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The experience of rural midwives in dual roles as nurse and midwife: "I'd prefer midwifery but I chose to live here"

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ABSTRACT

Objective: To explore and describe the experiences of working in the dual role as nurse and midwife in rural areas of far north Queensland, Australia.
Method: The methodology was informed by Heidegger's interpretive phenomenological philosophy and data analysis was guided by van Manen's analytical approach. Data was generated by conversational interviews. Eight midwives working in a dual role as midwife and nurse were interviewed individually.
Findings: Three themes were identified: Making choices between professional role and lifestyle: "Because I choose to live here"; Integration of maternity and general nursing: "All in together this fine weather" and: "That's part of working in a small place".
Conclusion: Participants recognized that in rural areas it is important to be a multi-skilled generalist; however they were concerned that midwifery skills could be eroded or even lost with the diminishing amounts of midwifery work available. Appropriate re-structuring of maternity services could provide better use of the midwifery workforce in rural centres, and reduce the current problems associated with transferring birthing mothers to larger facilities. Further research is needed to examine the extent to which the requirement to work in a dual, or multifaceted role is an impediment to the recruitment and retention of midwives to rural areas.

Introduction

Midwives are essential to good outcomes for mothers and babies.[1] In many rural and remote locations in Australia, midwives are often required to work in dual roles. They may work as nurse and midwife, at different times during a shift or on different days of the week. This geographic context presents midwives with many challenges including difficulty in maintaining competence in both midwifery and nursing; working in nursing roles and clinical areas for which they may have little interest; and a fear of working beyond their scope of practice. Unfortunately, the end result of these challenges is often dissatisfaction with the work environment, a known factor in staff attrition.[2]

There is increasing difficulty within rural and remote areas of Australia to maintain a skilled and competent workforce in the face of workforce shortages. There is also a need for rural and remote practitioners to be multi-skilled.[3,4] This issue is compounded for rural midwives, most of whom historically obtained nursing qualifications prior to midwifery qualifications, unlike the graduates who may now come from direct entry programs recently introduced in Australia. These practitioners often spend only a small percentage of their working day using midwifery skills, yet remain aware of the need to maintain those skills in the event a pregnant or birthing woman presents to the service.[5] Declining birth rates in rural areas, resulting from the policy which mandates that women must relocate for birth to larger regional or tertiary services, has been identified as a potential cause of the de-skilling of midwives in rural areas.[6,7]

Reiger[8] has commented on the preference, particularly in rural areas, for the employment of midwives with a nursing background as a way to address staffing shortages. As the vast majority of midwives currently working in Australia have been educated as nurses prior to becoming midwives, they have tended to acquire a dual professional identity; one of both nurse and midwife. The role of the midwife in Australia, as in most countries around the world, is situated in the 'wellness' model of care, where pregnancy, birth and the postpartum period are viewed as normal life events. This is in direct contrast to the common nursing model of care,

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particularly the case in acute care facilities, which is situated more within the biomedical or 'illness' model.[9] In the case of the midwifery role, the historical development of midwifery in Australia has resulted in confusion of the midwifery role in relation to that of the nurse. For example, in some past Nursing Acts, midwifery was defined as a 'restricted practice area of nursing'.[10]

Midwives in rural areas, like their nursing colleagues, have been highlighted as being multi-skilled generalists who work across many areas of clinical practice. Indeed, the opportunity to work across dual roles may be what attracts some midwives to work in rural areas, however, midwives may experience role stress or role conflict because of the expectation that they work both as a nurse and a midwife. Role conflict can be defined as "when an individual has two or more role requirements that work against each other".[11] To date, there is a paucity of literature that explores the experience of midwives required to work in this dual role in rural areas and it was this lack of evidence that provided the impetus for the current study. Therefore, the aim of this study was to explore the experience of midwives who work in rural hospitals in a dual role as both nurse and midwife.

Methods

The methodology underpinning this study was Heideggerian phenomenology. Phenomenology is particularly useful when a phenomenon is poorly defined or conceptualized,[12] as it helps to unravel meanings as we experience them in our everyday life (van Manen, 1990), and accepts that telling stories is both a way of communicating and making sense of our world.[13] Researchers using phenomenology must maintain a strong orientation to the phenomenon, reflect on their understandings, and hold their pre-understandings at bay (van Manen, 1990).

Setting and participants

The study was conducted in a rural area of Queensland. The four hospitals at which the participants worked ranged from 65 to 142 km from the nearest tertiary center. Births at each facility per year ranged from no planned birthing at one, to between 15 and 250 at the others with varying degrees of procedural medical support. Purposive sampling was used to select participants best able to share their experiences about the phenomenon of interest.[14] A total of eight participants, who identified as working in a dual role, were recruited using newsletter advertisements and word of mouth. After interviewing eight midwives, no new information was being disclosed and interviews were ceased. The criteria for inclusion were that all were working in a dual role as nurse and midwife in the study area and were willing to participate. All participants were assigned a pseudonym to maintain anonymity and to help preserve confidentiality. The demographics of the participants are described in Table 1.

Table 1
Participant demographics.

Participant	Age	Years qualified as midwife	Time worked in dual role
1	61	16	16 years
2	54	26	6 months
3	45	12	12 years
4	60	26	26 years
5	59	15	5 years
6	54	30	11 years
7	52	23	18 years
8	44	2	2 years

Ethical issues

Approval to conduct the study was gained from the Human Research Ethics Committees of the university and health district. All participation in the study was voluntary and after reading an information sheet, participants were reminded of their right to withdraw at any time and asked to sign a consent form. As some of the participants were known to the researcher, and because of the small number of midwives working in the communities, careful attention was paid to ensure individuals could not be identified in publications.

Data collection and analysis

Data was generated by conversational interviews conducted in a place chosen by the participant. Open-ended questions were used to encourage the participants to describe their lived experiences; a useful approach when significant depth is required about a subject.[15] Participants were asked to describe what it was like to work in the dual role, to describe a situation where they felt working in this way had enhanced their practice and where they felt it had challenged their practice. The length of time of interviews varied between 50 min and 2 h.

Interviews were tape-recorded with the permission of the participants and transcribed verbatim. A reflective diary was kept by the researcher to assist with the methodological process of the study;[16] particularly the identification of pre-understandings. The transcripts were read as a whole and in combination with the reflective journal to assist in identification of themes. Van Manen[17] suggests this reading and re-reading and identification of themes provides a method of giving meaning to the experience. Reflection on these themes helped to distinguish the phenomenon of interest,[18] uncover meaning, and promote understanding of the lived experience.[19] Rigour of the findings was enhanced by checking of data analysis by the co-authors.

Findings

The process of data analysis identified three core themes, each with a number of sub-themes that are summarized in Table 2. The

Table 2
Themes and sub-themes.

Theme	Sub-themes
'Because I choose to live here': making choices between professional role and lifestyle	• 'Nothing you can do about it' – lack of choice • Choosing to live rural – making a choice • 'You're a nurse first' – expectations to use nursing qualification
'All in together this fine weather': integration of maternity and general nursing	• Stress due to working across roles • Conflict with integration • Enjoying the variety
'That's part of working in a small place': shaped by location	• Sense of belonging to a community • 'you deal with what comes through the door' – being multi-skilled • Limitations of working in a rural hospital