerned with the substantive area" (Glaser & Strauss, 1967, p. 241).

3.5.6 Theoretical Coding

As previously mentioned, I employed the constant comparison method which facilitates theoretical coding by breaking down the data, comparing concepts and then reforming the data into similar concepts which then form categories. Once individual categories are established they contributed to the construction of the emerging and developing theory. The grounded theory methodology requires the researcher to discover causal links between categories and Glaser has suggested a number of 'coding families' with which these relationships might be articulated (Kelle, 2007). For example, in this study the participants identified that workloads cause them stress, so I sought to

discover contextual factors that impacted upon the workloads causing stress. Participants' perspectives are the main priority when analysing the concepts emerging from the data, which is in keeping with all the stages of grounded theory methodology. Therefore, theoretical coding provides a practical way of understanding and linking the data. The data was managed by the researcher by hand and not software; and collection and interpretation was conducted to understand the participants' perspective of what was actually happening in regard to stress within the midwifery role.

Open and theoretical coding is the grounded theory way of processing the collected data leading to construction of categories. Categories, developed from the analysis of the data collected for this study, emerged to represent causes, contexts, contingencies, conditions, covariances and consequences of midwifery work-related stress. I sought to use the coding family called the six C's devised by Glaser to guide conceptual analysis (Glaser, 1978, p. 74), which distinguishes data into exactly these six features. As each category was established, I began to generate codes that were emerging from the data. Links were made with the codes regarding causes, contexts, contingencies, consequences, covariances and conditions from the participant's perspectives. Categories either collapsed or expanded as the codes developed, and with each code I recorded short memos that helped to remember ideas that surfaced and contributed to the ongoing audit trail, as the theoretical coding process progressed.

As more data was collected and compared, fresh insights appeared and similarities were identified and categorised; names of categories also changed as links were recognised and new categories emerged. For example, it became clear that 'coordinators', 'traumatic incidences' and 'doctors' treatment of women' were three distinct areas that the participants were describing in their interviews and was emerging through the analysis. However, 'lack of organisational support' and 'small pockets of support get you through' were different areas being highlighted; one concerned the organisation's support of participants and the other was concerned with support the participants received from peers and colleagues, and neither 'fitted' together and appeared to be quite separate. This type of coding is selective and is a main strategy used to define core categories. Also codes that identified feelings of being 'ridiculed', 'crying after a shift', 'being part of a witch-hunt', 'victimised' appeared negative and emerged to a larger code indicating emotional distress.

3.5.7 The Definition of the Major Categories

A category emerges from the data that represents the essence of all participants' experiences of the phenomenon of interest (Glaser, 1992). In this study I identified links between codes and categories which resulted in the formation of major categories. The nature of each of the contributory major categories became apparent when individual pieces of data and/or concepts were directly linked to an identified core category.

Each of the major categories received a title or label, and each major category became linked and formed a 'story' revealing the emerging theory that midwives experienced stress in their midwifery role that directly impacted upon their career decisions. I continually examined and assessed all the codes and categories that identified that certain factors relating to midwives' working role impacted upon the stress they experienced. All participants experienced different stress-related issues in their clinical midwifery role that arose from incidents, colleagues, workloads or the organisations they worked for; and these stressors directly impacted upon their personal working role within midwifery and ultimately their career decisions.

The categories that emerged from the data were labelled to represent what each category signified; many category labels were directly taken from codes derived from participants' own words: 'Midwifery is Stressful but it is Not the Job Itself', 'Having to be 150% on Your Game all the Time', 'Being Between a Rock and a Hard Place Whether You Are Coordinating or Not', 'Going Pear-Shaped in Four Rooms at Once', 'People do not Have any Understanding What Midwives go Through Emotionally', 'Being an Advocate in the Face of Medical Disrespect is Tough', 'Toeing the Line and Giving our Pound of Flesh', 'Having Each Other's Backs', 'Knowing Other Midwives Understand', and 'Thinking Very Seriously About Leaving'.

The participants all described patterns of behaviour and practices from their roles as midwives that emerged as themed categories from the data. By engaging the constant comparison process, I was able to label the core categories conceptually and make links between categories that produced a story to answer the research question.

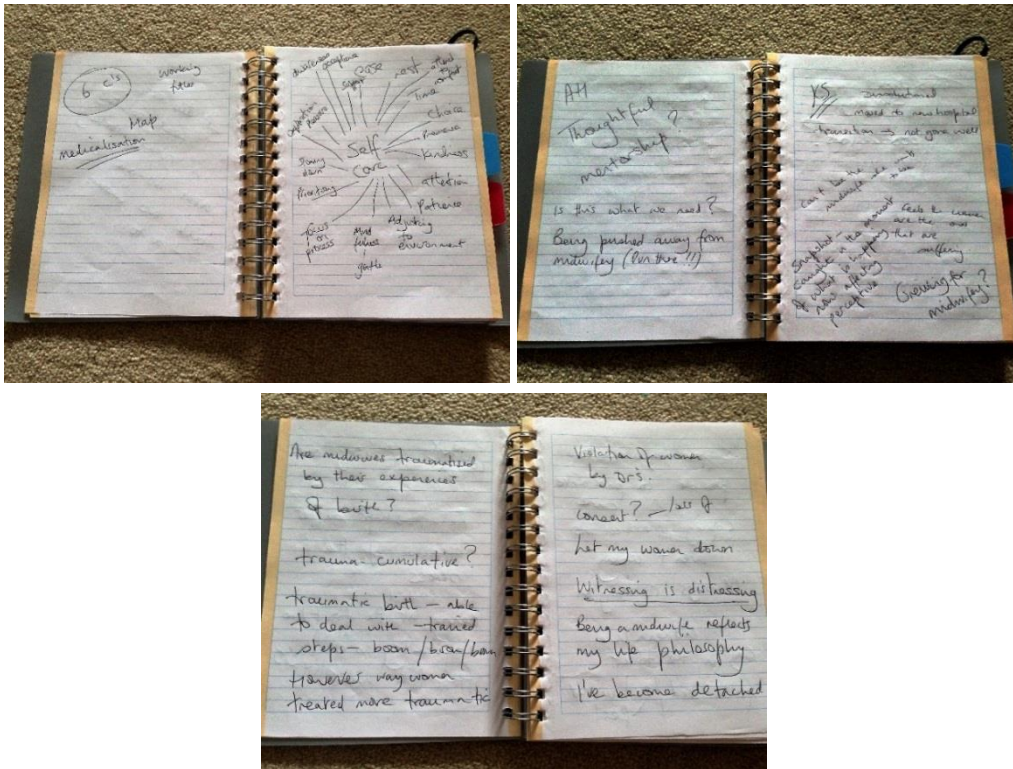
3.5.8 Memoing

As previously mentioned, I recorded memos during the data collection period that were also used in the preparation of this thesis. Memos helped me regarding the direction of future data collection and with analysis, as new themes were discovered. The memos were recorded initially to identify researcher bias, but were logged

regularly as the research progressed as a means of recording ideas and thoughts that occurred during the data collection and analysis period. Memos are viewed as an intermediate step (Charmaz, 2012), between the coding process and the writing up of a thesis. The memo writing helped to question and clarify what was happening during the data collection and analysis process. A memo recorded after interviews had taken place helped to formalise thoughts after interviews had been conducted and helped to identify meanings and ideas generated in the data.

Memo writing is significant in justifying and clarifying decisions made in the coding process and is said to “tap the initial freshness of the analyst’s theoretical notions and to relieve the conflict in thoughts” (Glaser & Strauss, 1967, p. 107). I kept memos in a journal, where pages could be removed and stored in a file for easy access once the writing process began. Glaser (1992) states that researchers need to be careful when constructing memos as it is possible to force the data into revealing a core category early and making all other data link to it instead of allowing it to emerge naturally. Not all the memos recorded by the researcher in this study flowed (Glaser, 1992), but were often hastily constructed as ideas occurred immediately after interviews or during transcribing or the analysis process.

I did not make notes during interviews as I felt it distracted both the interviewer and interviewee. Some studies using grounded theory methodology utilise diagrams to help with analysis (Buckley & Waring, 2013), which I photographed and have used in this thesis to show the analysis process, however, I did prefer to write memos.



Figures 2, 3 and 4: Examples of my Memos Kept After Interviews

3.5.9 Theoretical Saturation of Categories

One of the concerns I experienced was when to stop collecting data, as I was using grounded theory for the first time. Data collection continues until no new analysis of the data appears according to Glaser (1978), with this being the point of theoretical saturation. I found the challenge was recognising that no new concepts were emerging. The theoretical saturation of data shows that the collection of more data and analysis will not lead to new information related to the researcher's questions (Creswell, 2012). I recognised that no additional information about the phenomenon of interest was being discovered and repetition was occurring when data collected from participants did not develop new properties within the already established categories.

I continued collecting data but began seeing similar responses appearing in the data repeatedly. After discussion with my supervisors, it was suggested that I could be empirically confident that the categories were saturated. The categories were showing the participants shared experiences and feelings related to the questions asked.

As Glaser advises, "Once a category is saturated it is not necessary to theoretically sample anymore to collect data for incident comparisons. And of course, once many

interrelated categories of a grounded theory are saturated, theoretical completeness is achieved for the particular research" (Glaser, 2001, p. 192).

Therefore, I realised that the decision as to when to cease collecting data due to saturation was primarily my own. The descriptions of the categories were thick and a theory had begun to emerge, therefore I stopped sampling data and began completing the analysis. There does not appear to be explicit guidance for the actual determination of theoretical saturation and researchers are expected to support their assertion of saturation by explaining how it was achieved (Bowen, 2008). The application of saturation outside of the grounded theory methodology is a topic of debate and has been described as project specific (Morse, 1995; O'Reilly & Parker, 2012).

This suggests that if a different participant cohort was used, different data may have been collected. Therefore, theoretical saturation supersedes data saturation in that a participant's response is coded only if it provides a new property to the category, further delimiting the data collection.

3.6 WRITING THE THEORY

I conducted the interviews with participants and then transcribed it myself as I wanted to immerse myself in the data. A memo was recorded after each interview – often in the driveway of the participant's house so a thought would not be forgotten. The process continued by analysing each line of the transcript, scanning for codes in each sentence. This is the stage where the coding was unfocused and has been described as open (Kolb, 2012), and I was dealing with many codes that had meaning and relevance. Constant comparison of the data allowed for codes to be assembled and categories formed, and thus the formation of patterns and themes began emerging. The codes were viewed as the basis for the construction of the theory, and once codes were grouped and major categories were generated, I was guided towards theoretical sampling to recruit further participants to explore issues relevant to the study. This included identifying midwives who were also coordinators in the midwifery areas, as one of the generated major categories contained specific meaning related to midwifery coordinators.

When I considered saturation had occurred and no new codes or concepts were developing, and major categories had been identified with an over-arching core category revealed; I believed this was time to present the data as a substantive theory. It is a feature of qualitative research to use direct quotes from participants to provide a

richness to any study, which I also did, using square brackets to clarify content. The findings from this study are detailed in Chapter Four.

3.6.1 Trustworthiness

Trustworthiness of the grounded theory methodology has been described in the literature as being enriched by the use of extended engagement with participants (Houghton, Casey, Shaw, & Murphy, 2013); a clear audit trail devised (Carlson, 2010), peer group debrief and review sessions (Kennedy-Clark, 2012), triangulation of data sources (Hays & Wood, 2011), and negative case analysis (Koro-Ljungberg, 2010). I embraced these aspects to ensure trustworthiness in this study. I have included photographs in the thesis to demonstrate examples of the audit trail whilst data analysis was being conducted.



Figures 5 and 6: Examples of Trustworthiness / Audit Trail

3.6.2 Extended Engagement

Extended engagement with participants in this study consisted of in-depth interviews and follow-up telephone calls to clarify any issues arising from the information given. I also asked five of the participants if they agreed with the main findings from the categories that had arisen from the study once saturation had been reached after the twentieth interview. Those participants that were asked to review the findings unanimously agreed with the labels I had given the categories, thus validating the findings.

3.6.3 Audit Trail

Audit trails have been demonstrated to contribute to the trustworthiness and rigor of qualitative research (Bowen, 2008; Carlson, 2010; Cope, 2014; Cutcliffe &

McKenna, 2004; Morse, 2015) and have been described as “a means of holding up to scrutiny the methodological and theoretical decisions made throughout the research process” (Bowen, 2008, p. 305). This reveals transparency when making decisions and shows directions which influenced the research, and allows others to examine the process (Carlson, 2010). In this study memos were written to track decisions, directions and changes that became part of the audit trail, and also were used in discussion with supervisors during the analysis period. Therefore, in this study the audit trail became part of the data, describing thoughts and feelings expressed during and after interviews, interview environments, non-verbal cues observed from participants, and keywords or sentences that served as reminders during the analysis period.

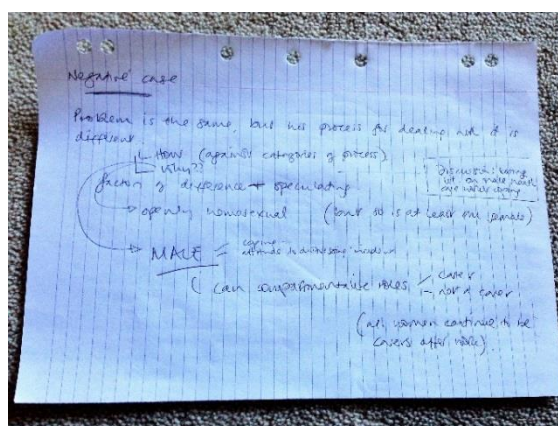


Figure 7: Example of the Audit Trail

3.6.4 Peer Group Debrief and Review Sessions

During the undertaking of this study, I was a member of the university's graduate research school, which provided support and mentorship for novice researchers conducting qualitative research. A small splinter group emerged consisting of those researchers conducting research on health related topics, where grounded theory research was regularly discussed. Within this group, researchers discussed memo construction – comparing and contrasting methods were demonstrated and peers were asked to validate thoughts and ideas that were emerging during data analysis and following interviews. Supervisors were also part of memo and coding checks – parts of interviews were listened to and validation of category construction was carried out regularly, adding to the peer review process.

3.6.5 Triangulation of Data

This study used the triangulation of data sources, which has been previously defined as the use of multiple methods or data sources in qualitative studies in order to develop a thorough understanding of the topic under investigation (Patton, 1999, p. 1190). This included the guidance of an experienced grounded theorist supervisor who helped to provide rigor by over-seeing the systematic steps involved with the grounded theory methodology. The supervisor was involved in each step of the process; from the recorded interviews, transcribing, categorising, analysis and the development of the emerging theme. One of the advantages of implementing triangulation in this study was the identification and exploration of the negative case.

3.6.6 Negative Cases

Negative cases are viewed as a positive influence within grounded theory methodology as it is thought to produce a subtle and richer analysis when some of the collected data from participants shows contradictions and inconsistency (Mathison, 1988, p. 15). In this study, I found that one participant who gave unexpected responses which ultimately strengthened my argument regarding stress impacting upon work-load stress for midwives. Therefore contradictions in the collected data are deemed part of the sampling process and negative cases are actively sought during analysis to support or reinforce findings (Morse, 2010). In this study the negative case represented a participant whose experiences differed from the rest of the collected data, and after an explanation was discovered, the findings were strengthened.

3.6.7 Transferability

Transferability is important within qualitative research and it is the task of the researcher to ensure that detailed descriptions are recorded to allow readers of the work to make informed decisions regarding the transferability of the findings to their specific context (Houghton et al., 2013). The point of transferability is that research findings can be used or compared in similar studies to explain situations and be a form of generalising or producing external validity (Tsang, 2014). This suggests that transferability sanctions the findings of a research study to be applied to similar projects because the information gained in context will be relevant. Glaser (1998) made a point about applicability or relevance of theory that has been developed with one group of people that would be applicable to a different group of people. This implies that knowledge gained in one context will be relevant in another context. Therefore,

transferability is comparable to generalisability and as a researcher cannot specify the external validity of findings, it has been stated that providing:

"a thick description is essential to enable someone interested in making transfer to reach a conclusion about whether a transfer can be contemplated as a possibility" (Lincoln & Guba, 1985, p. 289).

The term 'thick description' was first described by the anthropologist Clifford Geertz which suggests that details, conceptual structures and meanings, are explored and interpreted as opposed to a 'thin description' which tends to be factual and without any interpretation (Geertz, 1973). In this study, I concentrated on creating thick descriptions by contextualising the midwifery environment, the research methods used and providing direct quotes from participants in order that readers of the study could consider their own interpretations (Dawson, Mills, Durepos, & Wiebe, 2010). Thick descriptions allow readers of a study to have a deeper understanding of the concepts and make comparisons from the findings of a study with instances or similar situations that they have experienced.

3.7 LIMITATIONS OF THIS STUDY

One of the limitations of this grounded theory study is that the development of a substantive theory is only pertinent and significant to the midwives who participated in this research at this moment in time. This theory may not be transferable or applicable to other future research studies unless different models of care in different countries were used to collect and analyse data from. However, the principle aim of this study was to explore and understand midwives' workplace stress and its implications for their emotional wellbeing and career decisions within Western Australia. This has resulted in a substantive middle-range theory which may be transferable if contextual environments and participants matched those in this study.

That this study does have limitations is a distinctive feature of all types of research. Kolb (2012) has described how the grounded theory methodology has standard limitations, and as with other research conducted, this study has limitations in the use of its findings due to the specific participants, topic and time-frame chosen. Different findings using the same methodology may occur with a dissimilar cohort of midwives within other midwifery environments. In the literature such findings are described as being likely to "emerge from the data and will be idiosyncratic to each study" (Ammon-Gaberson & Piantanida, 1988, p. 160).

Many midwives in Western Australia have migrated from different parts of the world, and have practised in midwifery environments where they may have experienced more autonomy and a non-medical dominant culture of midwifery. Some of these midwives participated in this study and had varying experiences of years living and working in Western Australia. Therefore, the medical model of care which is dominant in Western Australia could have been an influencing factor in the findings and therefore a limitation to be considered. Despite these limitations, the aims of the study, which were to understand midwives' workplace stress and its implications for their overall emotional wellbeing and career decisions, have been met.

SUMMARY

In summary, I have used grounded theory to explore a social phenomenon, which in this thesis is midwives' workplace stress and its implications for their emotional wellbeing and career decisions and to develop an explanatory theory of it. The explanatory theory serves to explain themes and patterns that have emerged from the empirical data collected by the researcher, who throughout this process was not influenced by prior knowledge or the literature. Classical grounded theory was the paradigm chosen by the researcher for this study, which is an inductive and deductive process using the empirical data for theory generation.

Twenty-one participants were recruited who were all registered midwives working within the public and private maternity system in Western Australia. Audio-recorded interviews were the primary source of data collection, which continued until saturation of categories occurred. Transcribed interviews were analysed using the constant comparative method of analysis. As data was collected it was examined, analysed and compared to all the data and organised into categories. Memos were constructed and examined with codes. This process continued until a substantive theory emerged. In the following chapter, the findings from the analysis of data using these techniques are described in detail.

CHAPTER FOUR: RESEARCH FINDINGS

**“Research is to see what everyone else has seen,
And to think what nobody else has thought”**

(Albert Szent-Gyorgyi)

4.1 INTRODUCTION

This chapter begins with an overview of the themes in data collected via in-depth interviews, with 21 midwife participants residing and working in Western Australia, for the purpose of discovering their experiences of and response to workplace stress. The middle-range grounded theory that emerged from analysis of the data to characterise this phenomenon is then presented.

The theory, which comprises eight constituent sub-categories, characterises the causal, contextual and conditional factors in midwives’ work-related stress as well as the process midwives employ to deal with it. The findings underpin recommendations for ways to better support this under-threat workforce and maintain midwives’ emotional wellbeing so they remain in, and effective in, their roles. These recommendations are discussed in Chapter Six. The findings of this study are presented sequentially.

I will first discuss the causal, contextual and conditional factors that together form the core problem faced by the participants. These are discussed individually, then the core problem itself is presented. The first two subcategories together represent the direct causes of stress in midwifery, the next is a conditional factor that amplifies the problem, and the following three sub categories are about factors in the work context that contribute to the problem.

The core process utilised by midwives to manage the core problem they face in relation to workplace stress has two aspects to it, and these are described next in the form of two additional subcategories. The theory that emerged to characterise the core problem and the core process are then presented.

Participants' quotes are used throughout the chapter to provide the participants with a voice and to support and exemplify the categories. Where the midwifery participants are either referred to or quoted directly, they are identified by a number pseudonym to preserve their anonymity.

4.2 'FIGHTING A LOSING BATTLE': A GLASERIAN GROUNDED THEORY OF MIDWIVES' WORKPLACE STRESS

The theory, derived through a process of parsimony from the data collected in this study of 21 midwife participants' experiences of the phenomenon of interest, is labelled 'Fighting a Losing Battle'. The participants identified that the midwifery role was stressful, that it was not the actual job of working with pregnant, birthing or postpartum women but other factors that made it so, and that the multiple stressors they faced every time they went to work felt insurmountable; this was compounded by them having no time to fully 'regroup' and ready themselves for the next 'attack'. None of the stress factors that the midwife participants encountered were experienced in isolation; in all cases many, if not all, of the stressors described in the subcategories were at play every time they were at work. The themes, language and analogies in the participants' collective experience of workplace stress led the researcher to conclude that working in midwifery is akin to being 'at war' with a number of 'enemies' at once. The participants' accounts are infused with a sense of being under continual attack from 'missiles' from those 'enemies', of being able to get through each shift on a very superficial level because of the support and 'mateship' available from those who are 'in the trenches' with them, but of ultimately reaching the conclusion that the only way to 'win the war' was to become a 'deserter'.

The theory of '**Fighting a Losing Battle**' represents eight subcategories. As noted earlier, the first two subcategories capture direct causes of participants' workplace stress: '**Having to be 150% on Your Game all the Time**' represents the stress and pressure felt from heavy and complex workloads, and '**Being Between a Rock and a Hard Place Whether You Are Coordinating or Not**' is concerned with how shift coordinators engender stress; the conditional factor of the workplace suddenly becoming greater and more complex is depicted in '**Going Pear-Shaped in Four Rooms at Once**', in which the emotional toll that having to manage a number of traumatic clinical incidents at the same time is also defined.

The fourth subcategory is concerned with emotional distress as a contextual factor impacting the stress that participants experience through their work and is labelled **'People not Understanding What Midwives go Through Emotionally'**, while the fifth subcategory, also a contextual factor, is labelled **'Being an Advocate in the Face of Medical Disrespect is Tough'** and identifies doctors' disdainful treatment of women and of midwives in the environment in which midwives work significantly compounds their workplace stress.

The sixth subcategory, and the third contextual factor, is labelled **'Toeing the Line and Giving our Pound of Flesh'** and is concerned with the perceived lack of support their employing organisation afforded participants proportional to their perceived support needs; the data in this subcategory encompasses how this compounds the work-related stress experienced by midwives that was derived from the other sources identified in this research. Together, these six subcategories constitute the core problem that midwives face in relation to workplace stress: **'Midwifery is stressful but it is not the job itself'**.

The seventh subcategory, which is two-dimensional and the first of two elements of the process employed by midwives to manage the core problem, represents the contingency measure they use to deal with the stress they experience at work and are labelled **'Having Each Other's Backs'** and **'Knowing Other Midwives Understand'**. The first dimension, **'Having Each Other's Backs'**, explains how small pockets of support get the participants through their working day and buoy them so they can 'soldier on'. The second dimension, **'Knowing Other Midwives Understand'**, represents the recognition, empathy, camaraderie and sense of sorority, or 'mateship' the participants experienced from their colleagues. In practical terms this means midwives have people 'in the trenches' who recognise their experiences, and with whom they can safely 'vent' and debrief.

The eighth subcategory is labelled **'Thinking Very Seriously About Leaving'** and forms the second aspect of the process employed by the participants to deal with **'Fighting a Losing Battle'**, and speaks to participants having reached the conclusion that, for their own wellbeing, they should 'get out'. The subcategory label reflects that the decision is still very much yet to be made though, because there are a number of factors to consider in it, not least the participants abiding passion for and strong connection to working with, caring for and supporting childbearing women and more practically, the need to earn an income.

4.3 'MIDWIFERY IS STRESSFUL BUT IT IS NOT THE JOB ITSELF'

The midwifery participants in this study were highly cognisant of and precise about the presence of stress in the midwifery role, of the factors that impacted upon it in the clinical environment, and of its impact; they were candid and all discussed the causes, consequences, conditional factors and context of their perceived stress, and how it was affecting their current role and their thoughts and decisions about their future in midwifery. Many of the participants, having acknowledged that stress existed in their role, rationalised and spoke in terms of accepting it as inevitable.

Participant M2 exemplified all participants' responses in this regard when she stated:

"Stress is a big part of my role as a midwife. I feel some type of stress every day that I am at work – some days it is big stress; some days it is little stress."

Participant M14 further explained the nature of the stress midwives experience when she commented:

"There are different types of stress, it isn't particularly what I do as a midwife that stresses me. It is the incidences that happen in midwifery workloads that cause stress. These can range from not enough staff, poor coordinators and serious emergency situations. I have had some really complex cases to deal with that have made my whole shift extremely stressful. I often can't answer my bells because I am stuck in a room dealing with obstetric stuff or trying to put information into the computer for a discharge and no-one helps me. I want to cry by the end of those shifts!"

The participants recognise that their midwifery role is impacted by a range of factors, such as practising in the medical-model of care, commitment to the midwifery philosophy and future career decisions. The job becomes constrained and is negatively influenced. Like others participant M5 remarked on this being more common than not:

"When I have a good shift I can't imagine a better job in the world. But those shifts are becoming rarer – I have more tough shifts than good shifts."

Participants directly related factors associated with the midwifery role as the cause of stress for the midwifery role in the work place, and understood the link to retention in the profession. Work-related stress was consistently acknowledged by all participants as either impacting on their role, on themselves personally, their families or on their decision to stay in the midwifery profession. Three examples of participants' reflections on these consequences are provided below.

"It is only when I have a few days off together or on annual leave and that stress is lifted, do I realise how much stress I have at work" (M3).

"I would say that stresses have impacted on me and my family of late. My kids are saying to me 'you OK Mum'? And I have had to have that conversation with them. That I am OK just not happy at work at the moment. And that's OK because they have seen me really, really happy after having great experiences at work" (M10).

"The motivation, the enthusiasm – the thing that makes you stay, makes you like your job – the stuffing is knocked out of you. Will I stay? I honestly don't know" (M1).

One participant (M4) recognised that the stress encountered within midwifery was, in comparison, different and far greater than some other job roles:

"I remember this friend who worked at a video shop – I'm not a job snob, and he decided to quit because it was too stressful. [Laughs]. A video shop being too stressful to work in!! I know I shouldn't judge because I wasn't doing that job – but I was like – yeah, it must be hard putting videos back on the shelf! It sounded like a walk in the park compared to the stress I have in my role. I wonder if he would still have thought his job stressful if I had told him about the dead baby, with peeling and necrotised skin that I had to bath and make presentable for a mother last night."

The participants were able to describe specifically what they thought were contributors to stress that impacted upon their midwifery role.

4.3.1 'Having to be 150% on Your Game all the Time'

In this study the subject of workloads was mentioned directly on many occasions and these were in reference to a causal factor of stress that added a sense of pressure

and overload to the participants. The participants appeared to be describing a cycle of workloads, stress factors and pressure, and they identified how one of these pressures was caused by reduced staffing which in turn affected their workloads. Participant M6 describes:

"The executive aren't midwives. They seem to understand the pressures of ED [Emergency Department]; understand the pressures of [operating] theatres, but don't understand the pressures of delivery suite. I don't know why because theatres and the ED can have anything come through their doors at any time – and they are always staffed with the same number of people. No-one moves an ED nurse to the postnatal ward. The delivery suite is never staffed with the same number of people. Yet anything can come through the doors of delivery suite too – which could well be an obstetric emergency."

Regardless of the midwifery environment the participants were working in, they described workloads as stressful due to the increase in births, medical complexity of women birthing, staff shortages, rosters and the skill mix of the staff rotated onto a shift. The participants' experiences of the causes of stress within workloads are presented below in relation to the impact it has on the role of the midwife, and how that is changing midwives' intentions to stay within the midwifery profession. I did not ask any of the participant's questions specifically about their workloads, yet every participant raised it either as a cause of dissatisfaction within midwifery, as a factor impacting upon their role, or as a cause of stress within their midwifery role. Many participants spoke similarly about this issue:

"Workloads have changed and have become heavier with poorer skill mix in the midwifery area" (M1).

Participant M6 explained the issue more specifically as follows:

"Usually we have 12 births a month – for the last few months we have been averaging 20 births a month – with no extra help. The organisation has not recruited any extra staff and we are expected to cope."

The last two comments from participants suggest that where midwives perceive the skill mix is poor or staffing is inadequate, the sense of work overload creates the

inability to provide all the care needed for women in their care. By way of example participant M3 said:

"Having a workload that doesn't take into account a lack of staffing is stressful; sometimes colleagues will help, but often they are in the same situation as me and have a heavy workload themselves."

The time available in which to perform the duties of the midwifery role was clearly identified as a contributor to stress. According to participant M4 the level of stress is directly linked to time constraints whilst performing the midwifery role:

"We have been chasing our tails for months with no time to do the extras that we like to provide for women. And definitely no time for ourselves."

This theme is echoed in a comment from participant M1:

"I miss not having time to be with women. I'm expected to just soldier on and get on with things or get my paperwork done. I haven't time to cry / be happy with / grieve with / experience the joy of birth with women anymore. It makes me sad."

Participant M19 also describes time being a paramount factor affecting the provision of care for women and babies:

"There is such a rush to get women out [discharged] because we are so under the pump – education, everything for the baby must be done immediately and then get them out because we need the bed."

Many of the participants mentioned how their workloads created stress because of an inability to complete tasks despite *'being rushed'* or *'rushing around'*, as there is an expectation by themselves, and their employing organisation, in completing *'everything'* by the end of the shift. This theme of *'rushing'* care causing stress is highlighted by M9 who comments:

"You are so busy getting women discharged, others coming in for induction – every day there is bed stress – you don't have time to get to know the women or provide good, quality care."

This sense of being rushed was supported by M1 and M6, who additionally noted the midwifery role changing over the past few years and not, in their view, for the better:

"I think a few years ago there was time to do updates, chat, debrief, training sessions with junior staff – everybody had that opportunity. But not anymore. I don't think it is because the number of births has increased – we are midwives – we do birth. It is because the organisation has set quotas for midwives and if they think they have too many staff – they get offered a day off or are deployed to a nursing area" (M1).

"Midwives are run ragged on the wards; you don't get a breather. You don't get breaks. Years ago we would share a pot of tea and eat a piece of toast together. You don't have that time now" (M6).

The midwives in this study describe constantly working at full capacity, and whereas in the past when there were quiet periods in the midwifery environments, updates, training and debriefing would have naturally occurred.

According to participant M2, the lack of time has impacted on updating clinical skills:

"We used to do [practical clinical emergency] scenarios when we had quiet periods on labour ward – wasn't that long ago. We learned from that [scenarios]. You do a shoulder dystocia scenario or a PPH scenario and nobody put fluids up and nobody did this or that – and you know whatever you do you learn a bit don't you? But now – everyone is whizzing around – you don't get that anymore – we've lost that."

These responses clearly show that the midwifery role has changed and that time is apparently no longer available for clinical updates, providing quality care, debriefing and getting to know colleagues as team members. Workloads, which emerged in this study as both a separate and a compounding stressor in midwifery, are discussed next. When workloads were being discussed by participants, the labour and birth suite environment was cited as an area where workloads were seen as stressful. As participant M1 stated, it was evident that participants' felt that:

"Labour and birth suite magnifies issues that cause stress and there are often a lot of stressed people on it."

It is in fact commonly acknowledged among midwives that this particular clinical setting is highly dynamic. However, participants identified that it is incidents and issues over and above those inherent in the 'core business' work performed in that setting that cause stress, and that in turn, these additional stressors amplify those inherent in caring for labouring and birthing women and babies. Participants' labour and birth suite-related responses centred on how control and decision-making issues impacted upon those who worked in the environment.

The participants did also suggest that there was a different kind of stress attached to the labour and birth suite, not primarily workload related, but more closely associated with specific traumatic incidences; this finding is discussed later in this chapter.

Additionally, and related to work-load, many participants said they were often sent to work on labour and birth suite even when they were not rostered for that area, and this, some felt, was because it was known to be extremely demanding and was avoided by others. To illustrate, M9 who said:

"I work mostly in labour and birth suite. Not because I want to but I am on the rotation and even when I am supposed to be in other midwifery areas I get sent to labour and birth suite because no-one will willingly go. I have no choice because I rotate – I have to go."

And M19 said:

"As I am casual I can be sent anywhere in the hospital, but it is usually labour and birth suite because no-one wants to work there."

Several participants stated categorically that they had made the decision to no longer work on labour and birth suite, and were able to give very specific reasons why; these were either incident or workload related. Participant M4 comments:

"The reason I stopped working on labour and birth suite was that I found the work mentally intense – yet not nearly as physical as the wards, but so mentally and emotionally intense and you never know what you are walking into."

Some participants also described how although they did continue to work in labour and birth suite, that it was with a sense of dread that they did so. Complex

pregnancies, increasing birth numbers, staff shortages and poor skill mix amongst those rostered on to work, were cited as the cause of this dread.

Participant M20 describes:

"Sitting in hand-over on labour and birth suite, silently wishing that you don't get the mag sulph or the 150 kilo woman in labour with twins."

Whereas participant M4 describes labour and birth suite:

"I feel a bit like a soldier being sent to Afghanistan; I get sent to labour ward which feels like a war-zone because of the constant challenges I face there."

Participants also referenced the fact that they had seen an upsurge in the use of epidurals by women in labour, which has changed the midwifery workload on labour and birth suite; usually they mean that women are immobile and remain in bed whilst labouring. This is not generally perceived by midwives to be a good thing, because being active and upright arguably facilitates normal birth, which midwifery promotes where possible – however, some participants alluded to putting that core professional value aside because of the personal benefits of having a bedbound woman to care for.

Participant M7 explains:

"If a woman requests an epidural in labour, I think great! She will be stuck in the bed, can't move – no pain, no moaning – I will just do the obs, sit on a stool and wait. I definitely will have an easier shift."

The other participants did not specifically allude to epidurals, but some did mention that '*easier options of pharmacological pain relief*' and '*thank God for Entonox*'; did appear to them to make their shifts easier and therefore less stressful. Finally, some participants noted having seen an impact on their own and their colleagues' health from workload-related stress. Participant M8 shared that:

"Some of my colleagues are on sick leave due to stress caused at work – and all were on labour and birth suite when the stress occurred."

Participant M3, who works in all clinical environments revealed:

"Work related issues have caused me emotional distress and I have been on worker's comp ¹for the last four months."

Participants did discuss how the job impacted on their health, which is identified in several of the categories, but only two participants mentioned that sick-leave was required. Some of the participants discuss how they have changed their employment status to either casual or part-time to cope with the increased workloads they have experienced. Participant M19 states:

"Workloads have definitely increased. I went casual so I wouldn't have the added stress of nights and weekends – and I find I am usually given a heavier load. It is almost as if to say 'you aren't one of us now, you earn more so you can work harder'. It isn't fair and I have said so."

Another participant (M20), also changed her contract resulting in a different outcome:

"I changed my [work] contract to part-time and I was still feeling pissed off and burnt-out but wasn't so stressed; so I decided to go casual and now the roster thing isn't a big deal and I love labour ward now."

As previously discussed in Chapter Three, Western Australia is geographically large, with the land area quite large by world standards, but the density is low, with a small metropolitan area and a vast rural and remote area. I was able to recruit two participants who worked in rural and remote hospitals, and one participant who worked as an agency midwife occasionally in a rural hospital. These participants also described how workloads have increased causing stress, with M7 stating:

"My changing midwifery role increases my stress – in the country hospital where I work, I juggle working in different environments; antenatal, postnatal, labouring women and birth – all in one shift."

¹ Worker's comp is a slang term for worker's compensation, and is an insurance providing wage replacement and medical benefits to employees injured in the course of employment in exchange for mandatory relinquishment of the employee's right to sue his or her employer for the tort of negligence.

Participant M11 describes:

"Workloads for me in a rural hospital are stressful – for example, on my shift yesterday I looked after paediatrics, adult medical and midwifery. I just didn't stop."

Independent midwives are self-employed and choose their clients and to a great extent, their working conditions; most opt to work in women's homes to provide midwifery care. Midwifery Group Practice (MGP) midwives are, in the main, employed by an organisation but manage clients in a caseload model between groups of four – eight midwives, and in Western Australia at the time of writing, operate from birth centres or low risk maternity units. However, despite seemingly having more choice, control and autonomy than their hospital based colleagues, and despite working in a midwifery model of care, these participants also described work-related stress. For example, participant M13, who is a self-employed private practising midwife, commented:

"I do think my workload is stressful, it is different now I am not working in a hospital, but I am on call and that can be stressful when you are waiting for babies and juggling kids in the middle of the night."

A different kind of time management pressure-related stress is seemingly experienced by participants working in a midwifery model of care as opposed to the medical model of care; and participant M10 expands on this stating:

"I caseload and therefore manage my own workload, so I find it isn't as stressful compared to when I had a hospital workload. I work in a woman-centred environment, with beautiful women and great colleagues and mentors now – I don't have to play that game anymore. My stress now comes from over-due babies and who will watch my kids in the middle of the night if I am called out."

Despite it having its own unique (predominantly childcare-related) challenges though, working in a non-medical, non-hospital model of care did seem to be less demanding overall. M11 highlights this when she says:

"I only have two blocks of weeks in the year when I am on call for my main job now and the odd week when I am on back-up for an independent midwife friend – so my workload stress is greatly reduced. However, the

only thing that really stresses me when I am on call for birthing women is that I am a single mum. I worry about who can have my kids, you know the phone rings, a woman has gone into labour and I have to think – right, who can have my kids?”

The subcategories reported, and the core problem/theory derived from them reflect the workplace stress experience of midwives who are women; only one male midwife (Participant M21) came forward for this study. I was fully expecting to hear a similar story to those told to me by his female counterparts, however it was very different: his stress came from different sources than theirs, and as a consequence, participant M21 became this study's 'negative case'. A negative case is identified when searching for and discussing elements of the data in the analysis process, and it does not support or appears to contradict patterns or explanations that are emerging from the data analysis (Glaser & Holton, 2004). The male midwife interviewed differently on the topic of workloads in this study, as M21 did not find his workload a challenge:

“For me personally, I don’t find the number of women I care for stressful. Coming from a nursing background I am used to having 14 or 15 patients on a night shift to care for, whereas here I have six on the postnatal ward on a night shift.”

Also differently to the other participants, he encountered a stressor that they did not, on the basis of his gender:

“However, what I do find stressful, is when I am given my six women at the beginning of the shift and see I have been allocated women with Islamic surnames. There is always that risk that I go into a room to introduce myself – and I come straight back out to get a female member of staff because the woman or her partner don’t want me. That is far more stressful for me.”

Participant M24 also went on to comment that:

“If a woman decides she will not have me look after her because of her culture or faith, I find some coordinators become a bit bloody-minded and say ‘get back in there, this is a public hospital, she has no choice’. They won’t swap the woman to a female staff member – and I say ‘OK then, you go in that room and explain it to her because I can’t do anything in that room’ ”.

This was one of many responses from participants regarding how coordinators and their decisions impact upon not only workloads, but increase the stress experienced by the participants.

4.3.2 'Being Between a Rock and a Hard Place Whether You are Coordinating or Not'

This category highlights shift coordinators' role and behaviours as something cited by many participants as a causal factor of stress whilst working in the midwifery environments. Participant M16 states:

"Coordinators definitely add to stress levels. I sometimes coordinate when I work a shift, and I try to manage medical, surgical and maternity all in one shift. Having a coordinator that doesn't understand that or can't manage that is a huge stressor."

Participants not only identified coordinators' management abilities, but discussed how the 'power' the coordinator can wield and how personal characteristics of coordinators could also affect the midwifery shift. The participants recognised that confrontation and the power engendered by a hierarchical structure were defining influences which directly impacted upon their role as a midwife. In relation to the 'power play' that can occur, participant M17 commented:

"Some coordinators are real stress heads and really make a shift hard work. If someone doesn't like you they give you the shittiest cases to deal with, and sometimes you get a coordinator who keeps interfering with your woman."

Another participant, M14, also alluded to coordinator characteristics by mentioning:

"One coordinator is a real bitch – they all suck up to her because they know how much damage she can cause you."

Participant M4, also discussed how the coordinator affects the midwifery working role:

"It becomes stressful when you don't trust the coordinator in charge or she is a real bitch, because you just know she is going to make your life difficult."

Some participants did not appear to respect some coordinators and identified certain factors that may have influenced this perspective. Participant M7 comments:

"Some midwives shouldn't coordinate – they don't have enough clinical experience and some haven't had life experience. You need to know how to talk to people – not shout and be sarcastic, or flap around in an emergency."

Another respondent (M2) commented on working with a coordinator who appeared stressed:

"I am more stressed when I am working with a coordinator who is stressed. I find myself not only dealing with my workload, but also trying to help them deal with their [coordinator's] stress. Stress is infectious in that situation."

Participant M1 reinforced this viewpoint:

"There are certain coordinators on the wards and on birth suite that you can tell when they have been in charge of a shift. Staff are whipped up into an angst – it's like they project their anxiety and stress onto everyone else. And then it filters right down to the women. Buzzers are going, there are more gripes happening and it integrates into everything."

As the issue of coordinators was clearly being identified by participants during the research collection process, I selected participants who were also coordinators during the theoretical sampling process as described in Chapter Three. The findings reveal the stress coordinators experience, the pressure and causal factors for this stress and also the lack of preparation and training for the coordination role within the midwifery environments. Participants described being a coordinator using terms such as being stuck between a rock and a hard place, and coordinating birth suite is a very high stress job.

Participant M1 stated:

"It is stressful being a coordinator; often I feel my registration is on the line. And yet I haven't done anything wrong."

And participant M6 commented:

"No-one tells you how to be a coordinator. It can be a baptism of fire."

These comments are supported by participant M9 who observed:

"I don't think people realise how difficult it is to coordinate a busy ward or to look after a difficult student – it is stressful, really stressful."

Another participant (M2), who regularly coordinates on a labour and birth suite of a large tertiary hospital referred to the skill mix and staff available:

"As a coordinator you are on a shift and sometimes you look and you've got two or three level twos that you can delegate all the deliveries; and other times you have a pile of grads or students that need supporting. So you go into situations where you do take over rather than help, and with all the acuity and high risk – it's like full on all the time. My stress levels go through the roof on those shifts."

Respondents who coordinated were generally older and classed as senior midwives with several years of clinical experience; these characteristics usually signify authority and a degree of power and knowledge in order to make decisions and confront others' decisions. Participants discussed decision making by themselves and others as causing stress; participant M8 commented:

"The most stressful thing about coordinating is dealing with doctors and consultants who won't make good decisions. As a midwifery coordinator it is very hard to be telling the obstetric consultant what they should be doing."

Midwifery colleagues were also identified as causal factors in decision-making causing stress; participant M6 commented:

"Midwives sometimes ask me really stupid questions that I know they know the answers to. And I think to myself – is this a test? She coordinates herself – she knows the answer. Why is she causing me stress?"

Participant M2 also continued discussing this theme observed:

"People bombard the coordinator with questions and information and then you have to sift through it all deciding what is important. And people large

things up and you think to yourself hang on a minute – that is not really a drama.”

Participant M8 supports both these comments by stating:

“Midwives are very quick to drop decisions onto coordinators that they should be making for themselves.”

The findings suggest that coordinating and being the decision-maker does cause stress and puts the coordinator under pressure. Participant M6 comments:

“You have strong characters in midwifery that give you grief – it could be you have asked them to take their tea-break half an hour earlier than normal. They can give you a hard time over it, or you’ve got a senior doctor or consultant who doesn’t want to come in when you have called them.”

The findings revealed that participants did not think there was adequate training for the coordinator role; participant M1 commented:

“I did get a bit of training about coordinating on the ‘ALSO’ course, but other than that it was a case of being handed the red keys. But I’ve never had any real training.”

The lack of training for the coordinator role is also identified by participant M5 who stated:

“In the hospital I work there is no training to be a coordinator, you spend a shift working alongside a senior midwife coordinator – two shifts maximum – and it really depends on what input that person gets.”

Coordinator training was also highlighted by participant M7 who commented:

“Coordinator training is very dependent on the organisation; very much the routine stuff but it isn’t padded out. I don’t think [coordinators] are given support, or the tools to cope. This comes as you do the job.”

Participant M18 describes traits and personality influence the ability to be a good coordinator and stated:

“There is no training given regarding the ability to support staff, and to be honest you either have that or you don’t. Your personality and the way you

conduct yourself with your family and your friends make the traits for a good coordinator."

Some participants suggested that not all midwives could or should be in a coordinating role, participant M4 commented:

"Not everyone can be a coordinator – some people feel there is a natural progression when you have been there for a significant time."

Participant M2 supports this statement by stating:

"Some people want to be coordinators for the wrong reasons; not necessarily for the love of learning but for extra money and to move themselves from the level one position where they keep getting the brunt of the work. In the level one position on labour ward you never get an empty room as you always get a patient, so they choose to act up in a coordinating role sometimes for purely the wrong reasons."

Participants also described how some midwives were pushed or bullied into the coordinator role; participant M4 commented:

"Responsibility can be stressful. I think it has got worse because midwives are pushed into coordinating – it is an expectation because there are no staff. They are bullied into it."

All respondents in this study who were coordinators in the midwifery environments thought the coordinating role was stressful. They were able to identify stressors and relate them as factors that were not caused by the actual role of the midwife – but by factors that impact upon the role. A comment from a participant reflects why the stress is magnified; participant M6 observed:

"A friend of mine also coordinates in birth suite, and she says it really irritates her when she goes home and says to her husband that she has had a really stressful day, and he would say he has had a stressful day too. He is a painter and decorator. And she would say to him 'but when you have had a stressful day a wall doesn't get painted. When I have had a stressful day it could mean that someone nearly died' "

Therefore, participants are aware that stress is increased through causes that directly link to incidents which compound the stress they feel.

4.3.3 'Going Pear-Shaped in Four Rooms at Once'

The participants in this study all described how traumatic incidents impacted upon their midwifery role. Every participant made a comment regarding traumatic incidents; some participants were stressed by traumatic incidents, some participants described being stressed by fall-out from incidents and others felt watching women's treatment by doctors was construed as an incident that was stressful. Some participants were able to separate obstetric emergencies from traumatic incidents as this example reveals from participant M21:

"It is not the big incidences that stay with me. In an obstetric emergency it is a logical step – it is bang, bang, bang, and controlled because you are thinking through the steps – but it is hard."

Participant M1 agrees with this statement:

"It wasn't the actual emergency because I am trained to deal with that. It was the fall-out from that incident which caused me stress."

The participants here are suggesting that obstetric emergencies do not generate stress as a stand-alone effect, but that other factors linked to obstetric emergencies are recognised by the midwives as causing them stress. In most obstetric emergencies, quick responses are required, and the participants described dealing with the actual incident but 'fall-out' from the incident itself proved to be the stress factor. The participants described their reactions and how the 'fall-out' impacts upon them and the negative effect it has on not only themselves but their colleagues and the women and babies they provide care for. This is also supported by participant M6:

"Obstetric emergencies are exactly that – an emergency that I am trained to deal with. I find the way women are treated – like cattle – that traumatises me more."

Some participants described how some obstetric emergencies caused more trauma than others, for example participant M9 commented:

"I think some clinical incidents, like shoulder dystocia in particular, are more stressful for me than other obstetric emergencies. Seeing some of those babies dragged out was awful."

One participant described a shoulder dystocia occurring during one of her shifts and the doctor called to the emergency could not remove the impacted shoulders. In a desperate measure the doctor had turned to the participant and asked if she could try as all other manoeuvres had failed. Participant M2 described:

"I had a really bad shoulder dystocia where I broke a baby's arm. The registrar couldn't get the baby out. I got the baby out. Broken arm [demonstrates a break above the elbow]. Even now, and it was three years ago, I can still remember vividly that crack of the arm breaking in my head. I now get really anxious and feel super stressed if there is even a possibility of a shoulder dystocia happening."

One of the participants (M7), who works in a remote community also highlighted birth incidents from her perspective:

"I do think birth incidents and obstetric emergencies do impact stress in midwives, and I don't think these are worse in the country but the support networks are worse."

One respondent recalled an incident that happened several years ago when she was a midwifery student that she feels still has an impact today. Participant M4 commented:

"When I was a student midwife I experienced a traumatic delivery which the memory of it stays with me to this day. It was a shoulder dystocia and the midwife put her hands on mine and pulled so hard on the baby's neck that the skin ripped. I thought I was pulling the baby's head off. It was awful. Really, really awful. I can't forget that."

Another participant describes how the frequency of obstetric emergencies and incidents has affected her; participant M11 stated:

"I've been involved with a lot of really big PPH's [Post-Partum Haemorrhage] (one was 4100 mls), awful shoulder dystocia and things like that. I guess for a lot of people it would absolutely freak them out, but you tend to cope with them I think better when they are so frequent."

Many participants cited specific incidents, including obstetric interventions that were not obstetric emergencies but involved over-seeing trauma occur to women during the childbirth process. Participant M19 commented:

"What is much harder for me to deal with is watching a woman having a really awful forceps delivery and you are trying to help her – that is what bothers me more."

Participants were also able to define what type of incidents were particularly stressful or traumatic to them. Participant M13 stated:

"Quite often an incident isn't something really big – like a neonatal death – sometimes what is worse is where a woman is violated by a doctor or obstetrician. That is traumatic to me."

This comment alludes to interventions that many childbearing women are subjected to during pregnancy, birth and the postnatal period. Participant M10 commented:

"Women are subjected to interventions without being asked – consent doesn't exist most times. I have seen the insertion of Foleys' catheters that have made women cry out in pain and the doctor hasn't stopped. It causes me stress to have to try to intervene or just stand by and let that happen."

Many participants made similar comments regarding necessary and unnecessary interventions witnessed in all the midwifery environments as being quite traumatic and stressful to not only the women but to the midwives also. For example, participant M11 described:

"There are times when I wake up in the night with palpitations, dreaming about an incident. It can be three weeks down the track, it can be three months down the track – and it doesn't need to be a highly defined stressful incident – but an incident that I found stressful."

Many of the traumatic incidents that respondents discussed in this study occurred on the labour and birth suite. Participant M12 commented:

"There have been lots of stressful incidences, and they have all been on labour ward. It tends to be the area for high intensity 'big bang for your dollar' incidences."

There was direct reference to the fact that shortage of staff working or willing to work on the labour and birth suite causes stress for all staff in the area. Participant M15 observed:

"The big thing that happens in the labour ward environment is that when it is busy you don't have support or back-up. When something goes 'pear-shaped' it goes 'pear-shaped' in four rooms at a time and you know that the reason why you are not getting any back-up is because there is no-one to help you. They are dealing with dramas in their own rooms."

Participant M4 agrees with this statement by commenting:

"You have to muddle your way through on your own that is the thing that is most stressful. It is not the situation you are in but rather that you know there is no-one coming through that door anytime soon to help you."

Another participant describes the dilemma of whether to call for help and how that causes her stress; participant M6 stated:

"I know that if I push the bell help will come, but I also know that if I push the bell I am taking them away from another possible life-threatening situation. So I am less likely to push the bell, and I am then in a really stressful situation."

One respondent remembers an incident which caused her to cease working on labour and birth suite, participant M3 commented:

"I had an incident on labour and birth suite. It is many years now since I worked there. Actually it is 25 years ago. And I never returned."

Participant M3 continued to describe the incident which involved the birth of a 21-week fetus that had been diagnosed as being incompatible with life, and was declared to have been a death in utero, as there was no detection of a fetal heart-beat or fetal movements. The woman was induced and rapidly progressed through a short labour to birthing the 21-week gestation fetus in the caul. The participant's trauma and stress of the incident is revealed as participant M3 continued:

"I didn't expect that. I didn't know that would happen. No-one ever told me. I was thinking that at 21-weeks it [fetus] had been declared as deceased – yet it looked like it had survived the birth process. I did not

expect that. I tried to keep calm – but inside I was freaking. I hadn't seen anything like it. All its limbs were moving. I tried not to look shocked – the parents were looking at me and at it. I tried to be like – 'it is just nerves making it move'. I thought to myself – it can't be alive? Should I break the bag? Will it keep moving? It was such a shock to me. That one was quite traumatic for me."

The participants revealed similar incidences involving women and babies that were both emotionally traumatic and stressful, and most had vivid recollections of the incident and how they felt. Some participants discussed their feelings regarding perinatal loss (which will be discussed in the findings category 'People do not Understand What Midwives go Through Emotionally') and others described incidents involving the death of babies (as described in the previous paragraph) or the unusual occurrence of maternal death. Participant M5 commented:

"A code went out and I entered the room and had to start resuscitating a woman [who had just birthed] while the crash team arrived. You don't expect women to die in maternity. I remember crunching on her sternum – willing this woman to breath and her heart to start – and all the time I was thinking I was going to have a maternal death here."

Many respondents discussed how these traumatic incidents affected them; participant M6 commented:

"Sometimes an incident doesn't physically affect me but it shakes my confidence. It takes time to get your confidence back."

The findings revealed that the respondents were able to identify specific causes of stress that impacted upon their role. The next category to emerge from the data highlighted the emotional consequences that many midwives described in the interviews.

4.3.4 'People do not have any Understanding of What Midwives go Through Emotionally'

This category is comprised of participant's responses to the consequences of the stress that participants experienced through their work. Participants were clear that there were times when they have been distressed and relate it directly to their work situations or particular incidents that have occurred. Participant M10 observed:

"I have had emotional distress and more so in recent times. I have experienced a change in hospitals, a change in doctor's practice at the same time trying to be consistent with my midwifery values. Trying to do that constantly has caused me real distress. I'm fed up with fighting."

Clearly the emotional distress suffered by this participant had impacted upon her emotional well-being. Participants also discussed how the emotional distress they experienced manifested itself; participant M18 described:

"I've cried in the toilet at work and I've also cried driving home from work. I've cried through frustration and sheer exhaustion – I sound pathetic don't I?"

Many of the participants described crying as a consequence of emotional distress caused through work-related incidents; participant M4 commented:

"I didn't want anyone to see my distress, because I was distressed, I was sobbing my eyes out on the drive home because I didn't want my family to see me like this. So I have to get over it quickly. I still have to go to work the next day – even when I have had a distressing shift."

Six of the respondents described feeling distressed at witnessing women and their families' distress after a stillbirth or when working the Pregnancy Loss Service (PLS). It appears it is the death of a baby and the women's and families' grief that projects onto the midwives; participant M4 commented:

"I always try not to cry when I am dealing with a PLS woman, and I remember one woman saying to me 'it's alright, it shows you care' "

Participant M16 also admitted to feeling distressed in the same circumstances:

"I've sat and sobbed and sobbed and sobbed after a PLS – I feel like I am sharing the woman's grief. It really upsets me. I feel so inadequate with the woman. I just try to work through it by myself."

Although participants discussed feeling emotional distress, participants also relate distress experienced to future career decisions. Participant M10 stated:

"There have been many times I have been distressed by things which have happened while I have been a midwife. This distress is impacting on my

career decisions now. It isn't childbirth incidences that are causing this for me – it is the incidences in my work place."

As discussed in Chapter One, the midwife has historically endured persecution from authorities and religious leaders, professional attacks from the medical profession, and ridicule from society. Recently a newer phenomenon of ridicule from colleagues, has been documented in the literature and the participants of this study also identified this particular issue. One participant understands the need to take charge of her own learning from mistakes that may be made and acknowledges she faces ridicule from colleagues if that happens; participant M18 commented:

"Being able to make a mistake and acknowledge it is part of growing and learning as a midwife. Then you can look at ways of either correcting it or acknowledging it and taking ownership of it. Learning from it so you don't do it again. I don't expect to be ridiculed for it. But that is what happens."

Some participants also discussed how not getting a vaginal examination (VE) correct had been a source of humiliation and ridicule from colleagues. Their comments were despondent and describe a lack of respect from colleagues they worked with; participant M16 stated:

"If you just make one little mistake, like not getting a VE the same as a doctor or colleague – you are ridiculed. VE's are so subjective, yet your confidence can be destroyed over it."

Another participant described a similar incident involving performing a VE and feeling vilified following it; participant M5 commented:

"I can't take being shown-up and not trusted on labour ward. Because that is how they are. I won't be trusted now and everything I do will be checked. They will have someone watching me – without telling me of course. They will probably try to send me on a course or something. I've committed the cardinal sin – I didn't get a VE right."

Feeling ridiculed for making mistakes clearly had consequences for the participants in this study and many participants alluded to feeling disillusioned and persecuted by colleagues and management. Participant M21 stated:

"Sometimes I think about mistakes I may have made. I don't want to be labelled either for mistakes or for being male. If your face doesn't fit or your personality isn't quite right, people do end up with problems and are almost persecuted – certainly in the labour ward."

Participants used a variety of terms regarding the same theme of feeling or being ridiculed. For example, comments ranged from I would be ridiculed if I said emotionally I am not coping, or I would be victimised if others found out [about not coping]. This led to participants then describing how they feared that their emotional distress and the consequences of that would not remain confidential.

Several of the participants disclosed that they were concerned about confidentiality should they wish to discuss their distress with the organisation or management following a work-related incident. Participant M1 commented:

"Nothing is confidential in a maternity unit."

Many of the participants mentioned that a lack of confidentiality amongst colleagues was evident in the maternity environments where they worked, and that gossip and innuendo was rife within 'small, cliquey groups'. One respondent was very aware of this aspect and participant M6 described her experience following an incident at work:

"I didn't contact them [hospital support services] because I didn't know how confidential it would be as it was attached to the hospital."

Participants who expressed doubts regarding confidentiality in their work-place or from the organisation were able to relate this issue to being viewed as someone with a character flaw or as a possible impact on their career progression. Participant M16 described:

"If I off-loaded to the organisation's counselling service, I am not sure it would remain confidential. It would certainly be used against you. If you were ever going for promotion, or wanted to advance up the career ladder, it could be held against you. It could be seen as a flaw – a method of not coping. You are not the hard-faced bitch I am sweet-heart – so you couldn't manage the labour ward type of mentality."

Another respondent described her feelings and responses on the issue of confidentiality, particularly following an incident or mistake and the possible effect on her future career; participant M8 commented:

"I wouldn't say it is strictly confidential [hospital debriefing service]. I would be guarded in my responses. In a formal setting like that I know I would not disclose things like I would with my colleagues and friends. It might be used against me at a later date."

This suggests that the participants have experienced hearing or knowing about issues of confidentiality affecting colleagues or employees of the organisations. A further comment from participant M20 stated:

"There should be someone that you could go to – to talk in confidence. Not having to go to the people you work with. That you are friends with. You need someone who won't discuss what you say with other people in the tea-room. Behind your back."

The property concerning confidentiality was identified by participants as a further stress that was added to an already stressful event or incident occurring. Participants were clear in their responses that making a mistake and the ensuing lack of confidentiality impacted upon their perceived stress. This led to some participants feeling persecuted and their reputations being tarnished.

The term 'witch-hunt', which was identified in an historical context in Chapter One, was used by participants in this study to describe an awareness of being unfairly treated or when feeling persecuted, and their reputation or career is threatened. Several participants used the term witch-hunt when describing the after-effect of mistakes made regarding some decisions taken, or certain midwifery clinical practices such as vaginal examination (VE). Participant M4 describes such an incident:

"[The coordinator] came onto the room and asked the woman if she could do a VE with the next contraction to see how things were going – and as she was doing the VE she asked the woman to stop pushing as she was only 8 centimetres dilated and not fully dilated as I had said an hour previously. I was mortified. Honestly I could have died. My heart sank – the couple looked at each other and the woman started crying. I just wanted to

walk away – but I couldn't. And I knew I would be the latest target of a witch-hunt."

Comments made by participants often consisted of a small sentence tacked onto a description of an incident, for example *'It's a witch-hunt'*, and *'I've seen plenty of witch-hunts'* and *'I didn't want to be part of a witch-hunt'*. Participant M16 stated:

"I've seen several witch-hunts that resulted in someone leaving. Certainly on labour ward."

The respondents cited more witch-hunts occurred in the labour and birth suite environment than the other clinical areas. I was unsure of the reason for this, but many of the participants did remark that the labour and birth suite was a highly stressful area to work in. Another participant, M21, also commented on witch-hunts and the labour and birth suite and described:

"I don't find witch-hunts occurring on the postnatal ward – partly because the ward I work on is made up of misfits anyway. We have midwives who are open about their bipolar diagnoses, sexuality, their depression and self-harm issues. Having colleagues who have quite severe mental health issues means we don't have the witch-hunt scenarios that can be seen on the labour ward."

Some respondents also commented that if they spoke out on any issues that went against the majority they would 'end up in a witch-hunt'. Participant M13, who is an independent midwife but sometimes has to transfer women into local labour and birth suite, stated:

"I can't rock the boat – or I'll be part of the witch-hunt."

Interestingly the male midwife participant (M21) in this study made a comment regarding mistakes made in the clinical area that appeared to result in colleagues being victims of witch-hunts:

"I find when I work with male colleagues and they make a mistake, they can redeem themselves on the next shift. Then the mistake is forgotten. This doesn't happen with my female colleagues. They never forget a mistake and label someone so the mud always sticks."

The findings suggest that when midwives make mistakes they experience not only guilt, embarrassment and humiliation, but they know they will be the topic of ridicule, gossip and persecution. Many of the participants described how they felt when they were being targeted in a witch-hunt, by the organisation or fellow colleagues, by using terms and phrases such as *'I felt victimised'*, and *'Chinese whispers everywhere'* and participant M16 stated:

"Midwives do gossip and run each other down – certainly if you have made a mistake. Once they have their teeth into you, it is hard to shake off the label and innuendo."

As the findings were revealing the consequences of the stress the participants were identifying from their workplace, they began to discuss how these consequences impacted upon their emotional well-being. The participants began discussing how organisational and contextual factors that had created stress from the workplace affected them both physically and emotionally – usually the physical symptoms directly shaping the emotional effects. Participants were able to directly link physical and emotional consequences from the causes within the workload and knew the impact these were having upon them. Some of the participants described shifts leaving them physically and emotionally *'exhausted'*; being too tired to eat properly or *'eating when you don't want to because you might not get a break'*, feeling guilty about eating sugary, high-carb foods as they are the only foods available when busy, and engaging in unhealthy behaviours like drinking *'a big glass of wine or three to help me relax and* As participant M1 commented:

"I think not looking after ourselves is linked to the stress we feel. I often have a full bladder or indigestion through stuffing a meal down quickly. We put our women first before ourselves. I often think of the mistakes I could make by surviving on lollies or chocolate through the day. I get a sugar rush then crash and burn at the end of my shift."

Several participants made reference to a lack of self-care due to the nature of the workload, and many comments were very similar to this one by participant M10:

"I don't even have time to go to the gym anymore or do anything for myself. I work 12 hour shifts that leave me exhausted and on days off I do the housework and physically recover."

The participants described and appeared to clearly understand the link between stress experienced, self-care and their emotional state. Many participants identified certain activities they engaged in to help alleviate the stress they felt they were under. Not all of the activities mentioned could be deemed as healthy as some participants admitted they drank alcohol and ate 'food warmed-up in the microwave', directly after a shift and before going to bed. Some participants described engaging in physical activities and participant M3 commented:

"I try to engage in physical activity which reduces the stress I feel. Usually I go on a bike ride or I go for a long walk. [It] helps me think things through. But to be honest the stress never goes away, it eases off – but it is always there."

Although many of the participants did describe drinking alcohol as a way of relaxing after a stressful shift, not all of the participants mentioned this; participant M13 stated:

"I meditate when I feel stressed. I don't drink alcohol because I am usually on-call, and besides drinking alcohol is a cop-out. I do yoga and meditate."

One participant described how she had adopted an unhealthy lifestyle due to the long night shifts on labour and birth suite (12 hours) and the increased heaviness of the workloads; participant M8 commented:

"I've neglected myself really because of how heavy the workloads are and how hard I have worked, and now I am paying the price."

The participants understood that they were engaging in some unhealthy lifestyle habits which they attributed to the stress encountered through the workloads that have changed in recent years.

4.3.5 'Being an Advocate in the Face of Medical Disrespect is Tough'

Many of the participants identified that they did not like the way women were treated by some doctors, and this appeared to be spread over both public and private clinical environments. The responses in this study related to interactions midwives observed between doctors and women, not verbal interactions, but specific incidents where the participants thought women or themselves were being disrespected and poor decisions were made; causing stress to the participants. Many participants gave

one line statements that were similar before going on to describe an incident; 'I do not like the way women are treated by doctors', and 'doctors are not woman-centred', and participant M2 added to the way doctors treat women:

"The doctors sometimes make bad decisions regarding care of women and there is no way you can say 'that is unethical, that is bullshit, that is just wrong'!"

Participant M10 supported this statement by describing:

"It isn't the big things – the obstetric emergencies that distress me. It is the little things – the way women are treated by doctors and how I am disempowered and disrespected by doctors and the system."

The findings reveal that midwives are subject to stress as they observe the way women are treated during childbirth, and they feel that being an advocate for women puts them in stressful situations. Participants identified that this did cause them distress which I thought appeared to be a moral distress as opposed to a purely emotional distress. The participants described, through examples experienced in the clinical environments, a loss of integrity whilst trying to advocate for women which causes a moral distress and dissatisfaction with their working environment. Participant M16 commented:

"I felt very belittled by the medical staff. I was just doing my job as a midwife. With woman – duh!!! I went home and said to my husband that I have committed professional suicide coming to work here [Australia]."

Another participant describes advocating for one woman she was caring for; M1 described:

"When I came here [Australia] nine years ago I was nearly sacked because I would stand and argue my woman's point. I could not stand by and allow her to be VE'd by every Tom, Dick or Harry."

Clearly, the participants are describing that advocating for women can be a source of moral distress for them. The participants described many incidents where they felt they were disrespected by medical colleagues when they advocated for women in their care, and some who had immigrated to Australia expressed a concern

that midwives were not respected as equal health care practitioners. Participant M6 commented:

"I remember working on labour ward and not being able to deal with the obstetricians. Their absolute disrespect – not just for me as the midwife – but for me as a human being."

This statement was echoed by another participant M1 who stated:

"There is a completely different respect for midwives in Europe. There is no respect here [Australia] from the medical profession. They see you as a lower status, they don't see you as a comparable status. They see you as the little nurse. A hand-maiden."

These findings suggest that the midwifery participants demonstrate an understanding or realisation of their status in the eyes of some obstetric staff; this appears to be especially significant for participants that have emigrated from Europe to Australia, who are keenly aware that this is at odds with their own view of their status. In addition, there appears to be incidents where this clash of status has led to a physical confrontation. One participant describes an incident that led her to physically assault a doctor as she attempted to advocate for the woman she was caring for though labour. Participant M10 described:

"I have had run-ins with doctors when advocating for my women. I have smacked a doctor's hand for doing an episiotomy without consent, without anaesthetic – and I hadn't really thought that reaction through. He was as stunned as I was. But it wasn't right. And I told him that. I said 'how would you like me to snip your penis without consent or an anaesthetic'? He didn't report me. He could have. He knew he was in the wrong though."

Interestingly the findings reveal that two midwives working in country / rural hospitals and an independently practising midwife, said that they had good relationships with doctors. They did not comment on a shift in their status, however none of these participants had immigrated to Australia. These three midwives had been born and trained in Australia, and had not worked outside of Australia.

The participant who works in the rural hospital also commented about respect leading to good working relationships; participant M7 commented:

"Midwives try to always advocate for the woman and I must admit that I do have a good working relationship with the doctors out here in the country. They respect my knowledge and judgement. But I realise not all midwives have that good a relationship with doctors. And if you don't have that good relationship it is very difficult to be an advocate for a woman when a doctor is working from a base of fear."

The independently practising midwife, M13, describes her relationship with an obstetrician that she is currently working with:

"I do have a very supportive obstetrician who is amazing and has certainly been helpful getting my women appointments when needed. She is really good getting me ultrasounds for women who are post-dates, which enables the women to hang on for a homebirth. This obstetrician doesn't use the 'dead baby' card. She gives the women the facts and totally understands how the system works against private midwives. But this is rare. I can't name any other doctors who respect me as a midwife."

The participants repeatedly described many of the same statements through their discussions with me during the interviews. Participants used the terms 'condescending', 'belittling' and 'disrespectful' when referring to how medical staff appeared to view the midwives' when they advocated for women or challenged prescribed care. The described disrespect from medical colleagues does not appear to demoralise the midwifery participants in this study, on the contrary the participants strive to validate their midwifery identity. However, the participants did describe this conflict as a stressor that did impact upon their role and which there was little or no support forthcoming from the organisations that employed them.

4.3.6 'Toeing the Line and Giving our Pound of Flesh'

The participants expressed a general opinion that they expected the organisation to value their work contributions and express care about their physical and emotional well-being. The participants had all identified that increased workloads were attributed to organisational objectives and goals, and many described feeling a distinct lack of support or reward for their working endeavours. As far as who is accountable for increased workloads, participant M7, like others, lay the responsibility squarely at the door of her employing organisation:

"The organisation that employs us expects more and the workloads have hugely increased. That need for the organisation to have their 'pound of flesh' is more evident now."

The midwifery participants described a lack of organisational support available to them; participant M1 commented:

"Management have no insight into the issues on the floor. We have no staff and sick calls are coming in because midwives are being continually asked to do double shifts – and our emotional health and well-being is being affected by our working environment – and the execs are saying 'there must be a [sickness] bug out there'. But the bugs are here in this hospital – and they are the execs!!! It is lack of support and they cannot see it."

Participant M10 described:

"I have had two conversations with direct-line management and have told them that staff are beside themselves. With the changes in practice and technology, not being able to practice in the way they normally do – all these barriers in your way, especially for some of the older midwives – but I wasn't listened to."

Participant M8 made this statement:

"The organisation is not particularly supportive unless you go and seek it. You have to seek it and demand it – but they are very unsupportive generally."

One of the respondents (M7), working in a rural hospital, described why a lack of organisational support occurs in her clinical environment:

"There is a lack of support from organisations that are in rural / country areas. We don't have the bigger networks to work with and often clinical managers are midwives. We have only one manager who is a midwife too – and non-midwife managers just don't get midwifery."

Managers and the general management of midwives were seen as separate issues, as managers were known to the participants and were usually midwives and had a reasonable understanding of the issues involved, but the management appears to be a 'faceless' entity to the participants. Participant M10 commented:

"The management doesn't practice what they preach. It is about toeing-the-line. The executive doesn't want champions; they are not transparent or equitable. It doesn't leave you with any confidence in them."

Participant M6 observed:

"I just could not go to work. Not because of the midwifery work I was doing but because of the management staff. I knew that if I went to work and I actually saw them I would say something that could potentially affect my career."

Participant M6 stated:

"From managers you get a professional respect but you don't get anything from your higher executive team. I don't think they have any idea what it is like working in a midwifery unit."

Participant M16 commented:

"Management is spineless. It doesn't have the interest of its employees even though it pretends to. All it wants is its pound of flesh."

The participants were clear in their assessment that they received little or no support from their organisations regarding the value of their work contributions, and viewed the organisations as prioritising their own business goals and objectives at the expense of the midwives' interests and well-being.

4.4 MATESHIP HELPS BUT IT'S NOT ENOUGH'

The concept of support was an aspect of the findings that most participants discussed or alluded to during the interview process. Participants acknowledged who they turned to for support, and why that particular person or group were selected. The participants of this study described receiving support from colleagues as opposed to receiving support from the organisations who employed them.

4.4.1 'Having Each Other's Backs'

The participants were very clear about who they received support from; this included the colleagues they worked with or midwifery friends working in other clinical areas or hospitals. They did not suggest that as midwives they collectively supported each other, but mostly it was small groups within the midwifery environments.

Short comments from several participants included 'we have each other's backs', 'we are each other's support', 'you have emotional support in small cliquy groups' and 'there are groups of people that support each other'. Participant M2 commented:

"You pull together to help a person out of a hole – be it a clinical situation, be it a rostering situation, be it the way they've been spoken to."

One of the participants who worked in a rural hospital describes 'faceless' support provided by the organisation; participant M7 commented:

"It makes a big difference to your stress levels if you have face-to-face support networks – something we don't have in our rural hospital. We have each other [colleagues]. It isn't that there are not support networks but for country midwives they are all online. From my own experience, and also my colleagues because we have discussed this, country midwives would prefer face-to-face support rather than having to draw on faceless support."

One participant discussed how she believed she received support from colleagues on the postnatal ward, but did not feel supported by colleagues on labour and birth suite. Participant M4 described:

"It depends on which department I am working in regarding support I get from colleagues. Postnatal wards have a team approach where you can bounce ideas off each other, which often includes when you are having a tough shift and you want to someone to say 'are you ok'? Or 'do you need a hand'? The problem comes for me on labour ward – where I am isolated with one-to-one care and no-one comes to relieve me. Particularly when I have a complex woman to care for."

The participants identified that their support network usually involves their work colleagues as opposed to any organisational initiatives. However, the participants did describe debriefing as a major source of support from colleagues.

4.4.2 'Knowing Other Midwives Understand'

The participants in this study discussed talking through issues or incidents that caused them stress, and a general theme emerged which referred to debriefing with midwifery friends and colleagues. It was interesting to hear who participants chose to debrief with, who was deemed most appropriate and where and when debriefing

usually occurred. In this context, debriefing is the term the participants used when referring to informal chats or discussions with colleagues and friends after an incident or issue had occurred. I found that the participants used the term debriefing to mean any time they wanted to talk to someone about something that has impacted upon themselves during working time. Participants did comment about staff debriefings and talking with someone professionally qualified, however most participants expressed concern that knowledge about the midwifery role would be an essential component for successful debriefing to occur. Participant M6 commented:

"It would be good to have someone qualified to talk to, but preferably someone who knows about midwifery. Otherwise the whole process would become meaningless."

This suggests that the participants understand who is most appropriate for them to talk to or debrief with. Participant M10 reinforced this by describing:

"I do talk to my partner or another girlfriend that is not a midwife; they listen but they don't have that complete understanding. So I don't get so much from that and I don't necessarily get the opportunity for constructive feedback."

Participant M1 added to this theme of the importance of being able to debrief or talk with another midwife by commenting:

"They [midwives] know what you are talking about. They know the terminology you are using and they understand if you are talking about something happening clinically that causes you stress. Other midwives really understand how it feels to see and do the things we have to deal with."

These comments suggest the importance of debriefing with another midwife in order to not only expect an understanding of what occurred, but that because of the assumed knowledge there would be a good chance of being able to resolve issues or have someone acknowledge that any actions taken were the correct ones. This would be especially significant for midwives working in clinical areas that were located in rural or remote areas. Participants in this study, who worked in rural and country hospitals, did discuss the issue of being able to debrief or talk with other midwives. Participant M7 described:

"There is often nobody to run ideas by or talk about something that has stressed you other than a doctor, and a doctor isn't always there either. So there is no-one to debrief with."

Midwives working in rural and country areas often work in isolation or with Registered Nurses (RN's) and doctors, and participant M11 commented:

"I can't debrief with RN's because they don't get midwifery."

The participant who practises as an independent midwife (M13) also discussed debriefing:

"I usually go to midwifery friends and talk through any issues I have encountered or any stresses I am under – often these friends are in private practice like myself, as they understand the pressures and issues we face are often very different to midwives working in the system."

The findings from the participants, whether they worked in metropolitan or rural hospitals or practiced independently, suggests that midwives not only prefer to debrief with those who understand the nature of the work involved, but that they seek out those in the same internal environment. This implies that although an issue or incident can be the same, the context can also change how that issue or incident is perceived by the midwife.

It was identified from the findings that there were consequences linked to not only who or when debriefing occurred, but there were also possible negative outcomes to seeking or utilising debriefing. Several participants described requesting or requiring debriefing as a possible negative aspect that may affect their careers or reputations. Participant M16 commented:

"There is always that feeling that needing to talk is a sign of weakness. If you have something that creates a level of stress in you, you like to be seen as coping. And that is a big issue, which is why midwives choose carefully who they speak to."

This finding would suggest that there is a constraint in debriefing at work for some participants, and this is reinforced by participant M5 who added:

"Often midwives don't want to debrief at work as it is thought by some to be seen as a weakness."

The participants in this study appeared to prefer informal debriefing with midwifery friends and colleagues, as opposed to seeking out formal debriefing offered by the organisations. There were many comments from the midwifery participants concerning the need to debrief, and particularly the need to debrief after traumatic incidents. The participants had described how their workloads had increased and the number of high risk cases and increased acuity had led to more traumatic incidents occurring. This led participants to question their own and others' decision-making processes, mainly following a traumatic incident. Participant M21 commented:

"I think speaking about it is probably the best thing especially when you are clinically involved. You can work out whether you made the right decision or not."

Other participants also commented on debriefing as a way of justifying decisions made:

"I think sometimes you need to know whether you have done the right thing by talking with the senior girls" (M7).

The participants did not appear to value debriefing offered by the organisations, and some said it was not beneficial or ineffectual, while others were concerned about confidentiality if debriefing was conducted by management or arranged by the organisation. Some participants said *'there just isn't time to debrief'*, while others said *'it isn't always appropriate'*. Participant M1 stated:

"Sometimes when staff debriefings do occur they aren't beneficial because they are not one-to-one."

The participants described who briefing occurs with and listed partners, family, friends and colleagues. Participant M9, who is in a same-sex relationship, commented:

"I have a partner I can easily talk to as she is a midwife too. I can debrief with her. She knows exactly what I am talking about and how I feel."

However, one participant (M10), described how she tries to talk with her husband, who is not a midwife:

"I couldn't take that home to my husband [Describing an FDIU² she had cared for that shift]. I couldn't take that to him because he wouldn't have really understood. He claims he knows about midwifery after all these years – but he doesn't."

Interestingly the participants who said they did talk and debrief with partners and husbands did not discuss talking or debriefing with other family members or friends who did not understand midwifery or the role of the midwife. Coordinators were recognised as someone that could or should debrief a midwife, particularly after a traumatic incident.

Participant M3 observed:

"Often these things occur at the end of a shift and so there isn't time to debrief. We all have families and partners waiting at home and usually you are back on an early shift the next morning. You just want to get home. It really depends on who the coordinator is that shift as to whether debriefing is even offered."

Many of the participants described talking with colleagues as their form of debriefing regarding any matters occurring in the clinical environments. Participants appeared to place importance in talking to their colleagues, who many seemed to have developed close friendships with. As they worked together in the same role, they described understanding each other's perspective and acknowledged shared knowledge of the job and midwifery role. Some of the participants car-pooled to and from work and many said they *'debrief in the car on the way home from work'*.

Participant M20 commented:

"We debrief amongst ourselves on the way home, which helps me put things in perspective and makes me emotionally stronger."

Participant M21 describes why he talks and debriefs with colleagues:

"Another good thing about talking with my cohort colleagues is that I tell them a situation, they say what they would have done – and I say 'thank you' – because that is exactly what I did. It validates my practice and I move on. I'm concerned with me and my practice – that is probably what

² Fetal Death In Utero (FDIU) is the death of a fetus/baby before birth.

separates me from my female colleagues. I don't much care what others think."

One of the participants who worked in a country / rural hospital also described debriefing with midwifery colleagues, but she also identified how the isolated environment impacts upon her social life. Participant M11 commented:

"I have only my colleagues to talk and debrief with. The trouble is working in a rural hospital means we don't have time to talk at or after work. So we socialise and talk about work!! Sometimes there is only one midwife on a shift and that's it. So we only really get together socially, and work dominates our conversations."

The participants who were also coordinators discussed talking and debriefing with colleagues; none said they had used the organisation's debriefing services. Participant M8 stated:

"I talk to good midwifery mates – often before going home. I do keep a lot inside. I do tend to store it up and sometimes I will use it as a teaching opportunity to create an in-service around it which I find helps as it means I can actually come out with some of my own statements. It lets me get certain situations off my chest. I am more vocal these days than I used to be."

These insights from participants suggest that talking and sharing experiences happens between colleagues and midwifery friends; close working colleagues where relationships have developed primarily through a work-related experience. The participants in this study did mention debriefing after traumatic incidents, but they were much more focused on discussing how they talked through most work-related experiences amongst their colleagues or midwifery friends. Many respondents made brief similar comments, I try to ask staff if they are OK, and most of us ask each other R U OK?

One participant (M3), described how obstetric emergencies were becoming more common in every-day midwifery practice:

"Trouble is shoulder dystocia and PPH are becoming so common that senior staff don't seem to think they can be traumatic and that debriefing may be required."

Some of the participants again identified the role coordinators could or did play in debriefing after traumatic incidents, as opposed to the organisation being responsible for providing it. Participant M17 observed:

"The coordinator is often as exhausted as we are at the end of shift, and everyone just wants to get their notes done and get out of there. You are winning if you get to the end of the shift with a lovely normal birth and your notes all written up."

The participant is describing the constraints that impact upon debriefing occurring, particularly at the end of a shift, as usually there is not time before-hand due to work-load pressures and as the participant noted, often incidents can occur towards the end of a shift. Another participant described a positive experience when she approached a coordinator after a traumatic incident; participant M4 explained:

"I spoke to the midwife coordinating who is actually really good at coming and asking you if you are OK and stuff. I told her I wasn't expecting that to happen and she said she understood and most people don't realise that is going to happen."

This exchange is validating the participant's experience of an incident that had an unexpected outcome, and the simple phrase asking if the participant was OK seems to be valued.

Another participant, who was a coordinator, described debriefing from a different perspective and explains what can be involved in the debriefing process; participant M6 commented:

"An incident that happened not long ago changed the ethos of my debriefing. I was coordinating on labour and birth suite and something happened to somebody in the team that day. I offered her support, stayed with her after her shift ended at 2130, made sure her notes were all right and that she had written the correct sequence of events. We were there until 2300 and she had never had anything like that happen to her before. The registrar was really good, we were all debriefing together and it was OK. But the point was – she wasn't OK. She was going home after having been involved in an awful and distressing incident."

This demonstrates that the participants not only recognise the stress that impacts on them, but that talking with midwifery colleagues ensures empathy and that they can sympathise with each other following traumatic incidents. Interestingly, the male participant, who had previously commented that he only preferred to talk to midwifery colleagues he had trained with regarding work-related incidents, made a brief comment regarding debriefing after traumatic incidents. The empathy and sympathy approach did not seem to appeal to him, participant M24 stated:

"I'm not into cups of tea and tears after a shift."

Therefore, the findings suggest that there are two divergent points relating to debriefing; being able to unburden and receive empathy and support, and receiving validation regarding decision making and acknowledging an ongoing learning process.

4.4.3 'Thinking Very Seriously About Getting Out'

The findings from the final category have implications for the future of midwifery and midwifery practice in general. A sense of belonging within midwifery, as both a working environment and a profession, was important for the participants and was reflected in their intentions to stay working in midwifery or leave and go back to nursing or try something new. Participant M4 describes belonging as a sort of club:

"I suppose it is a sort of club really. We belong to a club, because even outside of work and someone says 'such and such is a midwife too', and you think 'oh really' – you automatically have this bond already, straight up like, because you just know that she knows what you know."

This statement is supported by another respondent who also alludes to belonging within midwifery; participant M18 commented:

"As soon as you qualify in midwifery you are in. You are a member. You are expected to get on with it. You knew what the rules of the club were when you were a student. That's the difference in midwifery. It is life and death right there."

Some of the participants described 'cliquey' groups within the midwifery staff and this varied between the different clinical environments. This appeared to make participants feel as if they belonged and wanted to stay, or leave either the area or

midwifery completely. One participant (M16) reflected on her experience of this occurring on the labour and birth suite:

"There are some real bitches working on the labour ward. They don't work anywhere else in the hospital and they think they are the cream of the workforce. They are cliquey and you are either one of them or an outsider. I'm an outsider."

The participants also identified how their age, health and changing attitudes to women and caring were impacting on their decisions to stay working in midwifery. Some participants raised negative points however some also maintained positivity about their role in midwifery. Participant M8 commented:

"Working on the floor is hard on the body. My BP is up these days, I'm over-weight, so I am not the healthiest woman in the world. But my mind is still pretty keen and I am adamant to hang in there and make the place just that bit better place to work. I am realistic and know what I can achieve."

Many participants remarked on their health and stress levels in conjunction with remaining working within midwifery. Participant M15 commented:

"Why would anyone do our job under the current conditions? I don't think my health will take it. I'm over-weight, drink too much and am stressed at work. Working at Woollies [Woolworths] sounds like a better deal!"

The findings reveal that a large proportion of participants were not particularly happy working in midwifery currently, and were able to identify the reasons for this. Participant M6 summarises this by commenting:

"There is not enough down-time, there is not enough debriefing time, there is not enough learning time – it is actually the pits working in midwifery at the moment."

These descriptions are in keeping with participant M20 who observed:

"I've only felt this way since I have got older. My back hurts, my knees hurt. I don't want to invest all that energy and pressure on my own body to help someone who doesn't appreciate me as a midwife. Some days are a real battle because we get some real low-life birthing now – they do drugs, are

on methadone – I don't want to be in their company, let alone birth their babies."

Many of the participants described feeling despondent about midwifery; some stating that it was not the job they thought it was going to be when they began training as midwifery students, and some had immigrated to Australia and had previously worked in a different model of midwifery care. Many midwives commented that the job they trained for and loved doing has changed and it was not the same then as it is now. The participant's comments regarding the midwifery role from the perspective they had when they were midwifery students were all very similar; participant M4 commented:

"The way I was sold midwifery is not what midwifery is outside of University. No offense – but your students won't know what has hit them when they graduate. I loved midwifery in University."

This observation is echoed in a comment from M9:

"When I was a midwifery student I loved midwifery. I had my University lecturers' who gave me great support and preceptors who showed you things and supported you."

The participants appeared to be mostly in agreement that they enjoyed being a midwife and if they were working in the role they were trained for then they would stay within the profession. However, many participants did say they had thought about or had already left the midwifery clinical environments; many were very clear on why this had happened and were able to identify the reasons or factors that had caused that decision. Participant M10 elaborated on this:

"When I provide care for women, the actual caring part, I love that. But it is the bureaucrats, the policies, the way you have to fight for women to have rights – that is what affects my fulfilment for the role."

Responses from participants who said they were going to stay in the profession for the foreseeable future implied that it was not the role or midwifery that was causing dissention but the change in the way midwifery was currently being conducted. Participant M3 commented:

"I have not thought of leaving the profession because I love what I do ultimately. I'm just not enjoying the way I am practising midwifery at the moment."

Participant M16 stated:

"I think Australia has a long way to go before it really understands midwifery because it appears we are behind the curve ball. I think Australia's technology and research is really good; the medical teams are good and we have some good midwives. But the understanding of how midwifery works and how important a role it is – I think Australia is way behind. And that is why I have gone back to nursing."

The male participant (M21), who was the negative case in this study, was also unsure of whether he would stay working in midwifery – but for very different reasons. Unlike all the other participants, one of his reasons for considering leaving midwifery was because of his promotion prospects. He commented:

"I was a nurse for 10 years before I trained to be a midwife and I still like nursing. I want promotion, but midwifery is like 'dead man's shoes'. So I may end up back in nursing because I want promotion but also because personally I think I have a 'sell-by' date when it comes to the labour ward."

This was an interesting comment, as none of the other (female) participants mentioned having a sell-by date; the findings suggested health reasons and the impact of health on the body as well as dissatisfaction with the current way midwifery is practised were the main reasons for considering leaving the midwifery profession.

Participant M21 went on to explain:

"Male midwives in their 30's are ok, but when you get to your 40's and 50's and working on labour ward – and for doctor's it seems to be fine – but when you are dealing with 20 plus year olds and you are a 50-year-old man, you start to look like an old pervert. Female midwives in their 50's are respected like a grandmother figure – but male midwives are not."

Participant M21 did go on to say that if he did consider staying to work within midwifery he would elect to work in the postnatal area:

"Postnatal is different and other male midwives have said to me that if they stay in midwifery they tend to stay in the postnatal areas."

4.5 FIGHTING A LOSING BATTLE

The substantive theory labelled 'Fighting a Losing Battle' emerged from the data in the categories in this study. In essence, the theory is that midwives experience their work environment as a place of constant challenges and stressors, that they perceive as very difficult to deal with individually, and even more difficult to deal with when they are compounded by other work-related factors, which appear to occur regularly.

All the sub categories relate to the core problem entitled 'Midwifery is Stressful but it is not the Job Itself', with statements used by the participants that reveal a theme that threads through the subcategories. The statements used by the participants to describe their experiences include: 'being in a war-zone', 'like being a soldier', 'dealing with aggressive people', 'the stuffing is knocked out of you', 'we are so under the pump', 'being deployed to a nursing area', 'you don't get a breather, you don't get breaks', 'I wake up in the night with palpitations, dreaming about an incident', 'not getting any back-up', 'I'm fed-up with fighting', 'you are winning if you get to the end of the shift with a lovely normal birth', 'some days are a real battle', 'the way you have to fight for women to have rights', and 'dead man's shoes'.

These statements make reference to the participants being in a war-like situation and the stated challenges, experiences and perceptions that the participants describe relate to these. The concept that emerged to theorise these participants' experience was that they are fighting a losing battle. There was one covariant factor, the category 'Having Each Other's Backs', that mediates the impact of these challenges and stressors, but it provides nowhere near enough support to counteract or deal with them fully.

This substantive theory was created when it emerged from the midwifery participants' data that had been critically analysed and developed into categories, revealing that:

- Workloads are heavy, and compounded by time constraints and staff shortages
- Coordinators and being coordinated causes stress in the midwifery areas

- Traumatic incidents and obstetric emergencies cause pressure and impact upon emotional well-being
- Midwives' clinical knowledge is undermined and their status disrespected when advocating for women
- The midwives' experiences are that they are fighting a losing battle
- Midwives are considering whether they stay or leave the midwifery profession.

A substantive theory is formulated from an area of study where participants either describe or demonstrate a pattern of behaviour in response to problems or concerns they are experiencing. Substantive theory then becomes the link "in the formation and development of formal theory based on data" (Glaser & Strauss, 1965, p. 11). In a grounded theory study, the major problem or concern describes the over-riding issue that participants have identified in the area under study (Glaser, 1992).

In this study the aim was to develop a substantive theory of how midwives working in Western Australia understood work-related stress in midwifery, and its link to emotional well-being and future career decisions. The substantive theory that emerged from this study was given the conceptual name of 'Fighting a Losing Battle', and it explains how midwives experience and recognise work-related stress and its link to emotional well-being and career decisions in a specific way. The theory's core problem of 'Midwifery is Stressful but it is Not the Job Itself' was identified by the participants and was central in their belief that midwifery was stressful; the job alone did not cause the work-related stress, but other factors surrounding the midwifery role impacted upon that role which led directly to work-related stress.

The substantive theory that emerged from the collected data in this study (see figure 8), was significant in that it contributes new knowledge regarding how midwives in Western Australia perceive work-related stress and how it impacts upon their emotional well-being and their future career decisions. Therefore, the substantive theory that was generated from the collected data of this grounded theory study significantly contributes new knowledge to the existing body of literature regarding how Western Australian midwives understand stress and its links to emotional well-being and future career decisions.

What is apparent in the categories that have emerged from the data is that the participants all experienced their work environment as a place of constant challenges and stressors that they perceive as very difficult to deal with individually, and even more difficult to deal with when they are compounded by each other, which appears to be often. The participants' statements made reference to working in a war-like situation and the stated challenges, experiences and perceptions of the participants relate to these. Therefore, the concept that emerges from the data to theorise the participants' experience is that they are fighting a losing battle.

The substantive theory demonstrates how the midwives understand work-related stress, and the importance of their well-being and retention within the midwifery profession.


CORE PROBLEM						CORE PROCESS	
Midwifery is stressful but it's not the job itself						Mateship helps but it's not enough	
Causative factors	Conditional factor		Contextual factors		Contingency measure	Consequences	
Subcategory 1	Subcategory 2	Subcategory 3	Subcategory 4	Subcategory 5	Subcategory 6	Subcategory 7	Subcategory 8
Having to be 150% on Your Game all the Time	Being Between a Rock and a Hard Place Whether You Are Coordinating or Not	Going Pear-Shaped in Four Rooms at Once	People not Understanding What Midwives go Through Emotionally	Being an Advocate in the Face of Medical Disrespect is Tough	Toeing the Line and Giving our Pound of Flesh	 Other Midwives Understand and We Have Each Other's Backs Having each other's backs Knowing Other Midwives Understand	Thinking Very Seriously About Leaving

Figure 8: Fighting a Losing Battle: A Grounded Theory of Midwives' Experience of and Response to Workplace Stress

4.6 SUMMARY

Grounded theory methodology was used to determine midwives' workplace stress and its implications for their emotional wellbeing and career decisions in Western Australia. Participant's voices, through the use of direct quotes, were used to form the basis of the discussion in this chapter. The core problem of **'Midwifery is Stressful but it is not the Job Itself'**, was discussed in relation to three major categories which included **'Having to be 150% on Your Game all the Time'**, **'Being Between a Rock and a Hard Place Whether You Are Coordinating or Not'** and **'Going Pear-Shaped in Four Rooms at Once'**. These causal, contextual and conditional factors were identified as causing stress.

'People do not Have any Understanding What Midwives go Through Emotionally', **'Being an Advocate in the Face of Medical Disrespect is Tough'**, **'Toeing the Line and Giving our Pound of Flesh'**, **'Having Each Other's Backs'**, and **'Knowing Other Midwives Understand'**, were sub categories that were identified as the consequences and process that affected, influenced and constrained the participants. **'Thinking Very Seriously About Getting Out'** was the final sub-category discussed that provides an understanding of the relationship between the core problem and sub categories.

The participants' statements made reference to working in a war-like situation and the stated challenges, experiences and perceptions that the participants described related to these. The concept that emerged to theorise these participants' experience was that they were fighting a losing battle.

Chapter Five provides a discussion of the findings and the substantive theory for this study, relating it to established knowledge within the current literature.

CHAPTER FIVE: DISCUSSION

“All discussion of the ultimate nature of things must necessarily be barren unless we have some extraneous standards against which to compare them”

(Sir James Jeans)

5.1 INTRODUCTION

Although the findings support some previous study outcomes, there are new insights from this study that show the importance of midwives' work-related stress within the context of Western Australia that helps to fill the gap regarding stress in the midwifery role in the extant literature. The aims of the research reported in this thesis were to understand midwives' workplace stress and its implications for their overall emotional wellbeing and career decisions, and to theorise ways to better support this under-threat workforce through maintenance of midwives' emotional wellbeing so they remain effective and engaged in their roles. In Chapters One to Four of the thesis I reviewed the related literature, discussed the methodology chosen for the study and my rationale for its use, detailed the design of the study, produced a report of the subcategories derived from data analysis, and presented the middle range theory that emerged from these. In this chapter I provide a discussion of the key findings that emerged from this investigation and define the construct and meaning of work-related stress in the context of this study and within the existing body of research and knowledge.

This study has provided a compelling new grounded theory that describes and explains the midwives' core experience of work-related stress, the impact of it on their emotional well-being, their efforts to manage it and the consequences for their future career decisions. It emerged from the data that midwives' work environment is an emotional battleground where midwives constantly encounter and must deflect a number of stressors that they perceive as very difficult to deal with individually, and even more difficult to deal with when they are compounded by each other. This insight will prove extremely helpful for understanding some of the potential issues associated both with the predicted shortfall of midwives in Western Australia (Pugh et al., 2013),

and the workforce challenges facing the midwifery profession in Australia and perhaps internationally.

In recent years Sullivan et al. (2011) have argued the importance of determining the factors that contribute to the retention and by implication, the attrition of midwives, and of understanding why they stay in or leave the midwifery profession. Historically, midwives have not voiced their reasons for being midwives and staying in the role, despite challenging working conditions and political climates. Therefore, the reasons underlying midwives' decisions to enter into and stay in midwifery have until now been largely unknown. The impending shortages of midwives both coming into and remaining in the profession means there is now an urgency to understand what drives them.

Recent demographic profiling of the midwifery profession in Western Australia has highlighted that it is populated by a large proportion of midwives approaching retirement age (Pugh et al., 2013). This study was designed to explore one factor known to be associated with workforce attrition not attributed to retirement in other professions, namely work-related stress, and the nature and effects of this in midwives' views.

It is evident from the data in this study, that the midwives experienced stressors that tended to impact negatively not only on their professional working lives, but also upon their personal lives, and this led to them either having decided to leave the profession or seriously considering doing so. The participants indicated that the professional midwifery role and their personal lives were entwined in that the job reportedly has a negative impact on their personal lives. For example, heavy workloads were identified by some midwives as having a detrimental effect on their bodies, and others reported that some critical incidents experienced in clinical practice affected them emotionally and influenced their home life. The categories and subcategories that emerged from the data reflected a series of factors that directly affect midwives' work-related stress and have consequences for their emotional well-being and their future career decisions. These categories were organised into one core problem, 'Fighting a Losing Battle', which also serves as the theory that emerged from this study to characterise midwives' experience of workplace stress. The core problem comprises eight sub-categories, 'Having to be 150% on Your Game all the Time', 'Being Between a Rock and a Hard Place Whether You Are Coordinating or Not', 'Going Pear-Shaped in Four Rooms at Once', 'People not Understanding What Midwives go Through

Emotionally', 'Being an Advocate in the Face of Medical Disrespect is Tough', 'Toeing the Line and Giving our Pound of Flesh', 'We Have Each Other's Backs', 'Knowing Other Midwives Understand' and 'Thinking Very Seriously About Leaving'. All of the sub-categories were saturated with data from a high number of participants, which indicates the experience of workplace stress applies across midwives regardless of specific work context and demographic characteristics.

In the literature review presented in Chapter Two, I identified that midwives' workplace stress and the implications of this stress for their overall emotional wellbeing and career decisions had not previously been adequately investigated on an empirical level. Stress and burnout amongst midwives has been explored (Beck, LoGiudice, & Gable, 2015; Creedy & Gamble, 2015; Foureur et al., 2013; Hildingsson et al., 2013; Mollart et al., 2013; Sheen et al., 2015; Sidebotham, Gamble et al., 2015), and whilst there have been a few studies examining midwives' career decisions (Mannix, Harrison, & Sumsion, 2013; Warmelink, Wiegers, de Cock, Spelten, & Hutton, 2015), there have been very few specifically relating these to emotional well-being.

Research has also been conducted on the emotional work of midwifery (Hunter, 2005, 2010; Hunter & Deery, 2008; John & Parsons, 2006; Rose & Glass, 2010), but none that investigates associations between the stress of midwifery, midwives' emotional well-being and their career decisions. The study reported in this thesis addresses this gap in knowledge; it substantiates the importance of recognising and understanding the impact of midwives' work-related stress, its implications for their emotional well-being and their future career decisions. The theory developed from this study speaks to the Western Australian context but it is potentially applicable further afield also.

5.2 FIGHTING A LOSING BATTLE: OVERVIEW OF A MIDDLE-RANGE THEORY TO EXPLAIN MIDWIVES' EXPERIENCES OF AND RESPONSE TO WORKPLACE STRESS

This study has produced a unique, previously unknown understanding of the way workplace stress impacts upon midwives; it has revealed that as the number and extent of stressors increase, the negative implications and effects for midwives rise as the opportunities to 'do' midwifery in the way they value decrease, and that commitment to and engagement with the work diminishes as a consequence. The substantive theory identified in this study was labelled 'Fighting a Losing Battle'. Although the participants said that midwifery itself could be stressful, their responses clearly identify that it is not

the actual job but other related, contextual and other environmental factors that make it so.

Factors that were identified by participants as work-related stressors directly impacted upon the ability to practice midwifery in a way they valued. Participants stated on many occasions that their ability to focus on being 'with woman' was severely constrained by the stressors they encountered at work, and they felt powerless to effectively deflect or eradicate them; further, those in positions of power and influence were not perceived to be doing anything to help the situation or providing support to deal with it – in fact, in some cases they were deemed to be contributing to the midwives' stress. The participants all spoke at length about 'battling' with not being able to be 'with woman' or to practice midwifery in the way they believed they were trained for and that they themselves valued, and the sense of loss this engendered was central to the labelling of this core category.

This 'inner battle' is not a new phenomenon and has been cited previously as a factor why midwives leave the profession (Curtis, Ball, & Kirkham, 2006b; Warmelink, Wieggers et al., 2015). However, what was identified in this study was that midwife participants rationalise and accept that stressors do affect their ability to practice midwifery within the traditional philosophy of being 'with woman', and are continuing to uphold their values and understanding of midwifery at a cost to their own well-being. Crowther et al. (2016) suggest resilience and sustainability in the midwifery workforce are reliant upon self-determination, self-care, cultivation of professional relationships and relationships with women, and a passion for practising midwifery in the traditional way. This work aligns with the findings of this study which suggests these key elements would significantly reduce work-related stress.

There is a dearth of literature examining the concept of midwives' values and their understanding of midwifery, but it is not known how these perceived values affect the midwifery role given that the values that are specifically appreciated or prized by midwives have not been established. Research has indicated what women value in midwives, which includes support, theoretical knowledge, professional competencies, communication skills, moral / ethical values and personal qualities (Borrelli, 2014). However, the philosophy of being 'with woman' was clearly affected by stressors reported in this study.

5.3 MAKING MEANING OF THE KEY FINDINGS

The midwives in this study were very clear in identifying workloads as being associated with one of the main causal factors of work-related stress. The participants reported feeling rushed to get tasks within their allocated workload completed, and that they could not always get paperwork and computer data finished during work hours, frequently staying after the shift should have ended. Many participants stated that the midwifery role had changed to incorporate an ever-expanding list of check-lists, paperwork and the added burden of imputing data into hospital databases, all of which impacted negatively in the care of women and babies.

The expanded workloads of the participants impacted on all areas of midwifery practice, but the ability to 'be' a midwife and be 'with woman' appears to be the most affected, with the midwives reporting this as damaging to their role identity and satisfaction. Therefore, the midwives appear to be lamenting the loss of the time and space to just 'be' a midwife.

All the midwives in this study felt they were working at full capacity all the time, with no periods to update skills, spend time with women, have teaching sessions with staff and students, or informally debrief. As one midwife said '*Years ago we would share a pot of tea and eat a piece of toast together. You don't have that time now*'.

Recent research conducted in the Netherlands corroborates what the West Australian midwives in the current study reported, in that the midwives in the Netherlands appeared to be working longer hours than they did previously, and to be spending increasing numbers of work hours on non-woman / baby related activities (Wiegers, Warmelink, Spelten, Klomp, & Hutton, 2014). Another recent paper also supports the notion that midwives are subjected to increased task orientation in their workloads, that creates barriers and frustration due to a more medicalised model of care within the midwifery environments (Hunter, Magill-Cuerden, & McCourt, 2015).

In this study workloads were mentioned frequently, and reasons cited as to why the midwives felt their workloads had become more stressful included an annual increase in births, increased medical complexity of women birthing, staff shortages, rosters, the skill mix of the staff rotated onto a shift and shift coordinators. The midwives in this study compared workloads as being '*a battle*' that they strove to survive through the challenges they encountered whilst providing care for women and babies.

Much of the dissatisfaction and frustration expressed by the midwife participants was centred on the shift coordinator role. Being both coordinated and being a coordinator of a shift were identified as stressful. For those who worked under coordinators whilst on duty, participants' dissatisfaction stemmed from how coordinators managed a shift, how characteristics of coordinators' personalities influenced their effectiveness, and how some coordinators used their power over others in a negative manner.

A coordinator's ability to manage a shift determined how much stress could accumulate as a result of workload issues for participants in this study. Clinical experience, 'people skills', and being 'unflappable' in an emergency were identified as necessary skills for a coordinator to possess to be able to be efficient in the role. If a coordinator had a reputation for being easily stressed by events or emergency incidents, then some of the participants suggested that the stress became 'infectious' and affected their midwifery role and even filtered down to the women being cared for. Some of the participants in this study aligned the coordinator role with the hierarchy of the organisation who employed them, and identified coordinators 'wielding power' by being confrontational and 'interfering' with the care of women.

Coordinators of shifts within midwifery are described as being pivotal in the management of escalating workloads (Fergusson, Smythe, & McAra-Couper, 2010), and being central to communication and the facilitation of teamwork (Mackintosh, Berridge, & Freeth, 2009). In this study, participants identified problems they perceived with coordinators, but did not report any good examples or positive attributes, instead focusing on the coordinator as a source of their stress. However, there is very little research that specifically explores midwives' perspectives of being coordinated and being in the coordinator role and work-related stress within midwifery.

For participants who were shift coordinators, the inability to focus on one client group's needs and inadequate preparation for and support in the role were held responsible for causing anxiety. Participants who were also coordinators described managing medical and surgery areas as well as maternity patients, during any given shift that they were coordinating, which caused them stress.

Interestingly, the midwifery participants in this study who were also coordinators identified having to make decisions on behalf of colleagues as a cause of stress. Coordinators suggested that often midwives would not take responsibility for decision-

making, and expected coordinators to make decisions that they should be making for themselves. It particularly frustrated coordinators when those midwives who coordinated themselves, would not take responsibility for decisions when working as a midwife – yet would make the same decisions when coordinating themselves. This suggests that some participants demonstrate a lack of responsibility to make decisions when they are not in the coordinating role.

However, some of the coordinators described how midwives were 'strong characters', and that they could 'give [coordinators] a hard time' when clinical decisions were required. Perhaps midwives are predisposed to being strong women as their role requires knowledge, skills, advocacy and the protection of the mother / baby dyad which links back through to the history of the midwifery profession (Litoff, 1982). When midwives are not in the coordinating role, perhaps their stress is reduced by letting someone else have the responsibility of decision making, but possibly to the detriment of their coordinating colleague's stress. Recent research has suggested the introduction of a cognitive model that guides decision-making when working in stressful clinical situations (Shirey, Ebright, & McDaniel, 2013). A cognitive model would help those coordinators with less experience in the role take into account the organizational context and situation factors that influence coordinator's cognitive decision-making processes.

As the participants in this study outlined, those that coordinate are often dealing with a poor skill mix allocated in shifts, in that particularly in labour and birth suite there are more students, graduates and junior midwives working in this area. This study found that many midwives (often with more experience) either refused or avoided working in labour and birth suite because of higher stress levels due to work- place practises (e.g., clinical decision making, medicalisation of birth, unnecessary interventions, fear of ridicule or making mistakes), or previous traumatic incidents, experienced in this environment. This is not a new phenomenon and has been documented in research previously.

Hunter (2005) explored emotion work and boundary maintenance in midwifery, and found that senior midwives maintained their position through unwritten rules and sanctions, that were supported by claims to greater clinical expertise and experience. In this study junior midwives rarely challenged this authority; their responses were often submissive and designed to create an appearance of compliance. The impact that midwifery work-places may have on sustainable practice and nurturing healthy resilient

behaviours has been interpreted as expecting midwives 'to toughen up' in a work-place setting that is socially, economically and culturally challenging (Crowther et al., 2016, p. 47). This particular study explored what sustains midwifery practice and how resilience is a quality required in practice, especially when dealing with stressful situations and incidents.

A recent study describes lack of midwifery responsibility as being attributed to institutional risk management, fear of involvement in adverse outcomes and personal values regarding physiological birth (Healy et al., 2016). This suggests that the amount of control over circumstances in the work environment may affect midwifery responsibility. It is stressful being in control but also stressful not being in control while being accountable for outcomes that cannot be predicted.

The requirements for those coordinating maternity care areas to also coordinate general nursing settings at the same time is not normal practice in most midwifery environments, however, as discussed in Chapter Three, Western Australia is geographically diverse and has many rural and remote services (Barclay & Kornelsen, 2016) that do not have separate midwifery clinical areas. Coordinators in these situations must experience some role confusion and an inability to focus in dealing with patients in the sick-model of care, and healthy women giving birth in the well-woman / midwifery model of care. Conflicting occupational ideologies have been identified in the literature as being a source of dilemma for midwives (Hunter, 2004), and one that causes contradictions because of different work settings that have diverse values and perspectives.

The midwives in this study who worked in environments where midwifery was not a separate clinical area, worked in rural / remote services, and identified the clash of nursing and midwifery philosophies by describing how coordinators and managers '*did not get midwifery*'. Individualised care as opposed to routine care, and wellness as opposed to sickness, are conflicting and dilemma causing.

Paradoxically, the stress experienced by coordinators was discovered in turn to impact upon the midwives working on the same shift; participants described how working with a stressed coordinator made 'a shift hard work'. One participant had described this type of stress as 'infectious', implying that if a coordinator was experiencing stress, it filtered down to the staff and women in that clinical area. There is evidence of stress being contagious and crossing-over into job-stress (Westman,

2006), leading to individuals experiencing each other's stress. An earlier study described how stress becomes contagious and could spill-over into other areas of a person's life (Bolger, DeLongis, Kessler, & Wethington, 1989).

Therefore, if stress is experienced in the working environment, it can result in stress in other individuals in that same environment, but can also crossover from the workplace and be transferred to the person's family in the home environment. Midwives in this study commented on trying not to take stress they encountered at work home with them by talking with colleagues, or indulging in unhealthy behaviours described by one midwife as '*drinking a large glass of wine or three*'.

Because of the stressful nature of the coordinating role and the negative impact on those around them of a coordinator whose stress manifested as, for example, shouting, being sarcastic and '*flapping around*' in an emergency, some participants in this study suggested that some midwives should not be coordinators. Further exploration of this point led many of the participants to state that there was inadequate training for coordinators to deal with the weight of responsibility of coordinating. One participant described that her training to be a coordinator consisted of being '*handed the red [drug cupboard] keys as I walked into the ward*', while another said that her training consisted of shadowing a coordinator for a day, and when she coordinated the following day it was 'a baptism of fire'.

The participants suggested that not everyone could or should be a coordinator, and that certain skills were required that were not always accrued through age or experience. This would imply that career progression and clinical experience alone are not enough to undertake the coordinator role, and that certain skills, such as managing people, debriefing and providing support may be extra learning requirements before assuming the role of coordinator. There is very little research conducted with coordinators in midwifery, and most of the literature discussing the preparation of people to manage others and deal with increased responsibility comes from the business literature. The management of people has benefitted greatly from the research conducted regarding the 'Hawthorne Effect' (Wickström & Bendix, 2000), where awareness of being observed impacts upon behaviour.

Effective management endorses management with people rather than of people (Twigg & McCullough, 2014), therefore coordinators require management of their ability to employ leadership, debriefing and people skills in everyday situations.

This requires learning, both on and off the job and being supported whilst learning in a structured environment. Leadership and management skills are viewed as an attribute of career advancement, leading to advanced practice and building a professional commitment to the profession (Kearney-Nunnery, 2015), which many midwives do aspire to. Therefore, the coordinator role should be a position where further learning and experience is required before it can be attained.

Coordinators of shifts are usually older, more experienced midwives who are deemed to have the clinical knowledge to make informed clinical decisions. As discussed in Chapter Two, the average age of the midwife is 50 years old (Australian Bureau of Statistics, 2015), and research suggests that physical and mental health (notably sleep patterns and fatigue), and a decreasing tolerance for shift work (Clendon & Walker, 2013), affects those working in nursing and midwifery clinical environments. Therefore, the burden of managing a busy shift and dealing with increasingly complex obstetric incidents, is being carried by an ageing workforce. This study has revealed that the coordinating role is viewed as a hierarchical command structure that depends on a line of communication and cooperation to effectively manage increasingly challenging working environments.

Midwives inherently believe that birth is a normal physiological process and that as experts in normal birth they are able to recognise adverse events that may threaten the lives of either mother or baby. All midwives are trained to respond to obstetric emergencies, however, often adverse events can lead to traumatic experiences for all those involved. The participants in this study all described how adverse events that led to traumatic experiences impacted upon their midwifery role.

All participants in this study made a comment regarding adverse / traumatic incidents; some participants were stressed by traumatic incidents, some participants described being stressed by fall-out from incidents. Some participants were able to separate obstetric emergencies from traumatic incidents, stating that they had been trained to deal with emergencies in a logical, step-by-step format. This suggests that participants are recognising that obstetric emergencies do not generate stress as a stand-alone effect, but that other factors linked to obstetric emergencies are acknowledged as causing stress.

In most obstetric emergencies, quick responses are required, and the participants described dealing with the actual emergency, but 'fall-out' from the incident itself

proved to be the stress factor. The participants in this study described how the '*fall-out*' impacts upon them, and the negative effect it has on not only themselves, but their colleagues and the women and babies they provide care for. Some obstetric emergencies that occurred caused more '*fall-out*' issues to arise than others. For example, the obstetric emergency of shoulder dystocia was cited by several participants in this study as being an extremely stressful incident because of the impact upon the baby after the emergency is over.

Current literature supports the views of the participants' in this study regarding obstetric emergencies, in that educational sessions and focused drills or scenarios lead to increased confidence and competency in dealing with emergency situations (Green, Rider, Ratcliff, & Woodring, 2015; Sørensen et al., 2014; Weiner, Collins, Bentley, Dong, & Satterwhite, 2016). However, research also suggests that shoulder dystocia is one of the most "terrifying of obstetric emergencies" (Beck, 2013, p. 34), because of the obstetric brachial plexus injuries, asphyxia and subsequent brain injury or death that the baby may be subject to after the emergency has occurred (Beck, 2013; Crofts et al., 2016; Dajani & Magann, 2014; Steer, 2014).

It seems therefore, that the participants were describing stress associated with traumatic incidents occurring at births as opposed to feeling stress from obstetric emergencies, which they believed they had received training to be able to deal with. Traumatic births have been described as:

"an event involving actual or threatened serious injury or death to either the mother or baby" (Beck & Watson, 2008, p. 229).

Research has begun focusing on Secondary Trauma Stress and Post Traumatic Stress Disorders in midwives associated with witnessing traumatic births (Beck et al., 2015; Leinweber & Rowe, 2010; Rice & Warland, 2013; Schrøder et al., 2016). Birth occurs usually in the labour and birth suite environment, and participants in this study described that many traumatic incidents tended to occur in that area. This supports current research that has identified midwives as experiencing higher levels of psychosocial health problems amongst those who have witnessed traumatic incidents in the birthing environment (Mollart et al., 2013; Schrøder, Larsen et al., 2016; Sheen et al., 2015, 2016). However, the participants in this study also described not having back-up because more than one incident can happen at once, and staff shortages as being issues associated with traumatic birth.

Having colleagues provide back-up and staff shortages were linked in this study, and participants were reluctant to *'press the bell'* to call for assistance as they were aware their colleagues were busy and the shift was under-staffed; they were worried about removing assistance from others who may also require help. This dilemma of whether to call for help caused participants stress in this study, but this has not been explored adequately in the literature. Some research has been conducted with midwifery students and clinical decision-making in response to simulated environments (Scholes et al., 2012), however there was not any conclusive evidence regarding whether calling for assistance, as opposed to escalating calls for assistance, helped the students' with the dilemma of when to press the buzzer.

Staff shortages have been identified as factors impacting upon performance when working in stressful clinical environments (Bradley & McAuliffe, 2009; Shimoda, Leshabari, Horiuchi, Shimpuku, & Tashiro, 2015), and research in this area is concentrating on resilience in midwifery and contextual influences that affect the wellbeing of midwives (Crowther et al., 2016). The midwives in this study did compare working with the constant risk of obstetric emergencies and traumatic incidents as being in a *'war zone'* or being on the *'frontline'*, suggesting that they are subject to conflict on a regular basis which impacts upon their well-being.

5.3.1 The Effects of Being Physically and Emotionally Stressed at Work

The participants in this study were able to recognise the consequences of the stress that they experienced through the factors that impacted upon their working role. The midwife participants acknowledged that there were times when they had been distressed and related it directly to situations or incidents that occurred during a shift. The data from this study suggested emotional distress was a consequence of the causal factors of work-related stress, which in turn affected the midwifery participants' clinical practice and ultimately their thoughts and decisions about their future in midwifery. Factors identified as consequences of emotional/moral distress that impacted upon the midwives' well-being were ridicule, lack of confidentiality, being persecuted or blamed for mistakes, and debriefing.

The consequences from the stress the midwives experienced are serious, as they used words that described how they felt that were quite intense and emotional such as *'shock'*, *'anxiety'*, *'crying/sobbing through frustration and exhaustion'*, *'distress'* and

'sadness'. These consequences in turn affect the ability of the midwife to provide quality care for women and babies.

Research has been conducted regarding work-related stress and burnout amongst midwives in Australia (Creedy & Gamble, 2015; Mollart et al., 2013; Sidebotham, Gamble et al., 2015) and in the international arena (Beck et al., 2015; Foureur et al., 2013; Mohammadirizi, Kordi, & Shakeri, 2012; Sato & Adachi, 2013; Schröder, Jørgensen, Lamont, & Hvidt, 2016; Sheen et al., 2015; Trzcieniecka-Green, Gaczek, Pawlak, Orłowska, & Pochopin, 2012; Yoshida & Sandall, 2013).

To date there are no known Australian or international research studies within the existing body of knowledge that suggest a substantive theory of midwives' work-related stress and a link between the implications for midwives' emotional wellbeing and career decisions. The body of existing knowledge has confirmed a link between midwives' occupational / work-related stress, job satisfaction and distress (Muliira & Ssendikadiwa, 2015; Pezaro, Clyne, Turner, Fulton, & Gerada, 2015), and these previous studies have established that these factors do impact upon midwives and their ability and commitment to the profession.

Other studies have explored the emotional consequences of midwifery and how it impacts upon midwives (Drach-Zahavy et al., 2016; Hunter, 2010), and midwives' level of commitment to remaining in the profession (Adegoke, Atiyaye, Abubakar, Auta, & Aboda, 2015; Pallant, Dixon, Sidebotham, & Fenwick, 2015). These studies have identified the multiple factors that constitute the causes and consequences that affect midwives globally. The current study also found that the midwifery participants of Western Australia had multiple factors that were directly related to their understanding of work-related stress and its link to emotional well-being and career decisions.

Emotional distress in this study was cited by participants as a consequence of work-related incidents that impacted on their emotional well-being. The emotional distress generally took the form of physically displaying distress, for example, crying and sobbing, and occurred either in toilets at work or on the drive home from work. Some of the participants said the childbirth-related incidents, for example, stillbirth and fetal death in utero cases, caused them emotional distress. Emotional distress has been defined as a negative emotional reaction which may include fear, anger, anxiety, and suffering, and has been described as a clinical empathy (Gleichgerricht & Decety, 2013). This suggests that midwives have the ability to be self-aware by recognising their

emotions in the course of 'being with woman', which is an essential component of compassion in clinical midwifery practice.

Recent studies have examined how emotional work is integral to the midwifery role, as midwifery involves caring for women who are often experiencing a highly charged emotional period of their lives (Rayment, 2015). However, there are few studies that have explored the emotional experiences of midwives within their role as midwives, and anecdotally, it is not a subject midwives discuss amongst themselves. Midwives often tend to *"get on with the job"* (Rayment, 2015, p. 10), and dealing with women's emotions as well as managing their own thoughts and emotions can be a challenging part of midwives' work and one for which they are not always adequately supported (Sheen et al., 2015).

The midwife participants described that they shared the grief of women they were caring for, particularly when a baby had died or a fetal death had occurred. The literature suggests that midwives are affected by perinatal death, but develop resilience in coping with this area of their work (Petrites, Mullan, Spangenberg, & Gold, 2016). This could be attributed to midwifery education which begins with students (Patterson, Begley, & Nolan, 2016), and is developed through continuing education in order for midwives to provide effective, meaningful and supportive care for the women in their care (Leyland, 2013; Thompson, 2016).

However, many participants said they suffered emotional distress over incidents like this in their work place, and this emotional distress was different as it concerned feelings of being persecuted, ridiculed and blamed for mistakes that resulted in them being targeted in 'witch-hunts' rather than the loss of the baby itself.

The midwife has historically endured persecution from authorities and religious leaders, professional attacks from the medical profession, and ridicule from society. A new phenomenon has recently emerged consisting of ridicule and bullying by midwifery colleagues that leads to emotional distress (Beech & Thomas, 1999; Curtis, Ball, & Kirkham, 2006a; Pezaro, Clyne, & Gerada, 2016; Pezaro et al., 2015), and which has been documented in the literature and the participants of this study also identified this particular issue.

The term 'witch-hunt' has been defined as the searching out and deliberate harassment of those with unpopular views (Merriam-Webster, 2016); it has also been defined as a way to subjugate people (Federici, 2006). 'Witch-hunt' has been used to

describe an awareness of how women have been unfairly treated or abused for their beliefs since the Middle Ages (Beech & Thomas, 1999; Ehrenreich & English, 2010). This term continues to be used where midwives' reputations and careers are at stake (Collier, 2015). Several participants in this study used the term 'witch-hunt' as a descriptor to describe what happened to them and the distress they suffered, after a mistake had been made in midwifery clinical practice, for example, in the incorrect assessment of a vaginal examination (VE), or a tragic outcome occurred. 'Witch-hunt' is a term still used in the twenty-first century, and it does appear to have significant relevance for the midwifery participants in this study. Midwives in this study described crying at work and outside of work, and they directly related their distress to situations or incidents that occurred during their shifts. This was clearly demonstrated by those midwives who expressed concerns around being persecuted, ridiculed and blamed for mistakes that resulted in them being targeted in 'witch-hunts'.

Participants who used this term during the interviews were clear that they felt victimised, distressed and persecuted when simple mistakes were made, and their distress and stress were further increased after the event because of the reactions of others. Thus the participants described a culture of blame that exists when simple mistakes are made. Part of the punishment in such situations consists of being publicly reprimanded by medical staff, coordinators and peers. The public humiliation appears to be very stressful for midwives, as some participants stated they would not return to work on the labour ward as their confidence in their midwifery capabilities had been shaken.

Interestingly, the male participant in this study was aware that the term 'witch-hunt' was applied to some midwives in practice, and acknowledged staff were labelled for mistakes made, but he suggested that the female gender was largely to blame for this in the way that they dealt with mistakes. He suggested that males approached the situation differently, in that a mistake was identified, discussed and forgotten. Whereas he said that females identified, discussed, gossiped and did not forget the mistake. This can certainly be supported by current literature that suggests women are more critical regarding workforce issues, and this is rooted in how women are socialised regarding cultural expectations and behaviour (Frankel, 2014).

Studies have linked stress with harassment and horizontal violence in the workplace from midwifery colleagues (Dahlen & Caplice, 2014; Farrell & Shafiei, 2012; Mciver, 2002; Rodwell, Demir, & Steane, 2013), where midwives have expressed distress,

fear, hurt, anxiety and devaluation of their skills by their peers. Interestingly, the participants in this study described how they feared that their emotional distress and the consequences of feeling persecuted, ridiculed and blamed for making mistakes, would not remain confidential. Participants disclosed that they were concerned about confidentiality should they wish to discuss their emotional distress with the organisation or management following a work-related incident.

Midwife participants also identified that a lack of confidentiality amongst their colleagues was evident in the maternity environments where they worked, and that gossip and innuendo was rife. Again, a direct link can be made back to midwifery history, where during the seventeenth century, maternity attendants who assisted the midwife were called 'gossips' (Pierson & Hughes, 2013). This can be explained with childbirth in this time period being a female only social event, where female relatives and neighbours would gather with the midwife, maternity assistants and the labouring woman and chat – thereby 'gossip' became a term for female friends talking. The word gossip did not have a derogatory meaning then, and was even included in one of Shakespeare's plays describing a childbirth scene (Pierson & Hughes, 2013). However, in the twenty-first century, gossip does have a negative connotation and the body of literature suggests that gossip is negative in the work-place and influences self-perceptions and behaviour (Wu, Birtch, Chiang, & Zhang, 2016). Gossip has also been associated with work-related emotional distress (Bora, Vernon, & Trip, 2013) and as a coping mechanism for stress in the work-place (Marshall, 2015), however what may be perceived as a coping mechanism for some may be seen as detrimental to others.

The midwifery participants in this study indicated that their stress levels were increased when they observed the way women were treated by some doctors. This related specifically to interactions midwives observed between doctors and women, where the participants thought women or themselves were being disrespected and poor clinical judgements were made. Research has identified that midwives are subject to stress as they observe the way women are treated during childbirth (Davis-Floyd, 2001; De Schepper et al., 2016; Mackin & Sinclair, 1999; Moyer, Adongo, Aborigo, Hodgson, & Engmann, 2014; Freedman & Kruk, 2014). The midwives in this study felt that being an advocate for women puts them in stressful situations.

Participants identified that this did cause them distress, which appeared to be a moral distress as opposed to a purely emotional distress. Moral distress has been described as an experience of a situation that is in complete contrast to a person's

personal or professional ethics, standards, and principles (Steltzer et al, 2015), which may be characterised by feelings of frustration, anger, anxiety and guilt when faced with perceived interpersonal conflict about values (Johnstone, 2013).

The participants in this study said that their distress was exacerbated by thoughts of being affected emotionally through certain factors encountered in their working role. The midwifery participants described lacking power, authority, or ability to right the wrongs they believed were committed by doctors towards women. The midwife participants were clear in describing how loss of integrity by not being recognised as a midwifery professional, whilst trying to advocate for women, caused them moral distress and led to dissatisfaction with their working environment. The midwives described many incidents in this study where they felt they were disrespected by medical colleagues when they advocated for women in their care. Furthermore, midwives who had immigrated to Australia from Europe, expressed concern that midwives were not respected as equal, autonomous, health care practitioners in Australia.

Midwives value the ability to work autonomously and exercise control over their professional working lives (De Vries, Nieuwenhuijze, Buitendijk, & Group, 2013). Disrespect from medical colleagues does not appear to have demoralised the midwifery participants in this study; on the contrary the participants appear to strive to validate their midwifery identity. This self-identity is an important notion in relation to the history of the midwifery profession. The compromises made in the past still influence philosophy and clinical practice issues today (Burst, 2010).

Before the medicalisation of childbirth, midwives were the lead healthcare professionals for childbearing women (Jackson, 2013), therefore autonomy (in clinical practice and decision-making), and the strong sense of advocacy on behalf of women, remain guiding principles for midwifery. The participants in this study identified that dissatisfaction with poor treatment of women by doctors, and lack of respect from medical staff increased their work-related stress. Examples of relevant experiences include verbal interactions between doctors and women, and poor decision-making by doctors that directly impacted upon birth outcomes for women.

Midwifery is associated with providing service for women, and midwives value an altruistic nature that ensures the woman is placed at the centre of care, that demonstrates optimal outcomes for woman and baby and increases job satisfaction for

midwives (Healy et al., 2016; Leap, 2009; Sullivan et al., 2011). Interestingly, it has been suggested that:

"generosity and solidarity towards one's own may have emerged only in combination with hostility towards outsiders" (Bowles, 2008, p. 326).

Referring back to the history of midwifery, as discussed in Chapter One, this statement aligns well with midwives' advocacy and service to the women they provide care for. Women have been midwives and healers for centuries, and were known as 'wise women' by other women, but as discussed previously, they were persecuted and called charlatans or witches by authorities (Ehrenreich & English, 2010). Therefore, the relationship built between childbearing women has always involved providing a service and investing some emotional attachment through the course of providing care.

Facilitating women to have the birth of their choice, culminating in a healthy baby and a good experience for the woman, provides satisfaction and reciprocity for midwives (Hunter, 2006), and is the greatest reward of the profession. Therefore, many midwives feel drawn to midwifery as a profession (Doherty, 2010), and view it as a calling as opposed to a career choice (Fox, 1993). Midwives in this study stated that they missed spending time with women, which suggests being 'with woman' remains their focus, but time constraints impacted upon this. Latest research suggests that not being able to spend the time midwives feel women need, emotionally affects midwives (Lawton & Robinson, 2016). This study highlighted the increasing shortage of midwives in the workforce, and suggests that there is concern that time-poverty will become a factor that may lead to a greater sense of professional dissatisfaction. Thus, the role of being 'with woman' can render midwives emotionally vulnerable (Davies & Coldridge, 2015).

Midwives are experts in normal birth (Lavender, Kingdon, Page, & McCandlish, 2006) and therefore act as guardians of keeping birth as normal as possible for women (Fahy, 2007; Fahy & Hastie, 2008; Russell, 2014) by keeping interventions to a minimum and holding space for the woman as she labours to birth her baby.

Some of the midwives in this study identified their integrity and autonomy were undermined by medical staff as they provided care for women. The limited research conducted in this area supports the finding from this study, suggesting that undermining is common in obstetric environments and can impact negatively on providing care (MacDougall, Adams, & Morris, 2013). Undermining appears to be

prevalent in stressful, heavy workload clinical environments that apportion blame as opposed to a learning culture.

A recent study suggests that a high level of interpersonal friction amongst doctors and consultants results in undermining and bullying within obstetrics (Shabazz, Parry-Smith, Oates, Henderson, & Mountfield, 2016), which in turn impacts upon obstetric clinical environments. However, two midwives working in remote / rural hospitals and one independently practising midwife said that they had good relationships with doctors. They did not comment on a lack of autonomy or a loss of integrity, but interestingly, none of these participants had immigrated to Australia. These three midwives had been born and trained in Australia, and had never worked as a midwife outside of Australia.

Recent research has begun to examine the reasoning and expectations of midwives who choose to leave their country of birth to live and work. Reasons identified suggest that they seek better working conditions, improvements in lifestyle, clear career progression pathways and a better practice environment (Humphries, McAleese, Matthews, & Brugha, 2015).

There are few research studies conducted with overseas midwives practising in Australia, and findings from these studies suggest that midwives are prepared to lose professional status and seniority of position to gain a better overall lifestyle for their family through migration (Sidebotham & Ahern, 2011), and that midwives appear to capitulate and detach themselves to fit into the Australian health system. However, there is research supporting the experiences of overseas nurses working in Australia (Hawthorne, 2010) and not receiving the same respect they had expected in their home country (Allan & Larsen, 2003; Brunero, Smith, & Bates, 2008).

The midwife participants in this study demonstrated an understanding of their status from the perspective of the medical staff they worked with; this appears to be especially significant for participants that have emigrated from Europe to Australia, who are keenly aware that this is at odds with their own view of their status. However, the midwives also describe how they have to continually fight for and on behalf of women to maintain their rights and to be an advocate in maintaining women's rights to make informed choices.

In this study the participants expressed a general opinion that the organisations they worked for did not value their work contributions or demonstrate care about their

physical and emotional well-being. All participants identified that increased workloads were attributed to organisational objectives and goals, and many described feeling a distinct lack of support or reward for their working endeavours.

Management were described by some of the participants as '*faceless*' entities and being '*spineless*', and regarded as a separate issue from the managers of the ward / birth suite clinical areas, as these managers were known to the participants and were usually midwives who had a reasonable understanding of the issues involved. In this study the participants did not believe the management of the organisations they worked for had their best interests foremost, although some said the organisations pretended this was the case. Participants used the phrase '*toeing the line*' as a euphemism for the control the organisation wielded over them, and one participant had stated that all the organisation wanted was '*its pound of flesh*'.

The literature has described how hospital-based midwifery is driven by the needs of the organisation and that providing care on a continual basis results in standardised care, where risk management, efficiency and effectiveness become the organisation's main goals (Hunter, 2004). Research has described how health workers can feel powerless and meaningless when organisations have an agenda that does not recognise employees' contributions, and pursues goals that are not in the employees' best interests (Tummers & Dulk, 2013). This is where ideologies of organisations and midwives clash, as the midwifery philosophy is based on providing individualised care and practising safely to be 'with woman', as opposed to being 'with institution' (Hunter, 2004). Recent research has described how organisations should concentrate efforts on improving autonomy for midwives, and improve processes for dealing with bullying and horizontal violence (Scott et al., 2015).

Another study conducted amongst Italian health-workers, has proposed that self-competence and organisational commitment can be improved by supporting employees through caring about their well-being (Battistelli, Galletta, Vandenberghe, & Odoardi, 2016). The midwife participants in this study stated that they received little or no support from their organisations regarding the value of their work contributions, and viewed the organisations as prioritising their own business goals and objectives at the expense of the midwives' interests and well-being.

5.3.2 The Value of 'Mateship' in Stressful Workplaces

The perception of support was an aspect that most participants of this study identified, and they acknowledged who they turned to for support, and why that particular person or group was selected. Mateship is an Australian cultural idiom that embodies equality, loyalty and friendship (Dyrenfurth, 2015). Receiving support from colleagues as opposed to receiving support from the organisations who employed them was a central point and an important issue for the participants. All participants said that having good support reduced their stress levels, and '*face-to-face*' support from colleagues was more beneficial than the '*faceless*' support of the organisations. Research has highlighted how peer support programs strengthen capacity and sustainability of the midwifery workforce (Brodie, 2013), and how informal debriefing occurs between midwives during tea breaks and handovers (Kuliukas, Lewis, Hauck, & Duggan, 2016), or as in this study, on the drive to and from work.

Debriefing is a strategy that can be effective in helping staff deal with work-related stress (Healy & Tyrrell, 2013), and midwife participants in this study stated they had limited time for debriefing. The need to talk when recognising stressors, to be listened to and be shown empathy has attracted minimal research studies. A study exploring midwives' narratives of stressful situations, identified when support and debriefing by colleagues was most required (Calvert, 2011), and it concluded that debriefing should occur informally as soon as possible after a traumatic incident or event. But the reality of clinical practice and time constraints, as outlined in this study, makes this difficult to achieve.

There are many studies that have been conducted and reported on that involve childbearing women and debriefing, and also midwifery students and debriefing, however, there are few studies that actually address the need for midwives to debrief. This study suggests that there are two different points relating to midwives supporting each other; being able to unburden and receive empathy and support, and receiving validation regarding decision making and acknowledging that making mistakes constitutes an ongoing learning process. This issue is considered further in the next section, which explores who the midwife participants believe truly understands their situation.

Many of the midwife participants in this study chose to talk to friends, family and colleagues, regarding issues or incidents that caused them stress in their work-place.

However, most of the participants said they preferred to debrief and look for support with colleagues or midwife friends after an incident or issue had occurred, and the participants used the term 'debriefing' to mean any time they wanted to talk to someone informally about something that had impacted upon them during a shift.

The majority of the participants said that other midwives were the best people to debrief with or look to for support, because of the shared knowledge about the midwifery role which they believed to be an essential component for successful debriefing and support to occur. Constructive feedback, terminology, and how it actually feels to be in some of the situations were cited as reasons why other midwives were the best people to debrief with and find support. This collective understanding by the participants suggests the importance of debriefing with another midwife in order to not only expect an understanding of what occurred and to receive support, but that because of the assumed knowledge, resolution of issues or acknowledgement of actions taken, were the correct ones.

As mentioned previously, there is very limited research regarding midwives' need for debriefing and receiving support from colleagues, however there are more studies available with nurses and debriefing and support. Nursing and midwifery, both by the nature of the work with clients, need to build trusting relationships that include intimacy, presence, and kindness, and a safe environment to debrief regularly has been recognised as a way to talk about feelings, experiences and support (McCorkle, 2016). Therefore, midwives require not only debriefing regarding incidents and experiences that cause stress, but support to develop coping strategies when managing stressors and the shared grief of women.

Research in this area with midwives is not extensive, but studies regarding midwives coping with the trauma of caring for women with stillbirth and fetal loss has suggested that midwives need practical and emotional support, preferably from other midwives experienced in grief and loss (Kenworthy & Kirkham, 2011). McCorkle (2016) suggests that midwives could benefit from the counselling and debriefing sessions that palliative nurses are offered in their workplaces, in order to deal with incidents and experiences that impact emotionally and can potentially cause stress. It has also been identified within the literature, that midwives can be totally unprepared and ill-equipped to deal with the fall-out from incidents and the stress of possible litigation (Hood et al., 2010).

Although midwives in this study hardly alluded to litigation as a factor that caused them stress, many said they sought the support of midwife colleagues that they had '*done the right thing*', in situations and incidents. Clearly this is another form of moral distress, where midwives have to make difficult judgements and decisions in often complex situations and look for validation from their colleagues that the course of action they took was the right one or one their colleagues would have chosen.

All of the key findings discussed so far lead to the final finding that reflects how dissatisfaction in the job increases the likelihood of leaving the midwifery profession.

5.3.3 Midwifery Practice Workplaces as War Zones

In this study, the final category 'Thinking Very Seriously About Leaving' identified the implications for the future of the midwifery profession. The impact of the factors discussed in this chapter causes work-related stress and the ensuing consequences pose threats to midwives' job satisfaction and retention in the profession. The key findings from this study reveal that the participants' all experienced their work place environments as places of constant challenges and stressors, that they perceive as very difficult to deal with individually, and even more difficult to deal with when they are compounded by each other, which appears to occur often. The participants in this study made reference to working in a war-like situation and the stated challenges, experiences and perceptions that the participants described related to this.

The midwifery participants derived satisfaction from positive feedback and appreciation when their professional efforts were recognised. This was reversed when midwives received negative feedback and did not feel appreciated for their professional work. The midwives communicated that feeling valued and appreciated was a strong determinant of job satisfaction and their tendency to stay in the midwifery profession. However, many midwives in this study communicated that their clinical work and needs were not valued or supported by their organisations, and in many cases not recognised or acknowledged.

The literature has reported that midwives feel frustrated and distressed by a lack of organisational support (Brodie, 2013; Menke, Fenwick, Gamble, Brittain, & Creedy, 2014), which is a factor that threatens job satisfaction and commitment to the midwifery profession. A sense of belonging within midwifery, as both a working environment and a profession, was important for the participants in this study, and was

reflected in their intentions to stay working in midwifery or leave and go back to nursing or try a new career pathway.

The literature identified the term 'belonging within midwifery' as a motivator in retention in the profession and maintaining job satisfaction (Sullivan et al., 2011). Previous studies also report a sense of belonging is a strong factor in midwives and midwifery students remaining in the profession (Kirkham, Morgan, & Davies, 2006; McKenna et al., 2013), and is associated with a shared understanding of the experiences encountered within the midwifery role. Interestingly the midwifery participants in this study described midwifery as being a 'club' in which one belonged through the shared experience of being a midwife. This sense of belonging was an important factor that many participants in this study identified with, and this would suggest that some factors in clinical environments bind midwives together as a group or club, yet other factors can isolate and separate others from the group or club.

The midwifery participants identified how their age, health and changing attitudes to women and caring were impacting upon their decisions to stay working in midwifery. This is consistent with an ageing workforce, where research has highlighted implications for dealing with older workers in healthcare (Raynor, 2015), and has suggested that interventions need to be designed and implemented to support workers at different points across the life span (Truxillo, Cadiz, & Hammer, 2015). Midwives have a very physical job that involves being constantly on the move within clinical environments, and higher pain scores involving aches and pains in the body, plus an increased prevalence of foot and musculoskeletal disorders have been identified in older nurses (Clendon & Walker, 2013; Reed, Battistutta, Young, & Newman, 2014). Therefore, aches and pains associated with an aging body appear to be a legitimate concern voiced by the participants in this study, and as being a factor that will influence their decision to stay working in midwifery.

Many of the participants were not happy in their current midwifery position which was a factor in them considering leaving the midwifery profession, and reported that their health and stress levels were being directly affected by working conditions that included the complexity of some of the women in their care. An increase in care for women who were drug and alcohol misusers was cited by some participants as increasing stress levels, which again related to being appreciated in their role as a midwife.

Midwives and nurses receive minimal instruction regarding training in intervention skills concerning alcohol and drug use in women (Lock, Kaner, Lamont, & Bond, 2002; van der Wulp, Hoving, & de Vries, 2013), and this is also the case with caring for pregnant women and these same women in labour. An alcohol and drug service operates within the tertiary maternity hospital in Perth, Western Australia, and it employs a small, multidisciplinary team that is available for women with addiction issues. However, the national increase in women using drugs and alcohol in pregnancy (Chasnoff, 2012) means that midwives in all maternity units are dealing with more women substance users than ever before. Therefore, providing care for these women is stressful for a midwife that is not specialised in this area, as the needs of these women can be very different and require careful management (Jones et al., 2014), and may cause some midwives to rethink why they remain working in midwifery.

Participants in this study appeared to place great importance in talking to their colleagues, with whom many seemed to have developed close friendships. Debriefing is an important aspect aimed at promoting reflective thinking (Decker et al., 2013), and lack of debriefing has been linked as a factor in health-workers retention in their professions (Tuckett, Winters-Chang, Bogossian, & Wood, 2015). Debriefing was discussed in a previous section of this chapter, but not in relation to retention in the profession. Recently, debriefing has been described in the literature as an effective support system in decreasing work-related stress and improving retention rates (Sandhu, Colon, Barlow, & Ferris, 2016).

A prevailing incentive for midwives to remain in the midwifery profession that arose from this study was the opportunity to be the midwife they believe they were trained to be. The midwifery participants appeared to be generally in agreement that they enjoyed being a midwife, and if they were working in the role they were trained for then they would stay within the profession. Some of the participants described how they had enjoyed the socialisation into midwifery as midwifery students, but after qualifying as Registered Midwives (RM), the midwifery role did not live up to expectations. There are some studies that have revealed that expectations of the role of the midwife differs from the one experienced as a midwifery student (van der Putten, 2008), however there are few studies that have specifically examined midwives' expectations of the role of the midwife.

Some of the participants did say they had thought about, or had already left the midwifery clinical environments; many were very clear regarding the reasons for this

decision and were able to identify factors, as described previously in this chapter that had caused that decision.

None of the participants identified lack of further education as a reason for leaving the profession, which has been cited as a factor in studies conducted with midwives in other countries (Tanaka, Horiuchi, Shimpuku, & Leshabari, 2015), although the participants in this study did bemoan the lack of time to clinically upskill or hold practice scenarios with midwifery students.

One of the most significant motivators for staying in the midwifery profession was the actual caring for women and being 'with woman', which is at the core of the midwifery philosophy. This did not cause the participants stress; all believed this was their role – it was the factors that impacted upon caring and 'being with woman', that caused the midwifery participants stress. Therefore, remaining within the midwifery profession appears to be closely aligned with being fulfilled as a midwife.

Those participants who indicated that they were going to stay in the profession for the foreseeable future, implied that it was not the role of the midwife or midwifery per say, but that dissension was being caused by the change in the way midwifery was currently being conducted. The participant's comments suggest that being a midwife was evolving into being an obstetric nurse because of the challenges faced by the midwifery profession in the twenty-first century.

This supports arguments made by others, who have also suggested dissatisfaction with midwifery occurs with the blurring of the midwifery role, and appears to have been an on-going concern for over 40 years (Walker, 1976; Watson, 2016). This is not a new perception, as this discussion separating the role of the midwife from the obstetric nurse has been ongoing since the nineteenth century (Humphreys, 1898; Walker, DeMaria, Suarez, & Cragin, 2012; Weir, 1901). Once again, the importance of the historical perspective reinforces the notion that the numerous challenges that midwives face today can be traced back to the roots of the midwifery profession. This study has highlighted areas that need to be targeted to minimise the causes of stress that affect the midwifery role, improve emotional well-being and increase the likelihood that midwives will want to stay working within the midwifery profession.

The substantive theory that emerged from the data in this study will now be discussed in greater detail, positioning it in the way it relates to what is already known

in the existing body of knowledge regarding work-related stress among midwives and the impact upon emotional well-being and career decisions.

5.4 FIGHTING A LOSING BATTLE: A NEW THEORY OF WORK-RELATED STRESS

Work-related stress in the psychological sense has been written about extensively since seminal work conducted by Selye (1956), who maintained that following the perception of an acute stressful event, a person is subjected to a cascade of changes in the nervous, cardiovascular, endocrine, and immune systems. These changes are known as a stress response and are often adaptive in the short term. The impact of work-related stress affecting the physical body as well as psychological health is a relatively new subject area. Research has been conducted that suggested stress was derived specifically from work itself (Dewe, Guest, & Williams, 1979), and from the work conducted in the nursing profession (Stillman & Strasser, 1980).

There have been some major developments regarding work-related stress that have influenced research and knowledge of the subject. Cooper and Marshall (1976) suggested there were two central features of work-related stress; the dimensions or characteristics of a person and the potential sources of stress in the work environment. The authors proposed that interactions of these features *"determined either coping or maladaptive behaviour or stress-related disease"* (Cooper & Marshall, 1976, p. 14). Karasek's Demand Control theory of stress, described how workplace stress is a function of how demanding a person's job is and how much control, discretion, authority or decision making the person has over their own responsibilities (Karasek, 1979). This theory outlined four kinds of job demands; passive, active, low strain and high strain that influenced work-related stress.

Job demands represent the psychological stressors in the work environment. O'Driscoll and Cooper (1994) proposed a framework for assessing the interrelationships between stressors, behaviours and consequences that occurred in workplaces. The authors developed an alternative approach to examining stress and coping skills, which was based on *"critical incident analysis of stressors experienced, including the behaviours people exhibited and the outcomes of those behaviours"* (O'Driscoll & Cooper, 1994, p. 344).

Siegrist's Effort-Reward Imbalance (ERI) theory (1996) defined threatening job conditions as a *"mismatch between high workload (high demand) and low control over*

long-term rewards" (Siegrist, 1996, p. 1128). Siegrist emphasised that personal control over long-term reward was important when dealing with distressing incidents in an occupational role (Siegrist, 1996). However, Cox, Griffiths and Rial-González (2000) took a slightly different position by specifying that work stress was a future health and safety issue, and employers should manage it in the same logical and systematic way as other health and safety issues.

This would suggest that the management of work-related stress should be based on the "adaptation and application of a control cycle approach such as that made explicit in contemporary models of risk management" (Cox et al., 2000, p. 130). Interestingly, Tennant (2001), recognised that the changing patterns in workforce structures in industrialised economies had impacted on job security and greater demands in the workplace. The author concluded that work-related stressors were leading to a rise in psychological disorders amongst workers, with depression becoming a leading diagnosis. It was also noted that occupational factors, which could differ according to occupation, also contributed to psychological disorders, that could have "significant implications for employees, their families, employers and the wider community" (Tennant, 2001, p. 702). These theories were instrumental in the translation of work-related stress theories to reduce risk to workers. This led to the introduction of holistic models of work-related stress that outline hazards and exposure as pathways to harm (Cox, Griffiths, & Rial-González, 2010; Crowther et al., 2016; Simmons & Nelson, 2007).

Just as there are many theoretical perspectives of work-related stress, there are also many definitions of the phenomenon. One definition that fits with the experience of the participants of the current study was that developed by Lazarus and his work on the Transactional Model of Stress (Lazarus, 1990). The transactional model defined work-related stress as *"resulting from certain environmental demands that cause burden to individuals, and that impacts and threatens the well-being of an individual"* (Lazarus, 1990, p. 5). This definition holds that the individual constructs a transaction that is at the centre of the stress process, and the focus of that transaction concerns what people think and do in a stressful encounter. The midwives in the current study were aligned with the Transactional Model of Stress, in that what they thought and did was an important aspect of their stress, however, the midwives' stressful encounters were impacted upon by varying work-related factors that also had long-term consequences for them. This definition provides an insight into the nature of the stress

process, but does not specifically address work-related stress in a midwifery environment.

Although Lazarus' (1990) definition resonates closely with what was happening for the midwives in the current study, it does not completely align with their experiences. There are no existing definitions or theories of work-related stress specifically concerning midwives. As discussed in Chapter Two, there have been studies conducted with midwives and work-related stress, burnout and job satisfaction (Beck et al., 2015; Foureur et al., 2013; Knezevic et al., 2011; Mollart et al., 2013; Oncel et al., 2007; Sheen et al., 2015), however, there are no reported theoretical works where the factors that influenced midwives' workplace stress and the contingency measures they employ to try and mitigate the impact of it. Given that currently there is seemingly no theory of work-related stress in midwifery, nor an existing non-midwifery centred one that explains the findings of the current study, it is proposed that the one developed in the current study represents an original contribution to the knowledge on this topic.

The substantive theory that emerged from this study has fulfilled the aim of using grounded theory as the methodology for this study, as Glaser developed the idea that a theory has to have relevancy for the people within the area of inquiry (Glaser, 1978). Glaser suggested that there were certain criteria required for evaluating grounded theory, which consist of fit, work, relevance and modifiability (Glaser, 1978), and that these criteria would demonstrate that by using grounded theory as a research methodology, these four criteria would be met.

Glaser stated that the 'fit' component of the criteria represents "the outcomes of the method of constant comparison" (Glaser, 1998, p. 18), and in this study it was achieved by the categories that emerged from the collected data. The 'workability' component of the criteria is reflected in the theory that emerged from this study by explaining how midwives understand work-related stress and its implications. The third criteria 'relevance' was achieved via the in-depth interviews that were conducted with the participants which produced important personal perspectives. The final criteria 'modifiability' was satisfied by the use of the constant comparative method, which in essence continually modifies and refines the evolving theory.

Glaser suggested that the resulting theory becomes intrinsically linked to the collected data despite modifications (Glaser, 1978), therefore producing a theory that holds relevance for the participants in that substantive area. The substantive theory

produced from this study, 'Fighting a Losing Battle', provides insights and generates knowledge specifically aimed at midwives; new understanding can inform change and improve outcomes for the midwifery profession.

The causes, consequences, context and processes, that form the theory of 'Fighting a Losing Battle' play a pivotal role in how the midwives understand work-related stress. The core category 'Midwifery is Stressful but it is Not the Job Itself' was directly linked to the midwives' work experiences and is a significant finding in this study. Therefore, this knowledge will be valuable for organisations in their efforts to improve job satisfaction for midwives, find ways to alleviate stress that impacts upon the midwifery role, and consider certificate level training for all midwives before they coordinate clinical areas. These recommendations may in turn encourage retention of midwives and improve recruitment to the profession.

SUMMARY

This chapter has discussed the categories and the substantive theory that emerged from this study and how it fits with known work-related theories and positioned it within the existing literature in relation to the issues that emerged from the study. Within the grounded theory methodology, comparing categories and properties from the data involves considering the data at micro and macro levels to examine what is going on or are the main concerns from the data.

This includes comparing concepts identified from the participant's responses that were examined in this chapter. Chapter Six follows, in which I present the recommendations, limitations and conclusion of this thesis.

CHAPTER SIX: LIMITATIONS, RECOMMENDATIONS AND CONCLUSION

**“I leave it to the reader to judge if that is a forced conclusion
or one that emerges”**

(Barney Glaser)

6.1 INTRODUCTION

In this final chapter, a summary of the study exploring midwives' work-related stress and the implications for emotional wellbeing and career decisions is offered. The implications of the study for midwives, midwifery students, midwifery education programs, hospital organisations and midwifery workforce administrators, especially those based in Western Australia, are outlined and recommendations are suggested based on these implications. Limitations of this research are presented along with recommendations for midwifery practice and further research, including the significance of this study in relation to future research that is concerned with a substantive theory of 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress.

This study was conducted to explore the concept of midwives work-related stress and its implications for their emotional well-being and career decisions, and has drawn on the direct responses provided by midwifery participants who were interviewed regarding their experiences of work-related stress. The use of participants' direct quotes has allowed for the identification of issues and factors that midwives themselves view as important and impacting upon their role within midwifery and their intention to stay in the profession. The midwives have identified inadequacies in relation to workloads, coordinators and traumatic incidents, which lead to emotional distress and impacts upon the commitment to midwifery and future career decisions.

Prior to the submission of this thesis, I was unaware of any other research that had been conducted into this substantive area using grounded theory methodology, concerning midwives work-related stress and its implications for their emotional well-being and future career decisions in Western Australia. My choice of selecting a grounded theory approach allowed the emergence of identified constructs which were

incorporated into a substantive theory that proposes a beneficial way of conceptualising the experiences of Western Australian midwives and their understanding of work-related stress.

6.2 SUMMARY OF THE STUDY

This study was conducted with permission from Edith Cowan University Ethics Committee (approval number 11347, Appendix E); participants were recruited through posters, social media and word of mouth and they gave informed consent to participate prior to interviews being conducted (Appendices A and B). Interviews were audio-recorded and transcribed by myself, and these interviews were assigned alpha-numeric codes to preserve participant's anonymity.

Classic grounded theory methodology was selected to explore midwives' work-related stress and the implications for emotional wellbeing and career decisions, and purposive sampling was first used to select participants, then theoretical sampling was implemented to select midwives who were also coordinators. The study was conducted in Western Australia, with twenty-one midwives (20 females and one male), who worked in public and private maternity units, a birth centre, a midwifery group practice, rural / remote maternity services, independently practising midwifery and a tertiary maternity hospital. Data was collected using face-to-face interviews and I used guiding questions (Appendix C) during the semi-structured interviews to obtain information and help the interviews to flow and put participants at ease.

Constant comparison, the main feature of analysis within grounded theory methodology, was used to search for emerging patterns and themes from the transcribed interviews, whereby identified concepts described what emerged from the data to provide midwives understanding of work-related stress and its consequences. The purpose of this study was to explore midwives understanding of work-related stress, and to discover if there were any implications for their emotional well-being, and if this impacted upon decisions made about future career plans. The generation of a substantive theory of 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress, was the major outcome of the study.

In Chapter One, the background to the study was presented, including the historical and contemporary perspectives that contextualised the midwifery role, which is the phenomenon of interest in this research study.

Chapter Two reported a review of the existing body of literature pertaining to work-related stress and midwives, to assess contemporary knowledge of this topic. In keeping with the grounded theory methodology, a limited review of the literature was conducted initially, however, an in-depth discussion concerning the current state of knowledge was conducted after data collection and analysis. Having conducted an exhaustive review of the extant literature, I identified that there had been no research undertaken on the topic of Western Australian midwives' work-related stress and the implications for their emotional well-being and career decisions, and it is this gap that this study was aimed at addressing.

An in-depth exploration of classic grounded theory was presented in Chapter Three, as this was the selected methodology for examining work-related stress and its implications for emotional well-being and career decisions of midwives. Previous use of grounded theory has been a popular choice of methodology in health care research during the last few years (Urquhart et al., 2010), and has enabled a large contribution in areas where little research has previously been undertaken. Grounded theory was chosen to enable me to focus on these experiences and reveal how the midwives dealt with the main issues of concern. A full discussion concerning the rationale, challenges, advantages and disadvantages of using classic grounded theory methodology for this study is offered in Chapter Three.

The findings of this study were presented in Chapter Four, which provide an explanation of the core and subcategories of this study, and reveal the emergent substantive theory of 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress. The substantive theory characterises how the causes and consequences of midwives' perceived stress factors have implications for their emotional wellbeing and career decisions within the Western Australian context.

The conceptual new theory reveals that midwives experience their work environment as a place of constant challenges and stressors that they perceive as very difficult to deal with individually, and even more difficult to deal with when they are compounded by other work-related factors. Midwives in the study made reference to working in a war-like situation, and used words like battle, war-zone and fighting for women's rights to describe challenges, experiences and perceptions.

The core problem of 'Midwifery is Stressful but it is not the Job Itself', is evaluated in relation to nine subcategories such as 'Having to be 150% on Your Game all the

Time' that represents how workloads are stressful and cause pressure. 'Being Between a Rock and a Hard Place Whether You Are Coordinating or Not', is concerned with how coordinators impact on stressful workloads, and 'Going Pear-Shaped in Four Rooms at Once' defines how traumatic incidents compound stress. These factors were identified as causing stress. The other subcategories were positioned in relation to the consequences, contexts, covariances, contingencies and processes that affected, influenced and constrained the midwifery participants. These were labelled 'People not Understanding What Midwives go Through Emotionally', that defines the effect of highly charged clinical events on participants'. 'Being an Advocate in the Face of Medical Disrespect is Tough', that is concerned with emotional distress as a consequence of how doctors' treatment of women and themselves as colleagues impacts on stress and identifies the conditions that compounds the stress of the participants. 'Toeing the Line and Giving our Pound of Flesh' is concerned with the lack of support the participants perceived from the organisations they worked for and encompasses the context perceived by the participants as to how they understood what / who were the causes, consequences and conditions of their work-related stress. 'Having Each Other's Backs' is identified as the process that participants undergo to deal with the context of work-related stress, and suggests that small pockets of support get the participants through their working day. 'Knowing Other Midwives Understand' concerns debriefing and contains details of who debriefing occurs with and talking with colleagues.

The final subcategory is labelled 'Thinking Very Seriously About Leaving', and is linked to commitment to the midwifery profession and future career decisions. Also included are issues of retention, clinical practice, motivation and grief for what the midwifery role/job was and is now. The categories revealed that the midwifery work environment is an emotional battleground where midwives constantly encounter, and must deflect, a number of stressors that they perceive as very difficult to deal with individually, and even more difficult to deal with when they are compounded by each other.

Chapter Five provides a discussion of the categories, and the construct of work-related stress was defined and explored in the context of this study and positioned within the existing body of research and knowledge.

The meaning of the key findings was explored and discussed, and three overarching themes were identified that represented the main learning points from the

study. These overarching themes were labelled as 'The Effects of Being Physically and Emotionally Stressed at Work', 'The Value of 'Mateship' in Stressful Workplaces', and 'Midwifery Practice Workplaces as War Zones'.

The understanding of the substantive theory of 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress revealed through this study, was examined in relation to the current existing body of knowledge, and links were explored between the implications for midwives' emotional wellbeing and career decisions. Clarification of the theoretical perspective of this study has been described, revealing the main elements of the substantive theory that emerged from the collected data and explains the context of how midwives understand work-related stress.

6.3 SIGNIFICANCE OF THE STUDY

The emergent theory from this study, 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress, provides insight into the complexity of the under researched area of Western Australian midwives' work-related stress and its implications for their emotional well-being and career decisions. In addition, this study offers theoretical understanding that builds upon the existing knowledge in the substantive area.

As discussed in Chapter Two there is growing evidence that raises concerns over the unpredictable nature of midwifery, which makes the job stressful (Skinner & Maude, 2016). There is also research to suggest work-related stress is associated with a declining midwifery workforce (Hildingsson et al., 2013; Mollart et al., 2013; Schluter et al., 2011). Workforce issues, including the suboptimal retention and recruitment of midwives, are a real threat to the profession and the midwifery organisation as a whole (Hildingsson et al., 2016; Pugh et al., 2013; Scott et al., 2015). This study adds to the understanding of the issues that impact upon the midwifery role, identifying stress and stressors that have consequences for midwives working in the clinical environments. One of the main contributions of this thesis is the observations offered by the participants that 'Midwifery is Stressful but it is not the Job Itself', with participants identifying that the midwifery role was stressful, however the subcategories demonstrated that it was not the actual job but other factors that made it so. The theory of 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress, explains how midwives perceived their work-related stress. This knowledge offers a means of understanding stress in midwifery and improving

outcomes for the midwifery profession. Moreover, the theoretical understanding suggests that when midwives understand their causes of stress, changes can occur so that they can be more effective in their role as a midwife.

The concept of the substantive theory of 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress, provides an understanding of the opportunity that midwives, coordinators, management and hospital organisations have to positively adjust the conditions that affect the clinical working environments. This would involve a review of what the hospital organisations realistically expect of their staff and the factors that cause stress that in turn affects midwives' emotional well-being, and influences commitment to midwifery and retention in the profession. By conceptualising how work-related stress and its implications for midwives' emotional well-being and future career decisions impacts upon the midwifery role, the actual nature of work-related stress provided can be understood and a theory developed. The substantive theory explains how the relationship, between work-related stress and hospital organisational factors, impacts upon midwives' capacity to be the midwife they want to be, including spending time 'with woman', as pertaining to the midwifery philosophy.

The understanding that midwives are affected by consequences of their work-related stress in a range of ways is important, as is their ability to deal with this, as it affects the delivery of care to women and babies. This research shows that midwives are affected by work-related stress, and their understanding of the causes and consequences is well developed, and where present, this stress often results in strain to emotional well-being that affects whether midwives stay working in the profession.

Finally, by explaining how work-related stress factors impact upon the clinical midwifery role and affect midwives' emotional well-being and future career decisions, this classic grounded theory offers understanding of how to theorise ways to better support this under-threat workforce and maintain midwives' emotional wellbeing so they remain effective and engaged in their roles.

6.4 LIMITATIONS

Some of the first limitations of any study that require consideration, are the chosen paradigm, methodology and data collection tools that may attract a variety of criticisms. This study incorporated the interpretivist philosophy, which has attracted criticism due to its supposition that explanations surrounding attitudes and behaviours

can be expressed by individuals (Oppong, 2014). Therefore, the interpretivist philosophy has been criticised for being subjective in nature and subject to bias on behalf of the researcher (Stahl, 2014). It has also been suggested that primary data that has been generated in an interpretivist study cannot be generalized because the data is heavily impacted by personal viewpoint and values (Boswell & Corbett, 2015). This has led to suggestions that the reliability and representativeness of data may to a certain extent be undermined (Gasson, 2004).

Criticism has also been made of symbolic interactionism, which is the foundation of grounded theory, for a lack of empirical testing (Andrews, 2012). However, symbolic interactionism generally has an emphasis on power, reflexivity, and social constructionism (Callero, 2003), which has helped it as a paradigm to survive criticism. It has proved to be a suitable framework for this study.

It has been suggested that grounded theory is simply a different version of a standard inductive argument (McCann & Clark, 2004; Timmermans & Tavory, 2012) and an "epistemological fairy-tale" (Wacquant, 2002, p. 1481). Other criticisms of grounded theory have labelled it an exhaustive process (Myers, 2013), that it has the potential for methodological errors (Evans, 2013), that the literature is reviewed without developing assumptions (Schreiber & Stern, 2001), that multiple approaches exist (Hallberg, 2006) and there is limited generalisability (Polit & Beck, 2010).

My role was conducted in an interpretive mode during the data collection and the following analysis period of this study. Grounded theory had an "intuitive appeal" (Myers, 2013, p. 111) for me as a novice researcher, as it allowed me to become immersed with the data. By being so immersed this translated practically into the constant comparison, coding and memoing approaches of data analysis within the grounded theory methodology. Grounded theory does not test an existing hypothesis, and the empirical data generated reveals concepts and theories (Glaser, 1978). This, in turn, excludes prior assumptions on the part of the researcher, which helped me with enhancing my personal creativity and inspired the development of new ideas. Grounded theory as a process encouraged me through a process of discovery where the themes and categories naturally emerged from the data. It allowed me to derive meaning and interpretations from the data and analysis using creative, inductive processes, which is a recognised process allowing emergence of original findings from data (Jones, Kriflik & Zanko, 2005). The use of grounded theory permitted the collection of rich data that enabled me as a researcher to develop analytical categories

that facilitated the production of new ideas. I believe that the interpretive stance I took revealed a credible reflection of this study's findings and a practical approach to discussing the findings within the professional midwifery context.

A second limitation may be noted that during the data collection period of this study, interviews were conducted once with each participant due to the time constraints associated with the requirement to complete the PhD project within a specific timeframe. Therefore, this study has focused the participants' experiences at one particular period of time, within one state of Australia, to understand the midwifery participants' core concerns. The development of a substantive theory that tends to have a local emphasis, was identified by Glaser and Strauss (1967) in that claims regarding the theory, could not be made about its generalisability or transferability. As the setting of this study was Western Australia and not Australia more broadly, this could raise the dilemma of generalisability.

However, the issues identified may be relevant to any Australian state and can be replicated via the clearly presented audit trail of this study.

There may have been different limitations if this study had been conducted in Europe, as Australia is vastly different geographically and much smaller in population size, and there is a larger proportion of midwifery care within the private sector of health in Australia than in Europe. However, there is the potential for a more detailed longitudinal study with possibly fewer participants. There is also scope to test the substantive theory that emerged from this study by using a state-wide sample of midwifery participants from Australia.

A third limitation of this study could be identified as possible researcher bias, as I am a midwife with many years of clinical experience. Methodologically speaking, this is accounted for in the grounded theory processes, and Glaser (1998) asserted that the research process involves the researcher taking advantage of previous experience and that having professional knowledge or experience may help the researcher to make sense of connections in the data. My experience of midwifery and being a midwife enhanced my theoretical sensitivity throughout this study, and I was able to recognise and grasp properties and emerging concepts from the data. I think my familiarity with my subject area granted me an easier access to research participants, who trusted that I understood their positions and experiences that, in turn, provided rich and sensitive data. I was also aware that I needed to be self-reflective throughout the process, which I have discussed in Chapter Three, and for this reason I continued with an

autobiographical reflection in this chapter. By being self-reflective throughout the study, I was able to recognise if I was influencing the research process and respond to it so I remained completely objective and did not force my interpretations on the data (Glaser, 1992).

A fourth limitation of this study was that only one male participant was recruited to participate in the research. The total number of male midwives practising in Western Australia is nine (NMBA, 2016), and only one of these male midwives agreed to participate in the study. Despite these limitations the research question, which was to explore the concept of midwives' work-related stress and its implications for their emotional well-being and career decisions, was answered and a theory developed that addressed a gap in knowledge that fit the four criteria of fit, work, relevance and modifiability.

6.5 RECOMMENDATIONS

Recommendations for decreasing stress in midwifery practice are now presented based on emergent categories that were significant in this study, along with recommendations for further research to expand the knowledge regarding work-related stress in midwifery, and its implications for the emotional well-being and career decisions of midwives.

6.5.1 Recommendations for Preparation of New Coordinators

Based on the findings regarding coordinators being a source of stress for midwives, and the coordinating role also being a causal factor of stress, it is apparent that the implementation of a formal training program consisting of people management skills, including communication, counselling and debriefing skills, should be considered. The hospital organisations have a responsibility and a duty-of-care to their employees to ensure their continuing education opportunities and their safety and emotional well-being.

- Recommendation 1: A University based program of continuing education could be devised and accredited, for example, at certificate level and consisting of two units, for interested midwives to enrol in and complete that would provide education and training in equipping them with basic crisis debriefing, stress and trauma counselling skills. This could be a compulsory competency that is required for promotion to a level two position and before being a coordinator in clinical practice. Currently there is no organised

coordinator preparation available through any of the Universities in Western Australia.

Workloads were also a causal factor of stress for the midwifery participants, and this appears to be a current global issue within midwifery. Retention of committed staff is essential, especially those staff who have gained experience and knowledge through working in the clinical midwifery environments. Participants in this study also expressed their dissatisfaction with the lack of appreciation they received from their organisations.

- Recommendation 2: Workloads need to be workable – and this should include time to be 'with woman' and complete paperwork / input of data into a computer, that does not appear to be currently factored into the division of work. At the writing of this thesis, none of the maternity organisations were using any type of work-force planning tool designed specifically for midwifery environments. All the maternity organisations were using Key Performance Indicators (KPIs) that evaluate factors that the organisations deem important.
- Recommendation 3: Hospital organisations should conduct an analysis on the sick leave that midwives in their employment are taking, and if possible whether the sick leave is stress induced. The sick leave accrued by midwives in Western Australia is currently unknown and has not been researched.
- Recommendation 4: Reward staff and show appreciation through a regular event that is peer and woman nominated which celebrates the care midwives provide. Some organisations were using a woman nominated scheme, but there did not appear to be much promotion of it or any rewards associated with being nominated.
- Recommendation 5: Midwives need a support network that is independent of their organisations – and should be encouraged to engage through social media sites, for example, Twitter which has a global network of midwives sharing and supporting each other. Midwives need a champion who will greet them every time they are on shift and who can provide confidential counselling if required.

Thinking ahead of the present challenges facing Western Australian midwives, future predicted patterns need to be considered, which includes the retirement 'ticking

bomb', and ensuring that working environments are supported to improve motivation and commitment to the midwifery profession.

- The substantive grounded theory of 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress could be used in the development of an initial organising framework for future midwifery work-force studies.

6.5.2 Recommendations for Further Research

On the basis of the findings from this study, further investigation is required, to explore interventions in reducing and preventing midwives' intentions to leave the profession. Considerably worthwhile for investigation in the near future are:

- A study to look at the reasons why Western Australian midwives stay in the profession
- A study to look at stress and burnout in newly qualified midwives in Western Australia

These suggestions arose from this study and have not been addressed in the body of literature. The main reasons that midwives provided for wanting to leave the midwifery profession were inadequate staffing levels and poor skill mix, heavy workloads and not having enough time to 'be with women' which they believed impacted on providing quality care to women and babies. Midwives need to be retained, as many are approaching retirement age, and staffing levels will not improve without trained midwives.

This in turn will have a 'knock-on' effect as having adequate staffing levels will allow midwives more time to spend with women and babies, thus improving the quality of care they give, providing midwives with job satisfaction and letting them be the midwives they trained to be. This will cause fewer midwives to leave the midwifery profession.

6.5.3 Implications for Education Regarding Work-related Stress Pre and Post Registration

The findings of this study suggest the need for education that should begin with midwifery students enrolled in midwifery programs that lead to registration, and in continuing midwifery education programs, that focus on work-related stress as a

professional risk. Midwifery curricula could include modules that highlight the signs and symptoms of work-related stress, which would help midwives to recognise the problem and the need to seek assistance. There are educational programs that have been developed to aid prevention of stress in clinicians, using reflective practice that could be incorporated into hospital organisations.

6.5.4 Support in Clinical Practice

Many other professions, such as the military and first responders, have mandatory protocols to help improve outcomes for employees who are exposed to work-related stress. Work-related incidents that may be perceived as traumatic events, are now included in the Diagnostic and Statistical Manual of Mental Disorders (DSM), which is the standard classification of mental disorders used by mental health professionals. It may be prudent for the midwifery profession to develop standards or protocols for midwives who are exposed and affected by work-related stress. This would help midwives to recognise they are not in isolation and have a pathway to seek assistance.

6.6 AUTOBIOGRAPHICAL REFLECTION

Whenever I have spoken with supervisors, colleagues and peers about undertaking a PhD, it is usually discussed in the context of a journey. However, I have found that conducting a PhD is more of a discovery process. It is like discovering a part of yourself that you did not know existed. No-one explained to me how much thinking I would do whilst immersed in my study; I lived with my categories covering my lounge wall for just over 18 months – my thinking patterns did not stray far from my topic. I kept a notebook with me to scribble furiously in after an interview, often while I remained parked outside my interviewee's home. I wrote sporadic notes or comments into my notebook while making dinner or watching the television, when I was supposed to be taking a break from study.

I awoke early most mornings to write, as I worked full time whilst completing my study – and realised I loved watching the sunrise – something I hadn't previously considered. Years of shift work had made me oblivious to sunrises, sleep was always a priority.

Learning about and understanding the nature of research is addictive; this PhD journey of discovery has forever changed me. There have been struggles and frustrations, and times when I thought I would never get to the end of it. But now I am almost at the end, I feel like my PhD has been like a pregnancy and labour, and the

production of a thesis is almost like a birth – completed with blood, sweat and fears. Fears like those that women express during a pregnancy, will my study be ‘perfect’, negotiating the twists, turns and pitfalls apprentice researchers encounter, and the focus on the expected date of submission and the examination process.

I read with different eyes now, questions drop into my mind when I am hearing something new, I welcome being able to challenge old ideas and ways of doing things. I feel like I have personally developed and have grown in my capacity as learner and I am looking forward to facilitating others to achieve this.

I hope that my research will go some way to improve the working lives of midwives. I have listened and recorded the voices of midwives as they recall their experiences. They told me of their unbearable stress caused by factors impacting upon a job they love. As a midwife rapidly approaching retirement age myself, I know the fight for midwifery and ‘being with woman’ is real.

FINAL WORDS

The grounded theory framework was a suitable approach for this research study, as it provided clear strategies and procedures for conducting rigorous qualitative research of an area of investigation that had not previously been explored. Considerations regarding ethical issues were adhered to regarding the participants of this study, ensuring their well-being and anonymity.

The aim of this study was the development of a substantive theory of how midwives working in Western Australia understood work-related stress in midwifery, and its link to emotional well-being and future career decisions. This study has shown that midwives recognise midwifery can be stressful, but it is not the actual job itself, but issues that impact upon the role. Midwives believe their work-loads have significantly increased due to a steadily rising birth rate and a growth in the complexity of pregnancy and birth. The increased cases of complex pregnancy and birth has led to traumatic incidents becoming more common-place, and the role of the coordinator can add to stress and pressure whether the midwives are coordinating or being coordinated.

Midwives also reported working without breaks and beyond their allotted working hours to provide continuous, safe care for women and babies. These amplified pressures and demands appear to be affecting the well-being and health of midwives working in the profession. Despite providing support for each other through work-

related incidents and issues, midwives reported that management and organisations were generally unsupportive and had an almost militaristic approach when dealing with work-force issues. Midwives also described how undermining behaviours from colleagues and medical staff disseminated into the culture of the midwifery environments.

The conceptual theory 'Fighting a Losing Battle': Midwives' Experiences of and Response to Workplace Stress, is a newly developed theory from the data collected in this study, that provides insights and generates knowledge specifically aimed at midwives, with the ramifications that new understanding can inform change and improve outcomes for the midwifery profession. The new conceptual theory reveals midwives experience their work environment as a place of constant challenges and stressors, which they perceive as very difficult to deal with on an individual basis, and even more difficult to deal with when these stressors are compounded by other work-related factors, which appear to regularly occur.

The midwifery participants made reference to being in a war-like situation within the midwifery environments, and the stated challenges, experiences and perceptions described by the participants, relate to these. The concept that emerged to theorise these participants' experience was that they are fighting a losing battle.

The midwives in this study understood the causes and consequences of work-related stress, and were equally clear that midwifery in its pure form was not stressful, but that it was factors that impacted upon the role of being a midwife that caused stress. Their passion for midwifery and 'being with woman' appeared undiminished, despite the challenges they described. None of the midwives raised the issue of salary; their main concern centred on unbearable levels of work-related stress. Many of the midwives indicated that they were unsure of how much longer they would be able to keep doing what they were doing. In the early twenty-first century, midwifery in its traditional form appears to be succumbing under constant fire from organisational stressors and constraints, as midwives fear they are fighting a losing battle.

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APPENDIX A



Dear Midwife,

Midwives' workplace stress and its implications for their emotional wellbeing and career decisions: a grounded theory study

My name is Sadie Geraghty and I am a midwife and midwifery lecturer in the School of Nursing and Midwifery at Edith Cowan University. I am conducting a study investigating whether midwifery practice has implications for midwives' emotional well-being, which will use grounded theory as the methodology. This research is being undertaken as part of the requirements of a PhD. This study will be collecting qualitative data using semi-structured interviews which involves participants offering their personal opinion to questions asked by the researcher.

As a midwife working in a clinical midwifery environment, I am inviting you to take part in this research by contributing approximately 30 - 40 minutes of your time to be interviewed. You are invited to participate in this research as you currently are employed as a midwife within the clinical midwifery environments.

This study will not identify participants, and only the researcher will interview the participants who will remain entirely anonymous. You will not be required to use your name in the interview and no identifying information is required. All completed transcripts from the interviews will be handled only by myself and my immediate supervisors and will be stored in a locked cabinet within the university to which I hold the only key. The interview responses will be analysed and used to produce a thesis on the subject. Portions of the study may also be used to produce a research paper which may be submitted for publication at a later stage. Midwives participating in this research will not be identified in any publication of the research findings.

The anticipated benefit of participating in this research is the opportunity to contribute your experiences of the emotional well-being of midwives working in sometimes stressful situations, to enable a better understanding of the retention needs of midwives.

Participation is entirely voluntary. Should you choose to participate, you will be asked to sign a consent form. At any stage of the process you can withdraw from the study. If you have any queries regarding this research, please contact either myself or my supervisors at the contact details below. Should you have an enquiry relating to the conduct of this research or queries relating to ethical considerations, please direct these to the ethics research officer.

If the discussion of critical incidents / emergencies should cause you emotional distress, the interview will be terminated and the researcher will provide you with resources / referral agencies that may be able to help you address identified issues.

I thank you for taking the time to read this information.

Regards

Sadie Geraghty RM

CONTACT DETAILS:

Researcher:

Ms Sadie Geraghty
Faculty of Health, Engineering & Science
School of Nursing and Midwifery
Edith Cowan University
Ph: (08) 6304 3485
Email: s.geraghty@ecu.edu.au

Principal Supervisor:

Professor Craig Speelman
Faculty of Health, Engineering & Science
School of Psychology and Social Science
Edith Cowan University
Ph: (08) 6304 5724
Email: c.speelman@ecu.edu.au

Supervisor:

Dr Sara Bayes
Faculty of Health, Engineering & Science
School of Nursing and Midwifery
Edith Cowan University
Ph: (08) 6304 3487
Email: s.bayes@ecu.edu.au

Independent Contact:

Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Ph: (08) 6304 2170
Email: research.ethics@ecu.edu.au

APPENDIX B



Consent Form

I (INSERT NAME) hereby consent to participate as part of the research: 'Midwives' workplace stress and its implications for their emotional wellbeing and career decisions: a grounded theory study'. In doing so I acknowledge that I have read and understood the information letter and consent document provided to me and have had the opportunity to satisfactorily clarify any questions I have in relation to the study.

In signing this consent form I acknowledge I am participating of my own free will and consent to the following: (Please tick the appropriate box)

- The data collected for the purposes of this research study may be used in further approved research studies / publications providing my name and other identifying information is removed
- The data collected for the purposes of this research study may not be used in further approved research studies / publications without my consent
- The data collected may only be used for the purpose of this study

Name of Participant Signature..... Date.....

Name of Witness..... Signature..... Date.....

APPENDIX C



Guiding Questions

1. What does the term 'emotional well-being' mean to you?
2. What are your experiences of witnessing traumatic birth incidents?
3. Can you describe a situation that may have caused you some emotional distress?
4. How do you cope with the emotional stress you encounter in your work?
5. Have you been offered any support from your working environment / Hospital?
6. Have you found career fulfilment in your role as a midwife?
7. Has emotion well-being or work related stress caused you to think about leaving the profession?
8. Have you any suggestions as to how midwives could be offered support in dealing with traumatic childbirth incidents?
9. Is there anything else you would like to share with me?

Prompts:

1. How did you do this.....
2. Can you tell me a bit more about this.....
3. Anything else you would like to add.....

APPENDIX D

**Winner of the Research Photography Competition 2015, in the Digital category at ECU.
(October 2015)**

Analysis of Grounded Theory study data requires the researcher to deconstruct transcribed interviews and group the resulting meaningful fragments into categories; together these categories describe and explain the common human experience of a particular phenomenon. There are a number of computer programs to assist this process, however PhD candidate Sadie Geraghty prefers the more traditional and tactile approach, in which typed transcripts are physically cut up and re-collated on wall-mounted storyboards.



APPENDIX E



JOONDALUP CAMPUS

270 Joondalup Drive, Joondalup
Western Australia 6027
☎ 134 328

www.ecu.edu.au

ABN 54 361 485 361 CRICOS IPC 00279B

Dear Sadie

Project Number: 11347 GERAGHTY

Project Name: Midwives' workplace stress and its implications for their emotional wellbeing and career decisions: a grounded theory study

Student Number: 10208641

The ECU Human Research Ethics Committee (HREC) has reviewed your application and has granted ethics approval for your research project. In granting approval, the HREC has determined that the research project meets the requirements of the National Statement on Ethical Conduct in Human Research.

The approval period is from 1 July 2014 to 1 June 2016.

The Research Assessments Team has been informed and they will issue formal notification of approval. Please note that the submission and approval of your research proposal is a separate process to obtaining ethics approval and that no recruitment of participants and/or data collection can commence until formal notification of both ethics approval and approval of your research proposal has been received.

All research projects are approved subject to general conditions of approval. Please see the attached document for details of these conditions, which include monitoring requirements, changes to the project and extension of ethics approval.

Please feel free to contact me if you require any further information.

Regards
Kim

Kim Gifkins, Research Ethics Officer, Office of Research & Innovation, Edith Cowan University, 270 Joondalup Drive, Joondalup, WA 6027
Email: research.ethics@ecu.edu.au Tel: +61 08 6304 2170 | Fax: +61 08 6304 5044 | CRICOS IPC 00279B