



Midwifery Job Autonomy in New Zealand: I do it all the time

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ABSTRACT

Introduction: This research aimed to identify what supports and what hinders job autonomy for midwives in New Zealand.

Methods: Registered midwives participated in an open-ended, online survey in 2019. Anonymised participants were asked to describe an incident when they felt they were using their professional judgement and/or initiative to make decisions and the resultant actions. The data was analysed thematically.

Findings: The participants identified that autonomy is embedded within midwifery practice in New Zealand. Self-employed midwives who provide continuity of care as Lead Maternity Carers, identified they practice autonomously 'all the time'. The relationship with women and their family, and informed decision making, motivated the midwife to advocate for the woman – regardless of the midwife's work setting. Midwifery expertise, skills, and knowledge were intrinsic to autonomy. Collegial relationships could support or hinder the midwives' autonomy while a negative hospital work culture could hinder job autonomy.

Discussion: Midwives identified that autonomous practice is embedded in their day to day work. It strengthens and is strengthened by their relationships with the woman/whanau and when their body of knowledge is acknowledged by their colleagues. Job autonomy was described when midwifery decisions were challenged by health professionals in hospital settings and these challenges could be viewed as obstructing job autonomy.

Conclusion: The high job autonomy that New Zealand midwives enjoy is supported by their expertise, the women and colleagues that understand and respect their scope of practice. When their autonomy is hindered by institutional culture and professional differences provision of woman-centred care can suffer.

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Statement of Significance

Problem or Issue

Midwifery is recognised as an autonomous profession, but not all midwives experience support for this.

What is Already Known

Job autonomy is the freedom to make decisions, schedule work and determine, how and when to do that work. High job autonomy influences work positively and increases job attitudes, work performance, and wellbeing. Community

midwives experience higher job autonomy than employed, hospital midwives.

What this Paper Adds

A detailed exploration of autonomy in midwives day-to-day work is presented in the context of a continuity of care maternity model. Autonomy is experienced differently depending on the midwives' work setting. Being advocates for women is a motivation for midwifery autonomy.

Introduction

Midwifery is recognised as an autonomous profession which enables midwives to provide, evidence-based, high quality, and ethical care for women and their families during childbirth [1]. In

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New Zealand, the expectation of professional autonomy is embedded in professional standards, regulation, education, and ethics [2]. NZ midwives have been able to practice autonomously since a change in legislation in 1990 [3] with midwifery regulation separated from nursing in 1994 [4]. Professional autonomy has been linked to improved resilience [5], confidence in decision making [6], capacity for critical thinking [7] and facilitation of normal birth [8]. On the other hand, reduced autonomy may result in a reduction of midwives' confidence in their skills [6] and feelings of powerlessness [9]. Overall, extant research on autonomy in midwifery and the wider health professions indicates that autonomy is a critical work factor that can influence job attitudes, work performance, and employee wellbeing.

However, definitions of midwifery autonomy as they relate to practice remain elusive with Herron [10], suggesting that autonomy is not something that can be given to an individual or attached as a title. A recent review exploring the concept of autonomy and its impact on international midwifery practice found that prevailing definitions of autonomy included key elements such as, "being knowledgeable of the scope of midwifery practice; having authority and being able to make decisions; being accountable for consequences of any decisions made" [6], p. 122. A suggested definition of midwifery professional autonomy in New Zealand is 'the right and responsibility to practice within the midwifery scope of practice in accordance with the professional frameworks defined by midwifery-specific standards, ethical codes, guidelines and partnership' (J Anderson, personal communication, June 12, 2018). It appears, midwifery autonomy is a term that often includes both professional and workplace autonomy, yet a pragmatic understanding of how autonomy translates to day to day midwifery work is still needed.

In management terms, job or workplace autonomy is usually considered to be the degree to which a role "provides substantial freedom, independence, and discretion to the employee in scheduling the work and in determining the procedures to be used in carrying it out" [11] p.162. In addition to the freedoms of determining work schedules and procedures, decision-making freedom has also been incorporated into contemporary conceptualisations of workplace autonomy. Within New Zealand maternity there are a number of different roles that midwives can work within. Maternity care is fully funded for eligible women, with the woman choosing the Lead Maternity Carer (LMC) to provide her primary maternity care. The LMC can be a midwife, obstetrician, or general practitioner. In 2017, 94% of women chose a midwife to be their LMC [12]. These women are able to receive continuity of care from the midwife from early pregnancy, for labour and birth, and for up to six weeks post-partum. The LMC midwife will refer to multi-disciplinary health services when the woman has existing or current pregnancy conditions which require specialist input [3]. Women have a choice of home, a midwifery-led unit, or in an obstetric hospital for their labour and birth.

The roles midwives fulfil in New Zealand's maternity system are unique and varied (see Fig. 1). Hospital midwives reported less autonomy, empowerment, and professional recognition than LMC midwives in a study on the emotional wellbeing of midwives in New Zealand (Dixon, Guilliland [13]). This suggests that the work setting may have an impact on midwifery job autonomy. Several professions collaborate to provide maternity care to women and, they include midwives, obstetricians, anaesthetists and neonatologists. Perdok, Cronie [14] identified that each of these professional groups experience job autonomy in a manner specific to their work context. In their research assessing how professional autonomy was impacted by changes introduced to the maternity system in the Netherlands, they found that community midwives experienced the highest level of autonomy followed by obstetricians, and lastly clinical (hospital) midwives. They also found that

Box 1: New Zealand's model of maternity care.

Self-Employed/Lead Maternity Care (LMC) midwives are 100% publicly funded and based in women's community; self-employed by government to provide on-call, accessible, continuity of midwifery care(r). Thirty percent of registered midwives work in this way with over 90% of woman/babies using this model of care. These midwives are referred to as 'LMC' in this study.

Employed/Hospital midwives work in a variety of settings for different employers nationwide. Fifty percent of registered midwives provide rostered shifts in a variety of hospital settings. These midwives are referred to as 'Employed' in this study.

Management/administration and education make up the remaining employment for midwives. These midwives are referred to as the 'Other' in this study.

Fig. 1. Brief summary of New Zealand's model of maternity care. Three descriptions were used to categorise participants' work context: LMC, Employed and 'Other'.

primary care midwives scored highest on their future perspective of losing job autonomy as the system became more integrated.

Traditional, closed-ended quantitative surveys have been used extensively to research work autonomy within midwifery [13–17]. The over-reliance on this method is not unique to midwifery as organisational research on workplace autonomy has also depended on quantitative surveys [18–21,21]. Closed-ended quantitative surveys offer an option that is efficient to administer, they tend to have high reliability and validity indices, and they leverage sophisticated psychometric techniques [22]. However, they do not explore autonomous practice as it is experienced by the practitioner [22–24]. Where autonomy in midwifery practice can hold a clear definition for closed-ended quantitative surveys, a deeper exploration of the context of work autonomy is teased out through more personal stories as reviewed in Zolkefli, Mumin [6].

This research reports on open-ended qualitative survey data from midwives participating in the second phase of the 2019 New Zealand Midwifery Work and Wellbeing (NZ-MidWoW) study. This analysis extends previous research in the area of midwifery wellbeing by adapting the critical incident technique [25] to obtain midwives evaluations of their autonomy in practice. The critical incident technique (CIT) refers to a range of procedures for collecting observations of human behaviour that have critical significance and meet methodically defined criteria [25]. Several researchers have extended the CIT for use in interviews and open-ended surveys [22–24,26]. Specifically, we use O'Driscoll and Cooper's [24] adaptation of the CIT to study experienced job autonomy amongst professional midwives in New Zealand.

The aim of this analysis was to explore job autonomy amongst New Zealand midwives (the freedom to make decisions, to schedule work and determine how and when to do that work) and to identify what supports/enables and what hinders/disables midwives ability to practice autonomously within their role.

Method

Procedure

Participants were contacted through the College of Midwives membership database via an email inviting members to engage with an open-ended online survey. Participants were informed of the voluntary and confidential nature of the study and could withdraw from the survey at any time without further notice. The survey was approved by AUTEK (Auckland University of Technology Ethics Committee) ethics board (AUTEK 19/33). At the completion of the questionnaire, participants were offered the opportunity to enrol in a prize draw for one of twenty, \$50 retail vouchers. Personal information of participants opting to enrol in the prize draw was collected on a separate survey to maintain confidentiality. Reminder emails were sent after two and four weeks of the initial invitation to increase the response rate.

Participants

In 2019 the New Zealand Midwifery Council reported that there were 3,226 midwives with a practising certificate working in New Zealand [27]. As described in Box 1, midwives in New Zealand work in a variety of ways, as well as across different work settings and regions of New Zealand. In September 2019, all actively practising midwife members of the NZCOM, who had a valid email address and had agreed to receive non-practice-related emails, were invited to participate ($N=2236$). This equates to 69.3% of the practising midwives reported to be on the register. For both the Phase 1 and a Phase 2 surveys in the NZ-MidWoW project, participant midwives provided a unique, anonymous identifier that enabled the researchers to recognise midwives that participated in both surveys. The final dataset ($N=253$) used in this research was separated out of a larger dataset of 602 midwives.

Measures

Critical Incident Technique (CIT)

In this study, we adapted O'Driscoll and Cooper's [24] version of the CIT. Participants were asked to respond to six questions using free text (Table 1) In phrasing our questions, we drew from O'Driscoll and Cooper's [24] recommendation to avoid using emotive or leading terminology. Thus, instead of using the word 'autonomy', we asked midwives to think of and describe instances that led to the use of personal initiative or judgement. Midwifery autonomy is a term that encompasses both professional and job/workplace autonomy. As such, the use of the term 'autonomy' may lead participants to relate to professional autonomy where the exploration of job or practice autonomy was the aim of our research. These questions were designed to obtain information on why and how midwives engaged in workplace autonomy, how

their decisions were received by relevant observers, and whether they were effective.

Thematic analysis

Data entered free text was downloaded into NVivo© software, and individually coded by a research assistant (RA) and one of the authors (JC). Then 3 researchers (RA, JC, and AG) met to discuss and agree on the coding. Data were read line by line and coded into NVivo as informed by Braun and Clarke [28]. A coding tree was developed to show how data were grouped into codes. The codes were then further analysed by the research team to identify themes. The themes that emerged were grouped into those that support autonomy and those that hinder autonomy. As shown in Table 3, the themes which emerged that support autonomy were partnership with the woman/whānau (family), midwifery expertise and relationships with colleagues. Table 4 shows the themes which hinder job autonomy. They were midwives' relationships with colleagues and the culture of their workplace.

Findings

Participants worked across 19 of the 20 health board regions in New Zealand and represented a range of work experiences and contexts. Midwives worked both part- and full-time with the mean at 36.3 ± 14.4 hours paid work per week and the average years worked in their role ranged from new graduate through to 42 years in the job with a mean of 16.8 ± 11.0 years (Table 2).

As shown in (Table 1), midwives were first asked (A1) to describe an event when they felt they were using their professional judgement and/or initiative to make decisions and resultant actions. This question is used to elicit times when midwives could be considered as exercising job autonomy [29]. The events which midwives described spoke to circumstances when a midwife acted from her own appraisal of the situation at hand, rather than following a set, generalised protocol, or practice guideline. Incidents were described in which the midwives drew on their own knowledge and expertise and the specific, personal knowledge of the women and their individual context. Autonomy was recognised when midwives made choices that felt different to what was typically expected or what others would choose.

Autonomy is embedded/integral to midwifery practice: "I do it all the time"

The majority of the midwives responded that job autonomy was a large part of what they did every day. Some LMC midwives were incredulous at the request to tell of only one experience, ". . . my whole work life is using my personal initiative and judgement. I can't single out one event as there are multiple events each and every day" (LMC A1). More than half of the LMC midwives responses agreed

Table 1

Open-ended autonomy (A) questions available if participants indicated they used their personal initiative or judgement in the prior 90 days.

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- | | |
|----|---|
| A1 | Describe an event when you used your initiative in as much detail as possible including what led to your use of personal initiative or judgement. |
| A2 | If other people (e.g., peers, other health professionals, clients) observed your actions or were affected by them, describe how they reacted to your use of personal initiative or judgement in your practice of midwifery. |
| A3 | Why do you think your observers (e.g., peers, other health professionals, clients) reacted in the way that they did towards your use of personal initiative or judgement in your practice of midwifery? |
| A4 | Describe what happened as a result of your actions or behaviours in response to your use of personal initiative or judgement in your practice of midwifery? |
| A5 | How did you feel about the results of your actions or behaviours in response to your use of personal initiative or judgement in your practice of midwifery? |
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Table 2
Role description for the participants enrolled in the merged data (n = 253).

Role Characteristic	Category	Participants
Employment Type (n, %)	Self-employed	117 (46.2)
	Employed	88 (34.8)
	'other'	48 (19.0)
Years in role Mean (h) ± s.d.	Self-Employed	15.1 ± 11.0
	Employed	16.8 ± 11.8
	'other'	17.8 ± 9.1
Hours/week paid work Mean (h) ± s.d.	Self-Employed	40.3 ± 17.0
	Employed	32.1 ± 7.5
	'other'	34.0 ± 14.3
Work Context (n, %)	Rural	36 (14.2)
	Remote Rural	7 (2.8)
	Urban	90 (35.6)
	Did not answer	120 (47.4)

that this is what they did as routine activity, constantly every day: "Every day I have to use my initiative and judgement with every text and call I get from woman. . . . This is what we do" (LMC A1) and "we do this all the time when working in the community" (LMC A1). This was prevalent but identified less frequently in the responses from midwives working in the 'Employed' and 'Other' work settings.

As shown in Table 3, the themes which emerged and appeared to be an important principle that supports job autonomy were partnership with the woman/whānau (family), midwifery expertise, and supportive relationships with colleagues. Table 4 shows the themes which appeared to hinder job autonomy which were unsupportive relationships with colleagues and the 'culture' of the facility where they worked.

Relationships with the woman/whānau (family)

When midwives responded to the question of what motivated them to use their initiative, many replied that it was the knowledge

of the woman and/or her whanau and their expectations. The partnership relationship underpinned this LMC midwife's motivation to use initiative:

A client who had a previous early miscarriage was very nervous and stressed about (her) current pregnancy. A morphology scan identified a condition which was likely to be incompatible with life. I was given the information by the radiologist verbally. I organised a repeat scan within half an hour and recalled her back to the scan department in order for her to be seen by the Obstetric specialist. I chose to give her the details of the scan and the information I had received from the radiologist. My reasons for taking this action and using my initiative to share the information prior to the second scan was owed to the relationship I had with the woman. My knowledge of her anticipated reaction and need for more detailed information as soon as possible. I judged that I could provide her with details about the decisions she and her husband may need to consider in light of the expected outcome of the pregnancy. (LMC A1)

In this situation, the LMC midwife was motivated to share information with the woman, before consultation with an obstetrician, because she had a relationship with her. When asked how others reacted to this decision, this same LMC stated:

The obstetrician was hesitant to give the true information and in my opinion gave a false positive description of the condition and outcome for the pregnancy. As a result he was critical of my actions (LMC A2).

The LMC anticipated the importance of revealing difficult information inside the safety of their partnership relationship. The knowledge of the woman and their relationship supported the LMC to consider the woman's needs and to make a judgement about the information she would require. For midwives working within a continuity model of care, becoming an advocate for the woman is a result of that relationship, her knowledge of the woman, and her expectations which are

Table 3
Examples of the original expressions in the survey, their codes and the themes generated for what enables autonomous practice.

Original Quote	Codes	Themes
"A woman chose to deny care I advocated for her." LMC A1 "I trusted she was doing what she needed and wanted to do." Employed A1	Advocating for the woman Women's needs/comfort/ safety central	Relationship with the woman/ whānau
"The woman and her family were pleased I was supportive of continuing the birth process at home." LMC A2 "Healthy mum and baby no bonding disruption and skin to skin maintained." 'Other' A4	Positive reactions from women and whānau/family Outcomes for the woman and/or baby were positive	
"Second midwife becoming anxious but I merely got woman to move and baby was born and unravelled from a tight cord." 'Other' A1	Confidence in own skills	
"I made the call to stay as it was obvious the baby was coming soon & transferring would be really difficult and probably not in time." LMC A1	Trusting own professional judgement	Midwifery Expertise
"I was still unhappy with this so went to the manager and voiced my concerns." Employed A1	Knowing when to intervene	
"I felt upset that we had to transfer but knew that it was absolutely the right decision for the woman and her baby" LMC A5 "It makes you feel that you are an independent practitioner able to discuss and hold your own, and advocate for the women" Employed A5	Professional responsibility Feel an independent practitioner	Relationships with colleagues
"Affirmed in professional role as competent practitioner." Employed A5	Affirmed in professional role	
"Practise colleagues were supportive and proud" LMC A2 "Lots of positive encouragement and team building and a sense of something new and of value." 'Other' A4	Positive feedback from colleagues Teamwork and team building	
"I am experienced and have a history of being thorough. I think my colleagues trust my judgement but I would equally have listened if they disagreed with me." Employed A3	Mutually respected expertise	
"My senior colleagues felt respected and helped out." Employed A3	Professional collaboration	

Table 4

Examples of the original expressions in the survey, their codes and the themes generated for what hinders autonomous practice.

Original Quote	Codes	Themes
"Occasionally I think they wish I'd just go away and leave them in peace!" Other A2	Negative reactions from colleagues	Relationships with colleagues
"I felt disrespected and judged without the chance to defend my stance and the proffer the woman's rights to choose her own birth journey." LMC A2	Disrespected	
"Obstetricians are sometimes scathing and I wonder what they say about me behind my back." LMC A2	Professional conflict	
"Sometimes ignorance to the role, skills and knowledge level of midwives. Sometimes some people think they know better" EmployedA3	Perceived as less experienced/less able	
"By working how I want to as an autonomous practitioner I am not supported by a proportion of the unit staff here." LMC A2	Philosophical differences	
"They don't always understand the length of labour and sleeplessness when there's the next day's workload to organise!" 'Other' A3	Lack awareness of midwifery role	
"The Ed Drs gave the impression they were in charge and discounted what I was saying" LMC A2	Judged due to perceived lack of experience	Culture of the work environment
"I now feel vulnerable from negative comments from my manager, LMC's and core midwives." Employed A3	Did not feel safe to speak up	
"In hindsight I was justified because of the outcome, but if the baby had not been so gravely unwell would my client have been so charitable in her acceptance of my decision to say what I did." LMC A5	Continue to worry about complaint	
"You do get the feeling of being watched, discussed and disapproval." LMC A2	Culture of suspicion	

built over a period of time and through multiple assessments and discussions.

This is not the case for midwives who are employees of a hospital or in 'Other' settings. However, Employed midwives also saw their role as one of supporting informed decision making and advocacy for the woman. "I have no hesitation to be the woman's advocate if under secondary care and the Obstetric staff/Drs are proposing something the woman may not want" (Employed A1). In this situation, the midwife supported women to navigate informed decision making within the maternity system. This hospital midwife demonstrated that despite having less time to get to know the woman, she saw her role as developing a relationship with and advocating for the women in her care.

Midwifery expertise

The theme of midwifery expertise was identified by all participants (Table 3) albeit in different ways. Midwives have a variety of skills, knowledge, and experience. One midwife described her experience of taking over care from an obstetric consultant during a breech birth in theatre:

The breech made good progress until it got to the umbilicus then there was no progression at all, the consultant attempted Lovesets manoeuvre with no joy, the OT went quiet- my role had been supporting the woman and helping her with pushing but when I looked at the consultants face and eyes- I could see she was in trouble. I said then, let me help, asked her to hold the legs and using similar manoeuvres to shoulder dystocia- went in to find the arms- as I was sure that they probably were in the nuchal position, I reached the arms and brought them gently out one by one, then delivered the head - the baby initially very flat did pick up well after some minimal resuscitation. I have NEVER done this before, but have been part [of] and [a] midwife for many spontaneous breech deliveries - I had taught and practised all the manoeuvres for a breech dystocia but never needed to use [them] ('Other' A1)

When asked what happened as a result of this initiative, the midwife stated, "I guess- what it has done is re affirm to myself that I am still a skilled practitioner whom has good judgement, despite having a non-clinical job." ('Other' A4). Another hospital midwife challenged a care plan that involved an induction of labour where there was no medical indication to recommend one. Her initiative was to provide information to the woman to support an informed

choice. The woman subsequently chose to decline the induction. After the spontaneous vaginal birth several days later, the midwife stated she felt "Very pleased as it was a great result for that individual and it made my colleagues more aware to question plans and to be an advocate and to work in partnership with women" (Employed A5). Job autonomy validated and satisfied midwives when they were affirmed in their expertise. For these midwives, job autonomy has resulted in higher levels of satisfaction which is more likely to sustain them in their practice [30].

For some midwives, job autonomy meant navigating the grey area between hospital protocols, their own judgements, and their accountability. As this Employed midwife said:

I was aware that given it was induction (lowest level synton only) I had accountability to hospital policy and the woman and her whānau, and feel I navigated the grey area between these when in an upright position we started to get intermittent pick up of the fetal heart rate, I kept documenting it along with the maternal heart rate. (Employed A1)

This midwife balanced autonomy and accountability against institutional and professional guidelines. Guidelines require that a woman having an induction should be continuously monitored by cardiocotograph. This midwife balanced the woman's choice to be upright, midwifery knowledge that an upright position is optimal for labour while ensuring safety and accountability of monitoring the fetal and maternal heart rates. Navigating the grey areas autonomously can also be stressful as this midwife said, "Although more grey hairs were produced as was still stressful having to support someone making very different decisions" (LMC A5).

Relationships with colleagues

Relationships with midwifery and other health professional colleagues was found to be either a support or hinderance to job autonomy for midwives wherever they worked. For employed midwives, there was more data about the negative comments or influence of colleagues be it from medical staff or other midwives. This was often related to providing care that differed to hospital policies and appeared to be a lot more difficult for Employed, hospital midwives than self-employed, LMC midwives.

Autonomy in midwifery is not synonymous with working alone. Many midwives spoke of how their relationship within a team enabled autonomy. In the situation below the LMC midwife needed to transfer a woman urgently during labour into the hospital.:

They just assisted me on arrival at the maternity unit, there was no criticism. An LMC colleague and the staff midwives assisted me. The obstetrician didn't question me either. (LMC A2)

The midwife described the importance of these collegial relationships based on trust, respect, and support. For midwives knowing the other team members was also an important aspect of enabling their job autonomy, "*I know the midwives on my team quite well so after discussion and communication about why we were doing these things/making this plan of care they reacted positively*" (Employed A2). Knowing the other team members appears to facilitate discussion and open communication, which is fundamental to safe practice [31]. It also appears from this study, that open communication also supports job autonomy.

In contrast, collegial relationships could also hinder and cause a barrier to job autonomy. This midwife had worked with a primiparous woman, first at home, and then in hospital from onset of labour to full dilatation. When the baby's head did not present within the time expected for a physiological birth, obstetric care was requested:

The Obstetrician, awoken at 1am to attend, noted that the labour was very long in judgement of my management and "ranted" to all core midwives in the "office" area about how long LMC had let the labour go on for while [I] and other midwives prepped the mother for OT.

I felt disrespected and judged without the chance to defend my stance and offer the woman's rights to choose her own birth journey (LMC A2).

When asked why she felt this had occurred, she stated "*They did not have all the information to hand, they did not travel the journey with the woman*" (LMC A3). She stated that she "*will be very wary now to follow my personal initiative and judgement*" and ended with "*I guess I will continue to practice in the same way but feel less confident and trusting*" (LMC A4). Feeling disrespected and judged by colleagues, appeared to impact on this midwives' confidence to make decisions based on their expertise. Where opinions were not valued, or where philosophical differences were apparent, job autonomy may also be hindered:

(I) feel that my opinions are not valued or taken into consideration. It makes me frustrated and beaten down. I love midwifery but feel it is becoming obstetric nursing. The joy of normalcy in childbirth is few and far between where I practice. (Employed A5)

This midwife was ignored when she reviewed an obstetric registrar's plan to induce a woman's labour for having had minimal antenatal care. The midwife felt that her judgment was not valued and felt "*frustrated and beaten down*". These negative feelings may result in midwives being less motivated and less confident in their work.

Culture of the work environment

Midwives in this study identified the culture of the work environment as having an impact on their ability to use their own initiative or judgment. One midwife stated that a "*Culture of suspicion and burnout in the workplace*" ('Employed' A3) restricted her job autonomy. The culture of a work environment can impact on all midwives, but for the LMC midwife who moves in and out of that culture it may be less likely to curb autonomy.

One LMC described her support for a woman who wanted to wait for a spontaneous labour for normally grown twin babies. The woman had previously given birth twice at home (singleton homebirths) without problems. The LMC midwife's support and advocacy led to negative comments from her colleagues. "*I think*

the negative comments came from a place of fear where they have witnessed the worst of the worst outcomes" (LMC A3). She stated "*it's wanting to protect themselves and feel like they can control the outcomes by having well babies at the end even if that's taken a toll on the mother with cascades of intervention*" LMC (A3). In a work environment, where there is frequent discrediting of midwifery judgement or there is a lack of woman-centred care, there may be an increase in fear towards exercising job autonomy.

In contrast, some midwives said they received positive feedback about their actions when others were fearful of speaking up or taking action – they were glad that the midwife had the courage to speak up. As this Employed midwife says, "*Because I had spoken up and challenged a decision which is not always easy to do or indeed encouraged*" (Employed A3). She felt that:

Peers often want to stand up but are too scared. They worry about their jobs or bullying. I think that's why mostly they are supportive of me sticking my neck out. ('Other' A3)

Midwives using their own initiative or judgement spoke up in places where it was not easy or encouraged for midwives to challenge a decision. They also described how other midwives want to speak up but are fearful, and as a result, when someone does speak up, they are grateful – it is the voice of midwifery. Autonomy can be impacted by a culture of fear, and where midwives are afraid to stand up and challenge a decision for fear of the repercussions, job autonomy is hindered.

Discussion

In this study, we sought to identify how job autonomy is experienced by midwives by asking about a time where they used their professional judgement and/or initiative to make decisions. Midwives were also asked to describe the responses of others to their initiative in the incident they described. In doing this, we have used a pragmatic approach to identify job autonomy as one in which the midwife has identified that she has had the freedom to make decisions, to schedule her work (based on the decision) and determine how and when to do that work.

The incidents which midwives described were often where complex, clinical decision-making was necessary. Frequently, their professional judgements, knowledge, and skills became visible to other colleagues and health professionals and demonstrated that autonomy could be supported or hindered. Zolkefli et al [6] in their systematic review, suggest that central elements of autonomy include decision-making, having the knowledge and skills required to support decision-making, and sharing decision-making with the woman. The midwives in our study have echoed these central elements and identified autonomy to be integral and embedded within their practice and in their day-to-day work. The number and types of incidents recalled reflected the embedded professional autonomy midwives' value in New Zealand.

Midwives identified that the relationships they had with women strongly supported their job autonomy. They explained how knowing the woman assisted them in identifying the options of care that would support that woman's philosophy and expectations. These relationships were built on woman-centred care, where the midwives' decisions were individualised to the woman's context and expectations, and respected the woman's autonomy [32,33]. This is a similar finding to a Canadian study by Vedam, Stoll [33] which identified that regardless of the woman's risk status, their maternity decisions were respected by midwives to a greater extent than other medical health professionals.

Having confidence in their own knowledge and expertise was also found to be an important factor in midwives job autonomy. Where incidents were often described as occurring at the interface between themselves and other health professionals, the decisions

were judged by others as appropriate or not. When midwives' scope of practice [3] was understood, respected, and recognised, their expertise was honoured.

Although personal initiative and judgement occurred “all the time” for midwives, the incidents described often involved multiple health professions and professionals. It is not surprising that these were labelled either as negative or positive; different health professionals have different levels of expectation of who is in charge at any point in time. Multidisciplinary maternity settings in health have a recognised and historical hierarchy of authority [34–36]. Determining who is clinically responsible for a woman, the limits of each health professional's job autonomy, and when their decisions are honoured or superseded by whom is complex and continually evolving. When the process is woman-centred, and decision-making is shared, it positively supports the midwives job autonomy. When the process involves conflict, the experience is negative, and job autonomy is not reinforced.

This is a similar finding to that of Bedwell et al [37] who explored factors that affected midwifery confidence, with 12 midwives in the UK. They identified that the influence of colleagues and perceptions could both positively and negatively influence midwifery confidence and described how the culture and hierarchical authority of maternity establishments contributed to a sense of disempowerment and lack of confidence for midwives.

In our study, autonomy in daily practice was strongly identified by self-employed, LMC midwives. When working in the community, LMC midwives will often work without immediate collegial support. Consequently, LMC midwives are accustomed to making decisions about their work, their practice and when, how, and where to do that work, as they said they “do it all the time”. LMC midwives can choose their practice partners, and align their philosophy with their colleagues [30]. Women can also choose a midwife whose philosophy aligns with their own. This means that for LMC midwives, autonomy is supported by being philosophically aligned with the woman, and her practice partners, and for them, autonomy is part of everyday practice.

For hospital midwives, autonomy was still highly important, but institutional and cultural influences impacted on their job autonomy. Davis and Homer [8] discuss workplace culture identifying it as the unwritten rules of a workplace which prescribes the norms of behaviour. In their focus group research with midwives from Australia and the UK, they found that midwives felt they were unable to work with the same degree of autonomy in the traditional labour ward environment of an obstetric unit. They described feeling ‘watched’ and needing to conform to obstetric expectations and obstetric-led policies. Copeland, Dahlen and Homer [9] describe the polarised view of childbirth between midwives and obstetricians, which can challenge midwifery autonomy. In their interview with 12 midwives exploring midwifery perceptions of childbirth, they found that midwives often described a relationship of conflict when collaborating with medical practitioners about a woman's care. The midwives described the need to rapidly build relationships, share information and build trust with the women to navigate the pathway within an institutionalised environment. However, authoritarian leadership and privileging obstetric knowledge impacted on midwifery autonomy.

In this research, midwives identified that workplace culture could have an influence on practice which could either support or hinder job autonomy. In the New Zealand setting, self-employed LMC midwives who practice in the community have control over their workplace culture, whereas employed, hospital-based midwives do not. The increased job autonomy community midwives experience outside of the hospital setting is consistent with work done by Perdok, Jans [38] and Perdok, Cronie [14]. In our research, it appears that when midwives' decision-making is supported,

women-centred care is sustained. However, if job autonomy is hindered midwifery confidence to support woman-centred decision making may be eroded and a sense of powerlessness can grow [6].

Strengths and limitations

The critical incident technique used in this study is both a strength and a potential limitation. A strength is bringing in an approach normally utilised in organisational research. This may also be a limitation in that the midwives in this research were not all part of the same organisational structure.

This study is strengthened by the number of midwives that shared their narratives in this survey format (n = 253). Yet, because it was conducted in New Zealand, where midwives have professional autonomy through legislation [39] the findings may not be generalisable to a setting where midwives do not have the authority to practice autonomously.

Conclusion

This study provides an exploration of midwifery job autonomy within a New Zealand-specific context. It has identified that partnership relationships and advocacy for women's informed decision-making supports midwifery autonomy. Criticism and negative relationships appear to hinder and inhibit midwifery autonomous practice and job autonomy. Midwives working within as LMC midwives within a continuity of care relationship identified that autonomous practice is embedded in their day-to-day work. Autonomous practice was more difficult for hospital and ‘other’ midwives but was still apparent and considered important. This research strongly links midwifery job autonomy with their provision of expert, individualised maternity care for woman and whānau/families. Consequently, when midwifery autonomy is eroded, woman-centred maternity care is likely to be affected. The difficulties women and whānau/family are confronted with, as they navigate the maternity system structures, are also felt by midwives. It is in the multidisciplinary maternity healthcare settings that midwifery-directed initiatives and judgements are most adjudicated. Hence, the nature and culture of the maternity healthcare setting either supports or hinders job autonomy, autonomous practice, and individualised, woman and whānau/family-centred care.

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