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Unsettling moods in rural midwifery practice

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ABSTRACT

Background: Rural midwifery and maternity care is vulnerable due to geographical isolation, staffing recruitment and retention. Highlighting the concerns within rural midwifery is important for safe sustainable service delivery.
Method: Hermeneutic phenomenological study undertaken in New Zealand (NZ). 13 participants were recruited in rural regions through snowball technique and interviewed. Transcribed interview data was interpretively analysed. Findings are discussed through the use of philosophical notions and related published literature.
Findings: Unsettling mood of anxiety was revealed in two themes (a) '*Moments of rural practice*' as panicky moments; an emergency moment; the unexpected moment and (b) '*Feelings of being judged*' as fearing criticism; fear of the unexpected happening to 'me' fear of losing my reputation; fear of feeling blamed; fear of being identified.
Conclusions: Although the reality of rural maternity can be more challenging due to geographic location than urban areas this need not be a reason to further isolate these communities through negative judgement and decontextualized policy. Fear of what was happening now and something possibly happening in the future were part of the midwives' reality. The joy and delight of working rurally can become overshadowed by a tide of unsettling and disempowering fears.
Implications: Positive images of rural midwifery need dissemination. It is essential that rural midwives and their communities are heard at all levels if their vulnerability is to be lessened and sustainable safe rural communities strengthened.

Introduction

To be a midwife within a rural setting is, by its very nature, to be a long way from tertiary services. Families make the choice to birth within the rural area perhaps not quite appreciating how much responsibility this places on the shoulders of the midwife who takes on their care. It is she who must watch for hints of problems, she who must ensure the family knows what to do if 'something' happens, she who must get to the labour in a timely manner (from wherever she may be) and she who must be ready to deal with any emergency that may arise. All this unfolds, family by family, sleep-disturbed night-upon-night, along with unpredictably long journeys to accompany a woman to the urban tertiary hospital. The midwife who carries the load has chosen her [sic] lot. This is also her community, the place she feels 'at home'. Her skills enable her to provide a vital service within this community; she is needed and valued. Within all this, the lack of sleep, the always-being-on-call and the long hours spent driving, it is likely that, after the birth, she remembers afresh why she does this. The joy of the moment of birth gifts in an energy-sustaining way.[1] Yet is this enough? This paper is drawn from a phenomenological study that explored the experience of childbirth in New Zealand's rural regions.

The methodology guiding this study is interpretive hermeneutic phenomenology. Phenomenological data requires lived experience descriptions of the phenomenon of interest in the form of stories.[2,3] Therefore, this study gathered stories of those living in and through the phenomenon of New Zealand rural and remote rural maternity. The stories were interpreted using hermeneutic phenomenological analysis. Other findings from the study are reported elsewhere.[4,5] This paper focuses on the moods that emerged from rural midwives' stories of their experiences. It seemed their burden was heavy yet they relished the opportunity to be listened to and heard. They shared something of the personal cost of practising in relative isolation, a long way from anywhere,

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yet paradoxically in a community where everybody knew them as 'the midwife'.

This paper draws on Heidegger's philosophical notion of attunement or mood.[6,7] Mood, in Heidegger's interpretation, refers to 'being in a mood' and can be also called feelings and affects, yet the meaning goes beyond than these psychological categories.[8] Mood is also more than emotion. Emotions such as sadness are able to be described and even measured in psychometric scoring; mood on the other hand is complex and part of our implicit understanding of "how we find ourselves".[9] Heidegger suggests that we are beings who have moods; mood is what makes us human. In other words, we cannot be without mood; we are always attuned in one way or another to how we find ourselves feeling. Along with the mood of our times, a culture or regional mood, moods are shaped by, and in turn shape, each experience. A fierce winter storm shapes a mood of reluctance to drive an isolated county road; such a mood has one driving with great caution. It is our moods that bring understanding about the events we find ourselves already living through. As the midwife drives through the storm the mood of anxiety heightens her understanding of the predicament she might find herself in should the labouring woman at the end of the road need urgent transfer to a hospital. We can say that rural midwives are always amidst the circumstances of their lives and practice. Driving away from her young daughter's birthday party to attend a woman in labour is likely to invoke a mood of disappointment, yet the midwife knows she will have to disguise such a mood when she reaches the woman. Moods are thus inside and outside, everywhere and nowhere. Mood is not simply a colouring to what is happening or some internal state, it 'is' what is happening around and inside of us. Moods are our pre-cognitive way of sense-knowing the world we live in.[10] Our fundamental humanness is to feel and sense the world we inhabit. Moods therefore, more fully disclose to us 'how we find ourselves' than our cognitive abilities. Thus understanding is always 'moody' and "an existential fundamental connection between befindlichkeit [attunement] and understanding".[7] It is the midwife's attunement to how she finds herself driving through the storm that has her thinking ahead to the predicaments she might find herself facing if there are problems with this woman's labour.

1. The New Zealand context

The maternity system in New Zealand (NZ) is based on a relational model of care in which continuity of carer is central. Outcomes of this model of care, specifically high levels of maternal satisfaction are comparable to other countries.[11] Caseloading self-employed midwives, called Lead Maternity Carers or LMCs, provide continuity of care through the childbirth year and make up approximately 40% of the midwifery workforce; other midwives work as employed hospital staff, called core midwives. Midwives in New Zealand are able to choose how they work in most cases, either as Lead Maternity Carers (LMCs), the focus of this study, or as a hospital based core midwife. While some rural LMCs may also be employed to staff rural maternity units because of excessive travelling times, the majority of rural midwives have no option but to work as self-employed LMCs. They provide continuity of carer for women throughout antenatal, intrapartum and postpartum care. Most LMCs work in community based practices although, in some remote regions, LMCs have to practice alone because other LMCs are too far away geographically. LMCs are funded by the government on a contract for service basis to provide midwifery care throughout pregnancy, labour, birth and up to six weeks postpartum. LMCs can also be GPs and obstetricians but the majority are midwives. Currently there are no GP obstetricians and very few rural GPs acting as rural LMCs. Government funding provides all New Zealand resident women access to free maternity care from an LMC and any secondary services that may be required regardless of where they live and choose to birth (Ministry of Health, 2007). The midwifery LMC service is integrated working closely with other professionals in the maternity care team. This involves LMCs practising across primary and secondary services in partnership with women and their families. To do this they need to provide 24/7 on call arrangements from the time of booking until postnatal discharge and to find cover when away from their practice, which can be challenging for some of the more remote LMCs. There is now national funding for rural and remote midwives to get some paid locum support to help ease this organisational and financial burden.[5] However, remuneration continues to be a concern for many rural LMCs. They often carry smaller caseloads due to population density and less bookings equates to less pay. LMCs in rural regions can also miss intrapartum payments due to referrals (this is challenging because payment from the Government is modular with intrapartum payment continuing to be the largest component).

Rural and remote communities in New Zealand (NZ) are often in mountainous terrain, with roads that are challenging to drive. Climate conditions such as floods and snow are not unusual. While some services are likely to be within one to two hours reach, tertiary services are more likely to be four to five hours drive.[4,12–14] Neighbours are sparse. There are emergency helicopter services but funding constraints, other demands and weather conditions can limit availability.

The reasons for midwives living rurally are many. Some have been born in these regions and, as such, it's a community where they feel most at-home. New comers to a remote or rural region may feel isolated by the unfamiliar situation of living far from city-based infrastructures. For Susan, the principal author, living and practising remotely in NZ was initially challenging due to the social and professional isolation. Yet over time it was local communities and colleagues that enabled her to 'feel' at home with further support from a trusted practice partner. Remoteness can thus be experienced as mood in a positive way. Bollnow writes: "Strangeness stands in contrast with what is his own. Strangeness is the area where man no longer knows his way around and where he therefore feels helpless".[15] Thus rural midwives who know their way around the community are likely to feel comfortable amidst familiar places, people and services. For them, it may be the tertiary hospital that brings a mood of unease.

Evidence is mounting about benefits of continuity of midwifery care.[16] Yet, despite success in sustaining the LMC model, there have been concerns about burnout, maintaining a work-life balance and adequate financial remuneration.[5,17–21] The extent and causation of these concerns in rural and remote regions remains uncertain. Despite an array of recent initiatives, the New Zealand Ministry of Health and the New Zealand College of Midwives are worried about the lack of adequate LMC provision in some rural and remote regions.[19] Although there is emergent research exploring the sustainability of New Zealand midwifery practice,[22,23] how the current model of New Zealand maternity care is experienced in rural communities requires investigation. This is particularly pertinent in regards to the retention and recruitment of health care providers in rural regions which is well-documented and a phenomenon that is shared globally.[13,24–32]

It is perhaps obvious that the experiences of providing and receiving maternity care in rural regions is unlike those in urban areas. For example, an urban midwife is one amidst many. Within an urban setting, the employed hospital midwife will have regular time off and the LMC will be more likely to get cover for post-birth sleep deprivation. Susan found that rural LMC colleagues who accompany a woman into the tertiary hospital can feel invisible in the busyness of place; and just be another LMC with just another

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