

Following the Dream:

A study exploring the reasons why British Midwives choose to practise in New Zealand



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Contents

<i>Introduction</i>	3
<i>Stage One – the postal questionnaire</i>	3
<i>Method</i>	3
<i>Results</i>	4
<i>Practice experience, age and access route to midwifery</i>	4
<i>Considerations in deciding to live and work in New Zealand</i>	5
<i>Employment patterns of British midwives in New Zealand</i>	7
<i>Conditions of Registration</i>	9
<i>Usefulness of the courses</i>	11
<i>Stage Two – Telephone interviews</i>	12
<i>Methods</i>	12
<i>Category One -The Context</i>	13
<i>Motivation for moving to New Zealand.</i>	13
<i>Employment Trends</i>	14
<i>Location</i>	15
<i>DHB Support</i>	15
<i>Category 2 - The experience of midwifery practice in New Zealand</i>	16
<i>Being prepared for difference</i>	17
<i>Working Practices</i>	17
<i>New Graduates</i>	18
<i>The interface between primary and secondary services</i>	18
<i>Feelings around autonomy</i>	19
<i>Supervision vs Midwifery Standards Reviews</i>	19
<i>Biculturalism vs Multiculturalism</i>	20
<i>Category 3 – The New Zealand requirements for registration</i>	20
<i>Discussion</i>	23
<i>Limitations of the Study</i>	24
<i>Conclusion</i>	24
<i>References</i>	25

Introduction

Midwives who have been educated and registered in the United Kingdom (UK) form the largest group of overseas midwives to apply for midwifery registration in New Zealand. Statistics collected by the Midwifery Council indicate that midwives from the UK made up 76% of all overseas qualified midwives seeking registration in New Zealand between January 2005 and October 2008 (Midwifery Council of New Zealand, in press). As midwifery remains a skills shortage area in New Zealand, recruiting midwives from overseas, with a focus on the UK, is likely to continue to be an important part of the midwifery workforce strategy.

In the UK, the New Zealand model of midwifery and the organisation of maternity services has been closely observed and monitored (Davies 2008, Wickham 2003). At the same time, a large research study 'Why do Midwives leave?' found that many midwives felt that they were unable to practice within a midwifery philosophical framework when employed within the UK maternity system (Ball, Curtis & Kirkham 2002, RCM, 2008). Do midwives come to New Zealand in search of opportunities to practice autonomous and woman-centred midwifery? What are their experiences when they begin to work as midwives? This research study explores what motivates British midwives to take up residence in New Zealand and how they feel about working as a midwife in New Zealand.

The research was undertaken as a collaboration between Christchurch Polytechnic Institute of Technology (CPIT) School of Midwifery lecturers and the Midwifery Council of New Zealand. Two methods were used: a postal questionnaire and telephone interviews.

Stage One – the postal questionnaire

Method

The first stage of the study comprised of a postal questionnaire designed to gain demographic data on the age, level and type of experience, education and career progression of British registered midwives who choose to live and work in New Zealand. It also included a few open ended questions asking midwives to briefly describe their reasons and rationale for moving to New Zealand, in order to gain a better understanding of the issues for this group of midwives. The results of this survey were used to inform and develop a semi-structured interview tool in order to explore these issues in greater depth with a small sample of these midwives via a telephone interview.

The postal questionnaire was sent to all (104) British registered midwives who had registered in New Zealand with the Midwifery Council between October 2004 and June 2007 and had given the Midwifery Council an address within New Zealand. This included midwives who held a Practising Certificate (87) as well as those who had not applied for one (17). A further 28 midwives had been registered with the

Midwifery Council of New Zealand but had not applied for a Practising Certificate or provided a New Zealand address were not sent questionnaires.

The Midwifery Council sent out the questionnaires in July 2007 with a pre-addressed FREEPOST envelope for the return of the questionnaire to the School of Midwifery, CPIT. This ensured that respondents remained anonymous to the researchers analysing the data from the questionnaires. A follow-up reminder letter was sent out to all the midwives four weeks after the questionnaires were posted to increase the response rate. The data from the returned questionnaires was analysed using SPSS-15 to look for patterns within the demographic characteristics, practice experiences and the midwives' expectations and experiences of taking up midwifery practice in New Zealand.

The information letter sent out along with their postal questionnaire included an invitation to participate in the interviewing stage of the project. Potential participants sent back their names and contact details. The project received Ethics approval from the CPIT Academic Research Committee Ethics Sub-committee.

Results

104 questionnaires were sent out and 55 midwives returned the questionnaire which is an overall response rate of 53%. 54 respondents were practising midwifery in New Zealand and one was no longer working as a midwife. This indicates a response rate of 62% for those midwives who held a Practising Certificate.

Practice experience, age and access route to midwifery

The highest proportion of respondents (38.2%) had 5 years or less of midwifery practice experience before arriving in New Zealand.

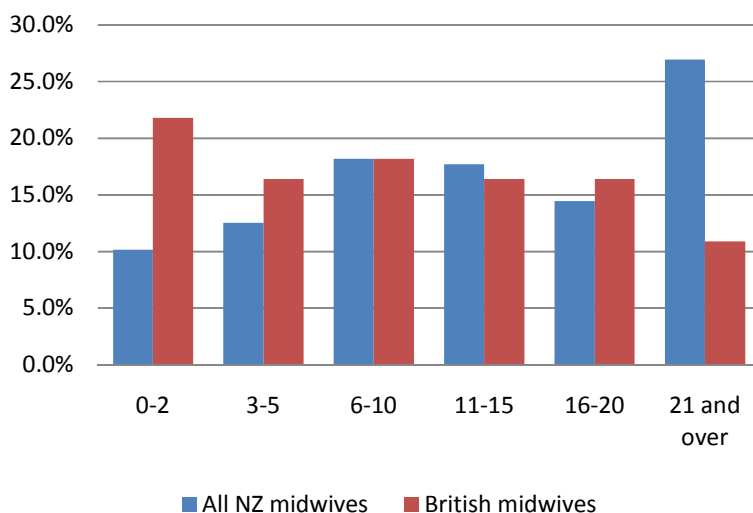


Figure 1: Years of midwifery practice, all NZ midwives compared to respondents

This reflects the findings from research in the UK which indicates high rates of attrition amongst midwives within a few years of qualifying (Ball, Curtis and Kirkham, 2002, p 34). A comparison to the Midwifery Council workforce data shows the midwives from the UK tend to have slightly fewer years of practice experience than the midwives in New Zealand (see Figure 1).

The British midwives who responded to the survey were more likely to be between the ages of 31-45 than New Zealand midwifery workforce (see Figure 2).

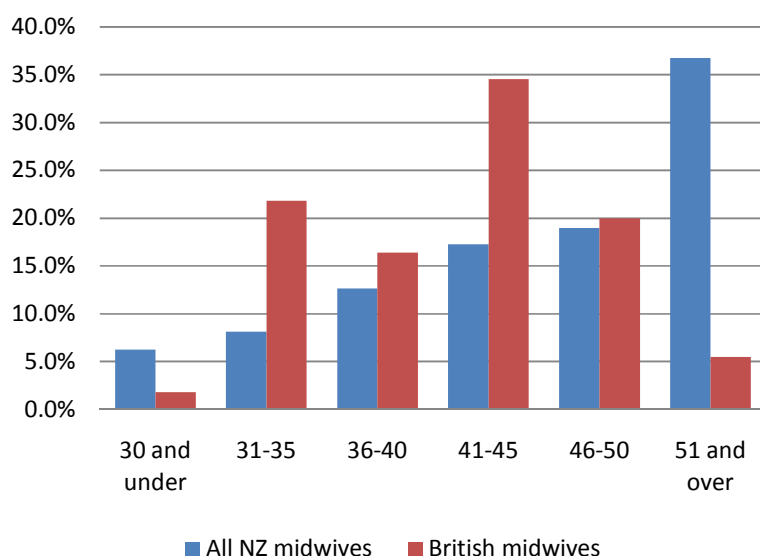


Figure 2: Age of New Zealand midwifery workforce compared to respondents

36.4% (20) of the respondents had attained a direct entry midwifery qualification, while 63.6% (35) also held a nursing qualification and registration in the UK.

Considerations in deciding to live and work in New Zealand

Most (83.6%) of the midwives who completed the questionnaire recorded that they intended to make New Zealand their permanent home. 12.7% (7) were undecided and 3.6% (2) noted that they had come to New Zealand with the plan to return to the UK. The majority (74.5%) were the principle applicant for a work or permanent residence visa, while the rest (25.5%) accompanied a partner who was the principle applicant. Most (34/41) of the midwives who were the principle applicant had a partner/ family who came with them to New Zealand. Thus, overall, 87.3% (48) of the respondents moved here with their partner/family.

Respondents were asked to rate how important a series of factors were in their decision to move to New Zealand on a four point scale comprising of the categories of major; fairly major; minor consideration and not a consideration (see Figure 3).

The most significant motivation for seeking to come to New Zealand was the aim of an improved lifestyle. This was a major or fairly major consideration for 85.4% of the respondents. Less than half (45.5%) of the respondents rated the model of midwifery as a major or fairly major consideration in their decision to move to New Zealand.

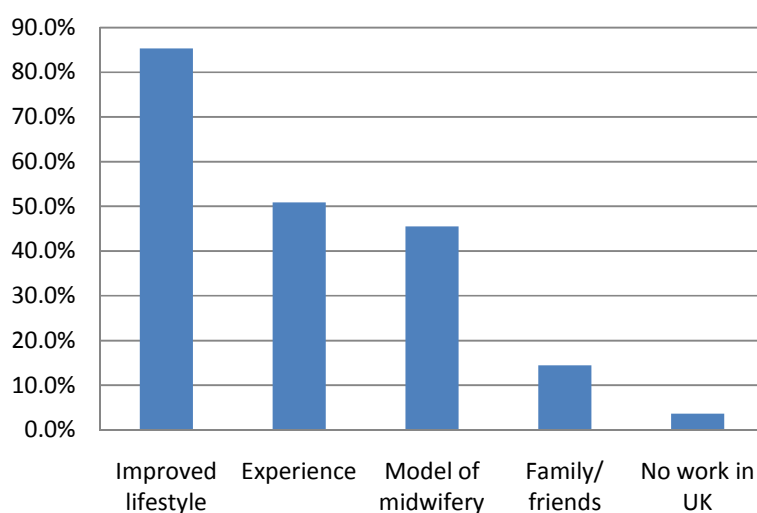


Figure 3: Major/ fairly major consideration in the decision to come to New Zealand

The data was analysed to check for correlations between demographic variables and the different motivations for coming to New Zealand. The only consideration that varied significantly across groups was the model of midwifery. Midwives with fewer years of practice experience tended to be more likely to rate the model of midwifery as a major or fairly major consideration. 62% (13/21) of the midwives with 0-5 years of midwifery practice experience identified the model of midwifery in New Zealand as a major/fairly major consideration. By comparison 13% (2/15) of the midwives with 16 or more years of midwifery experience considered this as major/fairly major factor in their decision. Midwives who were principal applicants were also more likely to have been motivated by the model of midwifery in New Zealand than those who were not the principal applicant (53.7% and 21.4%).

The questionnaire included a series of questions about what aspects of midwifery they had felt had been the most important in attracting them to take up midwifery in New Zealand. 'Experience a different midwifery practice' (74.5%) and 'Increased autonomy' (61.8 %) were the aspects of midwifery that respondents cited as being most appealing (See Figure 4).

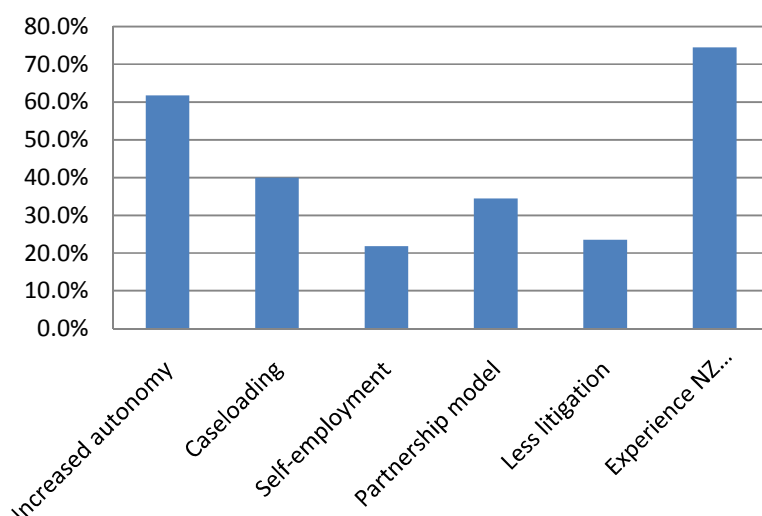


Figure 4: Major/fairly major aspects of midwifery in New Zealand

Employment patterns of British midwives in New Zealand

Most of the respondents had begun practising in the Auckland, Waitemata, and Counties Manukau areas (see Table 1).

Table 1: DHB are of first midwifery practice in New Zealand

DHB	Number	Percent
Auckland, Waitemata, Counties Manukau	26	47.3%
Central and Southern North Island DHBs	20	36.4%
South Island DHBs	9	16.3%

Of the 55 midwives who responded to the questionnaire, only one midwife has relocated to a different area within New Zealand from the one in which she originally began to work as a midwife. A few midwives reported that they were working in a neighbouring DHB.

The analysis revealed that 54 out of the 55 midwives who completed the survey are currently practising midwifery in New Zealand. A third of these midwives have changed practice since their first position (See Figure 5). This reflects a marked shift from hospital based workplace to caseload practice.

52.7% (29) of the respondents reported that they worked full-time and 45.5% (25) part-time. This is similar to the general midwifery workforce in New Zealand.

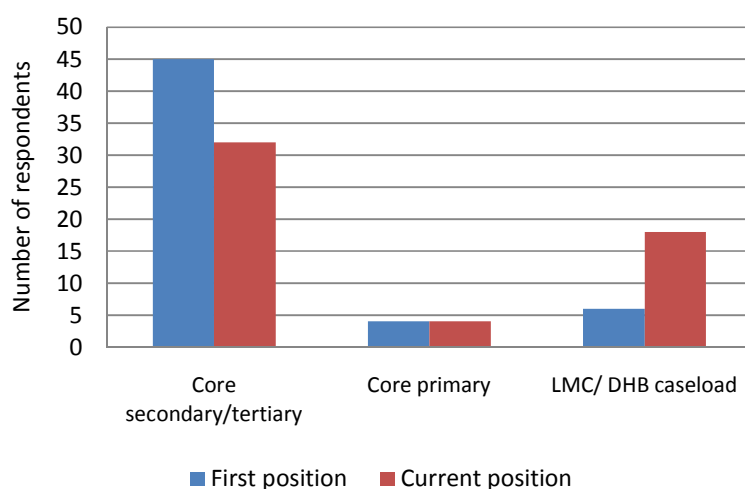


Figure 5: First and current work positions

Midwives were asked whether working in New Zealand had met their expectations. 29 (52.7%) indicated that working as a midwife in New Zealand met their expectations; 24 (41.8%) indicated that it had not and two were undecided. Notably, midwives who emigrated because of the midwifery system in New Zealand, particularly because of the partnership model, were more likely to have found that midwifery practice in this country had met their expectations.

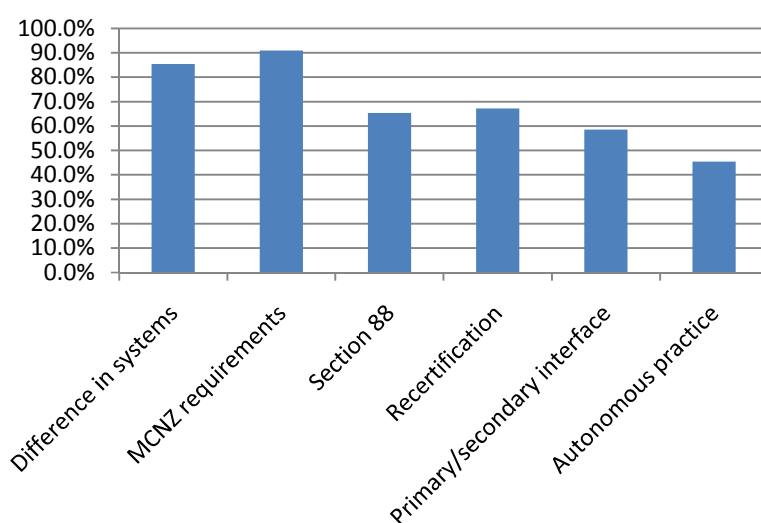


Figure 6: Challenging aspects of starting out as a midwife in New Zealand

The questionnaire asked participants to rate challenging they found various some of the aspects in midwifery in New Zealand (see Figure 6). Most of the midwives made

comments on what they found challenging in response to the open questions in the questionnaire. The key themes in these comments are:

- Almost half (49%, 27) of the respondents wrote that they felt they had less autonomy as a midwife here than they had in the UK. All were employed as core midwives within DHBs. Some noted that, consequently, they found midwifery unrewarding and unsatisfying. 70% (19) of the respondents who made explicit comment on the lack of autonomy also noted that midwifery in New Zealand had not met their expectations.
- A number of respondents commented that there was a lack of collegiality between core midwives and LMC midwives. Two stated that they felt New Zealand had a “two-tiered” midwifery system.
- Many respondents commented on the pressure they faced in meeting the Midwifery Council of New Zealand conditions of registration. Several noted that the requirement to complete the registration competence programme within 18 months was hard to achieve while also settling family in to a new country. Most respondents indicated that the courses were too expensive.
- Some suggested that employers were not as supportive as might be expected. Several commented on the need for both a DHB support and orientation programme for settling and for support to meet the Midwifery Council of New Zealand requirements.
- Several also felt that it was unfair that they could not enter into independent practice for a specified time (in the belief that this was a New Zealand Immigration Service requirement)

Conditions of Registration

The questionnaire included a series of questions relating to the conditions of registration that are required by the Midwifery Council of New Zealand for overseas midwives who wish to practice in New Zealand. These conditions are that the midwife:

- May not work in sole practice as a Lead Maternity Carer
- May not prescribe any medication
- Attends a Midwifery Standards (MSR) review within the first year
- Completes an approved registration competence programme within 18 months of the issue of their first practising certificate. This competence programme will include the following modules:
 - New Zealand maternity system, midwifery partnership and cultural safety
 - Treaty of Waitangi
 - Pharmacology and prescribing

The number of respondents who had completed all three educational components was 20% (11) while 14.5% (8) had not yet started any of these. About two thirds of the midwives had completed or were enrolled in pharmacology and Treaty of Waitangi courses (see Figure 7). 29% (16) respondents had completed at least one MSR, while 71% (39) had not.

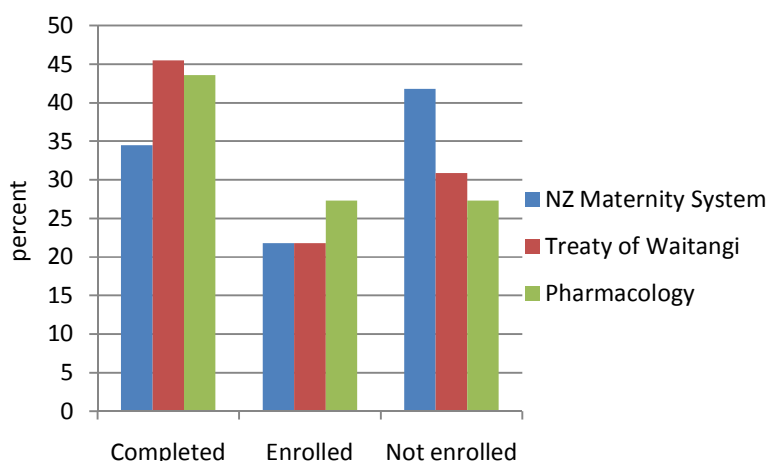


Figure 7: Progress through the competence programme

The higher completion rates for the pharmacology and Treaty of Waitangi courses is reflected in reported accessibility of courses (see Figure 8). Respondents found the Treaty of Waitangi courses the easiest to access. Possibly this is because most DHBs offer these while midwives are required to enroll in the other courses through educational institutions.

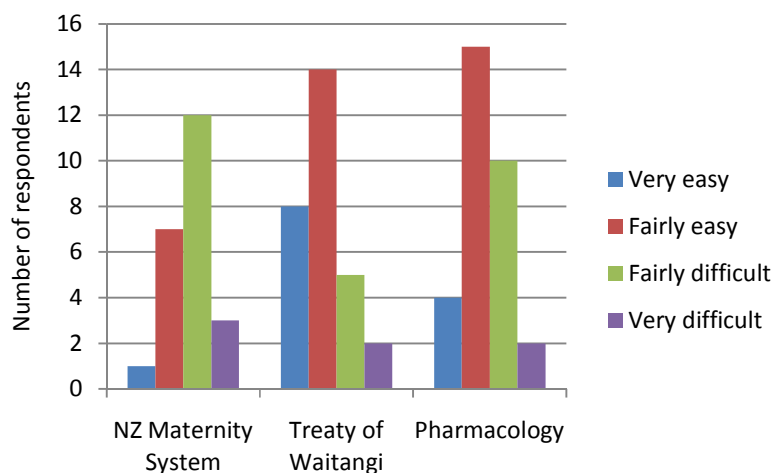


Figure 8: Accessibility of courses

Most respondents (50 out of 55, 90.5%) considered the Midwifery Council’s requirements were a challenging aspect of starting midwifery practice in New Zealand. 26 (47.3%) reported these as very challenging. The degree of progress through the registration competence programme was not related to differences in perception of how challenging these requirements are – except that midwives who had completed MSR were slightly less likely to record the Midwifery Council’s

requirements as 'significantly challenging' (see Figure 9). Thus completion of process does not make it seem less challenging for respondents.

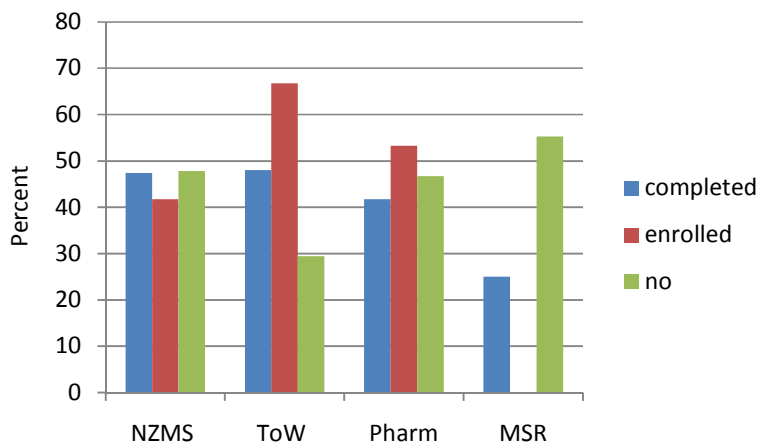


Figure 9: Progress through the programme of midwives who found the Midwifery Council requirements very challenging

Usefulness of the courses

The responses suggest that all of the courses were seen to be useful to a greater or lesser extent. However pharmacology was rated as being more useful than the New Zealand maternity system/ partnership and cultural safety course (see Figure 10).

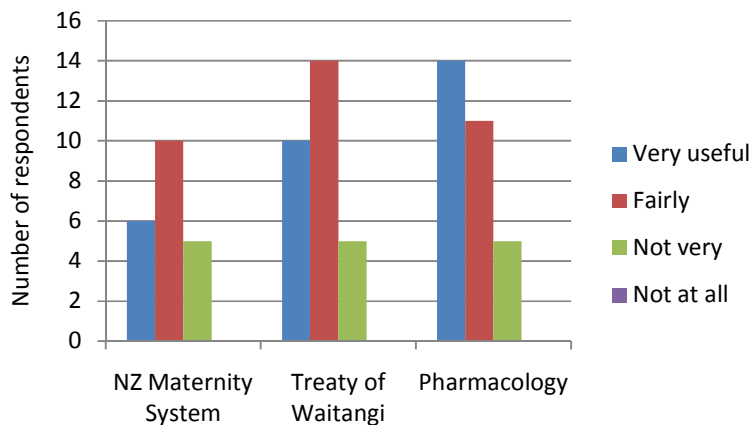


Figure 10: Usefulness of courses

The likelihood that respondents found the courses useful was cross tabulated against a number of motivational and demographic variables. No associations were found with any demographic variables such as age, years in practice, qualification, etc.

However, a slight pattern emerged suggesting that midwives who had sought registration in New Zealand because of aspects of midwifery that are emphasised New Zealand tended to report finding the courses more useful than those who did not come explicitly for the model of midwifery (See Figure 11).

There were more comments about the conditions of registration on the questionnaires than any other section. Some of the respondents were accepting of the restrictions on their registration which they felt to be reasonable and fair, and something that would ensure “safety of practice”. Others were more ambivalent in their responses. Several commented that although they could understand the need for the courses, and the pharmacology course was often mentioned, the “costs were punitive”. Others felt that having to do the courses was a slight to their professional integrity having worked as midwives for many years.

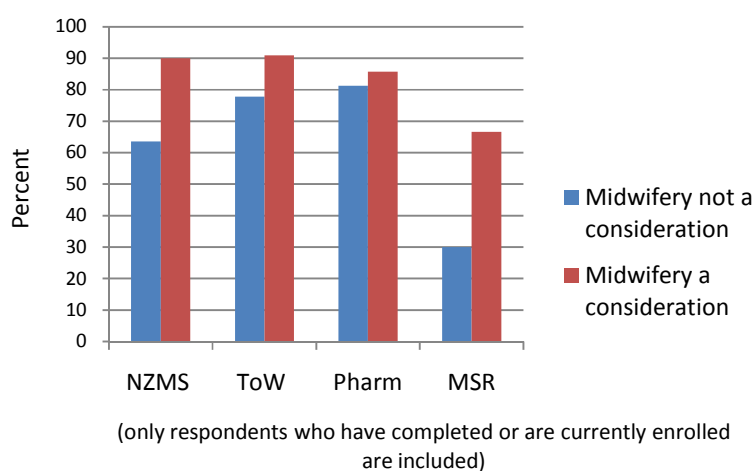


Figure 11: Course assessed as useful by whether the model of midwifery was a consideration for coming to New Zealand

Stage Two – Telephone interviews

Methods

The second stage of the project was focused on a series of telephone interviews which were carried out using Skype and were digitally recorded using the Pamela software system. These were carried out by a sole researcher in order to increase the consistency in questions and approach. Each interview lasted about half an hour. The telephone interviews were transcribed using pseudonyms with identifying personal information, names or identifying features of any workplaces removed.

The participants were invited to be interviewed in the initial survey letter. Out of the 55 initial respondents, 31 stated that they would be happy to receive a follow up interview by telephone. The selection of interviewees was purposeful, based on geographical location. It was felt to be important to include a representative voice from as many different DHBs as possible. These midwives were sent consent forms and were interviewed after the consent form was returned. Twelve midwives from 10 different DHBs around New Zealand were interviewed by telephone.

The aim of using the telephone interview as a data collection method was to gain detailed and specific data about perceptions, experiences and views of midwives from the UK who have chosen to live and work in New Zealand. A list of common themes, patterns, or trends identified from the analysis of the responses to the questionnaire was used to inform the questions that were posed during the interviews. These fell into three broad categories:

1. the context – demographic data and reasons for coming to New Zealand
2. the experience of practice in New Zealand
3. the New Zealand requirements for registration.

The analysis of the qualitative data helped to create a picture of some of the factors involved in British midwives' decisions to move to and practise in New Zealand in greater depth.

Category One -The Context

Motivation for moving to New Zealand.

The survey had already established that the majority of the midwives had come to New Zealand primarily for the lifestyle. Some of the interviews reinforced this trend, with a number of the interviewees acknowledging that the motivating factor had been to discover a better life for themselves or their children.

*I think the main thing wasone day I went to work, and I sat about and looked at all my work colleagues and thought, 'I don't want to be doing this in twenty years time'. Then I thought, 'There has to be more to life than what I'm doing ', so then I decided right I want to experience some of my life before I get too old. **(Lisa)***

*No it wasn't midwifery I would have to say. It was something I really didn't think about... There were lots of other reasons: the safety of the place, the future of our children, the education, the lifestyle here, so lots of other things. **(Jane)***

However a number stressed that the model of midwifery had played an important part in their decision to come here.

We thought about it for a lot of years and it was mainly a lot to do with the independent midwives, that was very, very important to me that where I moved to it

had to have the right maternity system that worked for me, and lifestyle and hopefully a better climate. (Ginny)

I came over for a holiday in 2002 and absolutely loved it. At that time I met a few midwives and looked at the way midwifery was set-up in New Zealand and thought that that was how I really, really wanted to work. (Rachel)

It was noted by at least one of the interviewees that the lifestyle aspects were the main focus of the marketing on the part of the DHBs who regularly advertised in the British midwifery journals.

They don't tell you anything about the midwifery here, just what an amazing lifestyle you can have. That's all very well but it doesn't do much to prepare you for practice. (Donna)

Employment Trends

The survey had identified that the majority of respondents were initially employed by a DHB in order to gain a work visa or residency. There was a degree of confusion around whether overseas midwives could actually set up as a self-employed midwife on arrival here. Some of the midwives indicated that New Zealand Immigration Services had informed them that DHB employment was a requirement and an information sheet on the Immigration website would seem to support this (NZIS 2008).

I was going to work full-time for three months, which was the Immigration stated we had to do for residency (Joanne)

The Midwifery Council requirements to meet the conditions of registration seemed to compound the problem for some. In fact, overseas midwives can work as LMCs but do need to join an established practice and have a midwifery partner.

I find it laughable that given my experience I can't work as an LMC for 18 months but new midwifery graduates can practise as LMCs immediately (Survey respondent)

However, many of the midwives interviewed indicated that they had made a conscious choice to work for a DHB and would not initially have even considered self-employed practice. Although some had now moved into caseloading either as DHB or self-employed midwives, others did not want what they considered to be the upheaval that such a choice would bring.

I did that (community midwifery) for many years in the UK. I did home deliveries, I was a community midwife who liked home deliveries. It's something that I have done, but it's not that appealing now. (Jane)

One midwife who went straight into LMC practice referred to what she considered to be a fairly confusing situation.

*The group that I was joining, was willing sort of sponsor me as such. They wrote a letter to sort of guarantee that I would be working within the group. So that was helpful in that it sort of clarified things with Immigration, although it was all very sketchy. You know Immigration weren't really sure about how midwifery worked, and the Council weren't sure how Immigration worked, so between everybody it was all a bit of a ... it was undecided for quite some time. It took us quite some time to get through the paperwork. **(Rachel)***

Location

The survey had identified that most of the midwives who responded stayed in the areas where they were initially employed on arrival. The reasons for this were frequently cited as not wanting to further uproot families. The responses of both Jane and Louise were fairly typical.

*I think mainly because of the age our daughter was ... she was thirteen, and so we thought, well it's been a major upheaval to actually move her at that age anyway, so we had to come and settle for at least until she had finished her education. **(Louise)***

*My children didn't want to come to New Zealand, but once we were here and they had you know settled into a school, you're under a great deal of pressure to stay. And you just sort of work where you've landed. **(Jane)***

Jane was not alone in expressing feelings of pressure when discussing the issue of settling families. This was usually accompanied with a sense of relief when the children and sometimes the partner showed signs of feeling settled. This may be partly due to the fact that the most of midwives were the principal applicant and perhaps that incurred an additional sense of responsibility.

*It's the strain that you put yourself under making sure that you know your kids settle fine and are organised at school, and then that your husband is OK. I think it was about four months or five months into it when I sat down one day and I thought, "Well the kids are all fine because they come in from school and disappear off with friends to do this, that and next thing, the husband's working, making friends, what about me?" **(Lisa)***

DHB Support

The District Health Boards with acute staffing shortages, appear to spend a considerable budget in an attempt to attract midwives from the UK to work in their hospitals. They use advertising in journals, and attend expos and conferences in an endeavour to recruit British midwives. Some of the participants raised the issue of the variation in the levels of support offered by DHBs around New Zealand in the questionnaire. When this theme was introduced for discussion during the interviews the mixed replies reflected those in the survey responses.

*I must admit they were helpful up until when I actually started the job (laughs). They were very sort of on the phone and it was all very friendly and chatty and lovely and then when I started it stopped. **(Doris)***

I guess in terms of the initial settling and things like that, they were helpful. (Sophie)

There was a lady who was from Human Resources when we first ... she wrote to me and said "This is where you can get help with housing", "This is where you can get help with ..." or you know "We can get you picked up from the airport and things", but nothing specific about starting work or anything like that. (Joanne)

They were excellent. Very good. Very good indeed. A lot of communication. A lot of assistance with my problems with immigration in terms of getting the visa. And yeah very good, gave me a relocation package and an excellent orientation when I got here. They have been super actually. (Donna)

It appears that some DHBs offer generous relocation allowances, whereas others offer none. Some assist in practical ways, helping with accommodation, locating schools etc, whilst others give little help in this way. Some of the hospitals were very supportive in practice, providing impressive orientation programmes whilst others seemed to expect the midwives to hit the deck running, even though more than one of the midwives had arrived only days before and were staying with their families in local motels.

I arrived on a Friday afternoon and I was at work on Monday morning and within two weeks I was in charge of the unit. (Jane)

This discrepancy in what is offered by DHBs has been reaffirmed in a recent consultation carried out on behalf of the Midwifery Council of New Zealand (Grigg 2008).

Category 2 - The experience of midwifery practice in New Zealand

This category primarily highlighted the differences between midwifery practice in the UK and in New Zealand which was identified by most of the survey respondents as the a major or afairly major challenge.

A series of themes and sub-themes relating to the experience of midwifery in New Zealand emerged during analysis of the transcribed data. These included:-

- Being prepared for difference.
- Working practices
 - Examination of the Newborn
 - Prescribing
- New graduates
- Interface between primary and secondary
- Feelings around autonomy
- Standards Review vs. Supervision
- Biculturalism vs. multiculturalism

Being prepared for difference

It emerged that many of those interviewed felt that they had been unprepared for practice in New Zealand. Some felt that this may have resulted from the heavy emphasis on moving here for lifestyle and not being so focussed on practising as a midwife here. However others indicated that it would be difficult to prepare for something that was really very different.

I read what I could, but I realise having come over here now that either the information wasn't there or I didn't look hard enough for it. I had a few contacts that tried to outline for me how different it can be, but I think like all things really you get a bit blinkered really. My goal was to get here and I am quite surprised now that I am here that it is so different. No I didn't really fully understand how it works when I was in England. (Joanne)

The participants who recognized that they had a limited understanding of the system here were often keen to convey this message to those midwives who may be following in their wake.

Working Practices

This section in many ways articulates with the sentiment expressed in the 'being prepared' section. Those who were not expecting a difference in the delivery of service and practice expressed surprised at how different things were. Two areas were identified by a number of practitioners as being significantly different. These were the the prescribing rights of midwives and the inclusion of the examination of the newborn within the scope of practice in New Zealand.

The requirement for completion of a prescribing and pharmacology course as part of the Midwifery Council's conditions of registration, was generally well accepted and those who commented in the interviews appeared to value this component. They saw it as bestowing considerable benefit.

It's absolutely wonderful, you know we can write scripts ... because for years I have spent hours standing outside GP rooms saying, "Can you write a prescription ..." "Can you write this lady some Flucloxacillin for mastitis" and now you can just do it. (Jenny)

However, there appeared to be some concern about the unpreparedness of British midwives for carrying out the full assessment of the newborn. Unlike New Zealand, where the examination of the newborn is seen as falling within the normal scope of practice, in the UK, the assessment is viewed as a specialist role that sits outside the recognised scope of practice at the point of registration. An intensive post-registration course is required before the midwife is felt to have the requisite skills to complete the newborn examination.

I'll tell you the one area that's a real loophole at the moment ... and you know again it depends how conscientious the midwives are about this ... and that's the paediatric check. And you know ... I was sort of thrown in... and they just said, "Do a check at

birth, and then a five day check on this baby". And I was like, "Well in the UK we just do a very basic check and then the Paediatricians do the hips and heart and" ... So I was sort of again thinking, "Gosh, you know here's something that theoretically I'm expected to do and I've got no idea". (Rachel)

New Graduates

A further difference between the two systems, highlighted on several occasions in the interviews, was that of the working practices of new graduates after completing their programmes of education. In the UK it is customary for midwives to enter the National Health Service (NHS) after completing their degree programmes. Very few midwives are in independent practice and other opportunities are limited. The idea of a newly qualified midwife entering the workforce as an autonomous self employed practitioner was something that seemed to create feelings of disquiet amongst some of the participants.

What I find very strange is that the new graduates go right out into independent practice, albeit with a mentor, but it's scary stuff I don't actually think they are properly prepared for what they are about to take on. (In the UK) it started off with a minimum of five years experience in the hospitals before you got out in the community, and it only just recently dropped to a minimum of two years. But you had no newly qualified midwives out in the community at all, until they had built up an all round grounding in dealing with things, and building up their confidence. (Lisa)

The interface between primary and secondary services

The issue of the interface between primary and secondary services was a recurring theme throughout the interviews. In the UK, the majority of midwives are employed by the NHS, where they work as either community based or hospital based midwives. The New Zealand system of having LMCs who are predominantly self-employed and core midwives who are employed by DHBs makes for a very different dynamic and this was picked up by many of the midwives interviewed.

Well I certainly find the interface between primary and secondary care a huge challenge constantly You know I'm pretty easy going, and will work in any sort of system if I could be clear on what it was that the system ... stated you should do in particular situation. But I mean I have been here two years now The communication isn't necessarily very good, and, you know, it is confusing for an outsider.... There are some very strong midwives here and they have opposing views. And that is very difficult to work with when you're a core midwife. (Jane)

After leaving what she considered to be a very clearly defined role with clear lines of demarcation in the UK, Joanne expressed her frustrations at what she considered to be a very unclear area.

It's all like ... this kind of concept of you can't give someone something without discussing things with the LMC first, and you can't do things and it's sort of "Ohhh,

OK". No one tells you that you can't do things without asking your LMC first, and you just ... it's a huge learning curve. (Joanne)

Feelings around autonomy

The perceived complexity of the issues relating to this interface also fed into how the midwives appeared to feel about their autonomous status. Many expressed feelings ranging from frustration to a sense of loss around what they considered to be their autonomous role. This usually coincided with the fact that they were working as core midwives and did not therefore carry out what they perceived to be their full scope of practice.

I didn't realise actually that we were actually following somebody's instructions more often than not, and that was the thing that I found very difficult. You know as opposed to being just left and looking after the woman on your own autonomy, which you were used to, so that was a difficult thing. I mean I was warned to some degree, but I think it still came as a shock. (Louise)

These frustrations were sometimes levelled against GP LMCs who the midwives viewed as another layer in a complex maternity system and again something that was very unfamiliar.

My big bug bear I think is working with GP LMCs. Because you're a bit like a handmaiden you know? It's not a big problem, but you do get the problem If they feel like doing the delivery. If they don't want to do the delivery, they expect you do the delivery. (Sophie)

The Midwifery Council Recertification requirements state that midwives have to work across the full scope in each three-year period and have to find ways of achieving that. However, many did not feel that that was happening. It may also reflect the fact that some of the midwives had fairly senior roles in the UK and had taken what they felt to be a demotion as part of the compromise of moving to a new country.

Supervision vs Midwifery Standards Reviews

Many of those interviewed expressed that they found themselves missing the Supervisory system that they had been accustomed to in the UK. In New Zealand a Midwifery Standards Review has been developed to encourage the midwife to reflect on practice with two trained reviewers - one midwife colleague and one consumer of midwifery services. The process assists each midwife to reflect on her annual practice by giving her the opportunity to consider statistical data, consumer feedback and self assessment against professional standards.

Midwives interviewed suggested that the Midwifery Standards Review system was something quite different and felt that it did not always meet their needs.

I think it just seems slightly ludicrous. I think ... to be reviewed by people who don't know you, don't know anything about your practice, it doesn't seem appropriate. I

suppose maybe ... I don't know whether I'm biased because I'm used to supervision.
(Louise)

However, at least one of the interviewees showed an appreciation of the system here.

"I think it is an excellent process for us to reflect about things ... I really think it is really good for us as midwives to just look at our figures and reflect on what we're doing, because that's something we didn't really do a lot of. We used to have Annual Reviews in the UK, but you never actually had to pull out facts and figures, you just had to talk about your practice, whereas this asks for your statistics, and it is really interesting to look back over the previous year. It is probably something you wouldn't make yourself do unless you had a review. **(Ginny)**

Biculturalism vs Multiculturalism

Some of the participants disclosed that they had some difficulty in understanding the bicultural context of life in New Zealand. Biculturalism has been defined as a society where two founding cultures are entitled to make decisions about their own lives for mutual co-existence (Te Hio 2008). It means giving prominence to two main cultures and traditions: Māori culture and the English-speaking Pākehā culture. This contrasts with the definition of multiculturalism as the existence of many cultures and ethnic groups within a society, all with a right to co-exist provided they do not infringe the basic rights of citizens.

I just had I suppose a bit of a problem with the Waitangi stuff, because to me it's very straightforward: you're treating everybody how you want to be treated, no matter of colour, race or creed. And back in the UK I was working with Hindus, Muslims, asylum seekers, it was ... you just respected everybody, or you tried to ... but I mean I'm glad I've done it. **(Rose)**

It would seem that this is not an uncommon response on the part of immigrants. Sibley (2004) suggests that immigrants from other cultural backgrounds have felt excluded by "Biculturalism" and the primary focus on just two cultures which it seems to imply. However, an acceptance of this status quo may take on particular significance in midwifery services where the partnership model is based upon the principles enshrined in a bicultural philosophical approach.

Category 3 – The New Zealand requirements for registration

As has already identified, the courses specified by the Midwifery Council of New Zealand as part of the conditions of registration were viewed by many of the respondents in the survey as being a serious challenge at a time when they were settling in to a new country with often unanticipated working conditions.

This was borne out in the pursuing interviews when the conditions were raised for discussion. Without exception, every one of the midwives interviewed stated that they had found completing the courses very stressful and only one had actually managed or felt that they were likely to achieve it in the eighteen months allowed. They conveyed the difficulties associated with trying to grapple with settling in their families and commencing employment that frequently had additional in-service requirements.

Speaking to a lot of the English girls that work here. None of them have done it within eighteen months. Just the whole cost of it, the whole ... you just get off the plane ...I had no idea how long it was all going to take. You know I didn't even think about doing it until I had been here for about nine months and then you register and think "Oh my God. It's all gonna take a lot longer than I thought it was going to take." (Joanne)

When you first arrive, there's so much. You know, I don't think people can realise unless they have done it, how stressful it is. I was struggling to get back into midwifery. Just the day-to-day tasks that I need to be able to do and be able to do efficiently, because I was the only one that could do them. You know, that was really hard. The first year flew by. And I was supposed to complete the two courses in eighteen months. (Jane)

Rose spoke of her frustrations,

I sometimes think, you know I wanted to say to them, "Look, you know, I'm trying to settle down in a new country. We've been here ... we've moved three times, I've had major surgery, I've had to get my kids settled into school three times, you know there's lots of other issues". It's not just like I'm a woman on my own. (Rose)

In spite of the fact that they felt that they were pressured in terms of time, a large number of the midwives had positive things to say about the courses. Mary spoke of attempting the pharmacology course after years without any formal study.

I looked at it for ages. I thought, "I don't know where to start", "I don't know what to do". I felt very daunted by it really. No, once I started it, it was great. I did enjoy it. (Mary)

...the Pharmacology it's been really good. It's all stuff that I know. It has made me look into things in much more detail, something that I haven't done for a long time as far as drugs and medication really. So yeah I've learnt quite a bit. (Jenny)

The Pharmacology one was very good and ... there were a few things that were different. But I found the Treaty of Waitangi and all that sort of thing hard, but I do understand why it is needed. (Rose)

This did seem to vary however according to which course that they had accessed.

No. I just didn't think it really fulfilled its purpose.....It didn't really prepare me for prescribing. It focussed in great detail in eight drugs. I needed much more of an overview. So yeah, I wasn't really impressed. (Jane)

Some of the interviewees felt that there were other obstacles in the way of completing the courses efficiently.

I mean now there is a whole list of courses up on the Council website as to what study days are considered valid and everything, but at the time they weren't. So you know I was backwards and forward, backwards and forwards and not knowing what actually I have to do ... there are lots of courses out there and you don't know which ones are valid and which one's aren't. (Rachel)

But the problem I have been having is actually getting into the courses. I have struggled to get onto courses. They haven't made it easy, let's put it that way. (Ginny)

I'm waiting for them to get back to me because I paid for it in September and I'm still not registered on the course. So I rung up and they were all gone away for Christmas, so I'm just waiting. (Joanne)

Another of the midwives raised the question of why she was pressured to complete the course in a limited time frame when she was never expected to prescribe as a core midwife.

... its just something you talk about, you're not prescribing anything. (Doris)

In response to a question around what they would consider to be a reasonable length of time to complete the courses, again the vast majority suggested about two years.

I think probably two years to be honest with you because I think that would just give you ... I mean from landing and from starting work I was always conscious that I needed to start doing or attending to the competencies. And I think that really I certainly didn't get around to it for about five, maybe six months. Really you've only got that year left to do it in. (Donna)

Some of the midwives had contacted Midwifery Council to discuss the fact that they were struggling to achieve the deadline. This did not seem to be a problem once they actually did this although others were afraid that they would be turned down if they attempted to do this.

I negotiated with the Midwifery Council. Yeah. I just said "It was totally ..." I couldn't do it in eighteen months. I said, "I work full-time, I've got three little boys that are all under seven", yeah moving house, I just couldn't do it. (Joanne)

The conditions of registration relating to not being able to practise as an LMC in sole practice appeared to have led to a degree of misunderstanding as discussed in a previous section. Many of the midwives seemed to be under the impression that they would have to complete their conditions of registration before they could go into self employed practice.

The other thing, it also states that you can't work solely until you've actually done this. (Mary)

Well I've worked with that DHB for a year now and it's been quite a heavy year, and I've still got conditions on my APC until about July so I anticipate really finishing all that off this year and I will start taking a caseload from early in 2009. (Donna)

Discussion

This research study set out to explore why British midwives choose to live and practice in New Zealand and what that experience is like.

The findings indicate that the primary motivation for emigrating is related to lifestyle factors with midwifery practice featuring to a varying degree between individuals. The major motivating factor appears to reflect the age and life stage of the typical midwife and her family coming here from the UK.

Many of the midwives felt that they were not fully prepared for working here. Although some accepted that they could have done more to prepare themselves, others felt that there needed to be an easier way of accessing relevant and authentic information about working as a midwife in New Zealand. A page on the Midwifery Council of New Zealand website may provide an opportunity for real midwives who have a solution focussed approach to any problems that they have encountered to tell their stories. The Midwifery Council has already made moves to put this recommendation in place as a result of interim reports on this study.

The vast majority of midwives who come to New Zealand are employed by a DHB. There seems to be a degree of misunderstanding around this with many of the midwives under the misapprehension that that they have to work for a DHB in order to meet the requirements of both the Midwifery Council of New Zealand and the New Zealand Immigration Services. The support offered by DHBs from the point of job offer to orientation programme is variable. The issue of parity across the DHBs in providing similar levels of support and orientation should be considered as midwives who do not feel adequately supported may not feel inclined to stay either within the workforce or the country.

The restrictions in terms of working in sole practice need to be clearly spelled out because many midwives interpret that as not being able to work in self-employed practice. This situation has been compounded by Immigration Services who are still carrying a notice on their website that states "*Current immigration policy requires that midwives applying for work permits or residency be employed in hospitals, not as independent practitioners.*" (NZIS 2008) The midwives who have come to work within what is recognized as a globally respected model appear to become frustrated having to work within a system which they consider to be even more fragmented than the one from which they emerged.

The problems that migrant midwives are facing relating to the completion of the education packages for the Midwifery Council Conditions of Registration, was almost unanimously voiced by those surveyed and interviewed. The juggling involved in settling into a new country, taking on a new job and all it entails and having to complete the required courses is a huge undertaking for many of the midwives, and

it has an impact on their families. The general consensus of those interviewed is that two years would be a more reasonable period for completion.

Additionally, there do not appear to be any clearly defined objectives around the requirements of the education packages offered to overseas midwives. This has resulted in the delivery of courses of different lengths and foci, which has led to further confusion and frustration on the part of those accessing the courses. The administration of the courses is also criticised by some midwives who feel that bureaucratic and administrative issues have prevented them from completing the courses in the required timeframe. A solution may be to produce courses which have shared content and outcomes and a shorter timeframe. This may then allow for the inclusion of a short introductory course on the examination of the newborn, which was identified as a significant omission in the scope of practice for some of the midwives coming from the UK.

It would be useful if midwives were more readily able to register for some of the courses from overseas, perhaps whilst waiting for departure. Currently they have to enroll as international students which makes it an additional expense at a time when high expenditure is incurred. However, unless they have residency, this will still apply when they arrive here anyway. This problem may also be ameliorated to some extent if the midwives were offered short courses that are not subject to the same government funding rules as degree level courses which raise the costs for students.

Limitations of the Study

The study was restricted to the midwives who have currently chosen to stay and live and work in New Zealand. It did not include those who stayed for only a short time and British midwives who live in New Zealand but were not working as midwives were very under-represented in the responses. These are a group who may have had a very different perspective and have added additional useful information.

The response rate could have been higher than 53% although the initial information was followed up with a reminder letter. A parallel online survey may have improved the response rate.

Conclusion

The workforce shortage in New Zealand is currently presenting a challenge for maternity services and it is accepted that part of the answer may lie in the recruiting of midwives from the UK. However, the study findings would suggest that this solution must be approached with a clear understanding on the part of the midwives arriving, the employers, and the support systems here for midwifery of the implications for all involved. With good planning on the part of the midwives themselves, and good support on the part of the service and professional organizations here, there is no reason why the challenges identified cannot be faced and addressed.

One insightful midwife had a pragmatic approach that may serve many of those midwives arriving, and help to ease the transition into midwifery practice in New Zealand for UK migrant midwives.

Be prepared for it to be different, because I think we tend to think it is going to be very similar. And just be prepared that it is a different culture and that there are different expectations altogether. But different isn't always bad. You know, you've got to accept things. I think if ... there's a tendency to go "Oh we did this in the UK", "We did it like this, we did it like this" and not ... It's certainly not perfect over there, and I don't think over here is perfect either, but ... there's got to be bad and good about everything. So just be prepared for it to be different and be open minded really. (Louise)

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