NEW ZEALAND RESEARCH

Partnership and reciprocity with women sustain Lead Maternity Carer midwives in practice

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ABSTRACT

New Zealand has a unique maternity service model, whereby women at low risk of complications receive their maternity care from a community based Lead Maternity Carer (LMC) who is usually a midwife, but could be a general practitioner or an obstetrician. Over 80% of women in New Zealand choose to have a midwife as their LMC (Grigg & Tracy, 2013; Guilliland & Pairman, 2010). LMC midwives practise under contract to the Ministry of Health, taking a caseload and providing continuity of care (which requires being on call) for the women booked with them.

This qualitative descriptive research set out to understand what sustains on call case- loading LMC midwives who have practised as LMCs for at least eight years. Eleven midwives with 8 to 20 years in practise were recruited and interviewed. Thematic and content analysis was carried out on the data. This article presents an overview of the findings from this study and extracts of selected data.

Themes emerged from the findings which described how midwives were sustained in on call, caseloading practice. Themes identified include: the joy of midwifery practice; working in partnership; supportive family relationships; supportive midwifery relationships; generosity of spirit; like-minded midwifery partners, practice arrangements; managing the unpredictability of being on-call; realising one is not indispensable; learning to say "no"; negotiating and keeping boundaries; and passing on the passion for midwifery. This paper is the first in a series. It explores the themes of partnership, and how working in partnership sustains the joy of practice and provides context to the study. Future papers from the study will report on other themes from the study. The significance of this research is that it informs present and future maternity service provision and education.

KEY WORDS

Caseloading, midwives, partnership, reciprocity, sustainability

INTRODUCTION

Sustainability of the Lead Maternity Care (LMC) model is a topic of interest to midwives and other health professionals both nationally and internationally. In the context of this study, sustainability means to enable something continue to exist, whilst maintaining the integrity of the mental and physical wellbeing of the agent. Women in New Zealand choose their LMC who may be a midwife, a general practitioner or an obstetrician. The LMC service is government funded so that maternity care is free for the woman (excepting for those who choose a private obstetrician who charges an additional fee for service) and provided for all New Zealand women regardless of where they choose to birth (Ministry of Health, 2007). LMCs can also be general practitioners who need to employ a midwife. LMCs who are midwives practise on their own authority, provide continuity of midwifery care throughout pregnancy, labour, birth and up to six weeks of the postpartum period for women who choose to book with them. LMC midwives are legally able to access named maternity facilities within their local maternity system. Midwives collaborate with other health professionals when the woman's circumstances require. They consult and refer to their obstetric colleagues when childbirth deviates from normal (Midwifery Council of New Zealand, 2013). There is an agreed set of criteria for consultation and referral (Ministry of Health, 2012).

There is a high level of satisfaction expressed by the majority of New Zealand women with the LMC model of care (Ministry of Health, 2011) and midwives working in continuity of care with women find this a satisfying way to work. LMCs are able to provide midwifery care across primary and secondary services. In their systematic review of Randomised Controlled Trials examining the benefits of continuity of care Sandall, Devane, Soltani, Hatem, & Gates (2010), found that midwifery led care improves maternity outcomes. In their Australian study, Tracy et al., (2013) found midwifery led care to also be economically beneficial. The challenge for midwives is to sustain this model of practice, especially being on call (McLardy, 2003). This research investigates what sustains LMC midwives in practice over a number of years. The issue of sustainability at the present time is being explored not only in relation to the environment but in every aspect of life, business and service provision. Kirkham (2011) goes so far as to say that midwifery as a model of care is not only sustainable but it also contributes to society's sustainability. The philosophy which underlies

midwifery is strongly aligned with sustainability since midwives promote normal (physiological) birth that aims to keep childbirth interventions to a minimum; only using interventions judiciously when clinically required. This means that midwifery care is not resource intensive (Davies, Daellenbach, & Kensington, 2011). It is estimated that the accumulation of childbirth interventions increases the relative cost of birth by up to 50% for low risk primiparous women and up to 36% for multiparous women (Dahlen et al., 2012). Caesarean section is the most expensive mode of delivery (Allen, O'Connell, Farrell, & Baskett, 2005). Rising rates of intervention, which are not associated with improved outcomes, are of concern both in terms of morbidity for low risk women and their cost to the state (Dahlen et al., 2012).

Hence physiological birth is sustainable economically but we also argue provides sustainable long term benefits to the woman and her baby. Walsh (2008) and Beech and Phipps (2008) claim that physiological birth may result in improved maternal-infant attachment, less Post Traumatic Stress Disorder (PTSD) and better parenting. The other important contribution which midwifery makes to sustainability is that midwives support health practices which positively contribute to the ongoing health and wellbeing of women and their families (Davies et al., 2011).

While the midwifery model of care is sustainable it is also important to understand what sustains the midwives who provide the service. In the United Kingdom (UK) researchers recruited midwives with greater than 15 years of clinical experience and interviewed them about their understanding and experience of resilience. The findings of this research identified managing and coping, self-awareness and the ability to build resilience as key to resilience in midwifery practice (Hunter & Warren, 2013). Hunter and Warren (2013) identified the need for further research which explores the resilience of midwives in different settings as they believe it will provide insight into sustainable practice.

This study focusses on the New Zealand LMC model of midwifery care which provides continuity of care and is embedded in the New Zealand maternity system. In other regions in the world continuity of care remains sporadic and not woven into the maternity system as a whole. Recent research on the experience of caseloading midwives in New Zealand has focused on issues related to the challenges of being on call, providing continuity of care, work/life balance and burnout (Cox & Smythe, 2011; Donald, 2012; Young, 2011). While these studies offer important insights into the experiences of midwives, the literature seems incomplete without the voice of what does sustain LMC (NZ caseloading) midwives. Although some themes are shared in the continuity of care international literature the New Zealand maternity model is able to provide new insights into how such provision is sustainable. This research positions itself to address these gaps in the literature in relation to the sustainability of LMC midwifery practice by giving voice to how a selected group of midwives have sustained the LMC model of midwifery care over their practice lives.

RESEARCH METHODS AND METHODOLOGY

A qualitative descriptive methodological approach was used in this research. The theoretical framework that informs the study is the paradigm of 'naturalism' in so far as the researcher seeks to gather information and describe a situation as it occurs (Burns & Grove, 2001; Sandelowski, 2010). A qualitative descriptive approach facilitates the interpretation and analysis of findings remaining 'data near' (Sandelowski, 2010). This type of methodology is particularly useful when describing a phenomenon such as sustainability of practice as it enables the 'what' and 'how' to be shown and facilitates the process of eliciting stories and insights from midwives about the sustainability of their practice (Neuman, 2011).

Ethical approval for this study was obtained through the Auckland University of Technology Ethics Committee (AUTEC). Data collection took place during 2011 and 2012. Eleven participants, from rural and urban areas across New Zealand who had been in practice a total of between 8 and 20 years, were interviewed. Purposive sampling using the researchers' professional networks meant that midwives who met the research inclusion criteria were able to be reached and recruited. The midwives were contacted by email, phone or in person and given the information about the study and asked if they wished to participate. Semi-structured and open-ended questions were used so that participants could readily present their practice and what sustains them in practice. Each interview took approximately 45-90 minutes and was audio taped and transcribed. Transcripts were returned to the participants when requested and when clarification was required. Confidentiality was maintained by the use of pseudonyms and details were changed that might readily identify the participant.

While the midwifery model of care is sustainable it is also important to understand what sustains the midwives who provide the service.

Thematic and content analysis was the method used to analyse data. A systematic analysis of the content was undertaken providing a provisional analysis, which facilitated data then being grouped into themes. These themes were then analysed by members of the research team. The analysis was brought back to the whole group for peer review and comment. The data were then further analysed using the comments from the peer review. During this process there was also a linking of themes, which showed a relationship to each other. This method meant that data rich in detail were collected and this enabled a description of the experience, followed by an identification of the themes and emergence of patterns across the midwives' practices. In this way an understanding of what sustains the midwives in LMC practice was formed.

LITERATURE AND SUSTAINABILITY OF MIDWIFERY PRACTICE

The sustainability of different models of midwifery care and, in particular, LMC caseloading midwifery in New Zealand, has been of interest for a number of years (Davies et al., 2011; Donald, 2012; Earl et al., 2002; Engel, 2000, 2003; Homer, Brodie, & Leap, 2008; McLardy, 2003; Sandall, 1997; Wakelin & Skinner, 2007; Young, 2011). A review of the literature shows there is limited national or international research regarding what sustains midwives in on call, caseloading practice. In 1997, Sandall's UK research, identified three themes that avoid burnout and positively contribute to sustainable midwifery practice in a continuity of care model. These factors were: occupational autonomy, meaningful and positive working relationships and supportive relationships at home (Sandall, 1997). Research since then has supported these findings but has also presented new factors which sustain—such as the relationship between the woman and midwife and the midwife's role in helping women achieve a 'good' birth (Sandall, Devane, Soltani, Hatem, & Gates, 2010). In New Zealand, the model of midwifery care, wherever the midwife practices, is philosophically based on woman-midwife relationship being one of partnership. This relationship is one of reciprocity and trust and has long informed the midwife-woman relationship in New Zealand (Guilliland & Pairman, 1994). The nature and quality of relationship between the midwife and the woman and her family/whānau is a significant factor in

a number of studies, along with the partnership and reciprocity that is developed through continuity of care (Deery & Hunter, 2010; Hunter, Berg, Lundgren, Ólafsdóttir, & Kirkham, 2008; Leap, Dahlen, Brodie, Tracy, & Thorpe, 2011).

Kirkham (2011) claims that models of care where midwives are autonomous are an important feature of sustainable midwifery. In England some midwives leave midwifery because they cannot practise autonomously. (Curtis, Ball, & Kirkham, 2006). The ability to practise autonomously and provide continuity of care, as in New Zealand, may create a more sustainable midwifery model. Kirkham (2011) believes that midwives in the UK value the New Zealand model where a woman chooses a midwife and midwives provide care for individual women. If autonomy and continuity of care are an important part of the sustainability of the maternity service, it is of the utmost importance that there is research to identify what sustains those who provide this service.

Recent New Zealand research on LMC caseloading midwifery has focused primarily on the issues of continuity of care and carer, workforce, work/life balance, and burnout (Cox & Smythe, 2011; Donald, 2012; Wakelin & Skinner, 2007; Young, 2011). Research has been undertaken on LMC caseloading midwifery and its impact on midwife's home-life identified the importance of boundaries (Engel, 2003). A survey of LMC midwives showed that continuity of care and the quality of relationships both sustained and were problematic for some midwives in supporting them in their practice (Wakelin & Skinner, 2007). LMC midwives in New Zealand, or their backup midwives, are available 24 hours a day, 7 days a week, to provide phone advice to the woman and assessment of urgent problems (Ministry of Health, 2007). Young (2011) showed that, within the provision of LMC midwifery service and the demands of on call, there is real potential for burnout. These findings are echoed in Donald's (2012) research on LMC practice and work and life balance, which concluded that midwives needed to ensure that they met their need for regular time off as well as meeting women's needs.

Throughout all of this research into LMC caseloading midwifery, whether the topic was burnout, work and life balance, or continuity of care, there was a common thread that midwives be passionate about, and find a real joy in midwifery (Cox & Smythe, 2011; Donald, 2012; Leap, Dahlen, Brodie, Tracy, & Thorpe, 2011; Young, 2011). In an Australian study, Leap, Dahlen, Brodie, Tracy and Thorpe (2011) audio taped their own personal conversation about midwifery models of care and, in analysing the conversation, identified crucial elements of sustainability. They claim, as had researchers from the UK that relationships are the most important aspect of sustainability. Building positive relationships with women, between midwives and with maternity care systems, ensured sustainable practice (Leap et al., 2011). In this conversation, however, other important aspects of sustainability were identified including good will, generosity of spirit, trust, feeling connected and taking care of one's self. They also made a case that sustainable midwifery practice required midwives to work with like-minded colleagues who shared the same philosophical beliefs. The conclusions that emerged from this conversation among midwives around a kitchen table, published under the heading 'Relationships – the glue that holds it all together', are confirmed by the findings of our research.

RESEARCH FINDINGS:

The midwives in this research articulated that it is relationships with women, midwifery practice partners, the midwifery community at large, and families and friends that sustain them in practice. Participants identified that the important features of sustainable relationships with midwifery practice partners are that partners are philosophically aligned, support each other in practice and on a personal level. Organised practice structures and arrangements that allow for regular time off were other aspects found to sustain LMC midwifery practices. The participants in this study spoke often about a generosity of spirit between midwifery partners as one of the single most important ingredients sustaining this relationship. Midwives also recognised supportive partners, families and friends who sustain them both practically and emotionally. In terms of relationships with women, midwives spoke of keeping the partnership with women safe by negotiating and creating safe boundaries. This means having the ability to say "no", and realising that an individual midwife is not indispensable to a woman.

Midwives in this study consistently identified that the joy and passion for midwifery primarily sustains them in LMC practice. Midwives spoke enthusiastically about the joy of being involved in such a special part of women's lives. Participants identify that their joy and passion for midwifery is sustained by the unique model of midwifery care in New Zealand which facilitates reciprocity through the philosophy of partnership; a woman-midwife relationship that is based on mutual equality and trust, keeps the woman as the focus and in which midwifery care is negotiated (Guilliland & Pairman, 1994). Participants expressed that midwifery is 'more than a job'; a midwife is someone they become; and a way of life. The participants state that the satisfaction they have in working in partnership with women and their whānau/family engenders their joy and passion in midwifery practice.

WORKING IN PARTNERSHIP WITH WOMEN AND THEIR WHANAU/FAMILIES SUSTAINS THE 'JOY OF MIDWIFERY PRACTICE'

Midwives in this research identified the primary factor that sustains them is the joy experienced in the reciprocal relationship formed when LMC midwives work in partnership with women and their families/whanau.

For Sheila the rewarding part of midwifery practice is supporting women to birth in the way that they aspire to:

> *It's about supporting women to do something empowering for themselves like being alongside them to do something that they've aspired to do and generally that's along the lines of giving birth without drugs, that's what I feel really passionate about.*

Reciprocal relationships between women and midwives appear to affect and influence the atmosphere at a birth (Berg, Ólafsdóttir, & Lundgren, 2012). Berg et al. defined this reciprocity as presence, affirmation, availability and participation. Parratt (2010) reports that good relationships with midwives can empower women to access their own intrinsic power in unanticipated ways. The 'love of midwifery', the vocation of midwifery, and midwifery being who one is rather than a job one does were also identified as a markers of resilience (Hunter & Warren, 2013). This same sentiment and passion is what LMC midwives in this research identified as sustaining them in practice.

Midwives expressed that it is working alongside women and their whānau/families in a community and the relationships they forge, which sustain their joy in LMC midwifery practice. Barbara speaks about the satisfaction she gains from caring for eleven women from one family:

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I'll tell you another thing, there's a family here, who I looked after now, a Māori family, I think it's 11 women I've looked after having babies now, last year, the granddad came out and he's a pretty old man, ...I saw him in the hospital corridor, and he came out and gave me a kiss and said, 'thank you for what you've done for my family.' And that was really special. And that's another thing, you think of those things and you think, 'that's why I do this...'

Providing continuity of midwifery care for a family gives Barbara satisfaction. The special moment of being appreciated by the grandfather gives her a sense of doing something worthwhile for the family and the community.

Karen also felt that she gains a lot from her relationships with women in her practice:

Women turn up at my practice and I've thought, 'well, this is why I'm here.' They've given me so much back. So that's been so rewarding and that's what you do it for is the clients.

For Karen, the woman-midwife partnership is rewarding for her personally, she says that clients have given her so much back, and this sustains her in practice. This echoes McCourt and Stevens' (2009) findings that reciprocity added to job satisfaction and less stress in midwifery. A study of community midwives in the UK found that midwives became emotionally fatigued when relationships were not reciprocal and fulfilling (Deery, 2009; Deery & Hunter, 2010).

The sense of specialness in midwifery, the magic of mother and baby meeting at the birth and the initial home visit are moments that help sustain Barbara in her practice:

I mean the thing that keeps me in midwifery is the first time a mother looks at her baby....I think of that moment....that's what keeps me in midwifery... and also the second point for me is the first time you visit a family at home, the baby's at home...Those two things are what keeps me in midwifery.

Barbara also speaks about a broader role in society in the following data. For her, midwifery extends to building good communities, and this is an inspiring aspect of midwifery that sustains her:

I really wanted to provide continuity to women, the actual concept of doing LMC work, I love it. I guess my thing is that I really believe that how a woman feels about her birth really affects how she parents her child. And so while I totally support physiological birth and I guarantee to do my best to allow a woman to have that, I still believe that it's still not so much about how she births it's about how she feels about it. I still absolutely believe that. And I totally support physiological birth you know, absolutely, it's about parenting afterwards, and we are there for such a short time... and her role... she must parent that baby well. Yeah. I mean for the whole society, I think it has absolute ramifications for society.

For Barbara working in partnership with the woman and her family is about ensuring the woman is prepared to parent her new baby well. Barbara sees a connection between her role as a midwife and society. Barbara's commitment to this sense of interconnectedness is congruent with the knowledge we have about attachment and interpersonal neurobiology (Siegel, 2001). Hunter and Warren (2013) also found in their resilience research that underlying the love of midwifery for many midwives is a fundamental commitment to making a difference at an individual, community and societal level. 'Contributing to the greater good' was a common theme in their study (Hunter & Warren 2013). It would appear that resilience and sustainability are in part, for some midwives, associated with a greater good.

For a number of the participants an important part of the reciprocity of the partnership is about negotiating boundaries with the women. Psu says it is important that the women are well informed about how the practice operates, when the midwives' weekends off are and who will care for the women so that is clear, and there are no surprises:

As long as you tell the women when you book them, "this is how I work… these are my boundaries. This is when I work. If I have a weekend off and you birth, actually my partner is going to be with you." And they're fine. If you spring it on them a week before-hand they're not, but we try, both of us to tell all our women that, this is how we work.

In Psu's practice the midwife works in partnership with the woman from the first meeting to establish a relationship which will help to sustain the midwife. Women are provided with written information about how the practice operates regarding time off, and within that booklet are the ways that midwives prefer to be contacted. The setting of boundaries for this practice and being very clear with women about how, when and why to contact the midwife places a boundary which protects the midwife's time but also keeps the partnership between the woman and her midwife safe.

Although midwives are inspired and sustained by partnership and reciprocal relationships, they also need to negotiate boundaries and ensure their professional and personal lives are integrated and balanced.

DISCUSSION

The joy experienced in reciprocal partnership relationship with women and their whānau, including the negotiation of boundaries, underpins resilience and sustainability in midwifery practice.

Midwives in our research identified the primary factor that sustains them is the joy experienced in the reciprocal relationship formed when LMC midwives work in partnership with a women and her family/whānau. The findings of this research reflect those of other studies (Doherty, 2010; Kirkham, 2011; Leap et al., 2011) which also identified that first and foremost it is the joy and the satisfaction of working with women that sustains midwives in their practice.

The decision to explore the theme 'working in partnership sustains the joy of practice' in this first paper, was because it was overwhelmingly present in the data. However, the 'joy of midwifery' alone does not sustain the midwives in LMC practice. The midwives in this research spoke at length about what is required for them to sustain this joy. The findings of this study highlight a seemingly paradoxical message. Although midwives are inspired and sustained by partnership and reciprocal relationships, they also need to negotiate boundaries and ensure their professional and personal lives are integrated and balanced.

CONCLUSION

Returning to the question this study asks: What sustains midwives in LMC practice? The findings show that the primary factor that sustains them is the joy experienced in the reciprocal relationship formed when LMC midwives work in partnership with women and their families/ whanau. The joy of midwifery practice is reflected in a passion for 'being

with' women and families, supporting and empowering them through their childbirth experiences and to have the birth they aspire to. The joy underpins the sustainability of midwives in LMC practice. Midwives and women need to ensure that the unique model of midwifery care in New Zealand based on partnership and reciprocity continues to define the maternity service in New Zealand.

As noted earlier, this paper is one of a series exploring sustainable LMC midwifery practice. The papers that follow will explore other findings from the research in regard to the practical and practice matters that sustain the joy of midwifery, such as supportive relationships, philosophically aligned midwifery partnerships, sustainable practice arrangements and the realisation that individual midwives are not indispensable. The health and wellbeing of midwives is integral to sustaining LMC midwifery care for the next generation of New Zealand women and midwives.

REFERENCES

Allen, V. M., O'Connell, C. M., Farrell, S. A., & Baskett, T. F. (2005). Economic implications of method of delivery. *American Journal of Obstetrics and Gynecology, 193*(1), 192-197. doi:http://dx.doi.org/10.1016/j.ajog.2004.10.635

Beech, B., & Phipps, B. (2008). Normal birth: Women's stories. In S. Downe (Ed.), *Normal childbirth: Evidence and debate* (2nd ed.). Edinburgh: Elsevier.

Berg, M., Ólafsdóttir, O. A., & Lundgren, I. (2012). A midwifery model of woman-centred childbirth care - In Swedish and Icelandic settings. *Sexual and Reproductive Healthcare, 3*(2), 79-87. doi:10.1016/j.srhc.2012.03.001

Burns, N., & Grove, S. (2001). *The practice of nursing research: conduct, critique & utilization* Philadelphia, U.S.A: Saunders.

Cox, P., & Smythe, L. (2011). Experiences of midwives' leaving Lead Maternity Care (LMC) practice. *New Zealand College of Midwives Journal,* 44, 17-21.

Curtis, P., Ball, L., & Kirkham, M. (2006). Why do midwives leave? (Not) being the kind of midwife you want to be. *British Journal of Midwifery, 14*(1), 27.

Dahlen, H. G., Tracy, S., Tracy, M., Bisits, A., Brown, C., & Thornton, C. (2012). Rates of obstetric intervention among low-risk women giving birth in private and public hospitals in NSW: a population-based descriptive study. *BMJ Open, 2*(5). doi:10.1136/bmjopen-2012-001723

Davies, L., Daellenbach, R., & Kensington, M. (Eds.). (2011). *Sustainability, Midwifery and Birth.* Oxon, United States: Routledge.

Deery, R. (2009). Community midwifery 'performances' and the presentation of self. In B. Hunter & R. Deery (Eds.), *Emotions in midwifery and reproduction* (pp. 73-89). New York: Palgrave Macmillan.

Deery, R., & Hunter, B. (2010). Emotional work and relationships in midwifery. In M. Kirkham (Ed.), *The midwife-mother relationship* (2nd ed.). Basingstoke: Palgrave Macmillan.

Doherty, M. E. (2010). Voices of midwives: A tapestry of challenges and blessings. *MCN The American Journal of Maternal/Child Nursing, 35*(2), 96-101. doi:10.1097/NMC.0b013e3181caea9f

Donald, H. L. (2012). *The work-life balance of the case-loading midwife: a cooperative enquiry* (doctoral thesis). AUT University, Auckland, New Zealand.

Earl, D., Gibson, E., Isa, T., McAra-Couper, J., McGregor, B., & Thwaites, H. (2002). Core midwifery: The challenge continues. *New Zealand College of Midwives Journal,* 27, 30-32.

Engel, C. (2000). *Towards a sustainable model of midwifery pratice in a continuity of carer setting: The experience of New Zealand midwives.* (masters thesis). Victoria University, Wellington, New Zealand.

Engel, C. (2003). Towards a sustainable model of midwifery practice in a continuity of carer setting: the experience of New Zealand midwives. *New Zealand College of Midwives Journal,* 28, 12-15.

Grigg, C. P., & Tracy, S. K. (2013). New Zealand's unique maternity system. *Women and Birth, 26*(1), e59-e64. doi:http://dx.doi.org/10.1016/j.wombi.2012.09.006

Guilliland, K., & Pairman, S. (1994). The Midwifery Partnership - A model for Practice. *New Zealand College of Midwives Journal,* 5-9.

Guilliland, K., & Pairman, S. (2010). *Women's business: The story of the New Zealand College of Midwives 1986-2010.* Christchurch: New Zealand College of Midwives.

Homer, C., Brodie, P., & Leap, N. (2008). *Midwifery continuity of care: A practical guide.* Sydney, Australia: Churchill Livingstone.

Hunter, B., Berg, M., Lundgren, I., Ólafsdóttir, O. A., & Kirkham, M. (2008). Relationships: the hidden threads in the tapestry of maternity care. *Midwifery, 24*(2), 132-137.

Hunter, B., & Deery, R. (Eds.). (2009). *Emotions in midwifery and reproduction.* New York: Palgrave Macmillan.

Hunter, B., & Warren, L. (2013). *Investigating Resilience in Midwifery:* Final report. Cardiff University: Cardiff.

Kirkham, M. (2009). Emotions in midwifery and reproduction. In B. Hunter & R. Deery (Eds.), *Emotional work around reproduction: Supportive or constraining?* (pp. 227-240). New York: Palgrave Macmillan.

Kirkham, M. (2011). Sustained by joy: The potential of flow experience for midwives and mothers. In L. Davies, R. Daellenbach, & M. Kensington (Eds.), *Sustainability, Midwifery and Birth.* Oxon, United States: Routledge.

Kirkham, M. (Ed.). (2010). *The midwife-mother relationship* (2nd ed.). Basingstoke: Palgrave Macmillan.

Leap, N., Dahlan, H., Brodie, P., Tracy, S., & Thorpe, J. (2011). Relationships- the glue that holds it all together: Midwifery continuity of care and sustainability. In L. Davies, R. Daellenbach, & M. Kensington (Eds.), *Sustainability, Midwifery and Birth.* Oxon, United States: Routledge.

McCourt, C., & Stevens, T. (2009). Relationship and reciprocity in caseload midwifery. In B. Hunter & R. Deery (Eds.), *Emotions in midwifery and reproduction* (pp. 17-25). New York: Palgrave Macmillan.

McLardy, E. (2003). *On-call 24/7: Midwives negotiating home and work boundaries* (masters thesis). Victoria University, Wellington, New Zealand.

Midwifery Council of New Zealand. (2013). The Midwifery scope of practice. Wellington, New Zealand: Midwifery Council. Retrieved from http://www.midwiferycouncil.health.nz/midwifery-scope-of-practice/

Ministry of Health. (2007). *Primary maternity services notice 2007:* NZ Government. Retrieved from http://www.moh.govt.nz/moh.nsf/pagesmh/5845/$File/s88-primary-maternity-services-notice-gazetted-2007.doc

Ministry of Health. (2011). *Maternity consumer survey.* Wellington, New Zealand: Ministry of Health. Retrieved from http://www.health.govt.nz/publication/maternity-consumer-survey-2011

Ministry of Health. (2012). *Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines).* Wellington: Ministry of Health.

Neuman, W. (2011). *Social research methods: Qualitative and quantitative approaches* (7th ed.). Boston, U.S.A: Allyn & Bacon.

Parratt, J. (2010). *Feeling like a genius: enhancing women's changing embodied self during first childbearing* (PhD). University of Newcastle, Newcastle, NSW. Retrieved from http://hdl.handle.net/1959.13/803830

Sandall, J. (1997). Midwives' burnout and continuity of care. *British Journal of Midwifery, 5*(2), 106-111.

Sandall, J., Devane, D., Soltani, H., Hatem, M., & Gates, S. (2010). Improving quality and safety in maternity care: the contribution of midwife-led care. *Journal of Midwifery & Women's Health, 55*(3), 255-261. doi:10.1016/j.jmwh.2010.02.002

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing & Health, 33*(1), 77-84. doi:10.1002/nur.20362

Siegel, D., J. (2001). Toward an interpersonal neurobiology of the developing mind: Attachment relationships. "Mindsight", and Neural Integration. *Infant Mental Health Journal, 22*(1-2), 67-94.

Tracy, S. K., Hartz, D. L., Tracy, M. B., Allen, J., Forti, A., Hall, B., ... Kildea, S. (2013). Caseload midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *The Lancet, 382(9906): 1723-1732*

Wakelin, K., & Skinner, J. (2007). Staying or leaving: a telephone survey of midwives, exploring the sustainability of practice as lead maternity carers in one urban region of New Zealand. *New Zealand College of Midwives Journal, 37,* 10-14.

Walsh, D. (2008). Promoting normal birth: Weighing the evidence. In S. Downe (Ed.), *Normal childbirth: Evidence and debate* (2nd ed.). Edinburgh, New York: Elsevier.

Young, C. M. (2011). *The experience of burnout in case loading midwives* (doctoral thesis). AUT University, Auckland, New Zealand.

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McAra-Couper, J., Gilkison, A., Crowther, S., Hunter, M., Hotchin, C., & Gunn, J. (2014). Partnership and reciprocity with women sustain Lead Maternity Carer midwives in practice. *NZCOM Journal* 49, 23 - 33. http://dx.doi.org/10.12784/nzcomjnl49.2014.5.29-33