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Sustainability and Resilience in Midwifery: A discussion paper

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## **Background**

Midwifery workforce issues are of international concern. Sustainable midwifery practice, and how resilience is a required quality for midwives, have begun to be researched. How these concepts are helpful to midwifery continues to be debated. It is important that such debates are framed so they can be empowering for midwives. Care is required not to conceptually label matters concerning the midwifery workforce without judicious scrutiny and diligence.

## **Aim**

The aim of this discussion paper is to explore the concepts of sustainability and resilience now being suggested in midwifery workforce literature. Whether sustainability and resilience are concepts useful in midwifery workforce development is questioned.

## **Method**

Using published primary midwifery research from United Kingdom and New Zealand the concepts of sustainability and resilience are compared, contrasted and explored.

## **Findings**

There are obvious differences in models of midwifery care in the United Kingdom and New Zealand. Despite these differences, the concepts of resilience and sustainability emerge as overlapping themes from the respective studies' findings. Comparison between studies provides evidence of what is crucial in sustaining healthy resilient midwifery practice. Four common themes have been identified that traverse the different models of care; Self-determination, ability to self-care, cultivation of relationships both professionally and with women/families, and a passion, joy and love for midwifery.

## Conclusions

The impact that midwifery models of care may have on sustainable practice and nurturing healthy resilient behaviors remains uncertain. The notion of resilience in midwifery as the panacea to resolve current concerns may need rethinking. Resilience may be interpreted as expecting midwives 'to toughen up' in a workplace setting that is socially, economically and culturally challenging. Sustainability calls for examination of the reciprocity between environments of working and the individual midwife. The findings invite further examination of contextual influences that affect the wellbeing of midwives across different models of care.

**Key words:** Midwifery, sustainability, resilience, New Zealand, United Kingdom, relationships, models of care

## Introduction

Sustainability and resilience are concepts which have recently come into use in the midwifery workforce literature (Wakelin & Skinner, 2007; Sullivan, Lock & Homer, 2011, Yoshida & Sandall, 2013). These notions have appeared within the literature around sustainable organisations (Kossek et al., 2014). This discussion paper aims to explore their relevance and usefulness within midwifery. The intention of this paper is not to provide a concept analysis or a systematic review of the literature but provide a comparative analysis of two distinct studies conducted by the authors. A comparative analysis compares and contrasts studies and highlights commonalities and points of difference that were not clearly seen before (Rihoux and Ragin, 2009). This paper draws on primary research conducted by the authors who explored sustainability and resilience within midwifery practice in New Zealand and the United Kingdom respectively. Comparative analysis of

these notions and the themes which emerged from these studies, offers insights and consideration of their utility for investigating the wellbeing of the midwifery workforce.

Our discussion encompasses both the sustainability and resilience of the individual, and the sustainability and resilience of midwifery practice as a whole. We will refer to these studies as the New Zealand (NZ) sustainability study and the United Kingdom (UK) resilience study.

### **Definitions**

Sustainability is a term used mainly in ecology, where it specifically refers to “conserving an ecological balance by avoiding depletion of natural resources” (Oxford Dictionary of English 2<sup>nd</sup> Edition 2003). In other words, sustainability is the capacity of systems or processes to maintain balance and endure. When applied to individuals, such as midwives, the word ‘endure’ takes on the double meaning of continuing to practise in the face of the difficulties and adversities encountered in that practice. To ‘sustain’ also means to support or maintain (Oxford Dictionary of English 2<sup>nd</sup> Edition 2003). Midwives not only support women in their childbearing, but also experience the social complexities of providing and receiving collegial support.

Resilience means to be “able to withstand or recover quickly from difficult conditions” (Oxford Dictionary of English 2<sup>nd</sup> edition 2003). Also an ecological concept, it covers the capacity of a system to absorb disturbance and still retain its basic structure and viability. It implies that an individual or system needs to be prepared to live with whatever surprise and disturbance arises (Folke, 2006). This term is also applied to organisations, businesses and individuals. For example Anderies (2004) refers to the robustness of systems that maintain stability despite unexpected changes. Resilience in physics is about the elasticity of materials, and elasticity is also an important factor in individual and organisational resilience. For example Skovholt and Trotter-Mathison (2016) suggest that a resilient individual is someone that has the “the capacity to bounce back from a negative force” (p4). The definition of resilience differs to that of sustainability, as resilience requires an element of difficulty, which is responded to either by holding steady, or by reacting but then quickly resuming a normal state.

### **Applying sustainability and resilience to midwifery**

A number of disciplines have contributed to the study of sustainability and resilience in the healthcare workforce and amongst health profession students (see, for example, Dyrbye et al 2010; Jeffcott et al 2009; McAllister & McKinnon, 2009; Tusaie & Dyer 2004; Wakelin & Skinner 2007). Some studies have a primarily psychosocial emphasis, focusing upon the individual characteristics of those who appear to best tolerate working practices common in the health professions such as shift work (see Saksvik et al [2011] for a systematic review). Research such as that by Suwazono *et al* (2010) has adopted a biochemical approach to study the impact of shiftwork on individuals. Some studies have taken a more sociological approach, such as the research on 'Why Midwives Stay' which explored midwives' work motivation and their sources of job satisfaction and dissatisfaction in the UK (Kirkham et al 2006) and New South Wales (Sullivan et al 2011). Others have taken an ethnographic approach (e.g. Glass 2009). Research on burnout in midwifery can also shed light on the factors which may be linked with burnout or protect against it, thereby sustaining practitioners (Yoshida & Sandall, 2013; Young, Smythe, & McAra Couper, 2015).

In the context of midwifery, practice sustainability has been examined in very different organisational contexts: in hospital and community settings, and in countries with very different maternity services (see, for example, Deery, 2010; Engel, 2000; Foureur *et al*, 2013; Gilkison *et al*, 2015; McDonald *et al* 2013; Hunter & Warren, 2014; Wakelin & Skinner, 2007). The emergence of such research points towards not only the importance of sustainability and resilience to midwifery, but also towards the significance of understanding the impact that local conditions and working arrangements may have in relation to resilience and sustainability. In the UK, for instance, care is mainly fragmented, continuity of carer is rare and midwives commonly move around within hospitals and between hospitals and community settings, which potentially disrupts collegial relationships. In NZ women may choose a lead maternity carer (LMC), usually a midwife, with whom a relationship can develop over time with families. 92% of New Zealand women receive continuity of carer from a midwife. The other 8% receive care from an obstetrician or GP (Ministry of Health, 2015). LMC midwives in NZ provide care for women through antenatal, intrapartum (home/birth centre or hospital) and for six weeks postnatally. NZ midwives can also work in maternity facilities and are known as 'core midwives' providing



care to women with complex needs (Gilkison et al 2015). These core midwives provide episodes of care akin to the fragmented model in the UK.

Relationships of different kinds (“with women, between midwives who work together and supportive relationships within the maternity care system” [Leap *et al*, 2011, p.61]) have been identified by “midwifery leaders” as central to sustainability in midwifery (p.61). The nature and scope of such relationships varies considerably across practice arrangements which may lead to professional sustainability and resilience manifesting differently in different places. Comparative analysis of some the existing research holds the potential to begin to tease out some of these issues.

Furthermore, in the introduction to their edited collection on *Sustainability, Midwifery and Birth*, Daellenbach, Davies and Kensington, make the point that “the underlying philosophy of the midwifery profession is essentially aligned with sustainability” (2010, p.2).

Sustainability is about encouraging birth as a normal life process, and working at grass-roots levels to support and strengthen women and families within, and as part of, local communities. Yet wider cultures of health care provision set the organisational scene for midwifery, and there may be fundamental differences between wider organisational culture (especially within institutional settings) and the social model of midwifery care (Edwards 2008, Murphy Lawless 1998, Reiger and Morton 2012). These differences create tensions which challenge workforce resilience and sustainability. Indeed one Australian study is entitled ‘How can we go on caring when nobody here cares about us?’ (Reiger and Lane 2012).

Beneath different studies on sustainability and resilience in midwifery lie ever present economic and political pressures. For example, within the neoliberal market economy, there is great pressure on all health services to do more for less; throughput and efficiency are measured and pressurised. In a service where staff salaries are a major cost, the logic of constant cost reduction does not support a staff structure with many highly experienced midwives. More experienced midwives bring practice wisdom, but they cost more.

However, the sustainability of such pressurised services is questionable. For example, Sally Tracy has noted that tendencies towards ‘costing birth as commodity’ sit uneasily with notions of birth as ‘sustainable public good’ (2010). When we consider the elements of

modern healthcare which do demonstrate resilience and endurance in the current climate, the success of biomedicine is clear. Market economics may rule modern healthcare, yet to a large extent medical dominance has remained resilient due to its “structural embeddedness” in that market and its degree of state support (Benoit et al 2010, p.480). The “standardising imperative of evidence based healthcare” has “effectively extended the premises of hegemonic obstetric discourse” (Reiger and Morton 2012, p.178). Standardisation fits the logic of an efficient service, all elements of which can be measured and monitored. Yet standardisation does not mesh easily with the midwifery values of woman centred care, given that women differ when giving birth and in how they care for their babies. In this context, key questions emerge as to how midwives can and do find ways to sustain and support themselves in such a way that enables midwifery and midwives (and thereby the women, babies and families they care for) to endure and flourish.

The difficulties for a largely female profession are compounded by the fact that women also frequently have to sustain multiple caring roles outside of their paid employment. For example, Trentmann (2009) sees ‘disruption as normal’ in life. Maher’s (2013) study of nursing careers views changes within individual’s careers as ‘an adaptive and resilient response to the everyday nature of disruption’ in the workplace and “the consistency of family change” (p.172). In this sense, the individual is seen to embark upon resilient behaviour by opting out of a given (perhaps adverse) work environment and changing to another. This may well also be the case in midwifery. Indeed, it is known that in the UK many midwives leave midwifery because they cannot practise as they would wish (Ball et al 2002). Nonetheless even if midwives choose to leave the profession, or to change jobs within it, the need for individual resilience remains if midwives are not to be scarred and limited by professional experiences such as those of loss and pain (Kenworthy and Kirkham 2011). It appears that sustainability and resilience are about balance: social, organisational and personal. Since maternity care is fraught with conflicting narratives, it is also important to examine assumptions as to what should be sustained and what is the nature of resilience.

### **Comparing studies**

Comparing the findings from our respective research studies provides an opportunity to interrogate the concepts of sustainability and resilience and to consider their significance in relation to midwifery in two different parts of the world. We chose the two studies because

they looked at similar questions (around sustainability/resilience) but were carried out in different contexts in terms of maternity systems and the relationships between midwives, between women and midwives, and between midwives and the wider maternity system. The two studies are ideally situated to be compared because they both look exclusively at resilience or sustainability amongst midwives (not midwives and nurses as in several other studies (e.g. Foureur et al, 2013; McDonald et al 2013), and neither study was carried out in the context of evaluating the impact of a particular initiative or intervention that was hoped to improve resilience. The unique focus of both the studies compared in this paper is that they focus exclusively on midwifery workforce issues. In addition, the use of the notions, sustainability and resilience to describe the findings provide an opportunity to scrutinise the overarching themes from these respective findings. This allows considerable scope to compare, contrast and highlight commonalities that help reveal beneficial practices that contribute to sustainable and resilient midwifery practice.

### **Method**

Comparative analysis was done across the findings of two studies following a collaborative review of the themes and sub-themes. Resultant commonalities and themes were identified through an iterative process of group discussions, writing and re-writing until agreement was established between the two research teams. Points of difference and congruence were highlighted by members of the primary studies.

The authorship of this paper is comprised of two researchers in the UK study (BH and LW), four researchers from the New Zealand study (JMC, AG, SC, MH). AF joined the analysis and writing of this paper as she is involved in an ongoing study exploring the sustainability amongst New Zealand core midwives (midwives working within institutions and not self-employed and case loading). MK was a critical reader of the UK study report and is currently working with the New Zealand midwifery research team. All authors are familiar with the findings of the respective studies and contributed to the analysis and writing of this paper.

### **The UK resilience study**

In the UK study Hunter and Warren (2014) define resilience as “the ability of an individual to respond positively and consistently to adversity, using effective coping strategies” (p.927). Conducted in 2012-13, the study was funded by the UK Royal College of Midwives. The research was prompted by concerns regarding persistent low morale within the UK

midwifery profession, and how it might be possible to address this. A national shortage of midwifery posts had been the subject of media attention and national campaigns (Campbell, 2012; Warwick, 2012), leading to governmental commitment to increase midwife numbers (Department of Health, 2012). Staff retention rather than recruitment was also thought to be problematic. Although applications for midwifery undergraduate programmes were high (Department of Health, 2011), a significant number of midwives were leaving within the first five years of qualification.

As noted, reasons for leaving the profession had first been explored over a decade previously by Ball et al (2002), showing that midwives experience a range of organisational, professional and ideological challenges, which place demands on their emotional, psychological and physical reserves. Providing support to women and their families at such a pivotal and emotionally demanding time in their lives can itself create challenges, especially when models of care and organisational culture are not conducive to woman-centred care or to facilitating the skilful emotional work that is needed (Hunter 2004, 2006). Additional contemporary causes of low morale were also identified: a rising birth rate at a time when the resources within the National Health Service were being scrutinised and services being reconfigured (House of Commons Public Accounts Committee 2014). This combination of increasing workload and national shortage of midwives inevitably increases strain on practitioners.

In the 2014 NHS National Staff Survey, many midwives identified poor work conditions (long shifts, no breaks and heavy workload) as contributing to low morale, work-related stress and sickness (NHS 2015). Yet, low morale is not experienced by all midwives. There are some that, despite adversity, are able to thrive. That is, they continue to find their work rewarding and could be said to demonstrate professional resilience.

This small qualitative descriptive study sought to explore the experiences of midwives who had been working for more than 15 years and self-defined as resilient, using a closed online discussion group (for further details see Hunter & Warren 2014). Thematic analysis indicated four overarching themes; the first theme related to the adversity experienced: personal and professional constraints, work conditions, and resulting concerns regarding the ability to provide quality care. 'Critical moments' were identified when individuals would be

particularly susceptible to the adversity experienced, such as when newly qualified or following an adverse incident. Three themes related to resilient responses to the challenges experienced. In Theme Two, midwives described short-term reactive strategies: day to day managing and coping facilitated by mood changers, social support and gaining a sense of perspective. Theme Three encompassed various elements of the self; including professional identity, having a love for midwifery practice and a strong sense of public service, the need to self-care, and managing expectations. The final theme: proactive strategies for the longer term building of resilience entailed taking steps to avoid or manage stressful situations, supporting vulnerable or inexperienced colleagues, facilitating the empowerment of others and learning from past experience.

As a preliminary study, this research provided some insights into midwives' experience of professional resilience, and the short and long term strategies that they used to manage workplace adversity. However, the study generated questions as well as insights. Although developing professional resilience may be viewed by some as the panacea for attrition and retention, placing the onus on the individual to adapt to adversities whilst ignoring the responsibilities of those in positions of power to improve working environments, is neither ethical nor sustainable. The most recent NHS staff survey in England (NHS 2015) identified that eighty-three percent of midwives worked additional unpaid hours on a weekly basis for their organisation. This survey also found that midwifery had the lowest score regarding satisfaction with quality of patient care, with ninety-five percent of midwives reporting clinical errors or near-misses in the last month. Given the results, it was unsurprising that nearly half of all the midwifery respondents reported experiencing work related stress.

#### **The New Zealand sustainability study**

The New Zealand (NZ) sustainability study used a definition of sustainability as 'to enable something to continue to exist, whilst maintaining the mental and physical wellbeing of the agent' (McAra-Couper et al., 2014).

The maternity system in NZ is world leading in its model of providing continuity of care with outcomes comparable to other countries and high levels of maternal satisfaction with the service (Ministry of Health, 2015). Although evidence is mounting about benefits of continuity of midwifery care (Sandall et al 2013) some NZ researchers reported factors that led to burnout and work life balance concerns for a sample of caseloading midwives (Donald

et al., 2014; Young et al., 2015). Yet there was limited research on what actually sustained LMC midwives in practice providing continuity of carer (Engle, 2000, Wakelin & Skinner, 2007, Leap, et al., 2011). Therefore research was undertaken to investigate what sustained midwives who had been practicing as LMC caseloading midwives for more than 8 years.

A qualitative descriptive approach informed the study and thematic and content analysis was used to interpret and analyze data. A systematic analysis of the content was undertaken which facilitated data being grouped into themes. These themes were analyzed by the research team and then underwent peer review and comment. This method meant that data rich in detail was collected which facilitated a description of the experience, an identification of the themes and emergence of patterns across the midwives' practice which revealed what sustained the midwives in LMC practice (McAra-Couper et al 2014; Gilkison, McAra-Couper, Gunn et al 2015).

The findings of the research showed 12 themes that reveal how LMC case-load midwifery practice is sustained: joy of midwifery practice; working in partnership; supportive family relationships; supportive midwifery relationships; generosity of spirit; like-minded midwifery partners, practice arrangements; managing the unpredictability of being on-call; realising one is not indispensable; learning to say "no"; negotiating and keeping boundaries; and passing on the passion for midwifery (McAra-Couper et al, 2014). In common with other studies of innovative but sustainable models of care (Sandall et al 2013; Leap et al 2011), the NZ study found that that the emotional and practical demands of providing continuity of care were balanced by relationships between midwife and women, midwives and like-minded colleagues, and their friends and families. In addition, the overarching theme of the 'joy of midwifery practice' and the sense that it is 'more than just a job' were clearly identified in the data (McAra Couper et al 2014 p.31).

The NZ study brought to light an irony, or paradox, that is integral to the sustainability of caseloading midwifery. There was acknowledgement that working in a close relationship with the woman and her family sustains midwives in practice, yet each individual midwife, is not indispensable to that woman or to her family. In other words, there will be times when she may not be available, and her midwifery partner will take over care. The NZ study clearly identified that the building of relationships with women supports a caseloading midwife to

have time off call in a sustainable manner without impacting on the women's satisfaction with her care.

### Comparing findings

This discussion paper is not about a detailed analysis of the two individual studies themselves but a comparative analysis of similarities and differences that highlight the principle elements of sustainable and resilient midwifery practice across two very different models of care. It needs to be stressed that the contexts in which these two studies were conducted differ considerably. The NZ study focused on the experiences of caseloading self-employed midwives providing continuity of care. LMCs work across primary and secondary services in partnership with their clients and other members of the maternity care team and are paid directly through a government contract for service. NZ women receive LMC care free at point of delivery if they are NZ residents or citizens. Approximately 40% of the NZ midwifery workforce work as LMCs, other midwives work as employed hospital (or core) midwives. In the UK study participants were not asked their place of work yet all were NHS employed midwives working a managed rostered system in either community or/and hospital. In the NZ study LMCs were purposively selected as being able to choose their working practice set up.

Sustainability and resilience are highlighted in both studies in different ways. Table 1 presents a summary of how the notions of sustainability and resilience were revealed in the NZ and the U.K studies. How these different notions came to be adopted in the respective regions is discussed later in the paper. Table 2 presents the comparative findings across the two studies following a collaborative review of the themes and sub-themes of the two studies. The resultant four cross-cutting themes in table 2 were identified through an iterative process of group discussions, writing and re-writing until agreement was established between the two research teams.

From table 2 it appears that despite the significant differences in models of care in the UK and NZ, the findings of both studies have much in common. Four comparative themes emerged from our analysis of the findings of both studies: Love, passion and /joy/passion for midwifery, self-care, self-determination and relationships. These themes are now discussed separately for the sake of clarity yet are not mutually inclusive or exclusive. These

interpretations are constituted of the shared insights, ongoing research interests and discussions of the authors of this paper.

### **Love, passion and joy for midwifery.**

Making a difference to the lives of women, their families and the wider community and society is what sustains midwives in their practice. The passion for midwifery, joy of childbirth and the ability to make a difference to the lives of women and families has been described as what sustains midwives in many studies internationally (Collins et al., 2010; Drury et al., 2014; Edmondson and Walker, 2014; Engel, 2000; Mollart et al., 2009; Rouleau et al., 2012; Sandall, 1997; Sullivan et al., 2011). Midwives in many settings describe a real pride in the midwifery profession and derive great job satisfaction from their practice. In order to sustain the passion for practice, other conditions need to be in place, and these have been revealed in our studies.

In both the NZ and UK studies the joy of midwifery manifested in the way that midwives described their pride and passion in upholding professional practice quality. Participants in both studies spoke about how they felt their work contributed to society and how they personally identified with the profession of midwifery. It was evident that making a difference to individuals and society was core to the NZ and UK midwives.

### **Self-care**

Self-care seems crucial in sustaining the joy and passion for practice and contributes to healthy resilience when midwives are working in difficult situations. For midwives in both settings a level of resilience is needed to cope with particular workplace challenges, or to deal with critical incidents in practice. Midwives in these studies described their need for self-care, and have a range of ways of caring for themselves. Midwives in NZ who work in a continuity of care model described practical things such as scheduling regular time off, and being supported by colleagues during critical incidents. In the UK, where continuity of care is not the predominant model, midwives spoke of self-care strategies such as avoiding stressful situations or by gaining a realistic perspective on their practice.

In the NZ situation midwives expressed the need to implement self-care measures often after dealing with a critical practice incident. As a result of critical incidents, some midwives felt like giving up practice and lost their passion for midwifery. They spoke of the need to



bounce back which was assisted by supportive colleagues, who would often accompany them to births for a period of time, or take over their caseload to give them a break. An element of resilience is evident therefore in midwives' experience of coping with critical incidents. Studies reveal that if midwives do not have the support of colleagues, or implement self-care strategies then they may not recover the joy of practice, which potentially leads to burn out (Young et al., 2015).

As noted above, resilience implies the existence of adversity, of 'difficult conditions', that one is able to 'withstand' or 'recover quickly from' (Oxford Dictionary of English 2nd edition 2003). What remains unanswered in these studies is whether there are healthy and unhealthy resilient behaviours and how much continual adverse situations can be tolerated and sustained over time.

Both studies focussed on individual resilience and sustainability. Although the current studies do not explicitly examine how some midwives can be scarred and damaged by their experience it is inferred within this theme of self-care. Young (2015) for example clearly highlights the devastating effects of burnout when self-care in itself became compromised. The ability to self-care would seem crucial in any professional group. What remains unclear is whether the infrastructures and models of care in which midwives work are actually sustainable and support healthy resilient pro-active responses over time. The theme of self-care links to the following theme of self-determination.

### **Self determination**

There were differences between the two studies regarding the potential for midwives to be self-determining. These were largely the result of the differing models of care in which midwives worked.

In the UK, midwives are mainly state employees in long-established working environments, frequently characterised as having adverse conditions with on-going staff-shortages and funding cuts. As employees midwives have comparatively little control over the conditions within which they are employed to work. However, that is not to say that UK midwives have no control at all over working conditions, indeed the UK study identified how midwives helped to build resilience in other midwives, thereby impacting positively upon the working environment, that is, the midwifery team. Some midwives also described changing jobs or

finding a professional 'niche' role to exert some control over their working lives. Focusing the research questions upon "resilience" in such a context was an appropriate and logical approach, as it developed understanding about how midwives might withstand, absorb and recover from working in difficult conditions.

In contrast, feeling in control of working life was significant in the NZ study as it helped midwives to deal with the unpredictability of being on call. In the NZ study having self-determination over work was important for the sustainability of caseloading practice. The unpredictability of being on call is one of the things which some NZ midwives said was unsustainable, yet paradoxically the ability to provide continuity of care through a case loading model and working in partnership alongside women and their families leads to the joy of practice and sustainable caseloading practice.

By virtue of being self-employed, LMCs in NZ have the capacity *within that* context to organise, structure and control their immediate working environment. As a result of this, NZ midwives spoke at length about the different ways in which they organise their practice arrangements (their on-calls, their team work, the size of their case load, the way they pay each other, the way they work with women, whether they run clinics or visit women in their homes for example) in order to best support themselves to continue functioning effectively as LMC midwives. Rather than the primary focus being upon how they cope and survive in given working conditions, the NZ midwives were also in a position, due to their context, to talk at length about how they adapt their immediate working conditions to support themselves and their colleagues. In this sense the relationship between midwife and immediate working environment was identified subtly as reciprocal; both feeding into and affecting the other. The key differences between UK and NZ models of practice needs further exploration; work and control over working arrangements are key differences.

### **Relationships sustain**

Relationships are a key theme across both studies. Relationships with women, families and colleagues contribute to both midwifery resilience and sustainability. In the NZ study the reciprocity of the relationships that midwives described also involved a negotiation and respect for boundaries. In the NZ context some participants' spoke of their partnership with women as necessarily involving a mutual understanding of the midwife's working arrangements, which inadvertently, developed the midwife-mother relationship during

pregnancy. The NZ study showed how LMC midwives treasure the relationships they have with women and their families and that their greatest satisfaction is from providing continuity of carer for women. The NZ midwives often worked with and cared for the same woman throughout a number of pregnancies, had gotten to know the woman's family members in that context, and/or had been the midwife to other family members. The midwifery care provided in such circumstances may become part of the fabric of a given family or community, and midwives spoke of gaining much satisfaction and fulfilment from being invited into a family and being part of a community in this way.

In the UK forming meaningful relationships with women can be compromised because of the dominant fragmented models of care. Midwives can feel over worked, dispensable and undervalued leading to unhappiness and possible burnout. Evidence indicates that relationships with colleagues are of prime importance to UK hospital midwives and critical to their sense of doing a good job, whereas community-based midwives place greater significance on their relationships with women (Hunter 2004). Yet the potential for developing reciprocal relationships is limited, especially in hospital environments (Hunter, 2006).

Sound collegial relationships are essential for the provision of safe midwifery care especially when dealing with consultation, handover of care and critical incidents. Importantly trust and getting to know one another is central to being resilient, because when there is a call for extra support there is a need that this will not be faced alone. Yet systems of care can erode relationships with colleagues. For example, in the UK institutional shift patterns have changed, inhibiting collegial social connections. Contemporary 12 hour shifts can deny the traditional handover times where overlapping of shifts acted as a kind of social glue within practice environments. The NZ study clearly shows that regular connections with colleagues are essential for sustainable practice. It also revealed how important it is to work with other midwives who shared a similar philosophy of birth and shared commitment to similar practice and with financial arrangements that are mutually respected by colleagues.

Sharing what is current in each other's lives forms lasting trusting collegial relationships and social capital (Walsh, 2006). Working excessively long hours, working alone, fearing censure, large caseloads, high acuity and shortage of staff impacts on relationships and is not

sustainable. Money and time saving organisation of practice is detrimental if relationships are not honoured. Both studies were explicit about how relationships with colleagues are crucial.

This raises questions about how maternity services are arranged. These studies have shown that maternity services need to be arranged so that midwives can form effective relationships with women and colleagues and at the same time work in a sustainable way. The centrality of relationships in midwifery is not new. Pat Brodie's (1996) work showed how midwives, with continuity of care, moved to a more client focus rather than institution focus. Keeping humanity within maternity systems is about engendering relationships; people are important – both health care providers, in this case midwives, and the women and families they care for. It would seem that, except for some continuity of carer schemes, UK midwives who try to provide relational care do so in a system that generally denies the significance and benefit of relationships. Acknowledging that relationships in midwifery practice are important is vital (Hunter et al., 2008). It could be construed that models of care influence relationships, and vice versa yet this needs further examination to see if this infers greater resilience and sustainability of practice.

## Discussion

Comparison of the findings of the two studies suggests a possible explanation as to why the concept of resilience emerged as an appropriate one through which to explore the experiences of UK midwives, and the slightly different concept of sustainability was adopted in the NZ research context (refer to Table 1). Whereas the concept of resilience relates to the ability of an individual or entity to “withstand” or “recover” in the context of “difficult conditions”, the concept of sustainability relates more broadly to practices that enable environments and people to remain vibrant and healthy as they interact with one another. In this sense, sustainability can be read as relating to a way of understanding the (natural or social) world that does not separate or differentiate that world entirely from the effects of human beings functioning in relation to and as part of that world. Put simply there is reciprocity apparent in the literature on sustainability: the environment will look after us, if we also look after the environment. The two can hardly be separate. In this context, there is an inadvertent material logic to “sustainability” having been the conceptual choice and

preference for the NZ researchers as they embarked upon their study of durable LMC midwifery practice, and for resilience to have been the concept of choice in the UK context.

This paper is not an argument for self-employment within midwifery (and such debates about the most appropriate ways for midwives to be paid are beyond the scope of this article). What this paper points towards, however, is the extent to which control by midwives over their immediate working environment (whatever the employment relations that enable that to happen) is significant in relation to the array of strategies that midwives are able to use to support themselves in making their practice durable over a number of years if not decades. Resolving current professional, economic and infrastructural issues in midwifery is crucial in all settings. The notions of sustainability and resilience may potentially provide an opportunity to examine ways of achieving systems and processes that would benefit both the maternity organisations and individual midwives. However it is important that these notions are understood properly by midwifery leaders and maternity policy makers to avoid exploitation.

To learn resilient behaviours does not necessarily mean that a midwife's strategies (or that of the organisation in which she practises) are beneficial and sustainable over time. Individual resilient responses may be covering up organisational and practice communities' unhealthy ways of working and models of care. Although resilience is an aspect of sustainability, being resilient does not infer sustainability. It is important to remember that one midwife's resilience is another's vulnerability and potential for burnout. Strategies for individual sustainable practice contribute to the resilience that is manifest in times of adversity. For example, there are occasional adverse situations in maternity that are unavoidable. Being resilient in the face of these situations requires healthy sustainable practice that includes acknowledging the significance of: relationships (collegial and with mothers/families) as a key element in the underpinning philosophy of midwifery, and non-discriminatory structural/organisational practice and funding arrangements.

When difficulties and hardships are encountered, as aptly revealed in the Christchurch earthquakes, the call for resilience alone appears to lack appreciation of other qualities (Hayward 2013). Although earthquakes are not childbirth and midwifery, they highlight how a community has needed to manifest resilience. Hayward argues that it is compassion and

an acknowledgment of shared vulnerability that overcome adversity. Hayward (2013) concludes “it appears that if we wish to achieve a more significant political transformation in our future, we will need rather less resilience and more vision for compassion and social justice, achieved through collective political action”( p. 36). Midwifery is a living system requiring a whole systems approach. A focus on the wholeness or ecology of maternity services and how midwifery is politically organised affects the experience of the midwifery workforce.

### **Further research and recommendations**

In our discussion we have identified many areas needing further research. These relate to micro, meso and macro considerations. There is urgent need to utilise our existing knowledge about what sustains midwives e.g. context/model of care and relationships with women and colleagues and explore how this knowledge can be implemented in policy and practice. Further research is required to explore the influence of contextual factors such as work environment and career stage on experiences of resilience and resilient strategies. For example it is possible to hypothesize those community-based midwives who provide continuity of care will face different types of adversity and develop different resilient strategies to midwives who work rotational shifts in an obstetric-led unit. What also remains unknown is how ‘resilient midwives’ are viewed by their colleagues. It could be argued that individual resilient strategies such as self-care and actively managing or avoiding stressful triggers could negatively impact upon collegial relations, where behaviour may be experienced as unhelpful or selfish and therefore contributory to the adversity of others.

An evidence-based model of sustainable midwifery for use in education needs developing and evaluating. Role modelling self-care and the importance of collegial relationships would be vital elements of this. Life-long care programmes for midwives including organisational support strategies require further exploration and evaluation. Developing self-care and managing personal and professional life is important across models of care. Showing and supporting students by role modelling self-care and the importance of collegial relationships is vital.

Relationships have been shown repeatedly to be at the heart of midwifery, yet models of care supported by health policy continue to be at odds with the centrality of this element.

For example, continuity of carer models continue not to be put into practice in the UK despite robust evidence of their efficacy. Both studies in this paper examined individual midwives' ability to continue in practice not the sustainability of current models of care. Funding policies impact on midwifery and implementation of new models of care, an area that needs researching and challenging.

Research designs, such as action and translational research that enable and facilitate sustainable changes to current midwifery cultures and maternity systems are required.

### **Conclusion**

The concepts of resilience and sustainability in midwifery workforce have been explored using two studies. Four common themes have been identified that traverse the different models of care. The NZ study provides insight into how case load midwifery can be sustainable enabling long term sustainability. The UK study highlights healthy resilient practices that enable practice. What remains uncertain is how models of care enable or disable sustainable long term practice and nurture healthy resilient behaviours within the different models of care. Whatever system of care and political environment a midwife is working within it is vital that she/he is not made to feel exploited. The notion of resilience in midwifery as the panacea to resolve current concerns may need rethinking as the notion may be interpreted as expecting midwives 'to toughen up' in a working setting that is socially, economically and culturally challenging. What is apparent from the comparative emergent themes in this paper is that self-determination, ability to self-care, cultivation of relationships both professionally and with women/families, and a passion, joy and love for midwifery transcends models of care. This paper points to the need to foster practice and models of care that allow these qualities to flourish. The focus needs to turn from systems that may appear to cope with continual crisis demonstrating persistence despite personal costs, to one that brings into focus the importance of the themes highlighted in this paper. This is vital if midwives and the care they provide to families is to be sustainable long term.

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Table 1: Sustainability and resilience in the NZ and UK studies

<b>RESILIENCE (UK STUDY)</b>	<b>SUSTAINABILITY (NZ STUDY)</b>
Ability to withstand or recover quickly from difficult conditions	Ability to maintain a certain rate or level of resources
Element of difficulty that requires a response	Concerned with maintaining balance
Ability to hold steady or recover following difficult events	Avoidance of depletion and focus on conservation ensuring something can continue to exist
Belief that resilience can be developed and learnt	Sustainability can be identified, recognised and taught to others
Individual resilience can contribute to the formation of resilient organisations/communities that lead to habitual protective mechanisms and strategies to deal with adverse and difficult events	Ability to maintain integrity of mental, physical, emotional and environmental aspects of individual and organisation/institution
Resilient practices and strategies allow individuals and organisations/communities to continue despite circumstances	Ensuring that practices and strategies are able to be maintained over time without harm to persons and environment
Resilient individual responses may contribute to resilient organisations/communities	Individual sustainable strategies/practices are essential for sustainability of organisation/environment
Resilient working behaviors may or may not be nourishing and may or may not allow others to flourish over time	Working sustainably allows for practice to be nourishing and enables those involved to flourish and enjoy what they doing over time
Resilient responses can be consistently positive and effective in managing stress and	Sustainable practices/strategies lead to positive and effective long term ability to work

adversity that may or may not acknowledge others as part of that process	resiliently throughout times of adversity and acknowledges others as part of that process
Resilience is nurtured through individual and macro level sustainable practices	Sustainable practices/strategies at individual and macro levels enable development of resilience when times and situations are more challenging

Table 2: Comparative Findings of the NZ and UK studies

UK STUDY	NEW ZEALAND STUDY
<p><b>Love of midwifery</b></p> <ul style="list-style-type: none"> <li>• Integration of personal and professional identity</li> <li>• Strong sense of public service</li> <li>• Feel part of midwifery community</li> <li>• Making a difference to individuals and society</li> </ul>	<p><b>Passion for midwifery and the joy of practice</b></p> <ul style="list-style-type: none"> <li>• The joy of midwifery practice</li> <li>• Pride and passion in the midwifery profession</li> <li>• Contributing to society</li> <li>• Upholding professional practice standards</li> </ul>
<p><b>Self-care</b></p> <ul style="list-style-type: none"> <li>• Looking after own needs</li> <li>• Managing expectations – self and others</li> <li>• Learning from past experience</li> <li>• Identification of ‘critical moments’</li> <li>• Avoiding stressful situations</li> <li>• Gain a sense of perspective via i) use of mood changers ii) seeking support</li> </ul>	<p><b>Self-care</b></p> <ul style="list-style-type: none"> <li>• Regular time off from being on call</li> <li>• Support of family and friends</li> <li>• Clear boundaries</li> <li>• Managing the unpredictability of being on call</li> <li>• Sustainable practice arrangements</li> <li>• Having the ability to say “no”</li> <li>• Having support during critical practice events</li> </ul>
<p><b>Self-determination:</b></p> <p><b>Adverse experiences</b></p> <ul style="list-style-type: none"> <li>• Lack of control of work situation</li> <li>• Volume of work - Unable to give quality care</li> <li>• Lack of professional autonomy</li> <li>• Poor work/life balance</li> </ul> <p><b>Positive experiences</b></p> <ul style="list-style-type: none"> <li>• Professional autonomy facilitated</li> <li>• Controlling what is possible to control ( e.g. changing job)</li> </ul>	<p><b>Self-determination:</b></p> <ul style="list-style-type: none"> <li>• Ability to control ebb and flow of practice – being self-directed</li> <li>• Ability to work/decide between caseloading or hospital midwifery practice in response to personal life</li> <li>• Providing continuity of care</li> <li>• Being an autonomous practitioner</li> <li>• Managing caseload size</li> </ul>

<ul style="list-style-type: none"> <li>• Finding a niche</li> </ul>	
<p><b>Relationships sustain</b></p> <ul style="list-style-type: none"> <li>• Social support from colleagues, family and friends</li> <li>• Professional support requires trusting relationship</li> <li>• Facilitating the empowerment of others</li> <li>• Supporting vulnerable/inexperienced colleagues</li> </ul>	<p><b>Relationships sustain</b></p> <ul style="list-style-type: none"> <li>• Partnership relationships with women and whanau/families</li> <li>• Good relationships with colleagues</li> <li>• Supportive friends and families</li> <li>• Generosity of spirit between midwifery colleagues</li> <li>• Working well together as a practice with partners with similar philosophical beliefs</li> <li>• Supporting/ mentoring others (students and new graduates)</li> </ul>

## Highlights

What is already known about the topic?

- There are international midwifery workforce concerns. Some of the reasons for this have been articulated.
- What sustains midwifery practice and how resilience is a quality required in practice have begun being researched.
- Models of care that focus on relationships have been shown to be beneficial to mothers, families and midwives.



**What this paper adds?**

- This paper explores and critiques the notions of sustainability and resilience as applied to midwifery
- This paper begins to examine the notions of resilience and sustainability across very different models of midwifery care
- This paper provides examples from two studies of sustainable practice and Resilience in midwifery across models of care
- Four main qualities/themes that traverse two models of midwifery care are identified and discussed: Love, passion and joy of midwifery, self-care, self-determination and relationships sustain

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