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AOTEAROA NEW ZEALAND RESEARCH

Balancing the joys and challenges of the continuity of care model: A study exploring the perspective of midwives and their family members

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ABSTRACT

Background: In Aotearoa New Zealand, women receive continuity of maternity care (COC) from a lead maternity carer (LMC), most of whom are midwives. Providing COC requires midwives to have periods of being on call. These periods can include multiple days on call, involving unpredictable hours, which may affect not just midwives' wellbeing but also their family life. More research is needed to understand how providing continuity of care affects the midwives, their family life and their social life.

Aim: To explore the effects of working as a community-based midwifery LMC on the wellbeing of midwives and family lives.

Method: We undertook qualitative research involving face-to-face and/or online interviews with midwives and their family member/s. Purposive sampling was used to recruit the 47 midwives (32 current LMCs, 15 former LMCs), alongside 51 family members who agreed to be involved in the study. An interview guide was used with prompts to support consistency. NVivo software supported a template analysis of the data from which three main themes were identified.

Findings: The LMC midwives described their work as intrinsically rewarding due to the building of valued relationships. However, challenges involved periods of being constantly on call, the unpredictability of call outs and potentially long working hours. These issues also affected family members. The midwives described a lack of operational support which often resulted in having to organise and pay for time off call, leading to financial vulnerability.

Conclusion: This study has identified a number of challenges to the current LMC midwifery model. A reasonable balance which ensures regular time off call yet still maintains the provision of continuity of care may be the key to supporting sustainability in the role and retention of the current workforce.

Keywords: midwifery continuity of care, rewarding, constantly on call, work-family life

INTRODUCTION

Globally, maternity systems differ and, with the exception of Aotearoa New Zealand, no countries have managed to scale up continuity of midwifery care at a national level (Bradford et al., 2022). A Cochrane review of models of maternity care found that the experiences of women who received midwifery continuity of care (COC) were more likely to be positive and these women were less likely to need medical intervention and treatment (Sandall et al., 2024). The review found that cost analyses trended towards a savings with COC. This was further confirmed in an Australian randomised controlled trial by Callander et al. (2024), where the lower intervention and treatment rates of the COC cohort translated to a lower cost to health funders. All of these benefits have led to other countries seeking to establish midwifery COC (Bradford et al., 2022; Sandall et al., 2024). However, implementing midwifery COC is proving to be complex. One of the issues is the temporal demands of labour. Specifically, a woman can labour at any time of the day or night and the labour can last for many hours. This, coupled with the unpredictability of the onset of labour, means that ensuring the availability of a known midwife can be difficult (Middlemiss et al., 2024). The introduction of COC requires careful consideration of the existing structures of maternity care, as well as an understanding of how to support midwives to provide COC and especially how to support on-call working arrangements.

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The Aotearoa New Zealand context

In Aotearoa New Zealand, continuity of midwifery care in the community (also known as primary care) has been the established model of care since the 1990s. It is funded through the primary maternity services contract, which specifies the care requirements and payment structure for the service (Primary Maternity Services, 2021). This national contract also identifies COC as an objective for maternity care, with a lead maternity carer (LMC) responsible for planning and providing care. Pregnant women are able to choose a single practitioner to provide their maternity care as the LMC. This can be a midwife, a general practitioner (GP) or an obstetrician. Midwives and GPs claim from the national contract; obstetricians also claim but can charge an additional fee for their services. This essentially means that midwives are contractors with Health New Zealand | Te Whatu Ora rather than employees (Table 1). Most women choose a midwife to be their LMC. Midwives have developed numerous working arrangements to provide COC and ensure availability for labour and birth. Many midwives work in large or small practice groups (teams). Others work as individual midwives with an informal backup arrangement with a second midwife. Working in partnership with the woman and her family/whānau in the woman's own community is fundamental to how midwives work within the COC model (Dixon & Guilliland, 2019).

It is known that conflict between work and family life can occur when the pressure of the work role negatively impacts the person's role within the family (Cavagnis et al., 2023). This conflict can be mitigated by having control over one's work, maintaining high self-esteem, and receiving the support of family and colleagues. Longer working hours can also have a negative social and psychological impact on families (Chu & Zhang, 2024). As far as we are aware, the impact of work on family life has not been studied within the midwifery domain.

The national shortage of midwives seen in Aotearoa New Zealand is mirrored in the global midwifery workforce (Te Whatu Ora | Health New Zealand, 2023; UNFPA, ICM, WHO, 2021). Consequently, retention and support of the workforce have been identified as priorities to mitigate workforce shortages within Aotearoa New Zealand (Te Whatu Ora | Health New Zealand, 2023). Workforce shortages can impact midwives' enjoyment of their work and may result in individuals leaving their current role (Harvie et al., 2019).

In order to inform policy changes aimed at improving recruitment and retention, a better understanding of how COC affects not just midwives' wellbeing but also other aspects of their lives is required. There is a need to consider the sociocultural, economic and family contexts. Accordingly, our study explored how the LMC work model affected our participant midwives' wellbeing in the context of their family and community lives.

Table 1. Continuity of care in Aotearoa New Zealand

Continuity of care in Aotearoa New Zealand is undertaken by midwives as lead maternity care (LMC) providers. They enter a contract under the Primary Maternity Services Notice with Health New Zealand | Te Whatu Ora (Primary Maternity Services, 2021). Prior to July 2022 this contract was with the Ministry of Health.
The contract specifies the responsibilities and requirements of the LMC when providing maternity care from registration (early pregnancy), through the labour and birth and for up to six weeks postpartum. An LMC can be a midwife, obstetrician or general practitioner (Primary Maternity Services, 2021).
Payments are made in a modular manner and at the completion of each module (e.g. labour and birth are one module; Primary Maternity Services, 2021).
LMC midwives provide maternity care to a caseload of women, with the caseload size dependent on a number of variables. These include personal choice, the number of other LMCs in the area, the population of pregnant women requiring care and whether the midwife or woman lives in an urban, rural or remote rural area.
LMC midwives are responsible for ensuring that each woman in their caseload has access to maternity care 24 hours a day, seven days a week (Primary Maternity Services, 2021).
Midwives often work with other LMC midwives in large or smaller group practices or with one or more backup LMCs in a self-organised, supportive arrangement.

Providing COC is intensely satisfying but also deeply challenging due to the on-call nature of the role (Gilkison et al., 2015). For rural midwives there are additional economic, geographic and weather-related challenges (Daellenbach et al., 2020). The low population density of Aotearoa New Zealand and long travel times can result in rural midwifery work being financially unviable and, before recent significant funding increases, had been described as "an expensive hobby" (Crowther, 2016, p. 26).

An integrative review exploring the wellbeing of the midwifery profession found that, to date, research has equated midwifery wellbeing only to the absence of mental health problems such as burnout (Mharapara et al., 2022). This focus is due to the frequent use of surveys to study midwifery wellbeing (Mharapara et al., 2022). Limitations of this approach are the minimal inclusion of positive indicators of wellbeing within the surveys and a focus on individuals in isolation from their social and cultural contexts. Mharapara et al. (2022) provide a contextualised framework to explore both the positives, such as happiness, financial security and physical and emotional health, as well as the negatives of the work. The framework includes the sociocultural, economic, family and community contexts as a basis for investigating midwives' wellbeing.

AIM

The aim of this research project was to explore the effects of their work as a community-based LMC on midwives' wellbeing and family life.

METHOD

A qualitative interpretive descriptive methodology was used. Participants were recruited via email through the New Zealand College of Midwives (the national professional body for midwives) to its members, or through snowballing by participants. To be eligible, participants were required to be a registered midwife and also a current or former LMC midwife. These midwives were asked to nominate a family member/s to participate in the interview. This study recruited midwives who identified as non-Māori and non-Pasifika. Studies exploring Kaupapa Māori- and Pacific Peoples-centred perspectives are ongoing.

We interviewed 47 midwives alongside 51 family members between September 2022 and June 2023. Participants were encouraged to choose their own pseudonyms and interviews were transcribed using these to ensure confidentiality and protect anonymity.

Interviews were undertaken either in the midwife's home (n = 20) or online (n = 27). The length of interviews varied between 70

minutes and 2.5 hours. All interviews were digitally recorded and transcribed professionally.

An interview guide ensured a consistent approach within the interviews. Midwives were asked to describe what they enjoyed most and what was most challenging about their work. Family members were also asked about their impressions of what is enjoyed or is challenging for the midwife in her work. Broader questions were also asked about the impact of the work on various domains of life (social life, community involvement, hobbies, etc.) for the midwife and her family.

Data analysis

Data were analysed using template analysis, which is widely used in organisational and management research disciplines (King et al., 2018). Template analysis uses hierarchical codes developed from a subset of data. These codes are then used to identify if further data fit within the codes, and are further revised and refined as needed. The codes are developed to ensure that a cross section of the issues and experiences of the participants are covered from across the whole dataset. NVivo software supported the template analysis of the data from which emerging themes were identified as per Brooks et al. (2015). A subset of interview transcripts was read by members of the research team (LD, JC, TM, JG-Y, KR) to develop the coding template. Themes were identified, discussed, further developed and agreed on by the team (Table 2).

Ethics approval

This study was approved by the Auckland University of Technology Ethics Committee, 15 August, 2022, AUTEC Reference number 22/161.

FINDINGS

Of the 47 midwifery participants, 32 were working as LMCs at the time of the interviews and 15 had previously worked as LMC midwives. Eight participants worked in a mixed rural/urban setting, 18 in a rural setting and 21 in an urban setting. The midwives worked in a range of cities and regions throughout the country, including (but not limited to) Auckland, Christchurch, Dunedin, Nelson, Wellington, Northland, Hawke's Bay, West Coast and Taranaki. There were 51 family members, with four interviews involving one midwife and two family members. Of the adult family members, there were 15 daughters, 4 de facto partners, 22 husbands, 1 mother, 2 sons and 2 wives. There were also 5 participants under the age of 18 (range 11 years to 16 years).

Intrinsically rewarding work

This theme illustrates the joy and satisfaction the midwife participants found in their work. It details how the work was intrinsically rewarding because the midwives were getting to know women and their families during an important time in their lives.

Building valued relationships

A large part of the satisfaction with the work was related to building relationships over time. Participants described the enjoyment they experienced in forming deep connections with the women and getting to know the families:

> *You know, when they hold that baby in their arms for the first time, or they figure out something about what their baby is needing or wanting, or they have a good night's sleep, or whatever it is, you celebrate those victories with them. It feels like a shared achievement because you've been working together*

Table 2. Themes, sub-themes, descriptions and representative quotes

Theme	Description	Sub-themes	Representative quotes
Intrinsically rewarding work	The participants described the satisfaction they gained from getting to know women and their families and working with women during a mostly positive time in their lives.	Building valued relationships	*So there's a real joy that comes from being able to get to know families so well through the continuity of care model; you know them from sometimes four weeks pregnant to then six weeks postpartum, it's a really, really long time of getting to know somebody, and you get to know their whole world; you get to know them as an individual client but then their partners and their families… and it's such a deep connection.* (Brigit, current urban LMC)
		The thrill of the birth	*But some of the amazing thrills of being a midwife is getting to be a part of that miracle of birth. And share the joy with the family as they come to motherhood. And yeah encompassing their baby in their family, I think that's what carries you through.* (Butterfly, current rural LMC)
		Returning clients	*I love it when someone comes back when they're pregnant again.* (Amy, current urban LMC)
Constantly on call	This theme identifies the challenges inherent in the current service contract which, whilst providing flexibility of working hours for routine care, also requires 24/7 availability from the LMC midwife or her backup.	Long periods on call	*For example, the morning meeting would be at 7am on a Monday and then clinic would start at 8 till 12.30, then I'd have five postnatals in the afternoon. About to go home and get called to a birth, get home at 4am and then have a clinic at 12 o'clock the next day that was quite hard to shift. So, you'd get home at 4am, kids are asleep. I'd get up at 10, they've gone to school.* (Kim, former urban LMC)
		Unpredictability	*I think just the unpredictability of it and the lack of being able to commit to anything.* (Debbie, former urban LMC)
Lack of operational support	The participants described the lack of adequate operational support for the midwives to provide 24/7 care, with time off call limited due to a minimal paid locum service. Midwives described organising and paying for time off call, which contributed to financial vulnerability.	Organising and paying for time off call	*If I take time off work I have to pay twice as much than I earn to a locum to cover my caseload, if I could find somebody.* (Beth, former urban LMC)
		Financial vulnerability	*We can't negotiate our own income. We can't do any of that which is often what contracting is. Yet we've got none of the benefits of being employed. So we're caught between a rock and a hard place.* (Amy, current urban LMC)

> *towards those goals. So that's really the part I think that's addictive, is how incredibly valued you know you are. And you see it because they tell you that and they express it in the way they interact with you. It's, I think, a unique healthcare relationship in that sense.* (Rosie, current urban LMC)

The comments of our participants seem to indicate these relationships appear to be reciprocal, with whānau appreciating the midwife and valuing the care provided through the pregnancy and birth, and into the postnatal period.

The thrill of the birth

Many of the midwives identified the joy and thrill they felt from being present at a birth, especially if they have come to know the family well. The excitement is captured explicitly in the quote below:

> *When someone rings and goes – My water's broken – I get excited because it means she's going to have a baby, and I do get really, really excited about it.* (Bonnie, current urban LMC)

Midwives' family members also described the passion and enjoyment the midwife experienced from attending a birth:

> *I think, from what I saw, it was her passion, so I loved that … But from what I saw she'd come home after a birth … she'd tell me … how much she loved it.* (Chelsea, daughter of Debbie, former urban LMC)

The buzz midwives experienced following a birth often spilled into their family life and appeared to be an important facet of the midwives' enjoyment of their work.

Returning clients

Many of the midwives described the satisfaction they gained from providing maternity care to someone they had previously cared for – a returning client:

> *But then the really satisfying thing is when they come back to you two years later and say – I'm having another baby, will you be my midwife?* (Jacinda, current urban LMC)

This satisfaction had several differing causes. One was knowing that the client was satisfied enough with their previous care to return for subsequent care. Others were the ease of resuming the relationships established in the previous pregnancy, and seeing the previous children growing up. The midwives enjoyed becoming known to other family members and being a midwife to different generations within the same family:

> *I still have families that send me pictures years on of their babies, and when you birth more than one baby in a family or you birth the sisters, the aunties and the cousins, you go to a house and the house is full of kids that you've birthed. It's great, it's amazing, so that side of it is lovely. It's very gratifying for your soul.* (Lagatha, current rural LMC)

Although the midwives described the rewarding elements of their role, they also identified the more challenging aspects.

Constantly on call

This theme identifies the challenges of managing the requirement to ensure access to maternity care 24 hours a day, 7 days a week (24/7) for the women in the midwife's caseload. It includes the need to be frequently on call and the unpredictability of being called to provide maternity care.

The midwives identified numerous different arrangements to manage the on-call aspect of COC, with some having only one practice partner and others working in larger (6-8 midwives) group practices. As Jayne explains:

> *We do have other midwives in the practice, but we couple up, two two two, and we try not to draw on the others.* (Jayne, current urban LMC)

The midwives generally undertook their routine work, such as antenatal clinics and postnatal visits, during office hours. The flexibility of being able to determine their work hours for routine care was often considered a benefit for midwives with children. As Bonnie explains:

> *I've learnt over the last five years since I've been an LMC while I've had my children, how to balance my work more effectively in terms of structuring how I book my bookings. So, booking around school holidays, for example, and trying to fit my work away from home within school hours. So that really works quite well for me having that flexibility.* (Bonnie, current urban LMC)

As indicated above, there were various ways of managing time off, the requirement to be on call and have a backup midwife. The most common was to partner with one other midwife and rotate the weekends on call to allow for time off call every second weekend. However, this resulted in long periods on call, as Darryl explains:

> *Being on call constantly is an issue when it's for two whole weeks in a row. If it was just for five nights of the week and you had a fixed time off, then that's manageable.* (Darryl, partner of Lisa, current urban LMC)

Long periods on call

Due to the practice of being continuously on call for up to 12 days (in the case of one weekend on, one weekend off), midwives could be called out multiple times over several days with little time to recuperate:

> *Carmen can be up for 24 hours. She can … drop the kids off, go to her clinic, see some ladies, and then maybe go and collect the kids, and then get called out, then she'll be gone all night long until the next morning and then may have to do it again … and sometimes that scenario might happen consecutively, called out multiple times overnight for the entire night, yeah, and just driving, that's not safe.* (Hamish, partner of Carmen, former urban LMC)

Frequent or long call outs could lead to sleep disruption and exhaustion. Being with a woman during a long labour can be emotionally and physically demanding. This is exacerbated when the work is during the night or when there are frequent night calls:

> *When I have a birth, it takes a lot of energy to do the job in that moment … it could be that it's a long time and it's really emotionally and physically draining, so I will feel quite depleted after that and have quite limited capacity for anything else.* (Brigit, current urban LMC)

Midwives and their partners often expressed concern about their safety when driving following long or frequent call outs. The second midwife fee was introduced in 2018 to provide relief and/or support the LMC midwife during labour and birth if the midwife becomes fatigued. It enables the LMC midwife to call for a second midwife to support her or provide the labour and birth care in her place. It is claimed separately from the LMC's labour and birth fee, by the second midwife herself.

Jayne described the positive impact this fee has had over the last few years:

> *But the big thing that's happened recently is that they've had a second midwife fee … That has been huge because that has kept us safe, because the number of times I've fallen asleep on the way home, driving home because I've been at a birth for 16 hours or something like that … But now we can call in a second midwife and say – We're tired, can you come? And they get paid now.* (Jayne, current urban LMC)

The midwives also described the variability within the call outs, and how this affected them:

> *12 days on call … And that's not so bad if you have a really quiet week or you do a couple of lovely normal births … But of course, a lot of weeks are not like that.* (Lisa, current urban LMC)

Family members were also affected by the on-call facet of the role, as John explains:

> *For me personally,* [something I find challenging is] *being on call when Jane's on call. So, if I take the dog for a walk, I have to take my phone. I'd love to go and not have my phone with me, but she says – Take your phone, I might get calls. I'm walking the dog and the phone rings – Can you come back and look after the kids?* (John, husband of Jane, former LMC)

For the midwives with children, their partners and other family members needed to be "on call" and available to provide childcare, so that the midwife could be available for her clients.

Unpredictability

Call outs were unpredictable, meaning that plans were frequently cancelled and there was always a need for backup arrangements. All midwives described the unpredictability of being on call and the inability to make firm plans. Many discussed the need to take two cars when going out with the family, in case they are called and need to attend a client:

> *You're constantly in the back of your mind thinking, am I gonna make it to this thing, who's doing what? Often, we'll take two cars to something that we wouldn't normally, so that if I have to leave it doesn't impact anyone else who's there.* (Amy, current urban LMC)

Some of the participants described asking their backup midwife for on-call cover if they needed to attend an important family function but, for various other family-centred needs, the midwives felt unable to constantly ask for additional cover.

Call outs were both unpredictable in timing and also in length. Once called to provide care for a client, the midwife would have no control over when the care would be finished. For midwives with children, there was often a reliance on the partner to meet their children's day-to-day needs:

> *I've been quite lucky to have a job that's pretty flexible, so when Serafina has gone or had to go overnight, or couldn't pick kids up from school, I've been generally able to do that, so we've been really fortunate with that.* (Bob, partner to Serafina, current rural midwife)

Others described a variety of arrangements to ensure consistent childcare, which included using other family members or hiring an au pair. Family members often described their respect for the importance of the midwife's work:

> *But again, I totally respect what she's doing, and I think all of us are really in the position to do everything we can to support her to do that.* (Bob, partner to Serafina, current rural midwife)

The support of family members helped to ensure consistent childcare but also demonstrated the esteem the midwife was held in by the family. However, for the children, the experience of never knowing when or whether their mother would be home was more challenging:

> *Yeah, the unpredictability, I wonder, you know, like when you're at school it's that thing of going to school and not actually knowing if your Mum's gonna be home when you get home.* (Bango, child of Amy, current urban LMC)

> *But I think it was more just the fact that she was gone rather than her actually being with me, knowing that she was going to a birth and I didn't know when she was going to be able to come home, or even contact her.* (Chelsea, daughter of Debbie, former urban LMC)

Bango and Chelsea describe the uncertainty that comes with the unpredictability of the midwives' working hours and the difficulty of communication due to the acute nature of the midwife's work. Serafina explained how she balanced being available for her family with being available for her clients:

> *I would be that mum who's always there, whether the kids really wanted it or not. So, they might not see me for a couple of days but when I'm around I'm always there; I make time for them.* (Serafina, current rural midwife)

Being able to meet everybody's needs – both clients and family members – can be difficult for midwives, and having a supportive partner and family appeared to be integral to meeting these challenges.

Lack of operational support

This theme describes a lack of operational support available to help midwives provide 24/7 access to maternity care. The midwives described needing to pay other midwives to provide on-call cover and maternity care so that they can have time off. The midwives also described the resulting financial vulnerability.

Organising and paying for time off call

Midwives providing a rural service are able to apply for a funded locum (substitute midwife) for up to 9 days (although this can vary annually), which allows them to have some time off:

> *We do have locum payments from the Government for a set number of days of the year, so as a rural midwife … But yeah, I just think it's really important for midwives to take the opportunity to have more time off and not miss out on important events in their lives and therefore have access to locums and access to payments for locums.* (Tracy, current rural LMC)

At present, the funded locum service is only available for rural midwives or for emergencies. Therefore, most urban midwives turned to their backup LMC midwife when having time off call or annual leave:

> *I mean, if there's something I want to go and do,* [my backup] *is pretty generous in covering me, so I feel like we are still able to go and do those things and we just maximise my off-call weekends and do everything we want to do in that time.* (Bonnie, current urban LMC)

Using a privately arranged locum midwife was costly because often the rate paid to the substitute midwife was higher than the income the midwife was able to claim:

> *We pay locums to be on call for each 24 hours, and then they get paid for any work done. So, if they attend a birth then they get paid for the birth; or if they're attending any appointments they get paid for those things. So, it costs us a lot of money to have time off call sometimes.* (Tracy, current rural LMC)

This was exacerbated for midwives who provided care in remote rural communities, once they had reached their allocated locum days limit:

> *I took the whole month of February off, but it did come as a cost for me because I have to pay for someone to be there … I had to employ people to come over and that came at a big cost because no one really wants to come to a rural community.* (Mathilda, current rural LMC)

The need to pay locums for time on call was a source of resentment for most participants, given that full-time LMCs are paid fixed rates that they perceive as insufficient to account for the long periods they spend on call.

Financial vulnerability

The midwives described the financial vulnerability they felt when they had to pay for a locum in order to have time off. They also described concerns about the business costs they had to pay due to being self-employed. They were unable to increase their income other than by increasing their caseload, which in turn would increase their workload. This was especially relevant when the costs of living increased:

> *You're paying for all your stuff, so your clinic rent, your car maintenance, all that kind of stuff, your petrol, everything you're paying for, so you're treated like you're self-employed but you're not; you're contracted to the Ministry so we can't change how much you get paid for the pregnancy or the birth, … none of that changes.* (Carmen, former urban LMC)

There was frustration from the midwives because they were unable to negotiate their income. Working as contractors with Health New Zealand | Te Whatu Ora essentially makes them self-employed, but with no way to negotiate or dictate their own fees for their work. In Rosie's opinion, they have none of the benefits of being self-employed and none of the benefits of being employed:

> *We have a contract direct to the Ministry of Health. Therefore, by default they sort of have this responsibility as we're their contractors, but we're not employed by them. So, it's a very unsatisfactory relationship because they're not in an employer role where they have legal responsibilities to look after the workforce. But also, there's nothing else and they do actually have a responsibility because … people don't quite understand, but a self-employed person normally would choose when they work, and they would choose what they get paid for their work. They have the right to set their own rates and people choose whether they want to pay that for the service or not … We don't have any of that.* (Rosie, current urban LMC)

Despite these challenges, many of our participants continued to be supportive of the current continuity of care model. The midwives described the positive effect that continuity has for whānau:

> *I really don't want to see the continuity of care model go; I think that would be really damaging for women and whānau, and that's why we do it … I would be so heartbroken for women, for whānau, for pregnant people to lose this brilliant system.* (Swift, current urban LMC)

Overall, participants believed the model makes a positive difference to women and their whānau, but that more operational (structural) support would help to make the model more sustainable from the perspective of midwives and their families:

> *So, on that practice level, boots on the ground, I think that part of its very sustainable. I think what's needed is just that more structural support around the workforce.* (Rosie, current urban LMC)

DISCUSSION

Our study has explored wellbeing by revealing the joys and challenges of working in a COC setting. The participants have described their deep connection with the women under their care and the reciprocal nature of that relationship. Internationally, improved healthcare relationships have been identified when COC models are introduced (Leavy & Leggett, 2022). Midwives report that being able to develop meaningful relationships is the most positive aspect of continuity of care (Pace et al., 2022). They also identify that close relationships facilitate safer care and better outcomes (Leavy & Leggett, 2022). Satisfaction and joy in midwifery practice have been reported by LMC midwives in Aotearoa New Zealand (McAra-Couper et al., 2014). Similarly, Daellenbach et al. (2020) found that midwives working in rural communities described a sense of passion in their work due to the sense of social connectedness.

Two aspects of our study have not been reported in other COC studies. These were the satisfaction midwives gained from providing care to a returning client and the thrill of the birth. Crowther et al. (2014) explored the joy experienced at birth conceptually, finding that midwives' experiences of this joy were often ignored, hidden or covered over. These aspects of care appear to support midwifery sustainability within the COC model and may offer a counterbalance to the more challenging aspects of the role.

LMC work seems inherently paradoxical, in that the elements which provide joy and satisfaction also present challenges. The participants in our study were committed to their clients and wanted to attend their births. But being constantly on call and the unpredictable nature of when they would be called out come at a cost to the midwife and their family.

Our findings reflect those of Leavy and Leggett (2022), who reviewed the experiences of midwives working in team COC models. Their study found that the downsides of being on call were stress and exhaustion, yet these were perceived to be balanced out by the advantages of the COC work. In their synthesis of research studies, Pace et al. (2022) identified work-life balance as one of the main challenges of the role. They argue that COC models should be responsive to the needs of the midwives as well as the clients if they are to be sustainable.

The unpredictability of being on call was also identified in a qualitative study undertaken by Gilkison et al. (2015). They found that regular time off call, coupled with a manageable caseload, were intrinsic to sustainability. These features were achieved through midwives sharing the on-call requirements within a group midwifery practice. This suggests cultural and socio-economic expectations that the responsibility for organising all aspects of on-call work is that of the midwife (the contractor). In turn, minimal responsibility falls on the contracting authority or maternity services. The participants in our study identified a lack of operational support for the on-call element of their role, in that they needed to organise and fund cover for time off call themselves. Locum provision is currently limited to rural LMCs or emergency cover. Having more regular scheduled time off call may help to prevent midwifery stress and exhaustion and would provide the midwives and their families with more certainty and more ideal prioritising of family needs.

Family members were also affected by the on-call aspect of the midwife's work. With sudden changes in plans requiring flexibility physically, intellectually and emotionally. Midwives with children needed other family members to be available and "on call" for

childcare. The on-call nature of continuity of midwifery care has been theorised as imposing a caring dilemma for midwives due to the conflicting needs of their professional responsibilities and their family responsibilities (Bourgeault et al., 2006). The caring dilemma has been described as the tension caused when an individual is obliged to provide care without the right to determine how that care is provided. It has been considered salient to midwifery practice because COC requires the midwife to be on call for significant periods of time to attend clients' births, with the midwife's family and social life becoming secondary to the midwife's professional responsibilities. All of this can lead to work-family conflict.

Work-family conflict can result when individuals are not able to participate in the family role due to participation in the work role (Allen et al., 2019). Individuals generally have multiple roles within society, including work, family life, community and social life (Cavagnis et al., 2023). Each of these roles can enhance self-esteem, personal growth and fulfilment but conflict among roles can cause stress and guilt. The midwives in our study highlighted the flexibility of their role and ability to work around their family's needs. However, challenges for the family included the unpredictability of the on-call element, such as when the midwife would be called out and how long she would be at work. High levels of work-family conflict are associated with increased stress, burnout, depression and reduced job satisfaction (Cavagnis et al., 2023). Within the family itself, work-family conflict can cause marital dissatisfaction, high levels of irritability in parenting roles and can also have a detrimental impact on the children. Families often develop effective coping strategies which can help to moderate the effects of work-family conflict. Cavagnis et al. (2023) undertook a systematic review of factors which are protective for women's wellbeing and can mediate work-family conflict. They found that high self-esteem, an internal locus of control and having a relationship-orientated personality trait were protective factors. Other protective factors were having a supportive family and work environment. Our study has identified that there are LMC midwives who have supportive families, but there is a risk of work-family conflict if family needs are not met.

STRENGTHS AND LIMITATIONS

A strength of the study is that it reflects and adds to the international qualitative evidence about COC models of midwifery care. The joint interviews helped to capture diverse perspectives and provide a fuller view of the impact of the work on the midwife and her family members. As a qualitative study of a self-selected sample of midwives in Aotearoa New Zealand, the findings may only be applicable to those who participated and cannot be generalised to the whole profession. The sample included former LMCs, so some data may not be as relevant to current practice.

CONCLUSION

This qualitative study has explored wellbeing of LMC midwives and family members by documenting and examining similarities that could be termed the joys and challenges of working within a COC setting. The midwives described their passion for, and enjoyment of, their role, which included building relationships with women, caring for return clients and the thrill of being present at a birth. The role was also flexible, allowing midwives to determine their routine work hours (i.e. those not related to labour and birth care). The challenges of the work included the necessity of being on call for long periods of time (involving up to 12 days at a time), along with the unpredictable nature of just when and for how long the midwife would be called to work. The family members described the need to be on call too and the flexibility required when plans suddenly change. Midwives have identified the need for increased operational support to enable more time off call. This would also reduce the potential for work-family conflict. In light of their experience, it seems that having a reasonable balance, between the use of their time to enable regular time off call yet still being able to provide COC, is key to ensuring sustainability of the role and retention of the current LMC workforce.

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KEY POINTS

- Lead maternity carer (LMC) midwives find deep satisfaction and joy in building relationships and supporting families | whānau throughout their childbirth experiences.
- Long periods of time on call and unpredictable hours can strain midwives' wellbeing and disrupt family life.
- A lack of operational support and an overarching financial vulnerability threaten LMC midwifery sustainability.

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