



UWS Academic Portal

Experiences and needs of Scotland's rural midwives

Crowther, Susan; Rankin, Jean; Deery, Ruth; Gilkison, Andrea ; Davies, Lorna; Daellenbach, Res; Kensington, Mary

Published in:
The Practising Midwife

Published: 01/05/2020

Document Version
Peer reviewed version

[Link to publication on the UWS Academic Portal](#)

Citation for published version (APA):

Crowther, S., Rankin, J., Deery, R., Gilkison, A., Davies, L., Daellenbach, R., & Kensington, M. (2020). Experiences and needs of Scotland's rural midwives. *The Practising Midwife*.
<https://www.all4maternity.com/experiences-and-needs-of-scotlands-rural-midwives/>

General rights

Copyright and moral rights for the publications made accessible in the UWS Academic Portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

If you believe that this document breaches copyright please contact pure@uws.ac.uk providing details, and we will remove access to the work immediately and investigate your claim.

COPYRIGHT ©All4Holdings Ltd, 2019. All rights reserved. No part of *The Practising Midwife* may be reproduced in any material form (including photocopying or storing in any medium by electronic means and whether or not transiently or incidentally to some other use of this publication) without the written permission of the copyright holder except in accordance with the provisions of the Copyright, Designs and Patents Act 1988, or under the terms of a licence issued by the Copyright Licensing Agency Ltd, 90 Tottenham Court Road, London, England W1P 0LP. Applications for the copyright holder's written permission to reproduce any part of this publication should be addressed to the publisher.

Designed and produced by Creativeworld. Tel: 01282 858 231.

Printed in the UK by The Magazine Printing Company using only paper from FSC/PEFC suppliers. www.magprint.co.uk ISSN 1461-3123.

Icons made by Freepik from www.flaticon.com. Illustrations created by Freepik.com.

Disclaimer: The sentiments expressed by the contributors and advertisers in *The Practising Midwife* do not necessarily reflect the views of either the Publisher, Editor or the Editorial Advisory Board.

PHOTOCOPYING Single photocopies of single articles may be made for personal use as allowed by national copyright laws. Permission of the Publisher and payment of a fee is required for all other photocopying, including multiple or systematic copying, copying for advertising or promotional purposes, resale, and all forms of document delivery. Special rates are available for educational institutions that wish to make photocopies for non-profit educational classroom use. For information on how to seek permission contact Jayne Purdy: jayne@all4maternity.com

DERIVATIVE WORKS Subscribers may reproduce tables of contents or prepare lists of articles including abstracts for internal circulation within their institutions. Permission of the Publisher is required for resale or distribution outside the institution. Permission of the Publisher is required for all other derivative works, including compilations and translations.

Electronic Storage or Usage Permission of the Publisher is required to store or use electronically any material contained in this journal, including any article or part of an article. Except as outlined above, no part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior written permission of the Publisher.

Title page

Title: Experiences and needs of Scotland's rural midwives

Authors:

Susan Crowther (corresponding author), Professor of Midwifery, AUT University, Auckland New Zealand, E: susan.crowther@aut.ac.nz Twitter: @SusanCrowtherMW

Jean Rankin, Professor (Maternal, Child & Family Health), Head of Division (Midwifery & Specialist Nursing), University of the West of Scotland, Adjunct Professor of Midwifery, AUT University, Auckland New Zealand. Email: j.rankin@uws.ac.uk

Ruth Deery, Emeritus Professor of Midwifery, University of the West of Scotland, Continuity of Care Lead/Community Midwife, University Hospitals of Morecambe Bay NHS Foundation Trust

Dr Andrea Gilkison Senior lecturer and Postgraduate Programme Leader for Midwifery, AUT University, Auckland New Zealand email: andrea.gilkison@aut.ac.nz

Lorna Davies, Co-Head of Midwifery, School of Midwifery, Ara Institute of Canterbury, New Zealand email: Lorna.Davies@ara.ac.nz

Res Daellenbach Lecturer, School of Midwifery, Ara Institute of Canterbury, New Zealand Email: Rea.Daellenbach@ara.ac.nz

Mary Kensington, Head of Midwifery, School of Midwifery, Ara Institute of Canterbury, New Zealand email: Mary.Kensington@ara.ac.nz

Abstract

Rural midwifery internationally is often misunderstood and is persistently compromised by recruitment and retention issues. In a climate of constant policy change and service development this has implications for morale with rural midwives who continue to practice in challenging yet rewarding contexts. This article reports on Scottish rural midwives' experiences as part of an international study examining New Zealand and Scottish rural midwives. Major themes from the study included the importance of relationships and a unique skill set. Scottish midwives reported feeling vulnerable in the face of constant policy direction and service changes that did not appreciate the context of practice realities. Considering current Scottish policy this paper highlights some implications for practice and ideas for further research.

Introduction

In a turbulent political and everchanging fiscal environment, with associated mobile populations, rural Scotland needs to focus attention on succession planning, recruitment and retention of rural midwives to ensure continuance of robust, highly skilled, accessible and acceptable rural services that provide choice and satisfaction for rural service users (Lironi, 2017, Grant, 2017, Harris et al., 2011, Scottish Government, 2019). While addressing significant concerns of accessibility to quality services for women and families (Hoang et al., 2014), it is equally important to acknowledge the morale of rural midwives as they encounter unique practice situations which are clearly different to their urban colleagues (Crowther et al., 2018b). To help address this, a group of international midwifery researchers embarked on a multi-center, multimethod international study including two universities in Scotland serving the needs of midwifery undergraduate and postgraduate education – Robert Gordon University, Aberdeen (North East) and the University of the West of Scotland. Likewise, two collaborating institutions in New Zealand included Ara Institute of Canterbury (Christchurch) and AUT University (Auckland).

The study aimed to illuminate the practice realities of rural midwives and further understand what practices enhance equitable and sustainable rural maternity care through a process of comparing findings and informing recommendations for education. Scotland and New Zealand have comparability in terms of population size and birth rates, rural topography, climate conditions and midwifery education, regulation and statutory status.

Table 1: Study objectives

- To establish the characteristics of sustainable rural midwifery practice
- To explore and identify personal skills, qualities and professional expertise needed for rural midwifery practice
- To explore and identify education needs for undergraduate and postgraduate midwifery education in Scotland and New Zealand

Full study findings were published in a series of three articles (Kensington et al., 2018, Gilkison et al., 2018, Crowther et al., 2018a). The first of these highlighted that courage, fortitude and resilience are essential underpinnings of rural midwifery practice (Gilkison, et al., 2018). The second paper explored pre-registration education experiences and views of rural midwives which asserted the value of including rural specific components in midwifery education (Kensington, et al., 2018). The third paper revealed the importance of relationships through the concept of social capital (Crowther, et al., 2019). Publishing regional specific articles was needed, therefore, one forthcoming article reporting New Zealand data is in press whilst this article focuses only on Scottish data.

Methods

The multi-method international study was conducted in two stages using online anonymous questionnaires. In the second stage New Zealand and Scottish midwives were divided into their respective countries and accessed an online anonymized, asynchronous discussion groups (open for 6 weeks). The groups involved midwives consenting to this stage. This approach was adopted because it was cost-effective and allowed easier access for midwives in remote areas to participate. Survey results informed the questions for the online fora

enabling more in-depth explanation of aspects touched on in the questionnaire. Ethical approval was obtained in New Zealand and Scotland.

An email with a direct URL link to the introductory information about the online survey and information leaflet including ethical aspects, was sent inviting rural midwives. In total, 77 Scottish midwives responded to the online survey and 3 Scottish midwives participated in the online discussion forum. The survey also provided demographic detail and characteristics of participants (see table 2).

Table 2: Scottish midwife demographic details and characteristics	
Total number of participants (n)	77 (100%)
<ul style="list-style-type: none"> Community (including labour/birth) Community (mainly antenatal/postnatal) 	51 (66%) 26 (34%)
Ethnicity	65 responses
<ul style="list-style-type: none"> White Scottish White other British White Irish 	50 (77%) 14 (21.5%) 1 (1.5%)
Age	65 responses
<ul style="list-style-type: none"> <30 years 30-49 years ≥50 years 	3 (5%) 26 (43%) 34 (52%)
Mean years of Registration	1995
Years in rural practice	65 responses
<ul style="list-style-type: none"> ≤5 years 6-10 years 11-15 years >15 years 	14 (21.5%) 14 (21.5%) 14 (21.5%) 23 (35.5%)
Transfer time	67 responses
Mean transfer time (from decision to arrival at obstetric/neonatal facility)	88 min
<ul style="list-style-type: none"> ≤60 min 61-90 min >90 min 	25 (37%) 12 (18%) 30 (45%)
Reasons for being a rural midwife	77 responses
<ul style="list-style-type: none"> Live rurally Enjoy working with rural women Ensure women have access to midwifery care Enjoy rural lifestyle Grew up in rural area Connection with the rural community 	43 (56%) 30 (39%) 29 (38%) 35 (46%) 21 (27%) 28 (36%)

Qualitative data generated from the survey and online forum groups were thematically analysed using the Braun and Clarke (2006) approach. The final themes and sub themes were both individually determined then collectively discussed through three face-to-face meetings until consensus was reached (see table 3).

Table 3: Themes and Subthemes (adapted from the 3 published related articles)		
Over all themes	Principle themes	Sub themes
Joys and challenges	Social capital	<ul style="list-style-type: none"> • Working relationships • Respectful communication • Partnerships • Gift of time facilitates relationships • Interface tensions
	Practice realities	<ul style="list-style-type: none"> • Autonomy of rural midwifery • Appreciation of rural women and the community • Beauty and a personal connection to the countryside/ land • Impact of travel distances, topography and connectivity • Commitment to equity for rural women
Courage and fortitude	Unique skill set	<ul style="list-style-type: none"> • Preparedness • Practical skills • Developing meaningful relationships • Resourcefulness in the context of rural midwifery practice.
	Safeguarding	<ul style="list-style-type: none"> • Sustaining self • Safeguarding women and families
Future proofing rural practice	Preparation for rural practice	<ul style="list-style-type: none"> • Confidence in normal physiological birth • Prepared, anticipate and respond • Rural specific education • Learning from stories from rural midwives • Rural placement alongside a midwife
	Living the experience and seeing the reality	<ul style="list-style-type: none"> • Relative isolation • The enormity of the responsibility • Rural women are different • Being adaptable and making do

This article reports solely on the Scottish study data and advances our analysis to present a broader range of Scottish midwives' responses than initially included in our previous published thematic analysis. This invites more detail of the professional and personal experiences of participating Scottish rural midwives. In presenting these findings we do not wish to further problematise Scottish rural midwifery but focus understanding on the current lived practice realities. Likewise, we avoid romanticizing rural midwifery across Scotland and seek a balanced picture firmly grounded in their own words.

Results

Study data suggests that despite often feeling challenged by the complexities of rural practice the Scottish midwives reported feeling '*as linked to the women as to the good outcomes*' (MW7). Relationships with women and other clinical colleagues that were embedded in social capital model were therefore important to the midwives. Connection with the rural community meant that '*you carry part of the community with you...there is no off switch*' (MW7). The same midwife also reported having responsibility '*not for a shift or a ward but a community*'. In rural areas, midwives often saw women who they had supported at birth and introduced to the members of the community as '*the midwife who delivered you*'. The same midwives also remained visible and supportive to the women they had supported during miscarriage or child protection cases. Positive multi-professional working with social services, health visitors and addiction workers was a key theme in the data. However, having '*no off switch*' came with its drawbacks as MW 3 suggests,

The stress of being on call after a 10-12 hour shift and having to get up in the middle of the night and take responsibility for a difficult high risk situation...a stressful transfer of several hours...a 2-3 hour journey before we reach hospital...

Rural midwives found it difficult to leave women they had transferred (as was policy at the time of data collection) when it seemed the women '*needed us the most*' (MW1) and that this separation caused increased isolation for the woman and her family. The main issue with staying with the woman was due to transport home again especially if transfer had been via helicopter. If rural midwives were able to stay in the hospital, they were only able to observe clinical care. As MW3 states,

they [hospital staff] do not understand the extra pressures of rural practice...they look down on us as less experienced and less knowledgeable in all areas.

From a professional perspective links with urban clinical colleagues were mainly positive and helpful especially with paediatricians and obstetric registrars. However, a recurring theme in the Scottish data was that links could also be tense and disrespectful with midwife colleagues, such as, '*frequently questioning our judgment and decision making*' (MW3) and '*constant undermining from other midwives*' (MW3). It was inferred this could lead to relationships with women and their families becoming less trustworthy and respectful.

Another midwife suggested there is '*no voice for rural practice*' and that it is not '*seen or valued...with no insight...other than an inconvenience*' (MW7). Midwives' words suggest there was no appreciation from urban colleagues of rural midwives who found '*themselves on the front line of situations normally dealt with by senior colleagues in the bigger centres*' (MW1). Clinical decision-making processes are different for midwives working in rural areas, a finding reflected in both the New Zealand and Scottish data, as they are often made in isolation where there is no medical backup. As MW3 states,

Every aspect of care must be considered as to whether it is care that can be safely provided by a midwife and if not, we have to refer to a hospital in one of two areas both a two-hour drive away.

Also, clinical decisions must be made earlier in a remote setting. This is necessary to inform and include women in the decision-making process and to arrange transport where there could be long waiting times for an ambulance which takes longer than *'pressing a bell for help'*. This is particularly the case during intrapartum care where the midwife is often on her own making clinical decisions. Again, MW3 states,

In an urban setting if an emergency occurs the room would be full of people, other midwives, doctors, paediatricians, whoever was required whereas we have to deal with the situation without any support from other health professionals and a doctor who is a long way away.

Some midwives referred to future models of midwifery and how these need to consider the specialist role of a midwife working in remote and rural areas and that appropriate remuneration to reflect these clinical skills are considered. This is crucial if sustainable rural services are to continue. MW7 describes the reality of needing to *'manage the unplanned and the planned'* which highlights the vulnerability and demands of rural Scottish midwifery. She continues by expressing her concern that this can only be achieved ...*'by ensuring we have a trained and dedicated workforce'*.

Discussion

The demanding issues highlighted by Scottish rural midwives in this study need addressing. Strengthening relationships between urban and clinical colleagues in this study remains a priority for rural midwives so that they can further build on existing collegiality and appreciation (Crowther et al., 2018a). This must extend to the interface between primary and rural services (Crowther et al., 2018a). Rural midwives often feel the buck stops with them (Harris et al., 2011) and any breakdown in communication only increases their sense of isolation and feeling misunderstood and unappreciated. This gestures to the problem of misunderstanding about rural midwifery, a misunderstanding that could result in rural

communities getting inconsistent fragmentary care which in turn may lead to poor decision-making (Crowther and Smythe, 2016a). It is essential that any transfer of care between services is seamless and appreciates the contextual realities of the rural practitioner and their clients.

Current policy and evidence is driving Scottish services towards continuity of care and carer from a primary midwife, with a push towards improving choice for women and keeping services as near to communities as possible (Grant, 2017). It is imperative that this is not established without the input of rural midwives. The Scottish maternity and neonatal plan (Grant, 2017), highlights the need for integrated services, with a focus on working together and a reduction of inequalities – all of which are admirable aspirations, yet vigilance is needed to ensure that any transformation in services is context sensitive. Regional variance in midwifery in the Scottish Best Start 5-year plan has been identified and different models of providing continuity (including rural) will be audited and evaluated (Grant, 2017).

The Best Start 5-year plan recommends the need for rural practitioners to access high quality education, training and support; a finding strongly reflected in our study and we would urge that this includes rural midwives' wellbeing. Untangling the concerns of the current maternity systems to improve the experiences of women is crucial (Edwards et al., 2018). The ongoing discord that can occur between rural and urban colleagues has been evidenced in Scottish rural midwifery (Harris et al., 2011). Although some change appears to be for the better, it is a decade since the Harris study. Now is the time to address this directly and eradicate possible unprofessional communications. Simultaneously, the resource and staffing needs of rural midwives must be addressed to ease any anxiety in a vulnerable workforce practising in a constant climate of change.

Implications for practice and further research

Key findings highlight implications for supporting professional practice and education for rural midwifery communities:

- Practical and personal resources are required for the development of a specific skillset, essential for safe and sustainable rural practice. (Gilkison et al., 2018)
- Positive working relationships built upon mutual trust and established communication pathways are needed to underpin safe rural practice. (Crowther et al., 2018a, Crowther and Smythe, 2016b)
- Education needs to have specific 'rural midwifery' embedded in pre-registration programmes. Activities need to acknowledge the contextual reality of rural practice, the needs of inter-professional working relationships and fundamental differences between urban and rural practice. (Kensington et al., 2018)
- Social capital needs to lie at the heart of sustainable rural midwifery. (Crowther et al., 2018a)

Further evidence is needed to inform policy guidance to sustain rural midwifery practice. Areas for investigation should explore the lived realities of practice for rural midwives; determine optimal practice development and educational opportunities to promote inter/intra-professional relationships, especially at the interface between rural and urban services. Additional exploration of interventions to support skill development, recruitment and educational strategies for rural practice is also required.

We must support our rural colleagues who serve their communities despite the challenges. It is time to listen to rural midwives everywhere and stop any undervaluing discourse - instead

working together we must ensure that our rural colleagues are well-resourced, understood and appreciated.

References

- BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. *Qualitative research in psychology*, 13, 77-101.
- CROWTHER, S., DEERY, R., DAELLENBACH, R., DAVIES, L., GILKISON, A., KENSINGTON, M. & RANKIN, J. 2018a. Joys and challenges of relationships in Scotland and New Zealand rural midwifery: A multicentre study. *Women Birth*.
- CROWTHER, S. & SMYTHE, E. 2016a. Open, trusting relationships underpin safety in rural maternity a hermeneutic phenomenology study. *BMC Pregnancy Childbirth*, 16, 370.
- CROWTHER, S. & SMYTHE, L. 2016b. Open, trusting relationships underpin safety in rural maternity a hermeneutic phenomenology study. *BMC Pregnancy and Childbirth*, 16.
- CROWTHER, S., SMYTHE, L. & SPENCE, D. 2018b. Unsettling moods in rural midwifery practice. *Women Birth*, 31, e59-e66.
- EDWARDS, N., MANDER, R. & MURPHY-LAWLESS, J. 2018. *Untangling the Maternity Crisis*, Taylor & Francis.
- GILKISON, A., RANKIN, J., KENSINGTON, M., DAELLENBACH, R., DAVIES, L., DEERY, R. & CROWTHER, S. 2018. A woman's hand and a lion's heart: Skills and attributes for rural midwifery practice in New Zealand and Scotland. *Midwifery*, 58, 109-116.
- GRANT, J. 2017. *The Best Start: A Five-year Forward Plan for Maternity and Neonatal Care in Scotland*, Scottish Government.
- HARRIS, F. M., VAN TEIJLINGEN, E., HUNDLEY, V., FARMER, J., BRYERS, H., CALDOW, J., IRELAND, J., KIGER, A. & TUCKER, J. 2011. The buck stops here: Midwives and maternity care in rural Scotland. *Midwifery*, 27, 301-307.
- HOANG, H., LE, Q. & OGDEN, K. 2014. Women's maternity care needs and related service models in rural areas: A comprehensive systematic review of qualitative evidence. *Women and Birth*, 27, 233-241.
- KENSINGTON, M., RANKIN, J., GILKISON, A., DAELLENBACH, R., CROWTHER, S., DEERY, R. & DAVIES, L. 2018. 'Living the rural experience-preparation for practice': The future proofing of sustainable rural midwifery practice through midwifery education. *Nurse Educ Pract*, 31, 143-150.
- LIRONI, J. 2017. A changing model of rural care. *The Practising Midwife*, 20, 27-29.
- SCOTTISH GOVERNMENT 2019. Maternity care survey 2018: national results. In: DIRECTORATE, H. A. S. C. I. (ed.). Scotland: Scottish Government.