What attributes do Australian midwifery leaders identify as being essential to effectively manage a midwifery group practice (MGP)?

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Glossary of Terms

**ACM** – Australian College of Midwives. The peak professional body for midwives in Australia.

**Caesarean section** – A surgical procedure to deliver a baby, through an incision in the mother’s abdomen.

**Caseload midwife** – A midwife who works providing continuity of midwifery care to a caseload of women and is their primary carer.

**Continuity of midwifery care** – Where care continues throughout pregnancy, labour and birth, and postnatally. This may be care by one primary carer and support by a group of midwives who may care for the woman when the midwife is unavailable.

**Epidural** – An anaesthetic placed outside the dura mater of the spinal cord used especially during childbirth to produce loss of sensation from the waist down.

**Episiotomy** – Where a surgical incision is made to a woman’s perineum during birth to expand the vaginal opening.

**ICM** – International Confederation of midwives. They represent, strengthen and support professional associations of midwives around the world.

**Instrumental birth** – Where forceps or vacuum are used to extract the baby’s head.

**Maternity Continuum** – the period throughout a woman’s pregnancy, labour and birth, and early postnatal period.

**Midwife** – A qualified professional who is educated and committed to providing care and support for women and babies during pregnancy labour, birth and the early postnatal period.

**MGP** – Midwifery group practice. Where a group of midwives work in a group to support each other to each have a caseload of women. Each midwife in the group provides continuity of midwifery care as primary midwives to a caseload of women, throughout pregnancy, birth and the postnatal period.

**MUM** – Midwifery unit manager. A certified midwife in charge of a ward, unit, service or team.
NaMO – Nurses and Midwives office within the Ministry of Health. NICU- Neonatal intensive care unit. A specialist unit within a hospital that caters for newborn infants requiring intensive care.

NUM – Nursing unit manager. A registered nurse in charge of a ward, unit, service or team.

Privately practicing midwives – Midwives who work privately to provide care to childbearing women. They may assist women to birth at home, and they may have access agreements to be able to care for women in hospitals. They generally have access to medicare rebates, have professional indemnity and work collaboratively with other health professionals. They may also be able to order drugs and tests.

SCN- Special care nursery. A unit within a hospital that cares for newborn infants that are unwell but not requiring intensive care.
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Statement of Authentication

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

..................................................
(Signature)
Paid editorial assistance

Ross Peake provided paid assistance to professionally edit this manuscript in line with the University’s expectation for editorial guidelines for higher degree students and in accordance with the 'Guidelines for editing research theses' developed by the Institute of Professional Editors (IPEd) and the Australian Council of Graduate Research Inc (ACGR).
Abstract

**Title:** Australian midwifery leaders’ views on the attributes required in managers to effectively manage a midwifery group practice.

**Background:** Midwifery Group Practice (MGP) is a service where women are cared for by one primary midwife, supported by another midwife or group of midwives, who work in partnership with them across all stages of the pregnancy, birth and postnatal period, within the public hospital system. MGP outcomes consistently show reduced medical interventions and high levels of satisfaction for women yet only 8% of women in Australia have access to this option of care. Midwives working in MGP are shown to display a higher job satisfaction and occupational autonomy compared to midwives providing standard hospital care. Management of services is closely aligned with staff retention and satisfaction and so is critical to MGP sustainability. Since little is known about the attributes of a manager for effective management of these services, this research is urgently needed to help ensure these models of care are sustainable.

**Aims:** The aim of this project was to discover the attributes required in a manager of a MGP in Australia in order to effectively manage the service.

**Methodology:** A qualitative approach using thematic analysis was used in this study. Eight midwifery leaders were purposively sampled and interviewed
face-to-face using semi-structured open-ended questions. The interviews were audio-taped and transcribed for analysis.

**Findings:** The overarching theme ‘Holding the ground for midwifery, for women’, described the role of the MGP manager as someone who stands up for midwives and women. Three themes demonstrate the complexity of the role of the manager and the intrinsic traits that make an effective leader, described as ‘having it’, the actual job of management captured under the theme ‘someone with their hand on the steering wheel’ and the job of ‘juggling forces’ that surround MGP. The theme ‘Helping managers to manage better’ describes the preparation for the role and the support required to help the manager in this demanding position.

**Conclusion:** The findings of this study will contribute to knowledge about what is required for effective MGP management to help enhance sustainability of these services and how best to prepare the managers for this role. Development of effective management and leadership styles could contribute to adopting a healthy, progressive culture within the hospital hierarchy. It is hoped this study will contribute to further research into midwifery management, MGP sustainability and barriers to MGP.
Chapter One – Introduction

This chapter will introduce the thesis, and offer some background to the topic. The concept and significance of Midwifery Group Practice (MGP) will be discussed along with the management of MGP.

Midwifery group practice

Midwifery Group Practice (MGP) began to emerge in Australia in the late 1990’s where midwives provide one-to-one midwifery-led care to a caseload of women throughout pregnancy, birth and the postnatal period (Hartz, Foureur, & Tracy, 2011). While there are group practices run by privately practising midwives in Australia, known as private midwifery care (Donnolley, Butler-Henderson, Chapman, & Sullivan, 2016), MGP is government-funded through the hospital system. Each woman has a named midwife who is on call for her apart from days off when other MGP midwives cover her care (Brown & Dietsch, 2013). Midwives work in partnership with the woman providing woman-centred care and collaborating with other health professionals as required (Monk, Tracy, Foureur, & Barclay, 2013).

Other names for this service are continuity of midwifery carer, caseload midwifery and midwifery-led continuity of care. There has been a lack of clarity surrounding the terminology used with models of maternity care in
make choices. Donnolley et al. (2016) have developed a classification system standardising the terminology to describe the different models. Using this classification system publicly funded continuity of midwifery care with back-up from other professionals as required is classified as ‘Midwifery Group Practice Caseload Care’ (Donnolley et al., 2016) for the purpose of this study. Midwifery Group Practice (MGP) will be used.

**Evidence to support midwifery group practice**

A recent Cochrane Systematic Review (CSR) comparing models of care reported MGP led to a reduction in preterm birth, foetal loss before and after 24 weeks and neonatal death (Sandall, Solanti, Gates, Shennan, & Devane, 2016). Intrapartum interventions were reduced including the use of regional analgesia, as well instrumental birth, amniotomy, episiotomy and the use of intrapartum analgesia (Sandall et al., 2016). Women were also more likely to experience a spontaneous vaginal birth. The CSR found no difference in the rate of caesarean section or intact perineum (Sandall et al., 2016).

Although the Cochrane review did not reveal a reduction in caesarean section rates, a Randomised Controlled Trial (RCT) from Victoria, Australia, did show a reduction of 5.5% in rates for women who were low risk (McLachlan et al., 2012). In this study of 2314 women, McLachlan et al. (2012) also found that women in the intervention group (MGP) were less likely to have epidural anaesthesia or episiotomy and more likely to have a spontaneous vaginal birth than women in the control group (standard care). Neonates were also less
likely to be admitted to Special Care Nursery (SCN) or Neonatal Intensive Care Unit (NICU) when they had care through a MGP (McLachlan et al., 2012).

Breastfeeding may be positively affected by MGP care, with higher rates of exclusive and long-term breastfeeding demonstrated in some studies (Lester, 2009). Homer, Leap, Edwards, and Sandall (2017) found a breastfeeding initiation rate of 91.5% among a socio-economically disadvantaged group of women cared for by the Albany Midwifery Practice in London, with 74.3% still breastfeeding at 28 days. Allen et al. (2015) conducted a study to examine whether MGP care makes a difference to the outcomes for young women. Although the authors found no difference in the initiation of breastfeeding rates for young women in MGP compared to standard care, it did demonstrate a reduction in the likelihood of NICU admissions (Allen et al., 2015). Reducing the separation of mother and baby is associated with improved breastfeeding initiation (Allen et al., 2015). Other studies have also found improved outcomes for women and babies who have MGP care when compared to other models (Beckman, Kildea, & Gibbons, 2011; Hartz et al., 2011; Hartz et al., 2012; S. Tracy et al., 2011).

Women’s satisfaction with midwifery group practice

The Cochrane Systematic Review by Sandall and colleagues that investigated women’s satisfaction with continuity of midwifery care reported women had higher rates of satisfaction with MGP care compared with other care models (Sandall et al., 2016). Another study conducted in a tertiary metropolitan hospital in Australia also showed women were highly satisfied with MGP care
A recent review of women's satisfaction of maternity services in NSW in 2015 revealed the two top performing services of 61 hospitals were Ryde and Wyong maternity services – both MGP free-standing birth centres (Bureau of Health information, 2017).

Midwives satisfaction with midwifery group practice

Midwives working in MGP models are on-call for the women in their caseload and as a result, many studies have been conducted to investigate the impact of this situation, especially in regard to burnout (Collins, Fereday, Pincombe, Oster, & Turnbull, 2010; Cox & Smythe, 2011; Newton, McLachlan, Willis, & Forster, 2014; Sandall, 1997). Sandall (1997) investigated midwives’ burnout and continuity of care, finding midwives could avoid burnout by having meaningful relationships with women, occupational autonomy and positive, supportive relationships at work and home. Newton et al. (2014) found midwives working in MGP models showed higher rates of professional satisfaction with less burnout than midwives working in standard care.

Newton, McLachlan, Forster, and Willis (2016) found in their study into the meaning of the work for caseload midwives, that they perceived their work as ‘real midwifery’ and the stress of being on call (after a period of adjustment) was generally offset by professional autonomy, flexibility of work time and meaningful relationships with women. However, the authors found some midwives were not able to become accustomed to being on call and they eventually left the MGP (Newton et al., 2014). The stress of being on call was perceived as more difficult by midwives in the study who were not on call
(providing standard hospital care) than by the MGP midwives, and was given as a reason, along with family commitments for not working in MGP (Newton et al., 2014). A study conducted in Australia by Collins et al. (2010) also found working in a MGP to be satisfying for midwives with occupational autonomy, social support and relationships with women cited as the reasons MGP midwives display high levels of satisfaction.

Cost of midwifery group practice

MGP is often seen as more expensive than standard care yet studies have shown the model to be cost effective (Toohill, Turkstra, Gamble, & Scuffham, 2012; S. Tracy et al., 2013). In a study investigating managers intentions to implement MGP in Australia, Dawson, McLachlan, Newton, and Forster (2016) found 22% of managers were concerned about the cost or funding of MGP. Dawson et al. (2016) suggested managers in this study did have legitimate concerns about the cost of implementation of MGP services, with most feeling compelled to employ a project person to implement the service. However, MGP has been shown to be cost effective once established (S. Tracy et al., 2013).

S. Tracy et al. (2013) conducted a study in two tertiary hospitals in Australia where women of all risk were randomised into MGP or standard care. They found the cost of care was reduced by AU $566.74 per woman in the MGP group (S. Tracy et al., 2013). The researchers attributed the reduction in cost to the higher rate of unassisted birth, higher proportions of spontaneous onset of labour, less pharmacological analgesia for labour, less postpartum haemorrhage and a shorter postnatal stay (S. Tracy et al., 2013).
Toohill et al. (2012) compared low risk-women in MGP to women of similar risk receiving standard care and found MGP cost less. This study found the assumption that salaried midwives providing MGP increase the cost of maternity care was unfounded, especially when assessed in the context of the overall package of care (Toohill et al., 2012). This study also supported up to six weeks postnatal care for women in MGP, since the overall cost of MGP was less (Toohill et al., 2012).

What this study can add

Managers can be defined as those who resolve conflict, control quality, set goals, oversee change and performance and control cost (Kurian, 2013). Managers are usually accountable to the owners or the shareholders (Kurian, 2013). Although managers might be seen as the brains of an organisation, leadership could be viewed as the heart (Stanley, 2011). Leadership is about communicating ideas and taking action in the context of relationships, and does not rely on hierarchy to reinforce the status quo (Stanley, 2011). Stanley (2011) describes leaders as being passionate, innovative, visionary and as non-conformist risk takers. The purpose of this study is to find the management and leadership attributes needed in a manager of an MGP.

MGP is a relationship-based model providing woman-centred care and has been adopted within the hospital framework, an industrialised, medicalised system designed to process many people in an efficient manner (Sandall, 2012). The manager of the MGP is part of the hospital hierarchy and management team. Hospital hierarchical management usually has an autocratic leadership style (Byrom & Kay, 2011; Ralston, 2005) and strives to standardise and control
midwifery practice (Kirkham, 2011). The midwifery unit managers are the buffer between upper management and midwives, and may feel torn between two different value systems.

Byrom and Kay (2011) suggest MGP midwives require management that is based on inclusion and connection, with most current literature recommending a relationship-based leadership style. Most midwifery unit managers do not have formal education in management and leadership (Clarke et al., 2012) even though leadership style has been linked to staff retention (Cummings et al., 2010). Retention of MGP midwives is critical to sustainability of the service (Deery, 2011). This study aims to explore the attributes MGP managers require for effective management and the optimal way of developing these attributes to promote service sustainability. With no previous studies on this topic, a qualitative, interpretive study using thematic analysis will be employed. Sampling will be purposive, seeking the involvement of significant midwifery leaders who have established, managed or worked in MGP models. This study is seeking to examine the experience and knowledge of well-known experts to provide a solid foundation to begin to understand this topic.

**My story**

My first child was born in Wellington, New Zealand (NZ), at home with an independent midwife. I was a practicing midwife at the time and after experiencing my first birth, I was enthusiastic at the prospect of providing other women with the same care. Setting up a group practice and providing continuity of care was easily achievable and very enjoyable in NZ. I worked as
an independent midwife throughout my childbearing years and returned to Australia after my third child was born.

Once I was ready to return to work, I discovered it would not be easy to work in Australia in the way I desired. Finding somewhere in the public system where I could provide continuity of midwifery care that valued the woman’s ability to give birth, was almost impossible. Eventually, I discovered that Ryde Maternity Unit was considering group practice and successfully applied for a job. I helped establish a MGP and free-standing birth centre, where I worked for 11 years.

Most women choosing Ryde MGP enjoyed one-to-one care, and appreciated being able to have their babies in an environment where the physiology of birth was respected, and where the midwives worked in partnership with them. I was proud of our outcomes and enjoyed having healthy relationships with women and the other midwives in a supportive environment. However, I was aware MGP was not available to all women and not all midwives had the option of providing such satisfying care. I also struggled with the hierarchical management style and the lack of inclusion for me as a midwife in a service where I had invested so much time and energy. I wanted to study the sustainability of MGP and decided to begin my research journey looking into the attributes required of the MGP manager.

**Research aim and objective**

The aim of the study is to explore the attributes required for effective management of a MGP by interviewing midwifery leaders experienced with
Management can be defined as Leadership can be defined Effective
t management should encourage midwifery staff retention and sustainability of
the MGP service. It is also essential to discover how best to prepare the MGP
manager for this challenging role as most do not have formal education in
management and leadership (Clarke et al., 2012). Appropriate preparation of
managers could lead to more effective management and leadership of the MGP
services, with increased retention of midwifery staff (Cummings et al., 2010;
Debono et al., 2016). Effective leadership might also lead to expansion of these
services, making them available to more women.

**Significance of study**

It is anticipated this study should inform further investigation into the management
and sustainability of MGP. Further investigation might expose areas that enable or
threaten viability. This research might lead to an increased awareness of the
importance of leadership in midwifery which may in turn lead to greater access to
midwifery models for women and midwives. Preparing midwifery managers might
encourage the support and education for all health care managers. This study and
others could contribute to a healthier management culture within hospitals.
Effective midwifery leaders are needed to increase the visibility of midwifery in
Australia, ensure midwives can work to their full scope of practice and improve the
maternity journey for Australian women.
Overview of the chapters of this thesis

This chapter introduces the thesis and discusses the background information on MGP and its management. Chapter two reviews the literature on management and leadership. What is known regarding the attributes required of the MGP manager is also examined, with areas requiring further research in relation to this topic identified.

Chapter three describes the qualitative methodology used in the study and why an interpretive description was used as a methodological approach.

Chapter four discusses the findings of the research, uncovering the themes discovered in the data and illustrating them with quotes from the participants.

Chapter five discusses the findings of the research related to the current literature. The limitations of the study are discussed along with recommendations for future research.
Chapter Two – Literature Review

Introduction

This chapter presents a review of the literature. In order to understand the management and leadership of MGP, midwives and the theory of management and leadership will be explored, comparing the different styles available to managers and the impact these styles may have on staff. While there is limited published research focusing on the management of midwives and even less focusing specifically on MGP managers, more is available from nursing which has some relevance to this topic. However, the majority of literature on management and leadership comes from other professions, especially business.

Methods

An integrative literature review was undertaken for peer-reviewed journal articles, textbooks, policies and reports regarding management attributes. The search was restricted to those written in English and to the previous 10 years (2006-2016) with some original seminal articles and books included. The search utilised Scopus, Cochrane Library, PubMed, Science Direct Elsevier, Emerald Insight, CINAHL and MEDLINE. The key terms searched were midwifery group practice, caseload midwifery management and leadership. The initial aim of the search was to uncover previous research on the
attributes required of MGP managers. The search was subsequently widened to leadership and management in midwifery, nursing and healthcare, emotional intelligence and midwife-nurse retention.

The key findings from the literature review are presented under the headings below. ‘Management and Leadership’ explores the history of leadership and management and what is known about leadership styles and management skills from a variety of professional standpoints. The heading ‘Attributes required of a Midwifery Group Practice Manager’ discusses the literature regarding management specific to midwifery and nursing, possible requirements of the manager and impacts of different styles of management in health care, and more particularly, in a MGP context.

**Management and leadership**

A vast amount of research has been undertaken on leadership theory and management in a variety of fields including health, education, business psychology and the military. Management can be defined as orderly planning, organising and controlling and is often found in hierarchically designed organisations (Bass & Bass, 2008). Byrom and Kay (2011) describe management and leadership as the boundary between order and chaos, with leadership leaning towards chaos and management leaning towards order. The authors also explain that management adds to but does not replace leadership (Byrom & Kay, 2011). Management has also been described as fulfilling the organisational plan by controlling and solving problems (Răducan
& Răducan, 2014). Stanley (2011) describes management as being about the business – establishing rules, systems and operating procedures – not about the people. The author also says people are often in the way of getting the job done (Stanley, 2011).

The relationship between management and leadership prompts debate, although most agree there is a need for both. Leadership can also be viewed as one of a manager's many functions, while others might view management as a role of leadership (Marquis & Huston, 2015). Not everyone agrees that both management and leadership should come together in the one individual. Stanley (2011) says the diverse driver motivators and objectives that both have make it difficult for one individual to be true to both and that attempting to do so can cause internal conflict. Leadership can be defined as a process in which an individual motivates a group of individuals to act and provides support to achieve mutually negotiated goals (Giltinane, 2013).

Historical leadership study

The 'Great Man' theory was born in 1840, mainly by Thomas Carlyle who suggested certain individuals (men) were a gift from God to uplift human existence (Spector, 2016). While Carlyle saw leaders as heroes from God, almost a century later Freud portrayed the single outstanding leader as primal and, from his theories on group psychology, argued the leader arose from a group's drive for dependence and love (Freud, 1922). Despite the lack of scientific rigour, The 'Great Man' theory drew attention to the qualities of
leaders and their differences from other non-leaders and focused on individual traits (Bass & Bass, 2008).

Historically, the ‘Great Man’ theory also gave rise to the assumption that leaders are born and not made (Bass, 1991) with Bennis (2007 p. 5) explaining this as ‘those of right breed should lead, others should be led’. Bass and Bass (2008) argue leaders are both born and made. Cummings et al. (2010) agree with this in their studies of leadership in nursing, saying effective leadership styles can be advanced through education.

‘Trait’ theory according to Colbert, Judge, Choi, and Wang (2012) suggests personality traits influence leader emergence and their effectiveness. However, this theory fell out of favour when results of studies were often inconsistent, with no qualities found to be universal to all leaders (Bass, 1991). Although through a recent consensus, the structure of personality using a five-factor model has emerged, enabling personality traits to be categorised more consistently (Colbert et al., 2012). While ‘Trait’ theory has fallen out of favour, Colbert et al. (2012) suggest revisiting this theory in light of a modest body of recently emerged evidence supporting it.

Leadership styles

Another way of looking at leadership is to examine leadership styles, often referred to as ‘style’ theory. Leadership styles can be categorised in a simplistic way as those focused on people and those focused on tasks. With non-relationally focused or task orientated leadership, the leaders take an autocratic stance, making decisions without consulting others (Byrom & Kay,
Examples of these non-relationally focused styles are laissez faire, transactional, autocratic or authoritarian leadership styles.

Laissez faire leadership is where the employee is left to their own devices to lead while the leader passively avoids issues, accountability and decision making (Jackson & Parry, 2011). Transactional leadership exchanges rewards for satisfactory performance (Vinkenburg, Van Engen, Eagly, & Johannesen-Schmidt, 2011). Transactional leadership relies on the assumption that people are motivated by reward and incentive – the leader focuses on the needs of the organisation, managing the mundane to keep things on track (Stanley, 2011). Autocratic or authoritarian leadership is where leadership is by control, bullying, discipline and is close-minded. However, Bass and Bass (2008) argue that if the negatives from this style are removed, it can be seen as taking full responsibility for employees’ actions. Unfortunately, this style of management has been traditionally used within health and midwifery, and has been associated with bullying and has contributed to the reason some midwives have left the profession (Byrom & Kay, 2011).

Examples of relationship-based leadership are democratic, authentic and transformational leadership. Democratic leadership is sympathetic, consultative and participative, where staff are treated like adults and tend to behave that way (Bass & Bass, 2008). Authentic leadership can be defined as showing transparent and moral conduct and encouraging the input of followers, with sharing of information required to make decisions (Avolio, Walumbwa, & Weber, 2009).
Transformational leadership is where leadership behaviour transforms and inspires followers to perform beyond expectations (Avolio et al., 2009). This style of leadership is said to project an idealised vision and subsequently communicate that vision as achievable (Cummings et al., 2010). Transformational leaders are expected to cope better with conflict (Jackson & Parry, 2011), use non-traditional thinking, encourage staff development while promoting trusting and cooperative work environments (Byrom & Downe, 2010). Although limited literature is available on midwifery leadership, most suggest transformational leadership as an effective form of leadership for midwives (Byrom, Byrom, & Downe, 2011; Byrom & Downe, 2010; Ralston, 2005).

Situational leadership does not subscribe to one style but changes according to the situation, with different situations requiring different approaches (Noel & Dotlich, 2008). This style has been put forward to address the failure of ‘style theory’ to explain how some styles of leadership are successful in certain situations and not in others (Stanley, 2011). However, Jackson and Parry (2011) say the situational leader might use one style over another depending on the maturity of the follower. A task-orientated approach might be used with staff who are developing skills; however, the leader might adopt a more relationship-based approach as staff become more competent and need less direction. Both Giltinane (2013) and Wong, Cummings, and Ducharme (2013) found situational leadership to be more suited to nursing.

Emotional intelligence
The concept of emotional intelligence was introduced by Salovey and Meyer in 1990 as the ability to monitor or control one’s own feelings and emotions (Bass & Bass, 2008). Emotional intelligence was popularised by Goleman (1998) as important for leadership, and brought emotion into the realm of leadership study. Goleman, Boyatzis, and McKee (2002) proposed that emotional intelligence was essential to effective leadership and every great leader has emotional intelligence. Emotional intelligence can be defined as a person’s ability to correctly recognise, assess and distinguish among emotions in their self and others. Emotionally intelligent people can appreciate, recognise and respect their own and others’ emotions to direct their thinking to cope with personal demands (Birks & Watt, 2007).

Not all scholars agree that emotional intelligence is necessary for successful leadership; Antonakis, Ashkanasy, and Dasborough (2009) argue it may not even exist. Conversely, Humphrey et al. (2003) say emotional intelligence has a legitimate place in leader selection, promotion and development. Byrom and Downe (2010) suggest emotional intelligence is necessary for effective midwifery leadership, education and practice.

Attributes required of a midwifery group practice manager

During the initial literature search, no published studies were found regarding the attributes required of MGP managers. The search was subsequently broadened to examine midwifery generally as well as nursing management and leadership.
Nursing and midwifery leadership history

Ralston (2005) appears to be one of the first authors to discuss transformational leadership in midwifery, and therefore was included in this review. Ralston (2005) discusses some of the history of the leadership found in midwifery today as originating from a military style of leadership. Nursing was established as an occupational group after the Crimean War, where Florence Nightingale was influenced by the military style of management, seeing it as an appropriate way to manage nurses (Fahy, 2007). When midwifery was brought under nursing control in the early twentieth century, midwives were managed using this style (Fahy, 2007).

This form of leadership was further established by Salmon in 1966 with the introduction of the nursing/midwifery hierarchy (Ralston, 2005). The style of leadership was mostly autocratic and authoritarian, with communication being top-down. The needs of staff are rarely recognised under this style of leadership and there is a culture of fear, although this is defended as ‘getting the job done’ (Ralston, 2005). Ralston (2005) suggests future midwifery leaders require vision and they need to be able to see the big picture and focus on people. The author says future leaders should motivate change towards a shared goal, and that a transformational leadership style is most appropriate for midwifery (Ralston, 2005).

Midwifery group practice and relationship

Leap, Dahlen, Brodie, Tracy, and Thorpe (2011) discuss how relationships in MGP are the glue that holds it all together. The authors discuss how managers
play an important role in overcoming hurdles in the development of MGP. Leap et al. (2011) suggest a different kind of leadership by the manager is needed where there is two-way trust and the manager can step back, letting the midwives develop their own strategies for dealing with challenges. The manager also needs to collaborate with other disciplines and incorporate a self-reflective and thoughtful leadership style (Leap et al., 2011). The model that can be employed to avoid ‘burn out’ is also discussed by the authors who draw on the three factors that need to be in place – discovered by Sandall (1997) and still relevant today – to guide the management of sustainable practice (Leap et al., 2011). The three factors are: the ability to develop meaningful relationships with women, through continuity of carer; having occupational autonomy and healthy relationships at work; and supportive relationships at home and work (Sandall, 1997).

The relationship between ‘good’ leadership and ‘good’ midwifery

One phenomenological study by Byrom and Downe (2010) was found and the authors investigated what made a ‘good’ midwife and a ‘good’ midwifery leader. This study identified that the same attributes were required by both midwives and midwifery leaders, and that along with emotional intelligence, a transformational leadership style was most beneficial for midwifery management, leadership, practice and education (Byrom & Downe, 2010). Byrom and Kay (2011) discussed midwifery leadership, expertise and collaboration, exploring the theory and practice of midwifery leadership. The authors also gave a review of the general history of leadership before studying leadership from a midwifery standpoint (Byrom & Kay, 2011). Byrom et al.
(2011) then explore the importance of leadership in midwifery, describing why transformational leadership is an appropriate style to use in the management of midwives.

Management and leadership education in nursing and midwifery

Clarke et al. (2012) conducted an interim study on the ‘Take The Lead’ (TTL) program using qualitative analysis on interview data. Phase One of the implementation of the project involved an assessment of nursing/midwifery unit managers (N/MUMs), revealing few were prepared beyond their basic nursing or midwifery training (Clarke et al., 2012). ‘Take The Lead’ was a multifaceted professional development program initiated in New South Wales to strengthen the capacity of N/MUMs. All N/MUMs in NSW were expected to participate from 2009 and in 2010, 1609 N/MUMs had completed one or more of the professional development modules (Clarke et al., 2012). The study revealed that managers' performance and confidence improved with preparation.

Further evaluation of the TTL program was conducted by Debono et al. (2016) using a mixed methods study. Although they concluded TTL did offer a vital contribution to strengthening the role of managers, they also found that networking which occurred as part of the program also had considerable impact on the managers, reducing feelings of isolation and increasing reassurance from shared experiences. However, it was impossible to determine outcomes for midwifery managers specifically.

Leadership styles found in nursing and midwifery today
Healthcare leadership is significantly associated with work satisfaction, performance and staff retention (Cummings et al., 2010). Azzare and Gross (2011) found in their qualitative study of nurse management styles in Ghana that leadership styles were mostly transactional where a reward was offered for good behaviour and managers were promoted due to seniority. They found the style of leadership was characterised by shouting, insults and intimidation from nurse managers which contributed to staff leaving (Azzare & Gross, 2011). Azzare and Gross (2011) also found management training was minimal with little emphasis on leadership styles.

Germain and Cummings (2010) explored the influence of nurse leadership on nurse performance in a systematic literature review. They found that leaders who include and engage their staff, and motivate staff to feel empowered to perform, report a more positive workplace culture and improved patient care. Cummings et al. (2010) suggested hiring leaders with relational skills or providing existing leaders with appropriate skills as a priority to improve health care, interdisciplinary collaboration, enhanced teamwork and work place culture.

Tyczkowski et al. (2015) encouraged healthcare employers to employ candidates for management who were screened for emotional intelligence and a transformational leadership style. However, they also discussed that emotional intelligence and leadership styles can be taught. In this study they assessed emotional intelligence and leadership styles and found most participants had high emotional intelligence while the most dominant leadership style was transformational (Tyczkowski et al., 2015). However, the
authors did acknowledge that 62% of respondents had undergone previous training in both emotional intelligence and leadership (Tyczkowski et al., 2015).

Two recent studies found having a healthy relationship with a supportive manager who encourages autonomy was important to retaining midwives in the workforce (Catling, Reid, & Hunter, 2016; Hildingsson et al., 2016). Hildingsson et al. (2016) surveyed midwives in Australia, New Zealand and Sweden about their sense of empowerment in relation to staying in the profession. The survey found Australian midwives had the lowest scores regarding professional empowerment; this was thought to be due to the struggle midwifery has in gaining professional identity distinct from nursing and achieving professional autonomy of practice relative to medicine in Australia. They found that health management styles might be the biggest barriers to empowerment and job satisfaction in midwifery.

Catling et al. (2016) studied midwives’ experience of workplace culture in Australia and found that improving satisfaction and ensuring wellbeing could improve retention of midwives. The authors suggested this could be achieved by ensuring midwives are able to provide woman-centred care and have good relationships with their peers and managers. The authors thought this could be achieved through manipulating work environments to enable woman-centred care and by strong, positive leadership exerting positive influence on workplace culture (Catling et al., 2016).
Discussion

Historically there has been a large volume of literature on management and leadership. However, little is known regarding the impact the manager has on the sustainability of MGP services. Since existing studies show the impact on retention of staff (Cummings et al., 2010), it would seem reasonable to assume a manager could have a considerable impact on the retention of MGP staff. There appears to be a strong positive relationship between transformational leadership styles and the intention of staff to stay in nursing and midwifery (Byrom et al., 2011; Cummings et al., 2010; Germain & Cummings, 2010; Ralston, 2005). However, most leadership styles within the hierarchical hospital management culture are autocratic and more likely to encourage staff to leave (Byrom & Kay, 2011). Since MGP is a relationship-based service, a relationship-based style of leadership used by the manager would appear to be best suited to this service. A leadership style that treats the staff as adults would also seem a logical choice for a group practice containing experienced, occupationally autonomous midwives.

Leadership, management and emotional intelligence can all be taught, although some individuals appear to have natural abilities (Bass & Bass, 2008). Management and leadership education are not requirements for midwifery and nursing management positions, leaving most without formal education in this area and many feeling ill-equipped for the job (Clarke et al., 2012; Debono et al., 2016). If new managers do not have education in management and
leadership, they must learn how to manage from their peers. If hospital managers are mostly autocratic, as indicated by Ralston (2005), the new MGP manager will most likely also adopt this style of leadership unless they have natural leadership abilities.

Recent studies show a strong correlation between workplace culture and staff intentions to stay (Catling et al., 2016). Managers are integral to the culture within the practice (Catling et al., 2016) and the success of the service (Cummings et al., 2010) which might be transferable to a MGP service, but this requires further investigation. The correlation in effective management and nurse performance (Germain & Cummings, 2010) might also suggest a correlation between the manager of a MGP and the performance of the midwives, suggesting an possible effect on outcomes for women.

Ralston (2005) said the hierarchical management systems within hospitals are mostly autocratic and Sandall (2012) suggests hospital hierarchies are industrial models focused on processing many people. Byrom and Downe (2010) discovered in the study on ‘good’ midwives and ‘good’ midwifery leaders that ‘good’ midwives are emotionally intelligent and use a transformational style of leadership themselves, and therefore the same would be expected of MGP midwives who provide holistic woman-centred care. This would indicate a large difference in value systems between MGP midwives and the hierarchical management, leaving the MGP manager feeling stuck between two value systems and adding further complexity to the role of the MGP manager. This is an area that requires urgent attention since little is known about the attributes required of the MGP manager, but obvious problems exist.
with service expansion and sustainability in Australia since few women have access to a MGP.

**Gaps in the literature**

The literature review revealed a significant dearth of research around the requirements of MGP managers, the impact the manager might have on sustainability of the service and best ways to support them in their role. Very little literature was available on midwifery management and leadership styles and how this impacted on midwifery services, the midwives and the women. The review also revealed a lack of literature around how best to prepare midwifery managers, what education and/or mentorship is needed and how this should be achieved. There is some literature around sustainability of MGP models internationally but little from an Australian context. While some studies examine the barriers to MGP, there is very little literature identifying possible solutions to the problem of funding for midwifery services in Australia.

**Conclusion**

As discussed in the introduction, only around 8% of women have access to a MGP service in Australia (McLachlan et al., 2012), yet women and babies have better clinical outcomes under this model of care (Sandall et al., 2016) and the cost is less than standard care (S. Tracy et al., 2013). Women who receive care through MGP feel more satisfied with their care (Sandall et al., 2016) and
midwives who work in these services display more satisfaction, less burnout and higher intention to stay in the profession (Newton et al., 2014).

Managers are integral to the culture within the MGP (Catling et al., 2016) and the success of the service (Cummings et al., 2010). There appears to be a strong positive relationship between transformational leadership styles and the intention to stay in nursing and midwifery (Byrom et al., 2011; Cummings et al., 2010; Germain & Cummings, 2010; Ralston, 2005). However, most leadership styles within the hierarchical hospital management culture are autocratic and therefore more likely to motivate staff to leave (Byrom & Kay, 2011). Leadership, management and emotional intelligence can all be taught (Bass & Bass, 2008); however, most midwifery managers do not have formal education in management and leadership (Clarke et al., 2012; Debono et al., 2016). Little is known about the attributes required of the MGP manager or the influence this has on expansion and sustainability of these models of care in Australia. With so few MGP services available to women, all factors that play a role in expansion and sustainability of these models require investigation.

The following chapter outlines the methodology and methods used in this study, and a discussion around how this study was conducted ethically and the strategies employed to ensure rigour.
Chapter Three – Methodology and Methods

Introduction

The key literature was reviewed in the previous chapter in relation to management and leadership and the attributes required of the midwifery group practice (MGP) manager. In this chapter the methods and methodology, used in this research will be described, covering areas such as qualitative research, interpretive description, participant recruitment, data collection and analysis. The strategies implemented to ensure ethical principles and rigour will be explored along with the importance of reflexivity.

Scott (2014) describes how ontology philosophises the nature of reality, generates theories on what we can know and is concerned with the sources of knowledge known as epistemology. Methodology encompasses the practice of how that knowledge can be produced and the methods or research practices that can be used (Raadschelders, 2011). Positivist epistemology focuses on knowledge generation through observable facts (Raadschelders, 2011). However, interpretivist methodologies accept that there is much more to know, such as feelings and understandings (Raadschelders, 2011), making them more suited for this study.

The methodology chosen for this inquiry is qualitative using thematic analysis guided by interpretive description. A qualitative approach was used to explore in-depth the views of midwifery leaders about, the vital attributes a MGP manager should have to encourage service sustainability. With no previous
studies found on the subject a qualitative study was chosen to explore this area. Creswell (2014) explains that a qualitative study is best suited when a topic needs exploration, but has had little previous research. Interpretive description was chosen to guide the design and analysis of the study, because it generates knowledge designed to be relevant to health disciplines (Burnett & Corlett, 2017) and is appropriate for a study where time is constrained (Thorne, 2008).

**Qualitative research**

Qualitative approaches seek to acquire comprehension of a specific phenomenon from the view of those who have lived it (Vaismoradi & Turunen, 2013). Information gained from qualitative research is not concrete nor indisputable, as might be the aim in a quantitative paradigm (Morse, 2010). However, it does offer an in-depth exploration of beliefs, behaviours and incidents from the participant’s point of view (Steen & Roberts, 2011). Primary qualitative studies are plentiful in health research, and qualitative research has been employed in the planning of and in combination with quantitative studies such as Randomised Controlled Trials (RCT’s).

Qualitative research creates theoretical explanations that explain reality through identifying concepts and patterns and subsequently finding relationships between concepts (Welford, Murphy, & Casey, 2012). The researcher is often intensely involved in the study and may remain in the field for long periods (Morse, 2015). Since there is no single reality in qualitative research, reality changes over time and any meaning drawn is situational and
contextual (Welford et al., 2012). Welford et al. (2012) explains there are several phases in qualitative research, beginning with an orientation to gain an impression of the phenomenon being studied. The research then moves to an intensive investigation of the phenomenon and validation that the findings are trustworthy (Welford et al., 2012).

In this qualitative study, large amounts of text generated from the transcribed interviews formed the data. Recursive and exhaustive exploration of the data was performed, drawing out codes and themes. The research is said to have reached saturation point when no new themes can be drawn (Creswell, 2014). When saturation was reached, no further interviews were conducted, producing a sample size (Steen & Roberts, 2011) of eight participants.

**Interpretive description as a methodological approach**

Interpretive description is a recent methodological approach, as described in 1997 by Thorne, Reimer, Kirkham and Mac-Donald Emes (Oliver, 2012). It evolved from a ‘poor fit’ of the more conventional methodologies in nursing research, to now be used in all applied disciplines (Oliver, 2012). Thorne (2008) describes interpretive description as a qualitative approach that can effectively inform nursing practice while maintaining academic credibility through adequate rigour. It is an inductive methodology inspired by naturalistic enquiry, grounded theory, phenomenology and ethnography (Olsen, Bradley, Lomborg, & Nortvedt, 2013). Inductive approaches start from the data and search for themes and patterns that suggest general rules (Green & Thorogood, 2014).
It is expected that some concurrent data collection and analysis occurs when using interpretive description (Thorne, 2008). Interpretive description also relies on the researcher being immersed in the study from the onset (Thorne, 2008). The engagement is continued throughout the entire process of the research (Thorne, 2008). Interpretive description provides a broad framework within which the design decisions that work for a particular research question can be effectively expressed (Thorne, 2011). It also offers a rational, methodical and justifiable research strategy to address practice issues in a way that makes sense to health-care disciplines and to advance knowledge that can inform change (Oliver, 2012).

Interpretive description is not a set of precise logical and sequential steps that reliably lead to new understandings; nor is it completely unique or devoid of theoretical or disciplinary underpinnings (Thorne, 2008). However, it is a way of naming and referencing the logic that nurse researchers have been using and calling ‘qualitative description’ or ‘generic qualitative research’ (Thorne, 2011). It is a much more appropriate and viable option than modifying ethnography, grounded theory or phenomenology (Thorne, 2008). The methodological approaches from social sciences are orientated towards theorising while interpretive description favours knowledge that can be applied (Olsen et al., 2013). Thorne (2015) describes how interpretive description evolved over time to allow researchers a legitimate and accurate approach in line with the understanding of how health care practice knowledge operates.
Interpretive description is a qualitative research approach that requires a practice goal and an understanding of what is known and not known, based on the available evidence (Thorne, 2008). It is appropriate for relatively small studies (Thorne, 2008) making it appropriate in this Master of Research study. It is also an appropriate strategy to study experiences in practical disciplines such as teaching, nursing, midwifery and management (Olsen et al., 2013). Thorne (2008) explains that interpretive description makes available the knowledge of expert practitioners available through pattern recognition, confirming interpretive description as an appropriate methodology for investigating the views of midwifery leaders.

A feminist approach

Feminist research focuses on women and making their voices and experiences heard within a social or natural setting (Gelling, 2013). Yet feminist research is not just about women and involving women it focuses on increasing awareness of gender inequality and oppression and strives to explore ways to remedy it (Jirojwong & Welch, 2014). This study is ideally placed to use a feminist lens when interpreting the data as it involves the care of childbearing women, the work of midwives who are mostly women and their (generally female) leaders, and the management of a social model of care in a patriarchal, industrialised health care system.

At the root of this study is MGP which has been shown to lead to better outcomes for mothers and babies when compared to standard care (Sandall et al., 2016), yet only 8% of Australian women can access this service (Dawson et
Childbirth is a women’s issue and occurs in a landscape where power is contested and medically hegemony is the norm, making it a feminist issue (Buckley, 2009). Childbirth however has been slow to gain any traction in the main feminist discourses (Oakley, 2016). While feminism has championed many other health issues for women, most women in Australia will give birth in a hospital under medical control (Buckley, 2009). Homer (2016b) argues given the strength of evidence supporting midwifery led continuity of care, it is no longer ethical to withhold these services from women.

Midwives themselves have been described as an oppressed group who have a fairly recent history of dominance from medicine and nursing (Fahy, 2007). The profession of midwifery is also largely dominated by women. In the past century (until recently) midwives have been required to become a nurse before being able to study midwifery (Chamberlain, Fergie, Sinclair, & Asmar, 2016). Midwives are slowly gaining traction in the primary care of childbearing women again, however, there is still much work to be done (Hartz et al., 2011). Keating and Fleming (2009) describe how midwives’ ability to facilitate normal birth is impeded by the culture of the industrial environment and the hierarchy of both medicine and management, who often support the medical model of obstetrically controlled birth.

Leadership until recently has been the domain of men, often within the military or bureaucracy and has focused on hierarchy, competencies and crisis management (Chamberlain et al., 2016). In the last century as a profession, midwives have had leaders who have been rewarded for maintaining the
status quo in hierarchical, autocratic settings (Ralston, 2005). These controlling leaders often viewed themselves as better than the other members of the oppressed midwifery group, contributing to feelings of powerlessness and behaviours such as horizontal violence (Stanley, 2011). Leadership is a key concept in the future direction of women’s health and in midwifery. This study should bring to light what is needed for the future leaders of midwifery to give them the tools to prioritise the needs of women and midwifery.

**Relevance to this study**

This study aims to explore the attributes required of a MGP manager in relation to service sustainability, examined through the experiences of a group of midwifery leaders. While the experiences of the leaders will influence their beliefs on what is required of a MGP manager, they have had varied and extensive experience of MGP services. Their experiences include MGP establishment, management and research, delivering a richness and authenticity to this study. The findings of this study should add weight to the need to adequately prepare MGP managers and show how this preparation needs to be specific to midwifery. It also might highlight the importance of good management and leadership in connection with MGP service sustainability.
Methods

Recruitment of participants

Sampling for this study was purposive; the participants were chosen because of their experience and insight into the research question. The participants are expert midwives who are well known in the midwifery community and are recognised as significant leaders. One inclusion criteria is that they have established, worked in or managed a MGP. The participants were chosen by the researcher and her supervisors. Most of these leaders had written or spoken at conferences about managing a group practice and were widely recognised as leaders in Australia. It was anticipated the sample size would be eight to 12 participants. Saturation point was reached at eight participants, where no new insights were available from the data (Steen & Roberts, 2011).

Participants were invited to take part via email (Appendix B). The email contained information about the study and what was expected of them, with the researchers contact details. If they expressed interest, a time and venue was arranged, with the participants interviews via Skype, phone or face-to-face. All the participants opted for face-to-face and completed consent (Appendix D) and demographics (Appendix F) forms before being interviewed.

Data collection

The interviews took 40 to 80 minutes. They were all one-to-one and semi-structured and took place in participant’s homes and offices and at conferences. The participants were asked open-ended questions developed
from Byrom and Downe (2010). Examples of the questions asked were: ‘With a MGP you have working in, developed or managed in mind, think about the qualities you would like the person running it to have.; ‘Now think about the qualities you don’t want them to have.’ and ‘Thinking about a world leader you admire, what are the qualities they have that make you think they are a great leader?’ The last question concerned the barriers of an MGP, rather than being specific to management. ‘What do you think are the reasons that MGPs are not available to all women in Australia?’ These questions were asked to help guide the interview but were flexible enough for participants to expand on, and for additional questions to be asked.

The interviews were recorded, with any observations noted during the interview (field notes) documented after the interview. The recordings were transcribed verbatim (five by the researcher and three by a professional transcriber) and the field notes were added. This process produced a large amount of text that formed the data for analysis.

**Data analysis**

The data for this project was analysed using thematic analysis. The analysis followed the steps that Braun and Clarke (2006) outlined to achieve inductive analysis to facilitate interpretation of the data. In inductive analysis, themes and details are taken by careful reading of the data without placing the data within any prior concepts from theory (Green & Thorogood, 2014). The text from the interviews was read and re-read, and the data set searched to find repeated patterns of meaning (Steen & Roberts, 2011). This process was not
linear but was recursive where movement was back and forth throughout the phases as described by Vaismoradi and Turunen (2013). Although analysis can be achieved by computer software packages, this study was analysed manually to familiarise the new researcher with the process.

Braun and Clarke (2006) describe thematic analysis as a foundational method used in qualitative research that is flexible and can potentially provide vivid and comprehensive yet intricate interpretation of data. It is widely used in qualitative studies (Jirojwong & Welch, 2014) and can benefit new researchers as it teaches core skills that can be used in other qualitative methods (Braun & Clarke, 2006). Thematic analysis is a method for recognising, exploring and describing patterns or themes within data, where the researcher plays an active role identifying the patterns and themes (Braun & Clarke, 2006).

**Ethical considerations**

Ethics approval was granted through the Human Research Ethics Committee at Western Sydney University (number H11713). The principles used in ethics are autonomy, beneficence, utility and justice (NHMRC, 2015; Vaughn, 2013). All researchers who intend to use people in their investigation are required to attend an ethical review (Vaughn, 2013). This process ensures that the research has been given ethical consideration, any risks have been identified and there is a strategy to minimise potential risks (NHMRC, 2015).

Autonomy refers to an individual’s ability to manage their own lives and make choices for themselves (Vaughn, 2013). Informed consent is part of this and depends on full exposure of any risks or potential harms, complete
information on the research obligations and is voluntary (Johnson & Hengstberger-Sims, 2014). The concept of beneficence is where the benefit of the research is considered, to the participants and/or the wider community and must justify any harm or discomforts to the participants (NHMRC, 2015). Utility refers to the greatest good over harm and acknowledges that harm is sometimes necessary to do good (Vaughn, 2013). Justice is where the research is judged to be fair, taking into account selection and exclusion of groups of participants, and that recruiting is just and there is no unfair burden from participation (NHMRC, 2015).

The participants are highly educated, autonomous women who are capable of deciding whether they will participate. They would not view the researcher as having any power over this decision. Information was sent with the invitation to participate, outlining the details of the study and contact details of the researcher if they had further questions. To avoid them feeling coerced, they were only contacted again if they indicated they would like to participate. Participants were assured of the voluntary nature of participation, that they could withdraw at any time and that withdrawal would not affect any further relationship with the researcher.

While some interviews can be distressing to participants, the interviews in this study were not emotive and were at low risk of causing harm. However, if a participant had become distressed during the interview, the interview would have stopped and contact details for support would have been given. These details are also available on the information form (Appendix C).
of their time may be viewed as an inconvenience; however, they may have enjoyed sharing their knowledge and contributing to the study.

It would be very unlikely the researcher would be at risk during the interviews, but she did contact her supervisor before entering the interview and on leaving to ensure her safety. All data from the interview was coded to protect confidentiality and the consent forms containing names were kept separately in a locked cabinet. Data was kept secure in a password-protected computer; paper data was kept secure in a locked cabinet in the researcher’s office. Data will be held securely for five years and then destroyed (Chater, 2014) – paper will be shredded and computer memory and audio files deleted (Long, 2007). It is intended for the research findings to be published in peer-reviewed journals and presented at conferences using pseudonyms. Some stories have been changed slightly to protect a well-known individual’s identity.

**Rigour and trustworthiness**

Steen and Roberts (2011) states that trustworthiness in qualitative research means ensuring the research represents the truth. While this is a difficult concept in qualitative interpretive work, the researcher endeavoured to represent an accurate representation of the midwifery leaders’ understandings of their experiences with MGP. Trustworthiness will be discussed within the concepts of credibility, transferability, authenticity, rigour and creating an audit trail.
Credibility refers to the validity of the data and its interpretation; it is associated with the credibility of the researcher (Steen & Roberts, 2011) and the integrity of the data collection process (Elo & Kyngas, 2008). As the researcher was relatively inexperienced, credibility was ensured by close supervision from two competent researchers, who also sat in on the initial interviews. Credibility also refers to how well the data and analysis processes address the focus of the study and whether the sample size was appropriate (Elo & Kyngas, 2008).

An audit trail of the research is an essential part of the trustworthiness of a qualitative study and involves ensuring that all steps are explicitly documented (Steen & Roberts, 2011). Transferability refers to how transferable the findings are to other settings or groups. Therefore, it is important to give a clear and distinct presentation of the group's culture, context of the participants, data collection, and analysis process (Elo & Kyngas, 2008). Authenticity refers to the researcher describing faithfully and fairly the experiences of the participants (Steen & Roberts, 2011).

Morse (2015) calls for trustworthiness to be replaced by the term rigour to be more in line with mainstream science. Rigour is the strictness of following successive steps, where these steps have been clearly set out and followed with meticulous attention to detail (Jirojwong & Welch, 2014). Rigour is also defined as displaying integrity and competence (Morse, 2015) and whether the study appears reasonable and appropriate (S. J. Tracy, 2010). The literature increasingly recognises the importance of reflexivity when showing rigour and quality in qualitative research (Morse, 2015).
Reflexivity

Reflexivity is where the investigator is aware of and reflects on their unavoidable presence within the research (Doyle, 2013). The researcher is aware of the potential bias she may have from extensive experience in MGP and reflected on this throughout the research process. The following reflexive paragraphs will be written in the first person.

I am extremely lucky to have been involved in innovative models of care and in situations where the management has been inclusive. I have been encouraged to be involved in the development of MGP services and have been supported to develop professionally. Most importantly, I have witnessed management with great leadership, displaying a vision for woman-centred care and for midwifery as a profession.

However, I have also been privy to a different style of management devoid of leadership and vision, where the staff who were previously included were no longer encouraged to be part of the development and progress of the service. There was little relationship between the managers and midwives, leaving midwives feeling spoken down to, and treated like children. An example of this lack of relationship was being told that an explanation for not attending functions was 'midwives and managers do not mix'. In this service, the management did not value midwifery nor encourage midwives to develop professionally. Eventually, good midwives left the practice where they enjoyed working and morale dropped within that group. Unfortunately, this environment ultimately adversely effects the care of women.
I realise I have an idealised expectation that management should be inclusive and democratic involving the staff in future directions of the service. I also realise my perspective is different from most, having worked as an independent midwife in a private practice where leadership came from within the group. However, I also appreciate that the role of the manager is necessary within a hospital structure. I acknowledge how difficult the manager’s job must be to manage a group of strong, experienced, passionate, midwives who are keen to move the practice forward. This would be made even more difficult if managers were feeling pressure from above, in the typical hierarchical management system.

Listening to the leaders during this research has given me a much greater appreciation for the manager’s role as an extremely difficult job to do well. While conducting this research, I have tried not to influence what the midwifery leaders have said, and have tried to interpret the data from their point of view, knowing I could easily influence the findings. I have had many conversations and points of reflection with my supervisors over the course of my candidature as well.

**Conclusion**

This chapter discussed the methodology, methods, ethical considerations and trustworthiness for this study. This is a qualitative study guided by interpretive description and analysed using thematic analysis. Data was generated from interviews with midwifery leaders, exploring their views on the attributes required in MGP managers. In addition, this section explored
how the study would be conducted ethically and how rigour and trustworthiness would be maintained. Reflexivity was also discussed, as an important component of qualitative research. The following chapter will present the findings of this study.
Chapter Four – Results

Introduction

In the previous chapter the methodology for this study was outlined, describing the research methods, data collection and analysis used. The aim of this study is to explore the attributes required in a MGP manager to encourage sustainability of the service through effective management. In this chapter the findings are presented. One overarching theme was discovered and three subthemes. Another theme was also found feeding into the overarching theme and intersecting with the three subthemes. These themes will be explored and illustrated using participants’ quotes.

Description of participants

Eight participants were recruited and interviewed—all had been midwives for between 25 and 39 years, and were female. All participants consented to being interviewed, and completed the demographic questionnaire (Appendix F). Participants were aged between 48 and 68 years, and had been involved with continuity of care programs for 17 to 36 years. Five participants stated their occupations as midwifery researchers, two were semi-retired academics and one senior executive. Of the eight participants six were born in Australia. All participants names have been replaced with pseudonyms.
**Themes of the study**

An overarching theme ‘Holding the ground for midwifery, for women’ was found and three sub themes: ‘Someone with their hand on the steering wheel’, ‘Having it’ and ‘Juggling forces’. As well the theme ‘Helping managers to manage better’ facilitates the three subthemes and strengthens the overarching theme.

The overarching theme described the role of the midwifery group practice manager in its ideal form, someone who stands up for midwives and women, guarding the birth territory, protecting the physiology of pregnancy and birth ensuring women have quality midwifery care. Three subthemes demonstrate the complexity of the role of the manager, the intrinsic traits that make a leader effective— called ‘having it’ —while the actual job of being a manager is described as ‘someone with their hand on the steering wheel’ and ‘juggling the forces’ that surround MGP. ‘Helping managers to manage better’ explains the need for managers to be educated for the role and the support or mentorship to help them in this demanding position as identified by the participants.
Thematic flowchart

The following thematic flowchart outlines the themes found in this study.

Holding the ground for midwifery, for women

The overarching theme ‘Holding the ground for midwifery, for women’ captures the participants’ views on the requirements of a manager of a midwifery group practice to protect, guard, promote and safeguard the service. Safeguarding the service, provides women with the option of woman-centred, one-to-one care, that is government-funded. It also means midwives can provide relationship-based care, using all of their skills and giving them occupational autonomy. This term was coined by one of the participants (Michelle) while discussing a successful service she worked in, ‘With a manager that was holding the ground, the birth territory
stuff, for her group practices’. Another participant discussed the concept of the manager as ‘Being strong, holding the line in a way’ (Lisa).

Central to this theme are the attributes required of the MGP manager who should guard the birth space by ‘Holding the ground’ and be- ‘Someone who advocates for not only the women but for the midwives and the profession’ (Kylie). This manager understands and defends the midwife/woman relationship, guarding physiology and protecting the birth territory, ensuring MGP is established and viable by facilitating a sustainable service to women.

A manager who is ‘holding the ground for midwifery, for women’ will require a complex set of qualities that are intrinsic to all great leaders; these are discussed under the subtheme ‘having it’. ‘Having it’ may be something she already has or something she can be taught but is the essential requirements to lead as an effective manager. The service needs to have ‘Someone with their hand on the steering wheel’ to manage the service, and ‘juggle the forces’ at play that are helping and hindering MGP. One theme that helps the manager to accomplish all of these requirements is ‘helping managers to manage better’ through education, support and mentorship so she is equipped to do the job.

**Having it**

‘Having it’ refers to an esoteric set of attributes that great leaders seem to have. The ‘it’ describes ‘who’ the person is, their attitude, personality and core values. ‘Having it’ appears to be a ‘big ask’ of someone as the participants identified a long list of attributes required for the job. One went so far as to say, ‘It's a calling of a higher order’ (Helen).
The participants all recognised that managers needed to be leaders, ‘They’ve got to have leadership qualities, not just management qualities’ (Lisa), and that ‘having it’ was having the necessary recipe for leadership. The participants clearly identified a difference between what they considered management skills and leadership qualities. They described the need for both leadership and management skills to be an outstanding manager; however, one could exist without the other but this was not ideal. More often they felt managers managed and did not lead as opposed to lead and not manage.

Being ‘visionary’ was identified by all of the participants as necessary to the job and they identified vision as the concept that would define someone as a leader.

_Leadership is a different matter and I think you can have a manager who’s also a leader, but leaders are visionary (Helen)._  

_They need to be visionary, you have to have somebody that you want to follow, and I think that’s the difference between a leader and a manager (Kylie)._  

Having vision means they see the picture—they know where they want to take the service and can work out how to get there.

_Vision, because if we don’t have managers with vision, they can’t see the big picture and they can’t see that what we’re trying to do nationally, around what women need and want (Jane)._  

_So, you want them to be visionary and you want them to also be flexible and enabling (Lisa)_  

_They have a vision of a world that is more equitable and caring of each other and of the planet (Helen)._  

Vision comes from ‘passion’ and was identified as an essential attribute to the position. Passion for women, for evidence-based woman-centred care, for making a difference in women’s lives and midwifery.
Determination, belief in themselves, knowledge, current knowledge, passion and alongside determination a deep commitment to what they believe in, not to be inflexible but to be passionate and in for the long haul (Julie).

They need to advocate for not only the women but for the midwives and the profession ... She appreciates that midwifery is about appreciating physiology giving the woman a good environment but also giving the staff an environment that is good for them as well. (Kylie)

Although they are passionate people, the participants thought managers also need to be 'realistic'.

They need to be a realist, and I think also pragmatic. Because if you're too aspirational too soon, often it will fail, because the people haven't come on the journey (Lisa).

Along with vision and passion it seems being 'courageous', having 'integrity' and 'humility', with a good sense of 'social justice' within a 'feminist' framework, were seen to be qualities a good midwifery leader should have.

She's got courage, she's got integrity, she's brave, she's got vision and she stands up for women. (Jane)

Humility goes with that—if you have that sort of social justice and feminism and those things then inevitably you’re humble (Mary).

One participant identified that even in a risk-adverse culture that good leaders take risks—they need to be 'brave' and willing to 'take risks', ‘because you need to take risks in lots of areas to be a good leader’ (Helen). With courage comes 'strength' which was recognised as being vital since the position, 'does require a strength' (Lisa).

They have to be quite brave, they have to be able to communicate with people in the hierarchy who are often bullies ... in a way that's respectful but very assertive without being aggressive (Mary).

She had enough courage and skills to stand up to doctors who don’t necessarily support the model (Julie).

Being 'authentic' and 'trustworthy' was also noted as 'having it'
They need to be authentic, and they need to be trustworthy (Kylie).

You trust them and they live up to your expectations of them, on the whole. So, generosity of spirit, humility, the ability to listen and to share (Mary).

The participants identified 'trust' must be reciprocal in a service where the manager may not see the midwives for days, they need to trust that the work is being done and the care of the woman is being skilfully executed.

You should trust your staff, you trust the process, you trust the system and you trust the model and you let them get on with it (Jane).

It's having the belief and the trust I think. What they do is that they galvanise followership ... They galvanise followership and they're clever at expressing the vision and they need to trust their midwives actually (Lisa).

Stepping back and learning to trust and promoting occupational autonomy is hugely important (Mary).

'Emotional intelligence' has been well documented as a necessary attribute of a leader and was thought by the participants to be a big part of 'having it'.

Emotional intelligence I think ... if you don’t have emotional intelligence you need to go find some, either by talking to kindred spirits or wising up (Julie).

There is a level of emotional and academic as well as management maturing or intelligence that needs to go on. That needs to be fostered in managers (Michelle).

'Including others' was also seen as important. It, consists of listening to the followers, realising they have something to offer and involving them in the conversation.

It was about the inclusiveness that she was trying to include everyone in the way forward (Kylie).

It’s an awareness of otherness and then once there’s an awareness of that otherness in all the people that they are dealing with ... it’s knowing that everyone has something to offer and a real leader allows everyone to feel that they can offer (Robyn).

If you want people to be autonomous or self-managing and self-responsible, then they have to be involved (Kylie).
Not only do they include others but they have the ‘power of persuasion’—they know how to bring the people along on the journey. They use their ‘charisma’ to help others see their vision and share their passion, they are ‘great orators’.

Able to persuade people to see his point of view, his way of being without being aggressive ... He was clever. He was clever with his persuasive powers, and a little bit of charisma is helpful, you know (Mary).

Able to sell their story so they need to be a great orator, they need to have charisma, so for someone to have charisma they need to have belief in what their message is (Kylie).

‘Having it’ captured numerous abstract qualities that seem to form a set of core values, personality traits and attitudes. Although ‘having it’ seems an impossible expectation of someone the participants discussed the difficulty of putting their finger on what ‘having it’ actually is. They felt some people naturally ‘have it’ and for others, it’s learnt. However, ‘having it’ means a manager can ‘hold the ground for midwifery, for women’, she can be ‘someone with her hand on the steering wheel’ and can ‘juggle the forces’ that encompass MGP. Without ‘it’, people don’t follow and hence this becomes an essential part of successful management of a group practice.

Someone with their hand on the steering wheel

The subtheme, ‘Someone with their hand on the Steering wheel’, refers to the management skills the participants identified as crucial to being an effective manager. This subtheme is divided into three parts: managing the service, ‘midwifing the midwives’ and supporting relationships.

Managers are still stuck in that hospital mentality and what I’ve seen with some of the group practices is, without a diligent and insightful, tenacious manager ... they morph ... and they become more normalised and transform into the old system. The machine, it’s going on, so unless someone’s got their
hand on the steering wheel and going, I know you want to go there but we are going back here (Michelle).

Managing the service

‘Managing the service’, was identified by the participants as fundamental to the role of ‘someone with their hand on the steering wheel’. One participant commented, ‘They have to be able to manage as well’ (Lisa). The participants consistently reported that the job involved a thorough ‘understanding of the concept of MGP’, how it works for the women and the midwives, the funding, skill mix and staff required.

You need to understand where the service fits within the health system, how it’s funded, what kind of staffing is needed, at what kind of skill levels and how you maintain them (Helen).

The managers have to know what it’s about ... The ones I’ve seen who really work well, they don’t have to have done it but it helps if they have, really helps (Mary).

They absolutely have to get that the work you do in a group practice is totally connected with the women coming through it and by that, I mean the decisions you make about, how you even organise and allow the workforce to be organised has to be totally in relation to the rhythms of the women coming through (Robyn).

The participants believed that to manage the service they should not only understand the practice but ‘promote the service’ as well. MGP is still not seen as a mainstream service and many may not understand it. One participant commented, ‘If they don’t really understand it they will criticise it’ (Michelle). Of course, being critical of a service that is not viewed as mainstream can make it extremely vulnerable. As one participant reported, ‘Need to shout about it. Because you know, the more people you tell about it, the more you show it off’ (Lisa).

The leader also needs to be out there promoting in every venue that they can, the importance of the work that the midwifery group practice does (Helen).
So, going to the very boring weekly or monthly meetings with all those nurses but making sure you know that you speak about midwifery and you speak about the group practice and how well it’s going keeping it on the front of people’s minds. Because the consequences of autonomy can sometimes be invisibility (Julie).

‘Managing risk’ was identified by the participants as another part of managing the service. One participant described it as, 'There’s pressures that come from above constantly about ... the risk, so they've got to be able to establish that this is a very safe practice' (Helen).

*Use their systems, do the risk management, do the incident analysis, do it for yourself. Don't wait for the risk management committee to do it, be public about it* (Lisa).

One participant argued that the relationship between the woman and the midwife is the element that mitigates risk, and should be clearly understood by the manager.

*With this whole idea of risk management that does not take on board that one absolutely pivotal spoke that really makes for true risk management which is the relationship between the woman and the midwife, the continuity midwife ... the manager who doesn’t get that is completely out in the wind, they’ve got no chance actually* (Robyn).

‘Being strategic’ was something the participants described as essential to successful management of the service and reaching goals. They discussed how small changes make it easier for those who resist change to accept.

*You’ve got to be a bit strategic about it, I’ve always found there’s probably a dozen steps here. So, you change this and you change that and change these things down here, and it falls over of its own accord. Nobody has noticed it coming because all those little changes are palatable.* (Lisa)

*We started with team midwifery ... then we moved on to the group practice but we were always going to do home birth and we were determined and it took us for ever, but we got there* (Julie).
An often-forgotten part of the job is ‘succession planning’. The participants discussed that, ‘Systems can't be reliant on one leader’ (Lisa). They described how a service can ‘fall over’ when the manager leaves and is not replaced by someone with the same philosophy and leadership skills.

*A series of people leaving and the leadership changes and then there wasn’t the cohesion, there wasn’t the commitment, there wasn’t the passion, there wasn’t the focus and it fell apart, seriously fell apart and now it doesn’t exist* (Julie).

*Sustainability requires leaders and managers to make sure they are breeding the new leaders and managers who will step in when they go. We all know people who are not happy about group practices, they will step in as soon as a leader goes and dismantle it quite happily* (Mary).

One participant suggested a way of addressing succession planning might be for midwives to take turns in being the manager.

*[MGP] should alternate managers [between the midwives] so that everyone has the opportunity to understand the sort of governance issues and the management issues around running a group practice* (Robyn).

While, student midwives were given some experience in MGP the participants recognised that as ‘new graduates’, ‘they're not allowed to practice in the first year in a continuity of care model’ (Lisa). They also suggested that not allowing new graduates to work in group practice might prevent them from ever working in MGP.

*We need to gobble them up fast and put them into models of care. Even if they only do two years before they go and have a baby that’s okay. That’s great, because that’s how they’ll come back. But if they don’t get given the taste at the beginning, we will lose them and they will get frightened. It’s the fear - fear-courage, balance* (Jane).

*If were trying to encourage best practice evidence which is continuity of care then those students should be going into group practice as soon as they finish which they’re not* (Robyn).
If they go into the system working shifts they get culturised or they will leave, the really good ones will leave because they can’t hack it (Mary).

Midwifing the midwives

The participants identified the job of ‘midwifing the midwives’ or looking after the midwives, as a critical component of the role of ‘someone with their hand on the steering wheel’. One participant said, ‘They actually need managing carefully to make sure that the staff are okay’ (Jane).

‘Midwifing the midwife’ in the best possible way, so as we midwives are ‘with the woman’ the managers approach should be using that midwifery philosophy of not telling people what to do, not telling them what’s best for them, but creating situations where they can take what they need to do and that includes in some cases shielding them (Julie).

Almost like a velvet glove where the managers manage but almost at arm’s length, not that there not supported, so I guess it’s more of a supportive role, an education role to keep them safe as well (Michelle).

One participant identified that, ‘understanding the role [of the caseload midwife], and being prepared to stick up for it, is another part of it’ (Julie). ‘Protection of the midwives’ is described as warding off misinformed criticism, investigating complaints, standing up for the service and shielding the midwives.

*I think a good midwifery manager has to protect the group practices ... and that means going into bat for them when people are accusing them of things, making sure that funding isn’t cut off, it’s about going in and defending them (Mary).

She [the manager] wouldn’t accept that the complaint was honest about the group practice midwife, so she would always look to see if it was a system issue ... So, they were protected (Kylie).

*Do the protecting and nip things in the bud when you’re sensing an agenda from people who have a purpose in stopping continuity (MGP) or undermining it (Lisa).

The participants discussed that another aspect of the job of ‘midwifing the midwives’ is to help midwives have professional boundaries, encouraging them to
not be ‘everything to every woman’. Although usually a temporary issue that resolves as midwives mature into the role, it can adversely affect not only the individual but also the other group members.

Midwives themselves are a problem because, the midwives who are passionate about continuity, they try to do too much. They try to be the provider of everything for the woman. They try to be the social worker and they try to be the counsellor and the doula and the midwife (Lisa).

It takes a time for professional maturing where you realise you don’t have to be everything for everyone and then you flow over into the job and that allows women to be themselves whether you’re there or not, that you’re able to be flexible with your work practices ... You’re actually putting a lot of stress on your fellow midwives and the service as well and you then don’t become safe to yourself and to the service (Michelle).

‘Happy midwives’ are more likely to stay. Making the service an attractive option for midwives, to encourage staff recruitment and a sustainable service for women, was discussed by the participants as a component of ‘midwifing the midwives’.

Managers need to make sure that the reality is good for midwives so that midwives sell it, so that every midwife wants to work in that way, so that every woman gets access. That’s the trickle-down thing. The motivations for midwives doing it. It’s not that they want to be different ... They’re just actually doing midwifery and it’s what we train them to do, so let’s let them do it well, properly (Jane).

The recipe for happy midwives was identified as ‘Jane Sandall’s mantra’. If ‘someone with their hand on the steering wheel’ can achieve all three steps of the mantra they are more likely to have a successful group practice according to the participants.

Jane Sandall’s mantra ... she actually identified three things for a successful group practice, which I think are the framework still today. The first of those points is meaningful relationships with women. Occupational autonomy is the second one and that’s a really big one for managers to take on it means that the midwives are on an annualised salary or whatever, and they organise their own work. The third of this simple little trilogy is support. Support at home because actually if you haven’t got support at home it’s very, very hard to do it but especially support at work (Mary).
The fact that if you've got those three—Jane Sandall's three elements—you've got happy midwives, generally ... As a manager, if you can't facilitate those three things, you will get burnt out midwives and you will get miserable midwives. As soon as the midwives are miserable, the model will fall over (Jane).

In regard to the mantra, respecting the midwives’ ‘autonomy’ and letting them get on with the job of midwifery is an important part of ’midwifing the midwives’ according to the participants.

Managers stepping back and learning to trust and promoting occupational autonomy is hugely important (Mary).

Being able to let the group practice midwives get on with their job but knowing they will come to you if they need you ... So support their autonomy, a high level of mutual trust and respect, so that things could be raised and things could be said, in a timely way that not only supported the individual group practice midwife but that kept the model intact and kept the model safe and, you know, not vulnerable to predators who would possibly like to see it undermined (Julie).

Being aware that midwives need to move out of MGP from time to time to develop different skills or for family/personal reasons was highlighted by the participants. They also explained that midwives need to be encouraged to keep ‘developing professionally’. One participant said, 'If you're a great midwifery manager, you would find ways of supporting your staff to get off and get their Masters or their PhDs’ (Helen).

So, keeping an eye on and you’re preserving the model, and you’ve got a good group of midwives but it's not static, and it’s probably quite healthy for group practice midwives to think about doing other things (Julie).

But fostering that culture. So I think a good manager fosters a culture of, of self-reflection and growth and um, feeling safe ... It’s ensuring that’s there’s ongoing education that goes on (Michelle).

Supporting relationships
Another duty of ‘someone with their hand on the steering wheel’ is ‘supporting the relationships’ within the practice. The participants described how the manager may need to influence and facilitate the midwifery relationships within the practice, for sustainability of the service. As one participant explained, ‘I think it takes a whole cohesive team involving the manager to raise a group practice’ (Julie).

As the manager, you try to bolster ... the morale and the collegiality and the friendship within your group so it's quite a balancing act ... Having a group that's that cohesive, it's really hard to tear it down ... There was strength in numbers and there was structure that could support each other and the group practices and the women, the manager was able to support those (Michelle).

One of the ways managers could facilitate healthy relationships between midwives was to encourage them to meet each week. The participants explained that ‘regular meetings’ were very important in enabling midwives to catch up and check in with each other, and develop their relationships.

Practices I have worked in as a group practice midwife, you need to meet regularly because you are responsible for the place you are working in plus the women you are caring for and that runs and it can't do that without meeting and talking about it. (Kylie).

You have to have a kind of once a week meeting, and I've been in many of those meetings and the world over, midwives do the same thing in those meetings (Mary).

I insisted as much as I could that everyone try to make a commitment to the weekly meeting, and that meeting was more than just sharing tasks, it was, you know, we would always start with a round of ‘how are you going’, it didn't have to go for long but we needed to connect at a human level to make sure people were okay (Julie).

Sometimes however, conflicts occur within the group, and the participants discussed how important it is for the manager to skilfully deal with it.
There will always inevitably be conflicts that come up within a group and you have to have a very good understanding of internal group dynamics and management of those conflicts that come up. Personalities can be challenging from time to time and I’ve seen groups disintegrate because of that. Managing those relationships are critically important to the survival of these kinds of models and the flourishing of them (Helen).

The participants also were aware that the relationships within the groups might need **outside help** and sometimes in order to support midwife relationships the manager might need to seek external support.

*Putting in place structures so that midwives can bring people into the group if they need a particular thing, you know, if they’re struggling with on-call or relationships or anything, you know sometimes it’s about bringing in somebody from outside to help rather than the manager themselves doing it (Mary).*

*Sometimes you need to get in an external kind of facilitation process to diffuse internal conflicts (Helen).*

The participants identified that ‘Someone with their hands on the steering wheel’ has the job of managing the service, ‘midwifing the midwives’ and supporting relationships between midwives. Managing the service involves a profound understanding of the concept of MGP, how to promote it, the risks, use of strategy, how to incorporate new graduate midwives and succession planning. ‘Midwifing the midwives’ involves encouraging ongoing education, occupational autonomy, protection and midwife happiness. Supporting relationships between midwives through opportunities to meet and dealing with conflict, helps to ensure a healthy service. As the participants identified, there needs to be ‘someone with their hands on the steering wheel’ to facilitate or let midwives be ‘with woman’.
Juggling forces

This subtheme describes the juggling act where the manager is constantly trying to communicate and collaborate with different forces from outside the service that affect the integrity of the group practice. As one participant explained: 'It’s quite a balancing act ... a juggler... protecting from outside forces' (Michelle). This subtheme ‘juggling forces’ has been divided into four sections: Trying to work in the system, the medical/nursing paradigm, the filthy dollar and making MGP work.

Trying to work in the system

'Trying to work in the system’ was identified as a difficult force to juggle by the participants, 'In every way we are trying to deal with putting something that is completely organic into a totally industrial factory model' (Robyn).

Traditional models of care within a medicalised system respond to the needs of the system rather than the woman. Unfortunately, many practitioners are unable to see any benefits in changing from traditional models of care. Despite having the evidence that outcomes of MGP are better than standard care, there is a fundamental ‘disbelief in the model’ as described by the participants.

People don’t believe it and we just have to listen to that obstetrician… that just said ‘I am philosophically opposed to it, despite it having evidence’... The dialog that goes along with managers, so we have a manager ... who has had research and has set up a midwifery model of care, goes and says ‘it’s all bullshit this budget stuff despite having evidence from trials’... So there’s a disbelief of the evidence. (Michelle)

[The MGP model] doesn’t fit their bias of what currently happens and it certainly doesn’t fit the biases of people working within the health system, the
doctors and the midwifery managers we currently have, or else why wouldn’t they just pick it up and say, ‘my God, we need to do this’ (Helen)?

Even the ‘idea’ of MGP is difficult for most people to comprehend being so different to standard care, ‘One big barrier is the concept. Like it’s almost too big a concept for people to contemplate ... we have made it too hard’ (Lisa).

The participants identified that ‘establishing a MGP model is too hard’. In an attempt to make the service robust, to stand up to scrutiny and meet all the requirements of ‘the system’, it is now so difficult to institute that even the most enthusiastic service providers find it difficult to achieve.

We’ve got to have a project officer to start it. You’ve got to do a risk assessment. You’ve got to, I mean, it’s just ridiculous ... All it is, is rearranging the way you staff. The same care, the same system, it’s this whiz-bang, clever thing over here that normal people couldn’t possibly do or set up. So, administrators in hospitals go, well, that’s too difficult (Jane).

The participants described that ‘trying to work in the system’ already established for a traditional model of care can be difficult. One participant described the standard model of care by saying, ‘It’s about beds. It’s not about the person who’s coming into the service to get those moments of care’ (Kylie). Therefore, it does not necessarily provide the environment or resources that allow a MGP to function effectively. Parking is an issue for most hospitals causing problems for everyone including pregnant women who might have small children and for midwives who may need to come and go several times in a normal day. There might be a lack of space for antenatal visits, meetings with groups of women and meetings between midwives. Some even have trouble accessing a car to do postnatal visits.

They set up lots of group practices, they didn’t have a base, they didn’t have anywhere they could meet, they had to negotiate meeting rooms, they didn’t have a place, they had to go to the antenatal clinic to see their women, beg space and book space (Mary).
But the environment should be of a birth house, not a bloody factory... Instead of this we’ve got them dashing here not being able to find a room, postnatally there, we are not allowed to go to the community because we don’t have cars I mean it’s just goes on, it’s ridiculous, so it’s just that total non-responsiveness to what we are trying to do in the system that we’ve got (Robyn).

The medical/nursing paradigm

‘The medical/nursing paradigm’ is another force for the manager to juggle. All of the participants saw ‘nursing’ as a dominant paradigm and power that was challenging for the MGP manager. Within this paradigm is the hospital hierarchy which is composed predominately of nurses and as one participant put it, ‘In terms of the people management, the issues are different for nursing’ (Julie). With midwifery seen by many nurses as another nursing certificate, they might not understand the capacity of midwifery and the benefit of MGP. If the nursing hierarchy does not see the value of midwifery models of care, getting MGP established and sustaining it can be a problem.

We’re still stuck in a nursing model and we’re still stuck with nursing leadership who don’t get midwifery—and frankly don’t want to (Jane).

Nursing is a bigger problem than obstetrics I think for midwifery. Of course, most of the leaders in hospitals and in systems are nurses. They don’t necessarily get midwifery (Lisa).

The participants identified that the manager of the MGP belongs to this management system. The culture within the management system often endorses a different management style than the style required to effectively manage a group practice. This can leave the MGP manager feeling sandwiched between opposing forces.

The participants described that a flat management system is an effective management approach, ‘What needs to work in a group practice is you have a flat
hierarchy’ (Mary). This is in opposition to how most hospital managements function. Another participant gave an example of effective MGP management as, ‘Midwives were trusted and supported and encouraged to be autonomous, make their own decisions, work out their own work plan for the day’ (Julie). This is not generally the style of management embedded within the medical/nursing paradigm. Therefore, belonging to a team with one style of management but being required to use a different style to sustain a group practice, would be difficult for the manager to juggle.

They [MGP managers] are under such competing forces so they want to be seen as doing the right thing they want to be part of the management team. They are frightened of the doctors coming back on them they are probably a bit frightened of what their midwives are going to say (Michelle).

It’s difficult managing in a tertiary hospital because her manager is saying to her: “whose side are you on, are you looking after the midwives or are you in the management team” (Lisa)?

The participants recognised that some ‘midwives’ might be opposed to MGP. Some midwives fail to see midwifery as a clear, distinct, woman-centred profession that is separate to nursing.

So there’s a cultural shift with midwifery, because I think the majority of midwives are ‘with institution’, they’re not ‘with woman’. So there’s a big cultural shift that would need to happen (Lisa).

Anywhere in Australia [for] midwifery as a profession, you know we don’t, we don’t understand, I don’t think we’re clear enough and upstanding enough about the role of the midwife (Julie).

The ‘invisibility of midwifery’ in mainstream systems in Australia was highlighted as a massive barrier to MGP by all participants. They discussed how midwifery in Australia is still seen as part of nursing, making it invisible. This invisibility makes providing a midwifery service that is different to nursing models of care quite
challenging. Juggling the forces of invisibility is therefore a complex issue for the manager.

*It goes back to fundamental issues of status and visibility and identity because without those things ... They get crushed by the system really fast (Jane).*

*[The problems in midwifery are] around addressing the invisibility of midwifery in maternity care in Australia and the consequences of not recognising midwifery as a separate profession (Julie).*

*When the midwives are actually valued as a profession that offers a real service to the public not as a component of a factory floor then we have midwives that are valued in society (Robyn).*

‘Medicine’ as the dominant and competing professional group was also seen by the participants as a force that threatens the establishment and sustainability of MGP programs. Doctors generally also see midwives as nurses making it hard for midwifery to gain traction in taking back the role of the midwife as autonomous primary care providers. Medicine still has a different status to midwifery, ‘When somebody with a lower status, i.e., a midwife talks to an obstetrician, all he hears is, blah, blah, blah’ (Helen). So, although MGP is supported by evidence, getting doctors to listen can be difficult and medicine still holds the power.

*We are trying to fit it into an acute care model that is becoming more and more medicalised and you know, it’s just getting worse and worse towards medicalisation of childbirth, and the power base is shifting all the time towards obstetricians, who see good midwives as being the ones who can work all the machines for them (Mary).*

*They’re [doctors] not interested in innovative midwifery care, it doesn’t enter their head, it just doesn’t come on to the horizon, because everything’s about production (Robyn).*

However, one participant had experienced a supportive doctor who was a positive influence on MGP, and argued we should put more effort into getting them onside.
But fundamentally they’re [some obstetricians] people who trust women’s ability to give birth and they have ... a great respect in trusting midwives ... So, yes, so we need great midwives who can influence great obstetricians (Helen).

The role of ‘nursing and midwifery unions’ is to protect nurses and midwives as a workforce within the medical/nursing paradigm, but participants also reported this as one of the forces that managers need to juggle. While the union does protect the nursing and midwifery workers, it can have difficulty understanding and responding flexibly to the needs of midwives who work in MGPs. Group practice is responsive to the rhythms of women, putting the woman at the centre of care and thus midwives respond and work when women require them, rather than clocking on and off a predictable shift with predictable hours. The participants described this by saying, ‘Actually, the unions would shut down ‘continuity of care’ like a shot ... because it buggers up all their normal industrial arrangements’ (Jane).

A big barrier is the industrial agreements, EBAs, they're a problem. So, the union is a problem (Lisa).

The participants also referred to ‘justifying and counting hours’, an industrial condition that is a hangover from the 38-hour industrial agreements, as problematic. The focus on hours takes the focus away from the care of the woman, and the trust away from the midwives to do their job.

The biggest problem we set up was trying to justify the amount of hours and the actual caseload. I think that undermines the whole concept of midwifery group practice (Helen).

The filthy dollar
‘The filthy dollar’ was identified by the participants as a major issue for MGP, ‘Our biggest barrier to everything that happens in maternity is the filthy dollar’ (Robyn).

The real barrier is the medical dominance of the health budget and so, whenever we have to prioritise medical care over midwifery, social, public health, it will be restricted … While ever midwifery is in hospital, it will be squeezed for a proper budget (Julie).

The participants said although MGP has better outcomes, and therefore is a cheaper service in the long term, this is not usually a consideration for most service providers. Long-term better outcomes and resulting cost savings are not always factored into short-term cost. Midwifery services are generally not considered a priority when it comes to government funding.

They look at how much money is expended on midwives working in these practices for the caseload that you’re working with. They don’t consider offsetting it by the decrease in caesarean section rate, decrease in epidural rate and the decreased consequences for the babies who get straight forward normal births down the track (Helen).

The money in the Australian healthcare system is a barrier. So, fee for service creates a reward—for the more you do, the more money you earn. So, you do more antenatal visits, you do more ultrasounds. So, we’ve got a perverse incentive there (Lisa).

One of the participants discussed how ‘bundling the pricing’ for maternity would benefit MGP. In this case, each woman would attract an amount of money for different modules of her care, helping to make funding a MGP easier, reducing the incentive to over-servicing and making better outcomes more financially attractive.

It’s almost impossible to fund caseload care in the mainstream hospital … Australia needs to look at the prospect of bundling the pricing for maternity, so that each woman is allocated a certain amount of money or the managers are allocated that money in public hospitals and they can do what they can do with that, but with a bundled price they’re given a certain amount of money
and what they want to achieve from that is the best birth for those women and the least expensive so we’ve now got no incentive to have elective caesarean sections, for example, and you might have an incentive to encourage midwives to offer this care in the community where you’re not having hospital costs (Robyn).

Making MGP work

‘Making MGP work’ describes how managers can help reduce the forces on establishing and sustaining a group practice by getting the culture ready for MGP, by forming relationships and by engaging help from the community and from the women themselves. One of the participants described her experience in getting the ‘culture ready’ for MGP by educating the staff to prepare them for the new service.

People would come on the course not just if they were interested in doing caseload but all the people who weren’t, you know the managers of the labour ward and all those sorts of people who might be quite quizzical about it to say the least the idea was to get them really in the know and understanding what it was … A lot of people came on that course and learnt, which made them supportive of the group practices when they started (Mary).

A preparation course worked well in this situation because it was when few people had heard about MGP. Although continuity of care models have been around for many years, there are still misunderstandings about MGP. Being able to find a way to get the culture ready before starting a new model of care might lead to less resistance to change.

‘Forming relationships’ was also seen as a positive force and essential to the role of the manager by the participants. The manager needs to keep nursing, midwifery, medical and industrial colleagues on side to help make the service less vulnerable and gain more support. The manager also needs to be able to form relationships with the group practice midwives, with the women and
families in the community and other community-based services that might impact MGP. As one participant explained, ‘Leadership is also about being able to cohere, bring people together’ (Lisa).

Another part of the manager’s role is to align yourself with the director of obstetrics … Also, the director of nursing and possibly the medical director … You need them to back you when the chips are down and the model is vulnerable (Julie).

You’ve got to have good relationships with your staff, good relationships with your community, and you have to have at least collegial relationships or a mutual respect with whether its medical or up the line management staff (Michelle).

Another force that can positively affect MGP is ‘sharing benefits and building communities’. Setting up a group practice within the community has benefits to the community, the women and the service. If the majority of care occurred in the community, it would take the burden off parking and space in busy hospitals. It would also afford women an opportunity to explore the resources available in their community and meet other women who live in the same area.

They need to see midwifery as a public health initiative … Understand the value of placing practices in the community where midwives can get to know their community and where they can tap into all the resources, and make sure that women are supporting each other, you know create situations to make it easier for women to tap into community services … They have to have a base, preferably in the community (Mary).

Its basis should be from the community. It should be primary healthcare provided and servicing the hospital when it needs to—that includes all the women who have difficulties because they too are not in the hospital that long (Lisa).

Another force is the women themselves. The participants described the importance and benefits of ‘involving the consumers’ in the service planning and delivery. ‘If you keep with the women, you make it happen’ (Jane).
You have to be known to the consumer group. The group should be self-managing however, but you need to be readily reporting up to that group as to here’s our outcomes, here are the current successes, here are the current challenges we might be facing and get the women to actually run, if there needs to be advertising etc., etc ... You have to have a core group of women who are actually demanding this kind of a service, otherwise, you don’t have a strong argument to use when you’re managing up (Helen).

Engaging women in service planning and provision leads to more ownership of a service by the consumers and makes it more likely to be a service women want.

Encouraging consumer groups is not only a good strategy for the service, but also gives the women an opportunity to build relationships and gain support from other mothers in their community.

Bringing women together to form friendships with each other is far more important than this relatively brief relationship that they will have with you, however important that is in the rest of their lives (Mary).

The participants identified and discussed the manager’s role of juggling forces.

These forces are trying to work in the system, the medical/nursing paradigm, the filthy dollar and making MGP work. While most of the forces make MGP harder to establish or sustain, the participants have also demonstrated how these forces can be cushioned or worked with, to benefit MGP. A woman-centred philosophy, communication, collaboration and building of relationships has been identified by participants as the key to juggling forces.

Helping managers to manage better

This theme captures the importance of education and support or mentorship participants identified that managers need to effectively lead and manage the service. Although the manager’s job is extremely important and difficult, there are few courses or mentorship programs to help prepare them for the position, as well
as few requirements, ‘We have to help or provide better mechanisms to enable people to be more creative, more courageous, more visionary ... But we’ve not, as a discipline, got that management and training’ (Jane).

_We imagine that it must come naturally, but you can train people in both management skills and leadership skills. They both have to come together in the person who manages a MGP, because it’s not easy (Helen)._  

_There’s some new knowledge and new training required to be an effective midwifery manager (Julie)._  

The participants said although the position of MGP manager was integral to the success of the service, preparation for the role was not given sufficient priority. While there are some management courses endorsed by the hospitals, these are designed for nurses and therefore do not always meet the specific needs of midwifery managers, especially those who manage MGPs, ‘It’s got to be the right sort of course and if it’s a course about doing the rosters and managing the budget, then it’s not going to help develop group practices’ (Mary).

_We don’t really have any sophisticated training programs, despite what HETI and various other organisations offer in terms of leadership training. It’s less about leadership in that case and more about actual management.’ It’s recognised as something important to do within their health system whereas doing a master’s or any other tertiary kind of study at university does not get the same kind of support. So HETI ... it’s for nurses and midwives obviously, so it kind of dilutes the focus (Helen)._  

_The biggest barriers would be lack of clarity of understanding of the [MGP] managers being unique and different (Julie)._  

However, the participants reflected that when courses and education opportunities had been available and were designed to help midwifery managers manage better, the attendance had been very poor.

_I put on a seminar here for midwifery managers—it's practically empty. But I put on a seminar on some clinical aspect and I have to shut
the doors. I always worry because I think, well, we’re not getting to the managers. We’re not obviously, and that’s just one silly example, but what is it that they aren’t getting to help them get to the next step (Jane).

Since MGP is very different to other services within the hospital system the manager may not have peers who can support them. As one participant said, ‘An acknowledgement that this is different and that you might need different networks and supports around you as a manager, I think would be useful’ (Jane). The participants thought support would be more helpful if it came from people who had experience in MGP and therefore this might need to be sourced from outside the institution where they worked.

Managers could seek mentorship through ACM (Australian College of Midwives) or through NaMO (Nursing and Midwifery Office, Department of Health) or wherever there is a group of senior mentors that can support the managers. They can get them [mentors] in academics or in other managers or in educators that also either have got experience in what qualities we should have, worked in group practice and know what it’s about ... Maybe ACM needs to have a body of mentors that people can tap into (Michelle).

There should be meetings to try and bring managers together who manage midwifery continuity of care, so that they get a sense of some sort of mentoring. (Jane).

Helping managers to manage better was recognised by the participants as something critical to the preparation and support of this essential role. If managers are not given every opportunity to learn to be leaders and good managers, and are not supported in the role, few would be able to achieve what is expected of them. With manager expertise being so closely aligned to the sustainability of MGPs it is essential that their support and preparation is taken seriously. While some managers just ‘have it’, others need to be taught ‘it’ but even those with a natural leadership ability will need support in their role. So, ‘helping managers manage better’ might
help them ‘have it’ so they can be ‘someone with their hand on the steering wheel’ who can ‘juggle the forces’ and can ’hold the ground for midwifery, for women’!

**Conclusion**

In this chapter the results of the study have been presented which aimed to explore the attributes required of a manager of a MGP that would help the service be sustainable through effective management. One overarching theme was identified from the study, *'Holding the ground for midwifery, for women'*. This theme describes the manager’s job of protecting the physiology of pregnancy and birth by protecting the space for midwives to practice and for women to birth.

Three subthemes were found in the data. The first was ‘Having it’. While the participants had trouble putting their finger on ‘it’, they knew it was something an effective leader and manager has. They described ‘it’ by exposing a list of abstract qualities such as core values, personality traits and attitudes, all of which need to come together to lead and manage a sustainable MGP. The second subtheme ‘someone with their hand on the steering wheel’ discussed the job of managing the service, ‘midwifing the midwives’ and supporting relationships between midwives. While this subtheme describes the core managerial work, this is only some of the attributes an effective manager requires.

‘Juggling the forces’ was the third subtheme. Here the participants described the forces the manager had to juggle to ensure the functioning
of the MGP. These forces were: ‘trying to work in the system’, ‘the medical/nursing paradigm’, ‘the filthy dollar’ and ‘making MGP work’. The final theme was ‘Helping managers to manage better’ which discussed the participants’ views about preparing managers for their job and described the need for a support network of like-minded mentors to help them in their difficult position. The following chapter presents a discussion of the findings in relation to the current literature and suggests ways this study may be used to influence clinical practice.
Chapter Five – Discussion

Introduction

In the final chapter of this Master of Research thesis, the key findings will be discussed in relation to the current literature. Also, addressed will be the limitations of the study, recommendations arising from the study and potential future research in the area. The aim of this study was to explore the views of midwifery leaders regarding the attributes required in MGP managers to be able to effectively manage a service.

Eight midwifery leaders with extensive experience in MGP were interviewed face-to-face to provide data for this interpretive descriptive study. Thematic analysis revealed one overarching theme ‘Holding the ground for midwifery, for women’ and three sub-themes: ‘Having it’, ‘Someone with their hand on the steering wheel’ and ‘Juggling the forces’. Another theme, ‘Helping managers to manage better’ also emerged from the data, and described the preparation and support required by the managers, to effectively lead and manage a MGP.

Synopsis of Findings

The role of the MGP manager as described by the participants was someone with multiple characteristics, a collection of personality traits, values, philosophies and attitudes, that were needed to manage this relationship based service. Most participants described the ideal manager as having both
leadership abilities and management skills and an ability to protect and promote the service. The manager should fully understand the concept of the MGP model understanding how it sits within the industrial framework and how it is funded.

The role of the manager requires good working relationships with other disciplines, namely nursing and medicine, the MGP midwives, the consumers and other stakeholders. They are also required to enable the midwife/woman relationship by ‘midwifing the midwives’ and supporting relationships between group practice midwives. The participants also identified that MGP managers required specific education around midwifery management and leadership and should have access to mentorship from a body of appropriate midwifery mentors.

**Why the management of midwifery group practice matters?**

The motivation behind this study was to find out what skills and attributes a MGP manager needs in order to support sustainable MGP programs and continue to expand the option of continuity of midwifery care for women in Australia. As previously described MGP is where women receive one-to-one continuity of care from a midwife who is supported by other midwives in a group practice. Midwives involve other health professionals if they are needed and the care is free to the woman (government funded).
The establishment of MGP has been encouraged in policy directives from State Governments (NSW Health Department, 2010) the Commonwealth Government (Australian Government, 2016) and countries such as the UK (NHS England, 2016). Recent evidence shows women receiving midwifery-led continuity of care had less intrapartum intervention, were more likely to have a spontaneous vaginal birth, and were less likely to have preterm birth or to have a baby die when compared to other models of care (Sandall et al., 2016).

A recent study of women's satisfaction with care in NSW showed that the two top performing services (Ryde and Wyong) were both solely MGPs and midwifery led (Bureau of Health information, 2017). Other studies have also found higher satisfaction in women receiving midwifery continuity of care (Sandall et al., 2016). The midwives working in these models report greater rates of professional satisfaction compared to midwives providing standard care and they also have lower rates of burnout (Newton et al., 2014).

While these services have slowly increased in Australia they still only provide care for a small number of women indicating an urgent need for further research into barriers to implementation and sustainability. At present only 8% of Australian women have access to this model of care (Dawson et al., 2016), while New Zealand offers government funded continuity of care to childbearing women with the majority of women (93.4%) choosing a midwife as their lead maternity carer (Hunter et al., 2016). In Australia, there are barriers to MGP, such as funding and support (Dawson et al., 2016), but the impact of the management of these services on their sustainability has not been investigated.
Leadership style is linked with staff retention (Cummings et al., 2010) which is critical to the sustainability of the service (Deery, 2011). Hospital hierarchical management usually has an autocratic leadership style (Byrom & Kay, 2011; Ralston, 2005) while MGP midwives require management that is based on inclusion and connection, with most current literature recommending a transformational leadership style as optimal (Byrom & Kay, 2011). Education in management and leadership styles is not a requirement to become a midwifery unit manager. Few Australian Nursing or Midwifery Unit Managers possess formal management qualifications leaving many feeling ill prepared for their role (Clarke et al., 2012). Management and leadership style can be learned (Carragher & Gormley, 2017) and an effective leadership style can enhance staff retention, satisfaction, recruitment and healthy work environments (Cummings et al., 2010). This study is the first of its kind looking at the attributes required in MGP managers and is vital to improving the sustainability of MGP services in Australia.

**Having it**

The participants in this study described the attributes required in an effective MGP manager as having trust in the midwives and the women, as well as being trustworthy themselves. They saw the manager as needing to include the midwives and encourage participation of others in the way forward with an awareness that everyone has something to offer. They described leadership as being based on relationships, and that the manager should encourage the midwives to reach their full potential. The participants identified the need for managers to have a clear vision of the future and be passionate with a deep commitment to what they believe in. Effective leaders are able to inspire
others to realise their vision by being great orators with charisma and the power of persuasion. Although one participant said it was a ‘calling of a higher order’, and the qualities do seem to be an almost impossible expectation of someone, they are attributes according to Bass and Bass (2008) found in transformational leadership. Previous studies have also found transformational styles as ideal for the management of midwives (Byrom & Downe, 2010; Catling et al., 2016; Ralston, 2005).

The participants believed it was necessary for the MGP manager to have emotional intelligence, with one participant saying that if the MGP manager didn’t have emotional intelligence, ‘she needed to get some’ (Mary). Emotional intelligence is also a characteristic of transformational leadership (Tyczkowski et al., 2015). The concept of emotional intelligence was introduced by Salovey and Meyer in 1990 as the ability to monitor or control one’s own feelings and emotions (Bass & Bass, 2008). It was popularised in 1995 by Goleman as a term encompassing a particular number of socioemotional abilities and attributes. Goleman (1998) believed that most effective leaders possess a high emotional intelligence. Bass & Bass (2008) explain emotional intelligence involves positive thinking, understanding relationships and conflict resolution. All of these qualities have been described as necessary for effective management by the participants with forming and supporting relationships being featured throughout this study.

The participants highlighted the requirement for a MGP manager to have both management and leadership qualities, and that they needed a good sense of social justice and feminism to be able to stand up for women. They also
identified that since MGP is a woman-centred relationship-based service, the
effective midwifery leader would probably need different skills to that
required of a nurse manager. Effective leadership in healthcare has been
shown to enhance positive outcomes for the consumers of the service (Wong
et al., 2013). Effective leadership has been identified by the participants in this
study as transformational leadership, although this is not the style generally
found in hospital management (Byrom & Kay, 2011).

Traditional nursing models tend to be managed with autocratic hierarchical
styles, that are top down approaches and may result in staff leaving (Byrom &
management came from the military, where nursing first established itself as
an occupational group during the Crimean war. When midwifery came under
the control of nursing, midwives also came under that autocratic military style
of management (Fahy, 2007). MGP managers are situated within the hospital
hierarchical management team and unless they have been educated in a
different style of leadership, they are likely to learn how to lead from their
managers and peers.

**Someone with their hand on the steering wheel**

The participants discussed the fundamental role of the manager as being
‘someone with their hand on the steering wheel’. Skilfully managing and
guiding a MGP service was described as a vital component of the manager’s
role. The participants said the manager must be able to undertake day to day
management as well as provide leadership. Byrom (2011) supports this stating that good management adds to leadership but does not replace it.

A significant part of managing MGP is ‘midwifing the midwives’ which the participants described as looking out for staff ensuring they are working safely and not getting burnout. The term ‘Midwifing the midwives’ was chosen by the participants to show how the manager should approach supporting the staff using a midwifery philosophy. They believed the manager should avoid telling midwives what to do, or what was good for them, but should convey that they care about them. Brodie (2013) explained midwives need midwifing to support them so they can provide compassionate care for women, babies and families. Participants said ensuring midwives felt well supported was an important priority for the manager and one of the keys to preventing burnout.

The model by Sandall (1997) was promoted by the participants as an exemplary guide for the manager to prevent burnout and support a sustainable MGP. This involves the ability for the midwives to develop meaningful relationships with women through continuity of carer, positive working relationships and occupational autonomy, and having supportive relationships at home and at work. Hunter et al. (2016) found good collegial relationships between group practice midwives to be one of the most important aspects of sustaining them in their practice. Midwives need to care for themselves and each other to be able to care for women. Midwives working in a MGP rely on each other to cover their ‘on-call’ and care for the women in their caseload when they are taking time-off. This requires a shared philosophy, and a spirit of generosity, trust and collective caring within the
group (Leap et al., 2011) and was identified by participants as a practice that needs to be facilitated by the manager.

The participants believed the MGP manager should encourage midwives to have time together, hold bonding sessions and make weekly meetings a priority. Leap et al. (2011) also highlighted this was an important part of the manager’s role. Gilkison et al. (2015) found in a study on sustainability of caseload midwives in New Zealand that a collective understanding of the working arrangements within the group was vital and that midwives required time together to build relationships and negotiate their working arrangements. This is also a time that the manager could touch base with the midwives to ensure they are coping and supported and not working too hard, which the participants identified as vital to the role.

**Juggling the forces**

The participants said managers of MGPs are often having to juggle outside forces while trying to protect the service. They identified one of these forces they needed to juggle was the positioning of MGP within the industrial hospital framework and the medical nursing paradigm. Another force to be juggled was funding embedded in a complex acute services structure.

Trying to provide a holistic, woman-centred service within an institutionalised system designed to treat many sick people was raised frequently by the participants and has also been a focal point in other studies (Hartz et al., 2011; Hartz et al., 2012; Sandall, 2012). How the MGP service is accepted and supported by the whole organisation depends on how it can be integrated into
an already functioning hospital (Dawson et al., 2016). The authors of this study also found participants identified that getting buy in from the executive was difficult and there was still an ‘us and them’ culture between core midwives providing standard hospital midwifery care and caseload midwives (Dawson et al., 2016). This demonstrates the difficulty of placing the MGP service within an acute care setting. However, Hartz et al. (2012) found consolidation of costs from birth centre, team midwifery and birth services into an overarching birthing services cost centre was a key component of successful organisational redesign, freeing money for changes to be more MGP friendly such as providing more ‘active birth’ appropriate rooms. Extensive stakeholder consultation and strategic planning days also played a large part in the clinical redesign to incorporate MGP into an already functioning hospital.

Participants said an example of the difficulty in establishing MGP in a functioning hospital was not having adequate parking, space for antenatal care and meetings or an appropriate environment to house the service. The participants also suggested the environment should be less medicalised and more home-like, and recommended one solution to the problem would be placing MGP in a community setting outside the busy hospital. Cornwell, Donnellan-Fernandez, and Nixon (2008) also supported placing MGP in community settings; provided it can be linked to the hospital’s computerised systems to order tests and check results. They found space to be a premium in the hospital and found midwives working off-site in community settings resolved many of the issues with space and parking; however, infrastructure
for computer access to clinical reporting systems in some situations was problematic.

The dominant paradigms of care were identified as medical and nursing. Nursing was also identified as a contesting power that challenged the MGP manager. Nursing paradigms are the hierarchical frameworks of hospital management that control the services and funding within institutions, therefore controlling the midwifery services. The participants discussed the way hospital management is comprised mostly of nurses who may not understand or value midwifery; this is especially the case with MGP where midwives are autonomous, involved in relationship-based care and working in a primary health care model. The participants said some managers still see little difference between midwifery and nursing. This is supported by Leap, Brodie, and Tracy (2017) who said midwifery was invisible within nursing. Homer et al. (2009) described how the invisibility within the community makes it hard to establish the full role and scope of practice in Australia, in relation to the International Definition of the Midwife (International Confederation of Midwives, 2014). Other factors contributing to this argument are the lack of a clear image of midwifery, the dominance of medicine (Homer et al., 2009) and nurses in powerful positions who have a limited view of the capacity of midwifery (Leap et al., 2017).

The participants recognised how difficult it was for the manager to fit into the hierarchical management system which predominantly displays a different style of management to that required of the MGP manager to be effective. This sentiment was also observed by Deery (2011) who said managers can feel like
the meat in the sandwich with one layer of bread being the staff and the second the upper management. Kirkham (2011) also described this phenomenon, saying the manager often feels trapped between two different value systems. Deery (2011) suggested the manager needed to be versatile, but that this versatility can be detrimental to the wellbeing of the manager.

Medicine was also seen by the participants as being a dominant and competing professional group that threatens the establishment and sustainability of MGP programs. Doctors were perceived as viewing midwives as nurses making it hard for midwives to gain traction in the role of autonomous primary care providers. Homer (2016a) described how there are still fears within the medical-nursing paradigm around the autonomy of midwives. The medical profession are always sceptical about the ability of midwives to provide safe maternity care, unless medically supervised (Monk et al., 2013). Dawson et al. (2016) said acceptance and integration of the model depended on buy in and support from maternity management and medical staff. The engagement and support of senior management and give and take between professionals affects how effectively the MGP performs and functions (S. Tracy et al., 2013).

A common thread throughout the study was the importance placed by the participants on the manager’s ability to form and nurture relationships with key professionals and consumer groups. Participants identified the need to have good relationships with the upper nursing management and doctors in key positions, for example those in charge of obstetrics, paediatrics and GP organisations. The support for MGP was much more likely to occur if the manager promoted the service at every opportunity—the participants
explained the consequences of autonomy can be invisibility. Taking every possibility to educate stakeholders on the benefits of MGP was also vital since people are more likely to resist what they do not understand. The participants said the manager needs to be able to form good relationships with key personnel who will back the service when MGP is threatened.

Dawson et al. (2016) found in the study looking at managers views on implementing MGP that support from stakeholders was vital to implementation and sustainability of the model. Poor inter-professional relationships in maternity have been the subject of some government reviews calling for harmony within the maternity workforce (Department of Health, 2009). However, Hartz et al. (2012) found the implementation of MGP became a catalyst for improving relationships, through robust, inclusive and transparent negotiation. Leap et al. (2011) suggest that identifying those in leadership positions who are supportive of the MGP service and building on that relationship can be an important strategy. They also describe collaboration as requiring those in power to relinquish it to those who have traditionally not had access to it. Brodrick, Mason, Baldwin, and Cowley (2011) also identify the need for professionals to have equity in status and roles to enable good collaboration, but are mindful this may be in conflict with traditional hierarchical healthcare services. Byrom et al. (2011) identified the need for the manager to be clear about their values and beliefs, while building relationships based on mutual dignity and respect.

The participants in this study described the issues around funding for MGP, how this is a constant threat and there still remains a belief MGP is more
expensive than standard care, despite evidence to the contrary. S. Tracy et al. (2013) found in a randomised controlled trial that MGP cost $566.74 per woman less than standard care; the median cost per woman was $5903.67 for standard care and $5497.34 for MGP care. This cost saving was attributed to more normal births, a higher proportion of spontaneous onset of labour, less use of pharmaceutical analgesia, fewer women with postpartum haemorrhage, fewer antenatal visits and a reduction in postnatal length of stay. However, Dawson et al. (2016) found service managers did have legitimate concerns regarding the establishment phase of MGP where start-up funding to employ a project manager is often needed. The authors also found in their study on managers’ views regarding implementing MGP that cost was seen as an obstacle by 22% of the managers who participated (Dawson et al., 2016).

The participants in this study also discussed cost of the MGP service as being seen as expensive because of the salaries of the midwives, which was often not considered in the context of the reduction in costs due to of less intervention and better outcomes for women and babies. Toohill et al. (2012) explain that assumptions about salaried midwives increasing the cost of midwifery models are not founded, especially if the cost is considered as part of the total package of care. Lower hospital resource use due to less intervention and better outcomes for mothers and babies means the overall cost of care is less (Toohill et al., 2012).

The participants in this study believed the funding of these services was extremely difficult in the present funding models within Australia, which are short term and acute service focused. Monk et al. (2013) also reiterated this
theme, saying that while MGP is situated within the industrial hospital system with no specific funding for midwifery models of care, the allocation of funding for these services will always be problematic due to competition from other more powerful disciplines. The participants in this study proposed a solution to the problem could be a bundled price for maternity services. Hendry (2009) explains how a similar system of payment for maternity care occurs in New Zealand where practitioners receive modular payments for each woman. These payments are divided into first and second trimester, third trimester, labour and birth, and postnatal. The woman needs to register who her Lead Maternity Carer is for the midwife or doctor to claim payments for care. The framework aims to provide the woman with one main health practitioner (Hendry, 2009). This form of funding could offer more incentive to encourage the growth of MGP in Australia. By having funding geared towards the woman’s needs and being flexible New Zealand has witnessed a revolution in maternity care over the past 20 years with more than 90% of women having a named midwife.

**Helping managers to manage better**

Participants said effective management was integral to the success of the service; this was supported by Cummings et al. (2010) who identified that improving managerial skill was the key to workforce sustainability. The participants described the apathy from managers in developing leadership skills by highlighting the lack of attendance when seminars on this subject were available. However, if the subject matter was clinical there would be interest, illustrating how leadership training is not prioritised.
participants explained that midwifery management training has not been a priority and the necessary skills do not always come naturally for managers. They explained how MGP managers needed to be educated in both leadership and management to prepare them for such a difficult job. There is debate in the literature about whether leadership is inherent in a person or can be learnt. The ‘Great Man’ theory states leaders are born and not made (Sethuraman & Tamilnadu, 2014); however, Carragher and Gormley (2017) argue leadership can be learnt and nurtured and that it evolves over time.

Debono et al. (2016) reported on the shortcomings in manager preparation and leadership development in Australia and discussed how some managers felt ill prepared for their role, with potential impacts on staff retention and satisfaction. The participants explained that preparation for midwifery managers needed to be specific to midwifery and not the same as nursing. The study by Debono et al. (2016) described all the participants in the evaluation of the ‘Take the Lead’ program as Nursing/Midwifery Unit Managers (N/MUM’s) and did not distinguish between them, even in the demographics section. The ‘Take the Lead’ program was designed to strengthen the capacity of Nurse Unit Managers and Midwifery Unit Managers in NSW. The lack of definition between the two disciplines in this evaluation highlights the challenge in providing management training specific to midwives when some do not see the professions as different. It also demonstrates that if the education of midwifery managers is to be specific to midwifery, it will need to be driven by midwifery as a profession because as discussed by Gray and
Smith (2017), midwifery is the profession that is fighting to be separate from nursing, not nursing (Leap et al., 2017).

Autocratic leadership found in most hospital hierarchies is an example of the transactional leadership style where a reward is offered for compliance (Giltinane, 2013). Giltinane (2013) argues a leadership style that incorporates both transactional and transformational styles—known as situational leadership—is more appropriate for nursing as it allows changes in styles as needed. This finding was also suggested by Wong et al. (2013) who said some elements of both transactional and transformational styles may be needed in nursing. Byrom and Kay (2011) described how midwifery managers require a more relationship-based form of leadership and management with more feminine values such as caring nurturing and intuition. These three studies support the participants view that midwifery managers require different leadership education to nursing managers.

The participants also discussed how the manager required appropriate support in the form of mentorship to prevent professional isolation and to support them in their difficult role. It was suggested by the participants that the Australian College of Midwives or the Nursing and Midwifery Office should have a body of mentors available to the MGP managers. They cautioned that the mentors would need appropriate experience and qualities to be effective mentors. Meetings for MGP managers to get together for networking was also suggested.
The need for mentorship was supported in a study by Morin et al. (2015) investigating leadership development in nurses in the United States and Canada. They found the mentorship relationship provided in the study was so effective it was continued after the study finished and has been so successful the mentorship program has been expanded. Byrom and Kay (2011) discussed how a study by Kay in 2007 found a system of mentoring was required for aspiring midwifery leaders so that the role could be supported and encouraged. Debono et al. (2016) found in the evaluation of the ‘Take the Lead’ study in NSW, that the participants in the study found leadership improvement was due to course content and networking that occurred due to ‘Take the Lead’. The participants in this study said they felt less isolated and gained reassurance from shared experience. The evidence suggests mentorship should be available to managers; and networking between managers is also important to encourage support and prevent professional isolation. Professional isolation would an even greater threat for MGP managers since most would be the only person in that role in the hospital.

**Limitations of the study**

Purposively choosing the participants for this study—while necessary to achieve the essential criteria and experience of the participants—means the selection bias may influence the results. The selection bias also threatens the external validity of this study because the outcomes may be preferential to the researcher’s biases. As well, the participants were known by the researcher and this could influence what they said. Another limitation is this study adopted a top-down approach by exploring the views of midwifery leaders and
not the actual managers or their followers, even though many of these leaders had also managed MGPs in the past. The study sample was small and may not reflect the views of the wider population of midwifery leaders; however, this was an appropriate sample size for a Master of Research study and allowed in-depth exploration of the issues. The majority of the participants came from one state in Australia which may also not be reflective of the wider midwifery leader population; however, most of the leaders had worked interstate and overseas and therefore could draw on other experiences.

**Recommendations**

Further research is needed into the management of MGP models, and into their sustainability. A world-wide shortage of midwives is forecast in the future (Büscher, Sivertsen, & White, 2009); with management skill linked to staff retention (Cummings et al., 2010; Hildingsson et al., 2016), it is paramount that managers have the leadership skills to take midwifery into the future. To improve outcomes for women and babies, more innovative MGP models are required, along with midwifery leaders who can generate innovative change.

Further research is needed on the proper preparation of these individuals for effective management and leadership, with a specific focus on MGP managers. Surveys could be undertaken to determine the leadership styles of managers currently employed in maternity units, and ways to improve areas of deficit in these individuals. Research into the attributes the midwives believe are necessary in a midwifery manager would also shed light in this area.
Universities should ensure they have appropriate modules of study to teach transformational leadership and management specific to midwives. This could be incorporated as part of a Masters in healthcare leadership. Education in midwifery leadership should be an essential criterion for midwifery and MGP management positions, which would make being educated in this area a much bigger priority. Part of the education of the managers and potential managers could incorporate opportunities for networking, to develop ongoing support. A professional body of mentors should be available to the managers, and this might be best identified through the peak professional midwifery body, the Australian College of Midwives.

In New Zealand and the UK, research has been conducted into the sustainability of caseload midwives to identify what helps individual midwives stay in continuity of carer models; it would be useful to gain an Australian perspective. Research into barriers to the establishment and sustainability of MGP would give further insight into how this service could be made more robust and more available to women. Further study of maternity funding, to reform funding for midwifery models of care, is vital. Studies of services established within the community would also contribute to knowledge of sustainability of MGP services.

Conclusion

This study focussed on the attributes required of a MGP manager to promote sustainability of the service. A qualitative inquiry based on interpretive description was used to explore views of participant leaders in midwifery on
the requirements for the manager’s role. A lack of preparation for the role specific to midwifery was identified, along with a dearth of appropriate mentorship. The opportunity to network with other MGP managers was also identified as necessary to prevent professional isolation. An effective MGP manager should have both leadership and management abilities and a transformational style of leadership.

Participants identified barriers to MGP as funding, competition between dominant groups, the invisibility of midwifery within nursing, and trying to fit a holistic model of care into an acute care system. They emphasised the need for the manager to form relationships with all stakeholders, especially nursing and medical key personal within the institution, and community and consumer organisations, with a view to establishing the majority of MGP care within the community.

The attributes of a transformational leader must include a strong midwifery philosophy and a commitment to the midwife-woman relationship. Commitment to supporting relationships is a vital component of the MGP manager’s job and the sustainability of the MGP service. ‘Midwifing the midwives’ and ensuring relationships between midwives are healthy will enable the midwives to provide woman-centred care.
References


Brodie, P. (2013). 'Midwifing the midwives': Addressing the empowerment, safety of, and respect for, the world’s midwives. *Midwifery, 29*, 1075-1076. doi:.org/10.1016/j.midw.2013.06.012


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Appendix A – Ethics approval letter

Locked Bag 1797
Penrith NSW 2751 Australia
Research Engagement, Development and Innovation (REDI)

REDI Reference: H11713
Risk Rating: Low 1 - LNR

HUMAN RESEARCH ETHICS COMMITTEE

11 July 2016

Professor Hannah Dahlen
School of Nursing and Midwifery

Dear Hannah,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H11713 “What attributes are required of managers to effectively manage a Midwifery Group Practice?”, until 1 April 2017 with the provision of a progress report annually if over 12 months and a final report on completion.

Conditions of Approval

1. A progress report will be due annually on the anniversary of the approval date.

2. A final report will be due at the expiration of the approval period.

3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to being implemented. Amendments must be requested using the HREC Amendment Request Form: http://www.westernsydney.edu.au/__data/assets/pdf_file/0018/491130/HREC_Amendment_Request_Form.pdf
4. Any serious or unexpected adverse events on participants must be reported to the Human Ethics Committee via the Human Ethics Officer as a matter of priority.

5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the Committee as a matter of priority.

6. Consent forms are to be retained within the archives of the School or Research Institute and made available to the Committee upon request.

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to the email address humanethics@westernsydney.edu.au.

This protocol covers the following researchers:

**Hannah Dahlen, Holly Priddis, Leonie Hewitt**

Yours sincerely

[Signature]

Professor Elizabeth Deane

Presiding Member,

Human Researcher Ethics Committee

Western Sydney University
Appendix B – Invitation Email

Dear XXXXXXXX,

I would like to invite you to participate in my research titled:

**What attributes do Australian midwifery leaders identify as being essential to effectively manage a midwifery group practice (MGP)?**

This research will form the thesis part of the Master of Research course through Western Sydney University. You have been chosen because of your considerable contribution to midwifery, your leadership qualities and your experience in midwifery models of care. I have attached an information form to read at your leisure.

Please do not feel under any obligation to participate. However, if you indicate to me via email that you would like to participate a consent form will be returned to you. If I do not receive a signed consent form no further contact will be made to you regarding this research. Please feel free to contact me by phone on 0407398576 or email at 18504978@student.westernsydney.edu.au if you have any questions.

Regards,

Leonie Hewitt

Master of Research student
Appendix C – Participation Information Form

Participant Information Sheet – General (Specific)

Project Title: Australian midwifery leaders views on the attributes required in managers to effectively manage a midwifery group practice (MGP).

Project Summary: The study aims to explore the views of midwifery leaders to find key attributes needed from a MGP manager. Good management of MGP is essential to caseload midwife retention and sustainability of these models of care.

How is the study being paid for?

You are invited to participate in a research study being conducted by Leonie Hewitt, Master of Research student, Western Sydney University. This research will be supervised by Professor Hannah Dahlen and Doctor Holly Priddis both of Western Sydney University.

What will I be asked to do?

You will be asked to attend one-to-one interviews at a time that suits you. You will be asked open-ended questions regarding your opinion on the desirable qualities of a MGP manager. The interviews will be audiotaped.

How much of my time will I need to give?

The interview is expected to take about an hour of your time.

What benefits will I, and/or the broader community, receive for participating?

There are no direct benefit to participants. There is little research on the requirements of a MGP manager. The results of this study will help to contribute to the research and understandings of the attributes required in this role and to the optimal way to develop these attributes.
Will the study involve any risk or discomfort for me? If so, what will be done to rectify it?

There will not be physical discomfort involved in this study. The questions are framed in a positive context and should not cause emotional trauma. However, if it does cause distress you can access counselling through Sydney Women’s Counselling Centre on 02 9718 1955 or Lifeline on 131 114.

How do you intend to publish or disseminate the results?

It is anticipated that the results of this research project will be published and/or presented in a variety of forums. In any publication and/or presentation, information will be provided in such a way that the participant cannot be identified, except with your permission. Only the researchers will have access to information on participants, the data will be coded and kept separate from the consent forms which will be in a locked cabinet. Pseudonyms will be used for publication, and you are welcome to view the transcript of your interview if you wish to.

Will the data and information that I have provided be disposed of?

Please be assured that only the researchers will have access to the raw data you provide and that your data will not be used in any other projects. Please note that minimum retention period for data collection is five years post publication. After this time, the data and information you have provided will be securely disposed of.

Can I withdraw from the study?

Participation is entirely voluntary and you are not obliged to be involved. If you do participate you can withdraw at any time without giving reason.

If you do choose to withdraw, any information that you have supplied will be disposed of.

Please contact the Chief Investigator by email or phone if you wish to withdraw from the research.

Can I tell other people about the study?
Yes, you can tell other people about the study by providing them with the Chief Investigator's contact details. They can contact the Chief Investigator to discuss their participation in the research project and obtain a copy of the information sheet.

**What if I require further information?**

Please contact Leonie Hewitt should you wish to discuss the research further before deciding whether or not to participate.

Leonie Hewitt, Master of Research student, phone 0407398576 or email on 18504978@student.westernsydney.edu.au

**What if I have a complaint?**

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through Research Engagement, Development and Innovation (REDI) on Tel +61 2 4736 0229 or email humanethics@westernsydney.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.

If you agree to participate in this study, you may be asked to sign the Participant Consent Form. The information sheet is for you to keep and the consent form is retained by the researcher/s.

This study has been approved by the Western Sydney University Human Research Ethics Committee. The Approval number is [enter approval number once the project has been approved].
Appendix D – Participation Consent Form

Consent Form – General (Specific)

Project Title: Australian midwifery leaders views on the attributes required in managers to effectively manage a midwifery group practice.

I hereby consent to participate in the above named research project.

I acknowledge that:

- I have read the participant information sheet and have been given the opportunity to discuss the information and my involvement in the project with the researcher.

- The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to:

☐ Participating in an interview

☐ Having my information audio recorded

I consent for my data and information provided to be used strictly for this project.

I understand that my involvement is confidential and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.
I understand that I can withdraw from the study at any time without affecting my relationship with the researcher/s, and any organisations involved, now or in the future.

Signed:

Name:

Date:

Return address: Leonie Hewitt email: 18504978@student.westernsydney.edu.au

This study has been approved by the Human Research Ethics Committee at Western Sydney University. The ethics reference number is: H/[insert number]

What if I have a complaint?

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through Research Engagement, Development and Innovation (REDI) on Tel +61 2 4736 0229 or email humanethics@westernsydney.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix E – Open Ended Questions for Interview

Questions for Interview

1. Think about a MGP you have worked in managed or established. It is important that it is successful, so now think about the qualities you want the person running it to have.
2. Think about the qualities you don’t want them to have.
3. Now think about a leader, someone who is not necessarily a midwife, but might be a world leader, what qualities do you think that person has that leads you to believe they are a great leader?
4. Are there any other qualities a MGP manager requires to encourage sustainability of the service?
5. What do you think are the barriers to MGP being available to all women in Australia?
Appendix F – Demographics Questionnaire

Research Project through Western Sydney University

Please take a few minutes to answer the following questions. Information from all participants will be combined to describe the participants who have taken part in the interviews. All responses will be anonymous.

1. How old are you? ____

2. Were you born in Australia?

   Yes 1
   No 2

3. Are you of Aboriginal or Torres Strait Islander origin? (circle one number only)

   No 1
   Aboriginal 2
   Torres Strait Islander 3

4. In which country were you born?

   Australia 1
   United Kingdom 2
   New Zealand 3
   Other ____________ 4

5. What is your current position?

   Clinical midwife 1
   Manager 2
6. How many years have you been a Midwife? ___ years

7. How many years have you been involved with midwifery continuity of care programs? ___ years

Thank you very much for taking the time to complete this survey

Western Sydney University study demographic information of midwife participants
<table>
<thead>
<tr>
<th>Theme</th>
<th>Sub-theme</th>
<th>concepts</th>
<th>codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Holding the ground for midwifery, for women</td>
<td>Having it</td>
<td>a manager that was holding the ground, the birth territory stuff,</td>
<td>Being strong, holding the line in a way</td>
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<td></td>
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<td></td>
<td>Vision</td>
<td>It's a calling of a higher order</td>
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<td></td>
<td>Passion</td>
<td>They need to be visionary</td>
<td></td>
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<tr>
<td></td>
<td>Realistic</td>
<td>Deep commitment to what they believe in, not to be inflexible but</td>
<td>to be passionate</td>
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<tr>
<td></td>
<td></td>
<td>They need to be a realist, and I think also pragmatic.</td>
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<tr>
<td></td>
<td>Courageous, integrity, Feminist,</td>
<td>She's got courage, she's got integrity, she's brave, she's got vision</td>
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<tr>
<td></td>
<td></td>
<td>and she stands up for women.</td>
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<td></td>
<td>Humility</td>
<td>Humility goes with that if you have that sort of social justice and</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>feminism and those things then inevitably you're humble</td>
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<tr>
<td></td>
<td>Strength</td>
<td>Does require a strength</td>
<td></td>
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<tr>
<td></td>
<td>Brave, take risks,</td>
<td>Need to take risks in lots of areas to be a good leader</td>
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<tr>
<td></td>
<td></td>
<td>They have to be quite brave</td>
<td></td>
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<tr>
<td></td>
<td>Authentic and trustworthy</td>
<td>They need to be authentic, and they need to be trustworthy</td>
<td></td>
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<tr>
<td></td>
<td>trust</td>
<td>You should trust your staff, you trust the process, you trust the</td>
<td></td>
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<tr>
<td></td>
<td>Emotional intelligence</td>
<td>system</td>
<td></td>
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<td></td>
<td>Inclusion</td>
<td>it's knowing that everyone has something to offer</td>
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<tr>
<td></td>
<td>Power of persuasion</td>
<td>clever with his persuasive powers, and a little bit of charisma</td>
<td></td>
</tr>
<tr>
<td>Characteristic</td>
<td>Description</td>
<td></td>
<td></td>
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<td>----------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
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<tr>
<td>Charisma, great orator</td>
<td>They need to be a great orator, they need to have charisma,</td>
<td></td>
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<tr>
<td>Someone with their hand on the steering wheel</td>
<td>So unless someone’s got their hand on the steering wheel and going I know you want to go there but we are going back here</td>
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<tr>
<td><strong>Managing the service</strong></td>
<td>They have to be able to manage as well</td>
<td></td>
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</tr>
<tr>
<td>Understanding the concept of MGP</td>
<td>Need to understand where the service fits within the health system</td>
<td></td>
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<tr>
<td>Promoting the service</td>
<td>Promoting in every venue that they can</td>
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<tr>
<td>Managing risk</td>
<td>They’ve got to be able to establish that this is a very safe practice</td>
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<tr>
<td>Being strategic</td>
<td>I’ve always found there’s probably a dozen steps here</td>
<td></td>
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<tr>
<td>Succession planning</td>
<td>Leaders and managers to make sure they are breeding the new leaders and managers</td>
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<tr>
<td>New grads</td>
<td>We need to gobble them up fast and put them into models of care</td>
<td></td>
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<tr>
<td><strong>Midwifing the midwives</strong></td>
<td>Midwifing the midwife’ in the best possible way</td>
<td></td>
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<tr>
<td>Protection of the midwives</td>
<td>It’s about going in and defending them</td>
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<tr>
<td>Professional boundaries</td>
<td>Because they try to do too much. They try to be the provider of everything for the woman</td>
<td></td>
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<tr>
<td>Happy midwives</td>
<td>Managers need to make sure that the reality is good for midwives</td>
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<tr>
<td>Jane Sandalls mantra</td>
<td>She actually identified three things for a successful group practice, which I think are the framework still today</td>
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<tr>
<td>Autonomy</td>
<td>Being able to let the group practice midwives get on with their job</td>
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<tr>
<td>Professional development</td>
<td>...It's ensuring that there's ongoing education that goes on</td>
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<tr>
<td>Supporting relationships</td>
<td>it takes a whole cohesive team involving the manager to raise a group practice</td>
<td></td>
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<tr>
<td>Meetings</td>
<td>that meeting was more than just sharing tasks</td>
<td></td>
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<tr>
<td>Outside help</td>
<td>it's about bringing in somebody from outside to help rather than the manager themselves doing it</td>
<td></td>
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<tr>
<td>Juggling Forces</td>
<td>a balancing act… a juggler… Protecting from outside forces</td>
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</tbody>
</table>

**Trying to work in the system**

- **Disbelief in the model**
  - Trying to deal with putting something that is completely organic into a totally industrial factory model
  - It doesn’t fit their biases of what currently happens

- **The concept is too hard**
  - It’s this whiz-bang clever thing that normal people couldn’t possibly do

- **Not providing an environment or resources**
  - The environment should be a birth house not a bloody factory

**The medical/nursing paradigm**

- **Nursing**
  - We’re still stuck with nursing leadership who don’t get midwifery –

- **Industrialised hierarchical environment**
  - Because her manager is saying to her whose side are you on?

- **Midwives**
  - the majority of midwives are ‘with institution’ they’re not ‘with woman’

- **Invisibility of midwives**
  - The invisibility of midwifery in maternity care in Australia

- **Medicine**
  - Who see good midwives as being the ones who can work all the machines for them
<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unions</td>
<td>The unions would shut down continuity of care like a shot.</td>
</tr>
<tr>
<td><strong>The filthy dollar</strong></td>
<td>Our biggest barrier to everything that happens in maternity is the filthy dollar.</td>
</tr>
<tr>
<td><strong>Making MGP work</strong></td>
<td></td>
</tr>
<tr>
<td>Getting the culture ready</td>
<td>to get them really in the know and understanding what it was.</td>
</tr>
<tr>
<td>Forming relationships</td>
<td>Managers’ role is to align yourself with the director of obstetrics—also the director of nursing.</td>
</tr>
<tr>
<td>Sharing benefits and building communities</td>
<td>Understand the value of placing practices in the community.</td>
</tr>
<tr>
<td>MGP in the community</td>
<td></td>
</tr>
<tr>
<td>Consumer groups</td>
<td>If you keep with the women, you make it happen.</td>
</tr>
<tr>
<td>Engaging women in service planning</td>
<td>Bringing women together to form friendships with each other.</td>
</tr>
<tr>
<td>Helping managers manage better</td>
<td></td>
</tr>
<tr>
<td>Manager education</td>
<td>We imagine that it must come naturally, but you can train people in management and leadership.</td>
</tr>
<tr>
<td>Manager reluctance to be Educated</td>
<td>I put on a seminar here – it’s practically empty.</td>
</tr>
<tr>
<td>Mentorship</td>
<td>Managers should seek mentorship through ACM or NaMO.</td>
</tr>
</tbody>
</table>
Table 1 Themes and sub-themes