

**Midwifery as Non-Standard Work
– Rebirth of a Profession**

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Patrick Firkin

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Preface

The Labour Market Dynamics Research Programme (LMDRP), funded by the New Zealand Foundation for Research, Science and Technology (FRST), is an interdisciplinary research project designed to explore and explain various dynamics of economic and labour market participation. The first phase of the programme sought to explain how individuals made decisions about access to, and participation in, the labour market, with particular emphasis on the lifecycle of the household. This was initially focussed on three regions: Hawkes Bay, Waitakere and Tokoroa.¹

The second phase of the LMDRP shifted to investigating aspects of non-standard work in New Zealand.² Non-standard work can be briefly defined as work that is no longer characterised by certain features that have been regarded as standard. These include full-time hours, a regular working week, access to non-wage benefits, having the status of an employee, and being located in particular places (see Burgess and Watts, 1999). Interest in non-standard work has been stimulated by its growing prominence in the last two decades of the Twentieth Century (VandenHeuvel et al., 2000; Burgess et al., 1999; McCartin et al., 1999; Mangan, 2000), and has occurred within the context of many major and well documented changes in the structure of labour markets in all industrialised societies (e.g. Henson, 1996; Crompton et al., 1996).

Since non-standard work has always existed, it is probably more accurate to note that what has changed in the last 20 years is the increase in the proportion and consistency of NSW (Zeytinoglu et al., 1999:1). By some estimates, about 25 percent of jobs are in non-traditional employment areas (**Management**, June 2000) and in a range of possible employment forms that defy traditional career assumptions (Arthur et al., 1996:6). In a New Zealand context, Carroll (1999) shows that although separate categories of NSW account for small proportions of the workforce, compared to the 43 percent in standard work, collectively they total more than half of all workers. By acknowledging that he uses a narrow definition of standard work, Carroll (1999) leaves open the possibility that even larger numbers could be classified and counted as non-standard.

Such estimates show that instead of working full-time for a single employer with the assumption of ongoing employment, there is a growing trend towards self-employment, part-time work, irregular hours that vary, and less continuity of job tenure. Similarly, reliance on direct employment is decreasing and, instead, labour requirements are outsourced or employees provided by intermediaries. A complex web of relationships and arrangements emerge because of the numerous exchanges among individuals, teams and employers – “The interplay may seem downright chaotic” (Littleton et al., 2000:101).

By way of trying to make some sense of such chaos within a New Zealand context, the LMDRP is committed to a number of research projects. A recent report has qualitatively

¹ A list of all previous LMDRP publications is provided at the end of this report.

² A discussion and review of the literature on non-standard work is presented later in this report.

explored the experiences of a group of 40 knowledge workers in the greater Auckland area (Firkin et al., 2002). Further broad based studies are planned. One will complement the study of knowledge workers with a qualitative exploration of the experiences of those in NSW in more traditional and/or contingent work. A second will contribute to developing a quantitative picture of NSW in this country based on an econometric model developed in Australia (see Borooah and Mangan, 2000).

In addition, three case studies of specific groups are being undertaken to explore the emergence of NSW in specific contexts. These have been prompted by the need to redress a tendency to situate much of the research on NSW at an aggregate level. For example, Fraser and Gold (2001) note that a great deal of research into self-employment has focused on the aggregate, micro-economic dimensions of self-employment, the role of self-employment more generally in the wider labour market, or efforts to define more precisely what is meant by self-employment. While such approaches are undoubtedly important, recognition that the self-employed are a heterogeneous group has seen growing interest in disaggregating this group so that the “term does not conceal more than it reveals as a labour market category” (Fraser and Gold, 2001:680). Similarly, Kunda et al. (2002) point out that the literature on contingent work largely overlooks occupation as a factor of analysis and the authors feel that such an oversight means that this important source of worker identity is consequently missed as a locus for sense-making and organising. The decision to separately investigate the experiences of female temporary office workers, accountants and midwives can be seen as a response to such concerns. This particular report focuses on the experiences of midwives. The two other reports that have been separately published by the LMDRP are:

□ **Temping: A Study of Temporary Office Workers in Auckland**

Patricia Alach and Kerr Inkson

□ **Non-Standard Work in the Accounting Profession in New Zealand: Some Preliminary Evidence**

Hector Perera

1. Introduction

This report presents findings from a research project exploring midwifery in terms of non-standard work (NSW). Although it begins by considering midwifery in a broad context – achieved through a brief historical account of the changes to its organisation and practice over much of the last century – the research is particularly focused on one subset of the midwife population, caseloading midwives. Though a small group have roles in areas such as management, policy, research and education, broadly speaking, midwives work in one of two ways. There are those who work in maternity facilities and are assigned to distinct areas of maternity care in line with the institutional fragmentation that sees such care broken up into pre- and post-natal wards, and labour and delivery suites (Fleming, 1996). These are known as core midwives. In contrast, caseloading midwives are those who act as Lead Maternity Carers (LMC).³ They may do so as employees of organisations or as self-employed midwives. The latter are often referred to as independent midwives. Either way, they provide continuity of care for clients, an important tenet of midwifery philosophy in this country and which will also be expanded upon in subsequent parts of the report.

Given the unique nature of caseloading midwifery in New Zealand, it attracts a great deal of local and international research interest. Indeed, I was warned when embarking on this study that midwives were rather over-researched.⁴ However, the particular focus of the research project is not so much on midwifery per se, but on what an examination of midwifery can contribute to our understandings of the emergence, growth and experience of NSW. Midwifery offers an interesting case study in this context for a number of reasons. Firstly, like those interviewed in the first study (Firkin et al, 2002), midwives represent a professional group of knowledge workers. However, unlike those interviewed previously, they rely far less on technology. This, I feel, offers a much needed balance to a debate which, while conducted under the banner of the “knowledge society”, is often actually confined to technology. Secondly, midwifery in New Zealand has without doubt undergone some radical changes since 1990 that have opened up new ways of working. Intriguingly, as will be more fully discussed later, this in large part represents a return to a way of practising rather than something that is necessarily new. Finally, while studies of NSW are often focused on the drivers that influence individuals, the preceding or surrounding contextual dynamics of change which open up these possibilities are not always as accessible to detailed study, except in the broadest macroeconomic terms. By contrast, midwifery readily allows a close examination of just this process and its constituent parts. Within that context, the motives for, and influences on, an individual to take up such opportunities can also be explored.

³ A Lead Maternity Carer (LMC) is an authorised practitioner (a General Practitioner with suitable post-graduate qualifications, a Midwife or an Obstetrician) who has been selected by a woman to assume primary responsibility for her care during pregnancy and childbirth. This is a formal designation in law (see Section 88, New Zealand Public Health and Disability Act, 2000).

⁴ The implication from this was that midwives might, thus, be reluctant to take part in yet another study. As I note in the acknowledgements, this proved not to be the case.

1.1 Report Outline

The report begins with a brief outline of the research process, including some details of the interview sample. A short overview of the issue of NSW is then undertaken. This allows the subsequent brief historical review of midwifery in New Zealand to also consider its inter-relationships with questions of NSW.

Following this background discussion, the findings of the research are presented. Earlier research on the alternative working arrangements of a group of knowledge workers explored a number of issues and themes (Firkin et al., 2002). These included examining the transition into NSW, future prospects and plans, and the structure and management of the business. How people organised and managed time, space and the home/work nexus were also considered, as were the disadvantages and advantages of working this way. Other issues canvassed included education and training, technology, networks, insider/outsider relations, and legislative/policy matters. While not all of these can necessarily or usefully be applied to independent midwifery it seems reasonable to consider similar issues as one way into exploring and analysing the findings from the midwifery interviews. Even though I have chosen not to replicate the format of the previous report, some consideration of similar issues has been interwoven into this report so as to provide a sense of connection through the issue of NSW between seemingly isolated pieces of research. In addition, I have drawn on earlier research conducted by the LMD group which prompted the development of the theoretical concept of entrepreneurial capital. This is used to provide an alternative way of examining and understanding particular aspects of the caseloading midwifery experience.

The concept of entrepreneurial capital is introduced and employed in the following section. By focusing on various forms of capital a wide range of findings in numerous areas can be considered. These include the human capital associated with caseloading midwifery, with some attention paid to the practice of mentoring, ongoing education and training, and prominent attributes and characteristics. The notion of social capital allows, among others, the role and importance of families, collectives and practices, and wider networks to be considered. Cultural capital focuses on the particular philosophic disposition of midwifery and the importance of partnership with women. Economic and physical capital consider the financial and tangible resource dimensions of caseloading midwifery.

Beyond the idea of entrepreneurial capital, the report then seeks to explore the transition into caseloading midwifery, in terms of the general context and more individual factors. The likelihood and reasons for a move out of a caseloading role is also canvassed here, as are the advantages and disadvantages of working in this way. Following this, the structure and organisation of caseloading midwifery is examined by looking at practical issues such as the organisation of work, payment, intensification and enrichment, monitoring of work, and the place of technology. How midwives manage a caseloading role is considered in the final section detailing the findings. This is dealt with in a number of ways including the management of time, time-off and space. As well, the management of insider/outsider relationships, both within the profession and between caseloading

midwives and maternity facilities/staff is considered. The final area to be canvassed relates to the home/work nexus, that is how midwives integrate, what are overlapping domains in their lives: home and work.

2. The Research

2.1 The Research Design

The aim of the research was to inform our understanding of changing work arrangements by exploring the experiences of midwives who were or had been working in non-standard ways. As will be argued in Chapter Four, caseloading midwifery can be seen to be a non-standard form of midwifery.⁵ It forms part of a larger project investigating NSW among particular groups and in different circumstances. As such, the goal was to generate an account that reflected the participant's subjective experiences and perceptions of working in a way that was different. Given this goal and following earlier research by the LMDRP into NSW (Firkin et al., 2002) the interview method was considered a useful approach to gathering the data we sought. Ethnography, as a methodological approach, endeavours to avoid prescriptions generally associated with the positivist methods of research. Additionally, it "is not far removed from the sort of approach that we use in everyday life to make sense of our surrounding" (Hammersley, 1990:2).

Non-probability sampling, which does not seek to establish a random or representative sample (Cohen et al., 1999:331), was used to identify potential participants who had the 'information' we sought. These were recruited in various ways that began with a 'cold call' to an educational facility and a similar approach was made to the New Zealand College of Midwives (NZCOM) – the professional body for midwives in New Zealand. Discussions were also held with contacts in the health sector. A number of contacts emerged from these approaches and the subsequent use of a 'snowballing' technique, which relies on respondents suggesting others provided further participants. As the interviews progressed some effort was made to get a balanced mix of respondents in terms of work context, experience and personal circumstances.

To be eligible to participate, people had to be registered midwives currently practising. Originally it was intended that the context of practice would be independent midwifery – that is, those in self-employment – but it became apparent that other forms of midwifery practice could be deemed non-standard and provide some interesting comparisons and contrasts. Thus, the criteria was opened to any midwives in a caseloading role. It was not necessary for them to have worked in non-caseloading roles and they did not have to currently be in a caseloading role. The last criteria was included as it allowed some exposure to midwives who had opted out of a caseloading position and the reasons and circumstances for this.

Prior to taking part, participants received an information sheet outlining the aims of the study and detailing their right to refuse to answer questions or withdraw from the study at any time prior to the beginning of the analysis. Each participant then signed a consent form. Confidentiality was assured. Given the size of New Zealand and the even smaller nature of the midwifery community this poses some challenges. Consequently I have

⁵ Though it should be added here that I also argue that in relative terms caseloading midwifery represents a return to the former way of practising that once predominated.

elected to provide only that background information that informs the research but to present it in ways that does not readily identify participants. The research was conducted according the ethical principles of the Sociological Association of Aotearoa/New Zealand and ethical consent was provided by the Human Ethics Committee of Massey University (Albany).

As the interview is an interactional sequence, in-depth interviewing provides an opportunity to find out what participants think and feel. The interviews for this research were in-depth, semi-structured and lasted about an hour. They took place in a variety of settings and were tape-recorded and then transcribed and analysed. The analysis sought to highlight commonalities and divergences between these interviews. Data was coded according to themes and presented as descriptions and interpretations. Quantification is minimal and statistical analysis played no role in the research. Some comparison is made between the findings of earlier research on the experiences of a specific group of non-standard knowledge workers whose profiles parallel those of midwives to some degrees (Firkin et al, 2002). As well, a theoretical model developed as part of other research conducted by the LMD group (see Firkin, 2001a; 2001b) is used as a novel way of analysing the data.

While the first interview mainly provided contextual material for the research, as did other discussions with staff from the NZCOM, the remaining interviews focused on the individual's experiences of practising as a caseloading midwife. An interview guide was used to ensure that similar themes were examined in each interview and allowed for an exploration of the experiences of participants in a number of broad areas relating to their personal and work experiences as midwives in general and as caseloading midwives more specifically. Of particular interest was the transition into (and out of) a caseloading role. The advantages and disadvantages of their current working arrangements were explored and interviewees outlined the attributes they saw as important or necessary for working the way they do. A range of questions were targeted at how different alternative working arrangements interacted with people's home, personal and family life. Some attention was paid to how business and professional imperatives were blended. The roles of networks, associations and collaborations, and their use of technology were also canvassed as was participants' involvement in education and training.

In summary, although I wanted to undertake the widest possible exploration of all the issues that arise at the intersections of NSW and midwifery I recognise that this richness is at the cost of generalisability and that the study only provides an exploratory snapshot of midwifery in the context of NSW. However, the in-depth interview method was chosen as it assists in achieving what Bauman (1990:231) suggests is an extended commentary on the experiences of everyday life. In this way, an attempt was made to construct subjectivity in a particular area of work as opposed to the more common quantitative research methodologies which tend to marginalise subjectivity and reduce the rich diversity of experiences to an average or mean.

2.2 The Sample

Ten midwives, all women and all living within the greater Auckland region, were interviewed as part of the research. They represented a broad range of professionals in terms of age, family circumstances and professional experiences. Ages of the midwives ranged from mid-twenties to mid-fifties. All but three were married or in like-relationships when interviewed. Two of these three women were single parents. Five of the remaining seven women also had children. Though their children's ages now spanned the spectrum, all these midwives had worked or were working in a caseloading capacity with young children.

Though all those who were interviewed had been or were in caseloading roles, this was in a variety of forms. Six were self-employed independent practitioners. The remaining four were working as employee caseloading midwives for two separate organisations.⁶ All but one of the midwives who was interviewed had qualified as a nurse prior to training in midwifery.

Given that there many different experiences of the transitions into caseloading midwifery depending on when this occurred for individuals relative to the legislative changes of 1990 (see Chapter Four), I found it useful to crudely categorise shifts as 'early' and 'late'. Those transitions made immediately following or soon after (say within a year or two of) the legislative changes are considered as early. These midwives are referred to, on occasions, as 'pioneers'. The term 'late' is used to describe transitions beyond this timeframe. Four of those interviewed can be classified as pioneer caseloading midwives. Prior to the move into independent midwifery one of this group was already a domiciliary midwife and another had part-time work providing labour support at home for women under the care of a General Practitioner (GP). A fifth midwife straddles the early/late transition demarcation, having moved into independent practice about three years after the legislative changes. This group had between around 15 and 30 years experience in midwifery, at least nine (and up to twelve) of which was in independent practice. It should be noted that one of the group had subsequently transitioned from a full independent role to one as an employed caseloading midwife.

Five midwives made later transitions into caseloading midwifery. Three worked as employee caseloading midwives – for different organisations – and two were self-employed. One of the former group was in the process of moving into independent practice after a period of three years in a caseloading role as an employee and more than twenty years experience in midwifery generally. A second of this trio had been out of her caseloading role for a time due to personal circumstances but was considering returning. She had been trained for around six years before working as a caseloading midwife for about two and a half years. The third caseloading midwife had just recently taken on this role after two and a half years working in a traditional hospital setting. Of the two who were self-employed, one went directly from her training into an independent role. She had

⁶ I have chosen to be deliberately vague here so as to offer the interviewees as much confidentiality as possible within the context of a relatively small professional community.

been practising this way for four years. The other made the transition after a year in a hospital setting and had been in independent practice for around two years.

3. Non-Standard Work – An Introductory Overview and Discussion⁷

The first issue to confront in any exploration of NSW is the question of whether there is such a thing? Certainly, a predominant pattern of employment and working has emerged since the Industrial Revolution and become a pre-eminent form for male workers in the Twentieth Century. While offering the hope of a yardstick against which employment categories have been constructed and understood, it must be acknowledged that there have always been exceptions to, or variations on, this and just trying to draw a coherent picture of any predominant pattern generates considerable challenges. At its most basic, such a pattern has generally been characterised by specific features including waged or salaried employment with a single firm, where individuals work full-time on the employer's premises and expect (and are expected) to be employed for an indefinite period of time (McCartin et al., 1999:2). As Carroll (1999) notes, however, this definition could well be extended to include structural aspects of work organisation such as the Monday to Friday week and the work-day.⁸ In short, though there may be certain characteristics that are often cited in relation to the predominant pattern of employment, unfortunately there seems to be no set of absolute standards. Even if the idea of a predominant pattern of employment is accepted, increasingly there are working arrangements that may not be standard but are none-the-less longstanding and widely practised.

Given the above difficulties it is unsurprising, then, that confusion plagues efforts to conceptualise and enumerate those people engaged in forms of work that are outside of the predominant pattern (Barker et al., 1998:11). Zeytinoglu et al. (2000), for instance, baldly state that there is no clear definition of NSW in the literature. More cautiously, Carroll (1999) suggests that non-standard workers are a disparate group of people and that any generalisations should be made with care, particularly as categories are not mutually exclusive and people often combine standard and non-standard forms. Carroll's observations are readily applied to those non-standard workers interviewed as part of earlier research on NSW by the LMD group (Firkin et al., 2002). This group provided a diverse array and multiple combinations of working arrangements, thereby continually raising challenging definitional and conceptual issues.

In response to such challenges many approaches have been offered as ways to describe, explore and explain working arrangements outside of the predominant pattern. Burgess et al. (1999: 9-10), for example, compare various characteristics of different modes of employment. They see the standard employment model in similar terms to that of the predominant pattern described above. That is, it is distinguished by employee status; full-time hours; defined, regular working week; and access to non-wage benefits. Burgess et al. (ibid) then suggest that NSW is characterised by one or more of the

⁷ This chapter is based on a much more detailed discussion of non-standard work undertaken in the substantive LMD report on this subject (Firkin et al., 2001).

⁸ The eight hour workday with standardised starting and finishing times.

following conditions: no employee rights or protection; no full-time income or guaranteed minimum income; no regular, predictable income; no regular, predictable working hours; and no minimum non-wage benefits. Furthermore, NSW differs in terms of precariousness.

Other approaches entail the use of a suitable adjective to capture the essence of alternative working arrangements. For simplicity's sake, the term 'non-standard' has been used in this and the previous report (Firkin et al., 2002) as a general descriptor of the variations on work arrangements that are being focused on. Other terms have also been employed to try and capture these variations – 'non-traditional', 'atypical', 'flexible', 'alternative', 'market-mediated', 'vagrant', 'vulnerable', 'precarious', 'disposable' or 'contingent' (Kalleberg, 2000:2). Like Mangan (2000) and Kalleberg (2000), I recognise that although each term makes some positive contribution to the wider theoretical landscape, more often it is most useful in a particular context. This can be illustrated using the idea of contingency, a term originally coined by Audrey Freedman in 1985. Cahoney (1996:31) and Hipple (1998:22) refer to 'contingent work' which is defined as jobs that are structured to be short-term or temporary and workers have no explicit or implicit contract for ongoing employment. A wider usage sees it refer to conditional and transitory employment arrangements (Houseman, 1999) that could include all non-standard forms of working. However, not all non-standard forms of work can be considered contingent, since they may vary hours of work but be based on permanent employee status. Thus, the failings and inadequacies of terms often appear when they are unable to articulate the wider or more general phenomena.

Beyond some descriptive terminology or metaphor of NSW, another approach is to identify particular working arrangements as non-standard. In line with this, Wooden (1998) suggests that casual employment, fixed-term employment and contractors have features that place them outside the scope of traditional or standard employment. McCartin et al. (1999) include part-time jobs, short-term or contract employment, employment through temporary help agencies and "own account" self-employment in their schema. Felstead et al. (1999:2) also identify four main categories that for them encompass most "non-standard forms of employment and these include part-time work, temporary work, self-employment (own account) and multiple job holding or 'moonlighting'". While they agree that there are other types such as homeworking, teleworking, agency working, subcontracting and franchising, Felstead et al. (1999) contend that most of these overlap in some way with one or other of the aforementioned. Casting his net much more widely than others, Carroll (1999) identifies a wide range of working arrangements that he considers non-standard. These are employees working part-time and more than 50 hours a week; the self-employed; employers; residual casual and/or fixed-term (non-permanent tenure) workers; multiple job holders; and/or unpaid family work. Carroll is unusual in adding employers and those working over 50 hours a week to his list.

Mangan (2000:172) chooses to limit his conception to a small number of categories – the bulk of part-timers, all temporary workers and the contingent element of those in traditional arrangements. Importantly, he adds that a hierarchy of non-standard jobs exists

and refers to independent contractors, contract company employees and teleworkers as the higher echelons of non-standard workers with a dominance of male workers. On-call workers are seen as a step down the hierarchy although there are still professionals in this category, namely nurses and teachers. Then there are casual workers who are frequently used in the agriculture, retail and hospitality sectors, and who are predominantly women.

From a focus on the types of arrangements that might or might not be considered non-standard, Beukema et al. (1999:112-117) shift our attention to the nature of the relationship between the parties. There are, then, non-standardised jobs with a direct employer-to-employee/contractor relationship, and non-standardised jobs with an indirect employer-to-employee/contractor relationship generally mediated by temporary staff agencies and contract companies. Drucker (1999:129) introduces another way of considering changing working relationships through the notion of the distancing of the employment relationship. By distancing, she includes all kinds of employment relationships where work is performed for a company outside a contract *of service* – i.e. temp agency workers, subcontractors, or the self-employed. Instead they would be engaged in contracts *for service*.

A final and more radical perspective on conceptualising NSW is drawn from the work of Arthur and Rousseau (1996:373) who suggest that contemporary employment can be defined as “a temporary state, or the current manifestation of long-term employability”. It can no longer be assumed that long-term commitments and stable relationships are a part of the employment relationship. Arthur and Rousseau accordingly introduce the idea of the ‘boundaryless career’. This is distinguished from the previously bounded or organisational career when terms were easier to apply, as systems were more static and defined with orderly employment arrangements. Furthermore, they suggest that the organisational career model was easily understood but that it is difficult to replace that logic with something more helpful in the new work environment. That contemporary context is now characterised by employment moving across boundaries involving separate employers; a career being validated outside the boundaries of an organisation/employer and sustained by external networks; hierarchies no longer being valid; and careers being rejected for family or personal lifestyle reasons. In short this creates *independence from* rather than *dependence on* traditional working arrangements (Arthur et al., 1996:6).

As will be apparent from the preceding discussion, there appears to be no one defining characteristic of all forms of NSW. This is likely to be due to the variety of non-standard forms of work that are possible, the different ways individuals structure similar ways of working, and the combinations of work roles they might engage in. This is Carroll’s (1999) observation as noted earlier, and a view that Mangan (2000) and Kalleberg (2000) agree with. Despite the lack of consensus over the terminology, definitions and conceptualisations of NSW in general, earlier research by the LMDRP (Firkin et al., 2002) has identified four broad areas – hours of work, tenure, relationships, and location – that can be used to develop an ideal, ‘standard’ type against which variations can then be distinguished and classified. This model takes the hours of work to be full-time, and that there is a workday orientation around the Monday to Friday week. Job tenure is permanent. The employment relationships are singular (only one job) and direct between

an employer and employee. Finally, work is carried out or based at the employer's worksite (though workers need not be physically on-site at all times).

Alternative forms of work can be made up of variations in one of these areas or, importantly, in more than one area. As will be apparent from the following discussion, many forms of NSW are made up of more than one distinguishing characteristic. Most obviously, variations in hours and/or tenure are often present together in many very familiar forms of NSW. Thus, while permanent employees might still experience variations in hours, as is the case with shift and roster workers as well as part-time employees, all of these groups can also be employed on a temporary or on-call basis.⁹ Similarly, while temporary or on-call workers might work short or broken hours, they can also work the equivalent of full-time hours. As well, multiple job holding or portfolio working has become a common and legitimate strategy for employment and income supplementation in the changing world of work – faced with increasing part-time work, a growing number of people increase their working hours by “patching together” (Felstead et al., 1999: 7) various part-time jobs.

Midwifery, as will be seen, certainly qualifies as one of the forms of work that is non-standard across many dimensions.¹⁰ In respect of caseloading midwifery, the hours of work are certainly of a lengthy and often unpredictable nature. They also frequently fall outside the normal work day. In some respects and aspects of their work they can be seen as on-call workers. The tenure of an independent midwife is certainly temporary, lasting for the period of the pregnancy, birth and aftercare.

Just as standard work involves a direct relationship between employers and workers, so too can many forms of NSW. However, it has been suggested (Cahoney, 1996:31) that employment is more frequently being arranged by an intermediary such as the temporary help agency or contract company. The importance of the intermediary is reinforced by the fact that payment is often arranged through them and not the company where the person is employed. Other relationship variations arise in various ways with alternative forms of work. While there have always been self-employed workers, new variants of self-employment, such as contracting, have emerged as a growing form of non-standard employment. These are particularly relevant to the discussion of midwifery. VandenHeuvel et al. (1995:6-7) and Greene (2000) further distinguish between *independent* and *dependent* contractors depending on whether the contractor provides labour services to one or mainly one organisation. The distinction is made depending on the degree of dependence in the employment relationship. Given their heavy involvement with one client, dependent contractors have also been referred to as *de facto* employees (Mangan, 2000). Some, like Carroll (1999:103), suggest that people are self-employed if they are not employing others. These are also referred to as ‘own account’ self-employed (Mangan, 2000:39). Midwives would fall into this category. In addition, another category of self-employed contractor – those who are in partnership with one or more other self-employed contractors – was identified in other LMD research (Firkin et al., 2002). Such a

⁹ Rostered workers do not necessarily work a standard Monday to Friday week.

¹⁰ At this stage of the discussion I am only very briefly signaling some connections between caseloading midwives and NSW.

distinction has some importance for midwives as well since they are often part of practices or collectives of some form. There are, as well, those who are self-employed and employing others, which are referred to as employers.

Finally, individuals can also fall into the non-standard category as a result of where they do their work. This is sometimes referred to as working from afar, though the expression teleworking is often used in preference. There are a myriad of definitions for working from afar but I favour Mangan (2000:45) who uses the Danish Board of Technology's (1997) definition of teleworking, which is "work in which an individual is for a considerable period of time physically distanced from, and in electronic communication with, the place, the customer or the organisation to which their work effort is directed". What is highlighted by such a definition is that many people telework to some degree, and this is certainly true of independent midwives.

4. A Brief History of Midwifery in the Context of Non-Standard Work

The history and changes to midwifery in New Zealand have been detailed in numerous places and the unique nature and role of midwifery practice within the provision of maternity services in this country has meant that it is of interest well beyond these shores (see, for instance, Abel, 1997; Fleming, 1996; Guilliland and Pairman, 1995; Hendry, 2001; Parkes, 1991). It is not my intention to rehearse in any great detail what others have already so comprehensively and competently provided. Rather, I want to provide sufficient relevant historical material to serve as a foundation for the current study. Within this historical account, I want to build on what has been tentatively begun in the preceding section by more deliberately and broadly integrating the general discussion on NSW with the emergence and practice of caseloading midwifery so that the two threads of the study are drawn together as a prelude to presenting the research findings.

While the history of midwifery could likely be seen to parallel the history of humankind, a much shorter history following the consolidation of Pakeha settlement in Aotearoa/New Zealand provides a briefer and more pertinent timeframe in which to consider midwifery in this country.¹¹ In particular, the first few decades of last century represents a critical period in respect of the role of midwifery and childbirth. Like other Western nations, New Zealand was experiencing high maternal mortality rates at the time. While contemporary examination of these circumstances shows that the reasons for this are complex, and that the inadequate training of both doctors *and* midwives was a factor, some of the major responses to the problem would focus on midwives and only serve to foster the “long-standing myth of the dangerous and incompetent midwife” (Parkes, 1991:166). Consequently, from a situation at the beginning of the twentieth century where most births occurred at home with a midwife in attendance, there is a marked change so that by the end of the fourth decade, “the lay-midwife was barred from practising, most babies were born in hospital, and a doctor was the usual attendant, assisted by a trained midwife or nurse” (Parkes, 1991:165).

Within the context of this shift, several major developments in relation to midwifery occurred. In 1904, legislation was introduced requiring the registration of all midwives who wanted to work with the state. The associated aim was the eventual phasing out of the lay-midwife who, without substantiation, had been heavily implicated in New Zealand’s high maternal and infant mortality rates at the time. This legislation also established the St Helens Hospitals which would serve as training schools leading to state-registered midwives and provide state-subsidised maternity to low income families. Midwives in these hospitals would be able to provide care in all aspects of a normal birth and doctors would be used only in the event of complications. As well as the seven hospitals that were in operation, a district midwifery service for women who wanted to have the birth at home was also to be provided.

¹¹ A whimsical aside was made by one interviewee who commented that midwifery was the second oldest profession. Indeed, a case could be made for it to be considered the oldest.

This period was also a time of intense struggle between medicine and midwifery over 'control' of maternity services. As Fougere (1994) observes, the eventual outcome – that birth became medicalised – was the result of a complex process involving numerous interacting players. Doctors cemented their position in various ways, particularly by popularising the view of birth as pathology and improving their training and interventions in this process. They were also successful in opposing state efforts to promote a midwife-based maternity alternative. On another front, nurses were active in weakening the midwives' position. As well, the state played some crucial roles, firstly in allowing only doctors to administer anaesthetics and so provide pain-free childbirth. Secondly, in responding to fiscal pressure and the lobbying of the medical profession they limited the role of midwives. In order to get doctors participation in the maternity benefit scheme substantial modifications were made to it that favoured doctors. The state's responses to public calls for safe and accessible maternity services, which included pain-free childbirth, only served then to strengthen the dominance of medicine.

Between the late 1930's and up to the 1970s midwives predominantly worked within hospitals. "Here they worked alongside nurses, from whom there was little differentiation in terms of expected duties. Midwives, like nurses, had become entrenched in rigidly defined structures controlled by the medical profession and bureaucratic regimes" (Fleming, 1996:343). In 1971 the provision of full maternity services was restricted by law to medical practitioners. Additional legislative and regulatory changes in the 1970s further cemented control of midwives under the medical and nursing professions, thereby restricting the nature, scope and location of their practice. This meant a very small number of midwives were community-based – those midwives providing post-natal care to mothers who discharged themselves early from hospital and a few domiciliary midwives providing a full range of care practised outside of hospitals (Fleming, 1996).

We have, then, the medicalisation and nursification (Hendry, 2001) of midwifery. Medicine's positioning of childbirth in terms of pathology in which their members are experts is part of the former process while the latter can be seen in midwifery's loss of a sense of professional identity separate from nursing. An example of the intertwining of the two can be most clearly seen in medicine's reconstruction of midwifery knowledge and skills into obstetric nursing (Guilliland and Pairman, 1995). As Guilliland and Pairman (1995) observe, the results of these two processes meant that most midwives had little conception of midwifery as an autonomous profession with specialist knowledge and practice in relation to normal childbirth. Citing the work of various other researchers, Guilliland and Pairman (1995) also outline the impacts for women of these processes. These include the "alienation of women from the [childbirth] experience, increased anxiety and guilt, loss of self confidence, loss of identity, dependency and ignorance, loss of bodily control and loss of control over their babies" (Guilliland and Pairman, 1995:14)

At this point, it is necessary to briefly divert the discussion into NSW. Often, the emergence of NSW is attributed to both supply and demand factors (Carroll, 1999). Some of the most common reasons given for these changes are that they allow employers increased flexibility, save on compensation costs, provide a way to obtain specialised

services or skills not available in-house, and economic risk is transferred to the workforce (Carroll, 1999; Gramm, 2001). Advances in technology have also enabled the growth of non-standard working in a myriad of ways. While large numbers of workers may have little control over the shift to non-standard arrangements and others, such as those caring for children, may see alternative arrangements as the only way of balancing competing responsibilities, for some with particular skills and backgrounds such a shift is by choice. The emergence of independent midwifery can be seen as largely lying outside the usual labour market and economic factors. While economic factors may certainly be considered as background to or on the periphery of the decision (Hendry, 2001), it seems that these changes were the result of the confluence of socio-political forces that lead to the necessary legislative changes that opened up midwifery to non-standard options. These occurred in 1990 with the amending of Section 54 of the Nurses Act (1977) to allow midwives to once more be responsible for caring for women throughout their pregnancy, labour and postnatal period. The 1990 amendment added just three words to the original Act but required changes to five other acts and twenty-two sets of regulations.

While the period prior to this change had consisted of a radical reshaping of midwifery by the state and the medical and nursing professions – in negative ways from the perspective of midwives – it was also a period when consumers and midwives began to resist. On some occasions, action and resistance was prompted by proposed legislative changes. However, there is also a sense of more general discontent with, and opposition to, the nature and state of maternity care and services, and the diminishing status and roles of midwifery within them. As early as the 1950s, Parents' Centre had sought to empower women in birth by providing antenatal education; the formation of the Home Birth Association in the late 1970s was based on similar goals as well as increasing home birth options (Guilliland and Pairman, 1995). A consumer led organisation, Save the Midwife, was formed in the mid-1980s to provide a vehicle for women and midwives to raise the profile of midwifery and highlight the plight of maternity services. Midwives were also engaged in a difficult process of establishing a separate identity within nursing. For instance, they formed a special interest section within the New Zealand Nursing Association and, in 1988, the New Zealand College of Midwives was established. Since membership in this organisation was open to both midwives and consumers, it signalled a unique opportunity for partnership (Fleming, 1996) and it became the focus of efforts towards achieving the legislative independence of midwifery practice via the 1990 amendment that removed the requirement for a midwife to be supervised by a doctor. Also playing a part in the push for changes was the fact that some domiciliary midwives in parts of the country were unable to have medical supervision because no doctors were available and the law changes would protect and enable this group to continue their valuable and necessary service.

Other broader contextual factors can be identified that have some relevance to understanding the law changes. Firstly, the period between 1985 and 1990 saw an increase in births which highlighted the negative effects of the restructuring and shrinkage of the midwifery workforce (Hendry, 2001). Secondly, Guilliland and Pairman (1995) point out that the political climate from 1984 up to the time of the changes was a time when the incumbent government was sympathetically disposed to women's issues. More

specifically, at the time of the changes there was a female Minister of Health. Not only did she have a strong commitment to women's health generally, but she had been lobbied over many years on the issue of midwifery and maternity care and appeared to have a sound grasp of the issues and some sympathy for midwifery's cause (Abel, 1997).

Inter-related to the political climate is the third factor which focuses on the question of women's rights in the health system, and consumers' rights more generally. Both were given added impetus by the report of the Cartwright inquiry into the management of cervical cancer at the county's leading women's hospital (for more on this see, for instance, Coney, 1988). At the same time, consumer health groups were gaining greater visibility and voice, and there was a growing demand for alternative health care providers other than doctors (Hendry, 2001) and different philosophies of care. Underpinning midwifery is a client-centred philosophy based on the belief that continuity of care should extend throughout pregnancy, birth and a period after. While all maternity professionals might claim to provide such continuity, those under other professionals "still enter a hospital for the birth not knowing the midwife who will be her primary caregiver during labour. In some instances, especially when labour lasts longer than one 8-hour shift, more than one midwife might be in attendance" (Fleming, 1996:353-354). It was apparent that women were increasingly keen to have such continuity (Abel, 1997).

Importantly, however, as Fleming (1996:352) observes, these changes were a beginning rather than an end since there were only a few practitioners able and willing to immediately take up independent practice. Hendry (2001) notes that in the first year of autonomy around only three percent of the midwifery workforce was self-employed. Undoubtedly this is partly explained by a slow and careful response to such radical new opportunities. As well, the medicalisation and nursification of midwifery meant that many midwives lacked skills and confidence. One of the midwives interviewed as part of the study and who worked through this period recognised that "for a long time a lot of skills that are midwifery ... have been taken over by doctors, so midwives did have to pick them up and come up to speed". In addition, while the period prior to the changes was clearly a time of activism, as the same midwife described it, the years immediately after the legislative changes were also quite fraught in some instances. She recounts the response of a large institution to the legislative changes.

They kept taking legal action, they were a big organisation, a big structure with huge amounts of money, they just kept pushing out the timeframe of when they would actually meet you.

It was a difficult transition, something not always apparent in the literature:

We had another two years [after 1990] of negotiations and legal battles until the facilities would give us bed access rights. We then had to go to court and threaten legal action under the Commerce Act etc ... It took a full two years before we were then given what we were entitled to under the Act, which was access to book women under our own care, free from having a doctor involved in the process.

The transition was also affected by antagonism from the medical profession and some problems between various groups within the midwifery profession itself.

Thus, from before its inception, independent midwifery has been enmeshed in a socio-political struggle, and that continues to varying degrees today. This can be viewed on a number of levels. There is, for example, the institutional context where midwives must work to deliver babies, and where there has been some resistance to independent midwifery. The development of caseloading midwifery care within institutional settings, as outlined shortly, probably reflects a major shift within institutions. Tied to this, but also needing to be recognised separately is, surprisingly, the socio-political context within the profession. The midwives who were interviewed reported varying degrees of ongoing resistance to the existence of independent midwives though it had diminished significantly over time.

When we first came into the workforce a lot of the antagonism was from our midwives colleagues because they were threatened by us.

Sometimes you do detect a bit of sort of not animosity but a bit of a unsettled kind of feeling. ... I know even from working as a CHE midwife, there was a lot of people around me all the time that would be very quick to judge or criticise independent practitioners coming in and I never really saw why that was necessary and there is still a lot of that going on.¹²

Then there is the broader social context, with a recognition that over time the public have become more aware of midwives and what they do.

I think that the community very much as a whole is beginning to see us more as who we are, the independent practitioners that we are, the autonomy that we have, the fantastic job that we do and that we are providing for what women want.

For various reasons, large numbers of women are opting for independent midwives as their LMCs. However, the medicalised view of childbirth, built up and reinforced over many decades and as outlined above, still persists and must be overcome.

But there is still very much alive and well out there of the doctors are god scenario, why would you have a midwife you need a doctor, and there is still a lot of that around and it has been there for a long, long time.

This is augmented by periodic panics which focus on negative aspects of midwifery.

In the beginning there was all this stuff in the media about midwives have got this and that. A lot of that stuff was blown out of proportion and of course you will always get personalities on both sides.

There have been periods of times when there has been a lot of really negative media about midwives and you do notice there is a fallout to that that women will then think well I can't possibly have this dangerous person look after me. Midwives are dangerous, look at what it says here in the paper, you know. Midwives are drowning babies, that was last week. There is always, its awful stuff to say.

The medicalised view of childbirth signals a further and more contentious socio-political context which centres on the relationship between midwifery and the medical profession. While on an individual level genuine and sound relationships are formed and

¹² CHE is the acronym for Crown Health Enterprise, the name given to public hospitals as a result of the 1991 government health reforms.

maintained between midwives and medical practitioners (i.e. GPs, specialists, hospital based registrars and house surgeons), the latter, as a group, remains a source of resistance to the independent practice of midwifery and any extension of that. They contribute to creating a difficult environment for midwives to practice in.

There has been so much in the media from time to time over the years about midwives doing awful things, a lot of that is media hype, but we know that we are witches, that's where it stems from, witches that were burnt at the stake - they were midwives, and there still is a lot of witch hunting going on out there.

In short, as one midwife summed it up, things are changing positively but old attitudes and fights persist, though it needs to be remembered that independent midwifery is still relatively new.

I guess we are fairly new in the bigger scheme of things, we are only ten, eleven years down the track so although we are doing really well there is still a lot of that around and a lot of comments that you get.

Despite its newness and the demanding socio-political contexts that it exists in, over time the number of independent midwives has grown. Importantly, independent midwifery is part – a significant part it should be noted – of the much larger phenomenon of caseloading midwifery – the style of practice where midwives take a continuity of care approach to looking after a pregnant woman from ante-natal care, through birth and onto post-natal care. Caseloading midwifery can take many shapes. In the course of this study I spoke with caseloading midwives who would be considered self-employed and others who were employees. The emergence of independent practice was not the only change that occurred as part of the legislative changes. Hospitals also eventually radically changed the way many of the midwives that they employed worked. Certainly, many midwives still work as core midwives. As well, though, hospitals are looking to innovative provision of midwifery services. These include the team, domino and 'know-your-midwife' (KYM) approaches. As one of the midwives who was interviewed observed, "a lot of women choose not to have hospitals as their LMC because they don't want to have to see somebody different each time they go to the clinic and not know who is going to be there when they are in labour, so I guess by the hospitals setting up the KYM scheme ... and the Domino scheme ... it makes it a bit more financial for them I guess and it is providing for the women, what they want". The financial benefits come from the hospital getting the income for directly providing the service rather than just a provider of facilities and services to outside LMC's who use it.¹³ Importantly, within the competitive maternity market this can be seen as a response to the demand for continuity of care offered by independent midwives. It also offers an option for midwives who may not want to enter self-employment, though it still requires innovative rostering and some flexibility by midwives. Fleming (1996) suggests that small hospitals and birthing units have been best suited to such responses.

¹³ It should be noted that recent changes to legislation have significant implications in this area. Whereas before the hospital itself would be designated the LMC, now it is the midwife, even if they work for a hospital, that is recognised as the LMC. Some implications of this are discussed later in the report.

Alongside the changes to midwifery practice there are, of course, changes in the way that midwives are trained. Prior to 1990, those entering training as a midwife were required to firstly have a nursing registration. Midwifery had thus been turned into a post-graduate qualification for nurses. While nurses still form a number of those who train as midwives, it is no longer a pre-requisite. Rather, since the early 1990s midwifery has become a stand alone qualification based on a direct entry three year programme. From 1997 this has been at a degree level.

What these changes in the practice of midwifery force us to confront about the study of NSW is that it is plagued by ambiguities and that the notions of 'standard' and 'non-standard' must be viewed as both objective and, importantly, relative qualities. Here I acknowledge that I am using a proportion based approach to establishing standard versus non-standard. This is the basis of the 'pre-dominant pattern' identified in relation to standard work in Chapter Three. I do not feel that this approach is unreasonable in the context of midwifery.

As a starting point for demonstrating the relative nature of NSW using midwifery as an example, a view from within that profession must be adopted. Up until the beginning of last century the standard way that midwives worked was independently or in a caseloading fashion. However, the factors that saw them moved into hospital settings represent a relative shift, within the profession, into non-standard employment. During the subsequent period, the complete dominance of hospital based employment saw this become the standard. In these terms, the small group of midwives still offering home births during that time can be considered non-standard within the profession. Though their numbers are steadily increasing, so too can the independent midwives who are a focus of the study. Such growth may eventually force a reconsideration of this relative status.

An objective view of NSW situates midwifery in the broader context of the labour market. While it is debatable whether the 'standard' or ideal (as described earlier) had been achieved in the New Zealand labour market at the turn of the century, midwives working independently would be one group who would increasingly been seen as outside that emerging ideal. Even though the subsequent dominance of hospital based work may have become the profession's standard way of working, in an intriguing twist, most would still fall objectively outside the parameters of standard work since they work shifts and rosters. While there are midwife positions that fit much more closely with the ideal type, because the care of pregnant women and provision of birthing services must necessarily be a seven day a week, 24 hour a day activity, the bulk of midwives by virtue of their hours of work at least would be non-standard. An irony that this generates is that while those midwives working Monday to Friday and regular office hours would be usually considered standard in wider labour market terms, within the midwifery sector they would be considered non-standard!

Given its parallels with contracting, independent midwifery represents an objective form of NSW. What is intriguing about independent midwifery is that it represents a return to the model of practice that existed before the radical changes early in the Twentieth Century. As such then, it represents a return to standard work in respect of

midwifery if the long term is considered. In this report however, relative to the predominant pattern of hospital employment and objectively in relation to standard employment characteristics, independent midwifery is seen as NSW.

There are, of course, relative differences between groups in any occupation and against this standard or core group of midwives – that is, the hospital midwife working shifts and rosters – there are other groups who would both relatively and objectively be characterised as non-standard. There are, of course, midwives who are casual or part-time employees of organisations and those who work for employment agencies and who are engaged casually or temporarily. Of more interest to this study, there are, also, caseloading midwives working as employees of District Health Boards (DHBs). Whilst they still have a permanent *tenure* and employee/employer *relationship*, their hours of work are very different from the shift/roster model. Like independent midwives they maintain an on-call availability beyond their usual hours of work. Similarly they also work in a variety of *locations* (though in this sense they might replicate many other employee health workers). A similar but distinct group are those employed by private and public organisations (other than DHBs) as caseloading midwives. Again, the variations may be usually but not exclusively based on hours of work

Independent midwives represent a group who exhibit many more dimensions of being non-standard. Being self-employed, they have very different employment *relationships* than midwives employed by hospitals or health providers and the *tenure* of any contract is limited to the period of pregnancy, birth and aftercare. The fact that they derive their income from one source – ultimately central government via its agencies – but provide services to individual clients introduces some interesting paradoxes to the nature of their contractor-like status. Given that they provide continuity of care (and with the nature of births) their *hours* of work can be long and unpredictable at times. Providing that care within a particular philosophy can also mean that independent midwives conduct their work in various *locations* and make use of technology – the ubiquitous cellphone in particular – to facilitate the process. Within independent midwifery there are many variations on how practice is organised which has implications for many of the above aspects of NSW. These will be examined in some detail later.

By way of closing this section, I want to offer some limited data on the breakdown of the midwifery workforce in New Zealand as presented in Tables 1, 2 and 3. The first table shows the make up of the midwifery workforce depending on whether they are in a caseloading or core role. A third group comprise those working in areas such as research, policy, management or teaching. Table 2 takes further analyses the caseloading group (from Table 1) according to whether they are in self-employment or not. In contrast to Table 1, which includes all nurses and midwives with midwifery qualifications, Table 3 presents data for midwives who hold a direct entry qualification only.¹⁴

Some interesting observations can be made about this data. Table 1, when taking all midwives into consideration, shows that just on half of them are engaged in core

¹⁴ These are the midwives who trained under the changed training regimes instituted in the early 1990s and discussed earlier in this section.

midwifery roles. If numerical terms are used to decide on what is standard or non-standard we can see that there is not a huge difference between what has been considered for many years the standard way of working as a midwife (core) and newer ways (caseloading). Within caseloading midwifery the bulk of practitioners are self-employed, itself a very different form of work compared to core roles. That said, a significant number of caseloading midwives are not self-employed indicating that there are growing numbers of such positions available within other contexts (such as hospitals). Such a trend has implications for the make up of the midwifery workforce and further confound the issue of what is standard/non-standard. Interestingly, Table 3 shows a reversal of the more general trend in Table 1, with the majority of midwives holding direct-entry qualifications engaged in caseloading roles. Perhaps this indicates where the newer generation of midwives might more often prefer to work. If it continues and builds then what is standard in midwifery is likely to take on a new form.

Table 1
Worktype, across all employment settings, for active nurses with midwifery qualifications working in the midwifery sector in New Zealand, 2001¹.

Worktype	Total	Percentage
Caseloading	840	42.0
Core	1012	50.6
Other ²	147	7.4
Total	1999	100.0

Notes: 1. Includes midwives with direct-entry midwifery qualifications (see Table 3).
 2. Administration & management, research, education, and professional advice/policy development.

Table 2
Employment status breakdown of caseloading midwives from Table 1

Worktype	Total	Percentage
Self-employed	505	60.1
Not self-employed	335	39.9
Total caseloading	840	100.0

Table 3
Worktype, across all employment settings, for active midwives with direct-entry midwifery qualifications working in the midwifery sector in New Zealand, 2001.

Worktype	Total	Percentage
Caseloading	87	54.4
Core	64	40.0
Other	9	5.6
Total	160	100.0

Sources

New Zealand Health Information Service [NZHIS]: New Zealand Workforce Statistics 2001 – Nurses and Midwives, available <http://www.nzhis.govt.nz/stats/nursestats-p.html>, retrieved 13 November 2002, and additional data supplied by NZHIS on request. Both sources draw on data from New Zealand Nursing Council's survey of nurses and midwives as part of the annual registration renewal process.

5. Caseloading Midwifery and Entrepreneurial Capital

5.1 Introduction

The concept of entrepreneurial capital has been developed more extensively elsewhere (Firkin, 2001b; Firkin, *in print*) as a resource-based approach to exploring aspects of the entrepreneurial process. In short, it generates an analysis of entrepreneurial activity through identifying all the resources that the entrepreneur may possess or acquire – that are themselves composed of many different facets – and which are then employed in the entrepreneurial process. Thus, it considers how an episode of entrepreneurship is made up of a mix of various forms of capital, which themselves constitute entrepreneurial capital.

Importantly, the idea of entrepreneurial capital rests first and foremost on a very broad conceptualisation of entrepreneurship. Following Reynolds (1991), I opt for a continuum approach that identifies entrepreneurship as incorporating a range of activities from self-employment to the creation of substantial organisations. Independent midwifery clearly falls within this continuum, as was recognised by some of those interviewed.

Maybe our age group was quite entrepreneurial in realising early on that there were a lot of opportunities for us. ...there was a whole big entrepreneurial group who saw a whole new use for this law change.

Thus, the model of entrepreneurial capital can be usefully applied to an analysis of this type of midwifery. A couple of provisos need to be borne in mind however. Firstly, my intention in applying the model is not to reduce the many rich dimensions of midwifery practice to a strictly business or economic perspective. Many of the midwives who were interviewed were keen to point out that although independent midwifery is a form of self-employment, and thus has to be approached in business terms, this is not the primary way it is understood by midwives and I am keen to honour such a sentiment.

I think there are obviously some midwives who see themselves as operating a business. They clearly identify with being self-employed and this is the childbirth business that they do. I don't think most midwives see themselves as that. They see themselves as self-employed, they want to be professional, but ... the business side of it ... someone else can sort of do that.

Indeed, one intention behind the development of the model was to expose the multifaceted nature of entrepreneurial activity and to counter an all too frequent concentration on financial or business aspects. It is my belief that the model succeeds in doing this for midwifery and, in turn, that midwifery proves to be an excellent case by which to demonstrate the model in action. By way of reinforcing the latter contention, this study provoked an addition to the model in the form of bodily aspects of human capital.

Secondly, though in this part of the report I am clearly interested in those midwives who are self-employed, many of the experiences of employee caseloading midwives in some areas of their practice are similar enough to be considered as well. Thus, while each group have very different income sources, both rely on similar degrees of family understanding and support to help them cope with on-call work. As a consequence, I have

chosen to draw on the experiences of employee caseloading midwives where appropriate to augment the discussion. The views that employees can demonstrate entrepreneurial thinking and behaviour within firms add further support for this selective incorporation.¹⁵

The following section begins by outlining in a little more detail the broad make up of the model of entrepreneurial capital. Then the various component forms of capital are described. This provides a basis for integrating interview material to illustrate the various ways and shapes that these forms of capital are present in independent midwifery.

5.2 The Concept of Entrepreneurial Capital

Entrepreneurial capital is made up of the total capital that an individual possesses – that is, the sum of their economic, human, social, cultural, and physical capital. The broad definitions of each form which follow allow for this total capital to encompass a wide range and number of resources. However, not every aspect of a person’s total capital will be useful in an entrepreneurial sense, nor does every person have access to the same sorts and levels of capital. The entrepreneurial capital a person possesses is made up of the components of their total capital that have an entrepreneurial value or some worth in an entrepreneurial context and in relation to the entrepreneurial process.

Entrepreneurs identify and develop their entrepreneurial capital by extracting entrepreneurial value from their total capital or, in other words, converting the various forms of capital they can access to derive entrepreneurial value. Since it is the “identification, acquisition and combination of resources that results in the unique identity of the business” (Greene and Brown, 1997:163), generating entrepreneurial capital can be seen as a key role for entrepreneurs. As part of this role the entrepreneur may possess these resources, have to acquire or access them in some way, or may convert some into other resources that are useful in the entrepreneurial process. The particular mix of capital can be different depending on the nature of an enterprise and the entrepreneur. Importantly, the ideas of entrepreneurial value and capital must be seen as dynamic concepts since, as Brush et al. (1997) describe it, over time “some resources are re-organised, new ones are acquired, some become specialized and others may become idle”. Thus, resources can change across time in relation to the lifecycle of the enterprise, the people involved, as well as internal and external circumstances.

In the following discussion, I will examine the various forms of capital that are identified as part of the model of entrepreneurial capital. Following a general discussion on each form of capital I will identify its constituent resources in the context of independent midwifery. In addition to looking at human, cultural, social, economic and physical capital, I will also consider the convertibility of these various forms, giving examples of this transformation in a midwifery context. The order I have chosen to present them in is deliberate and represents an effort to portray a hierarchy of resources necessary to embarking on and sustaining independent midwifery. Though the human capital of the entrepreneur is often of interest, the subsequent order – privileging cultural

¹⁵ See Guth (1999), for instance, by way of introducing this view of entrepreneurship. This is an introductory article for a special issue on this subject.

and social capital over economic and physical resources – reflects, I believe, their relative importance in relation to midwifery.

5.3 Human Capital

Human capital is often interpreted in a limited way to include ideas about formal qualifications, skills and work experience. However, human capital can be seen to entail a great deal more. As Shanahan and Tuma (1994:746) recognise, “it is a compendium of all traits and abilities that make human beings economically productive in a society” and which includes both innate and acquired characteristics. Both dimensions are included in the notion of human capital as employed in the concept of entrepreneurial capital.

As well, though not usually considered in existing notions of human capital, it also seems reasonable to incorporate the properties and capacities of our bodies. Such an extension appears congruent with the understanding that Shanahan and Tuma (1994) are encouraging. While rather different to the qualities described above, they are undoubtedly human in nature. Although they could be classified in a separate category, to do so would appear to be an unnecessary fragmentation.¹⁶ This form of capital represents an addition to the model as formulated previously (Firkin, 2001b; Firkin, *in print*). It has been added after the analysis of the midwives’ interviews revealed what had not been previously drawn out of the experiences of self-employed people in other LMD research that prompted the development of the model of entrepreneurial capital, but which on review was quite apparent. Importantly, however, some care must be taken so as not to blur the distinction between the bodily dimensions of human capital and embodied cultural capital (see below). Both are very different and the latter is a much more complex notion. The features that are captured by the former are things like fitness, strength, stamina, dexterity, acuity of senses and so on. It is hardly contentious to suggest that certain occupations require different combinations of particular physical attributes. Like all the forms of capital and their constituent parts, as discussed below, people wishing to enter a particular type of self-employment may possess or need to develop the required physical attributes. Having these or anticipating that these can be acquired or built up over time may influence the type of self-employment chosen. Conversely, lacking these, believing that one is not able to develop them, or disliking having to employ them as part of the job may influence the decision to not pursue certain types of employment or to opt out of them.

Following this short outline of the composition of human capital within the model of entrepreneurial capital, a discussion of the interview data can now be presented. It is organised in four broad areas. Firstly, there is some further albeit brief consideration of the bodily dimension of human capital. Then education and training is considered. Thirdly the issue of work experience introduces a discussion of the practice of mentoring. Finally, the attributes of independent midwives are considered.

¹⁶ If this were done then the options for a descriptor are complicated by physical capital already being understood in the literature in terms of tangible resources. To shift its meaning to bodily capital would entail upsetting this established meaning. Alternatively, a suitable term would have to be chosen and argued for.

5.3.1 *Embodied Human Capital*

In my conversations with midwives, I was continually reminded of the very physical nature of midwifery. Again and again, they described or referred to what they did as ‘catching babies’. While used in a metaphoric sense, there is a degree of realism in such a phrase as it describes the physical involvement of midwives as a partner in the birth process with mothers. Obviously aspects of this physicality are better understood in the context of embodied cultural capital (discussed below), but other elements are more usefully categorised in human capital terms. Such elements might include dexterity, acute senses and the like.

Very obviously, as well, was the need for caseloading midwives to possess considerable stamina, which seems to be the most prominent aspect of embodied human capital evident from the interviews. It is clear in the experiences of this midwife.

I had one of those days – actually three of those days – when I was on-call for eight [other midwives]. And I think from the Tuesday night until the Friday morning at 8 o’clock I had actually been in my house nine hours. I think I had delivered three or four women that were not mine¹⁷ and I was just going home to sleep at 8 o’clock on the Friday morning ... when one of my women walked in, in labour, so I stayed. ... Thankfully she was fast. I was home by 2 o’clock. ... I wouldn’t have had the stamina to go another ten hours.

Caseloading midwives must also have the physical ability to cope with being called out at all hours. Though, as one interviewee noted, being called out unexpectedly in the middle of the night was much better than knowing you were on night shift for a week, it still makes physical demands on people.

5.3.2 *Education and Training*

The key determinant of being able to work as an independent practitioner is registration as a midwife. This establishes midwifery as an “independent health profession with a distinct body of knowledge and a separate Code of Ethics and Standards of Practice (NZCOM, 2002b). The training of midwives equips them as “specialists in pregnancy and childbirth. ...[who] have a fundamentally different approach to pregnancy and childbirth to standard medical management. [Midwives’] care is founded on respect for normal pregnancy and birth as healthy processes...” (NZCOM, 2002b).

Beyond these foundational qualifications, it was clear from the interviews that midwives recognised the importance of ongoing education and training and were committed to accommodating this into their work lives. Indeed, such a recognition and commitment seemed to be a universal attribute of those interviewed and was supported and encouraged by the profession as a whole. While each midwife realised that they were individually responsible for this on a personal level, they also expressed a collective desire for midwives to be highly knowledgeable and skilled, and to demonstrate a high degree of professionalism. As a consequence, the costs associated with education and training appeared to be accepted as a very necessary expenditure. A range of approaches

¹⁷ “Not mine” refers to women this midwife was not the LMC for. Rather, she was the “back-up” midwife when their LMC was having a day-off.

to acquiring additional, and augmenting existing, human capital are presented in the following discussion.

One way was the ongoing development of expertise and knowledge by continual reflection and professional engagement with other midwives. This was one of the benefits of belonging to collectives and practices. All those interviewed talked of the formal and informal ways that the members of such groups provided support, feedback, guidance and various forms of assistance to one another. Importantly, it was readily acknowledged that this was an ongoing process for all midwives and not limited to new practitioners.

Everybody asks everybody something, you know. Even now. Someone was asking me the other day, you know I've got this women with this, this and this what would you do? And you'd say well you know I'd do this. Oh good, I've done that.

A key and very formal approach involved the regular reviews of practice undertaken by midwives via the NZCOM. While not mandatory – Guilliland's (1998) research, for instance, reveals an uptake of around 56 percent of self-employed midwives, with regional variations – all the midwives who were interviewed undertook these. Though this process is also considered elsewhere in the report (see Section 7.3.2), it is included here as it represents a substantial commitment to critically reflecting on one's practice and thus falls broadly into the area of education and training. Since these reviews demand a great deal of preparation they demonstrate a significant commitment, not only to education and training in the form of specific objectives or plans, but also to monitoring and improving the quality of care.

Two other main types of education and training were identified from the interviews. Firstly, there were the regular mandatory skill or competency updates. Secondly, there were other education and training undertakings of various forms, from short one-off type courses to much longer and more demanding programmes such as a Master's degree. Having access agreements with hospitals where they delivered meant that midwives could attend education and training programmes within those institutions.

The major issue with education and training was managing such commitments alongside the demands of work. This was not unlike the knowledge workers interviewed in the earlier LMD research (Firkin et al., 2002) though the degree of unpredictability was likely much higher and the ability to 'diary-out' intrusions less easy. Flow on effects of working 24 hours a day were a further difficulty. Thus, the unpredictable nature of maternity care meant that attendance at a course could be interrupted by phone calls and call outs. As one midwife put it,

Having attended many [courses] and myself having taught several, midwives always have the phone and there is always midwives coming and going. When you are teaching midwives you just come to expect that they will come and go, because that is what they do.

It is of course possible to arrange cover from other midwives but each is aware of the extra demands that this places on their colleagues. While short courses can still be interrupted, they are often manageable and as they are usually run on a frequent basis can

be more easily rescheduled. Longer and more demanding programmes of study or training pose greater challenges.

[You] hope like hell that you are not delivering on that day otherwise you might miss out on something [but] its not that bad.

As she notes, despite these potential problems, this midwife found that her experience of actual interruptions was minimal, a sentiment shared by others. A further major issue regarding education and training was that the demands of work by itself made finding the time and energy not only to attend courses but to study and complete coursework quite challenging. All this as well as having a personal life.

It is really hard to find the time to do that. I'm probably looking at doing one or two papers next year if I can fit that in. It is important and I see it as important for me to further my education and my knowledge for the women's sake obviously, but it is hard to fit it in.

In short, this research confirms much of what Guilliland (1998) identified in her exploration of the self-employed midwifery workforce. Firstly, she identified that the “commitment to ongoing education is considerable in a service where the midwife is generally on call 24 hours a day” (Guilliland, 1998:141). She also found that the midwives she surveyed made considerable efforts to find suitable courses. In concluding that there is a “need and demand for ongoing education which is comprehensive, wide ranging and therefore easily accessible to all midwives” (1998:145), Guilliland very much captures the impressions of this study.

5.3.2 *Work Experience and Mentoring*

Many of those transitioning into independent practice have spent time working as midwives in other settings, such as hospitals. While such preparatory experience might be viewed as unproblematically positive by many, according to the midwives who were interviewed it can present pros *and* cons in relation to a transition into independent practice. Certainly, one can gain skills and experience, but this is in particular settings and there are, consequently, limits to the benefits in other contexts. For instance, as one interviewee observed, in a hospital setting there might be fewer opportunities in normal ante-natal care – though it is, of course, dependent on the nature of the hospital. As well, hospitals are orientated and organised in particular ways.

I think [hospital experience is] quite a good idea, but your whole outlook can be skewed by working in a hospital setting where it's more medical.

The very negative assessments by those interviewed of many of the hospital settings that they had worked in – being stressful places to work, understaffed and so on – is also of some relevance in this regard since the nurture and support offered new graduates and staff in general can be variable. Despite these negative aspects, it was acknowledged that experience in hospital settings can be of help when you have to operate in those facilities as part of your independent practice. It was also seen as providing invaluable midwifery experience and a chance to consolidate one's training.

Once midwives successfully complete their training and gain registration, they are considered competent to practice by the NZCOM. However, as one midwife observed, it

is difficult for anyone at any stage of their midwifery career to truly understand the responsibility that independent midwives have to accept as part of their work until they experience it. A new graduate who went directly into independent midwifery captures some of these sentiments in her observation that,

I knew midwifery for what I had experienced as a student, which was something very different in reality.

Thus, the realities are that newly qualified midwives, as with any professional, need time and assistance to settle into roles and work settings. Mentoring serves as a means to facilitate that transition.

For newly or recently qualified midwives, the profession has an active mentoring process to assist them in moving into independent practice. The NZCOM has identified mentoring as a relationship of negotiated partnership between two registered midwives to enable and develop professional confidence (NZCOM, 2000). No such concept was evident among knowledge workers interviewed in the NSW Report (Firkin et al., 2002). This serves as a particular way that human capital is augmented and thus adds value to the baseline human capital acquired through training as a midwife.

One of those who was interviewed decided to enter independent practice immediately after qualifying so her experiences are particularly germane to the discussion. As part of this she had to select a practice, which also meant finding someone within that practice willing to mentor her. Because she had worked at a particular practice as a student she had been able to assess the qualities of the practice as a whole and of the individual members to a degree. On the other side of the coin, her future mentor had been able to assess her as well.

I wanted a new partner and to me we needed another person in the group, what better partner can you get than someone you have worked with, who knows your working style that well.

Alongside new graduates, other midwives with more experience could make use of the mentoring approach when they entered self-employment. For example, one of the midwives who was interviewed opted to join a practice that served a geographical area that she had never lived and worked in before. So, while she was more experienced in her practice, she was still grateful for a mentor to assist her in developing her practice in an independent setting and, as important, for help in getting orientated to, and familiar with, many new people and places.

It appears from the comments of many of those interviewed that mentoring for new or very recent graduates can take many forms. Timeframes vary as can the nature of input, though there are minimum requirements in terms of numbers of supervised births. The balance of workloads – between the mentor and mentored – can be organised very differently as can the payment arrangements, if there are any.

In response to a specific question some comments were offered regarding the mentoring role and the appropriateness of new graduates entering into independent practice immediately upon graduating. Interestingly, the institution which provided a

caseloading service that two of the interviewees came from did not allow this. Management were reluctant to even allow those with some experience “on the wards” to join the caseloading service, even though these two interviewees recognised recently qualified midwives who would have been well suited and skilled for caseloading work.

I think it's a pity really because when someone is enthusiastic and a couple of these girls are really good midwives, they would have been an asset and I think it's a loss, there have been a few midwives that they've lost like that.

Interestingly, one of the independent midwives had tried to enter a hospital-based caseloading scheme a little while after qualifying, but had met considerable opposition.

I really would have liked to have gone into [a caseloading scheme within a hospital] and I tried to encourage them to set up a new graduate programme within [that] and it just didn't work, it was just like talking to a brick wall really.

There seemed to be some consensus that the appropriateness of a new or recent graduate entering independent practice depended in large part on the individuals involved.

It depends upon the individual. ...It depends upon the midwife and it depends upon who's mentoring them.

Clearly, for various reasons, working as an independent midwife is not for every graduate.

I've had a lot of student midwives work with me and over the last three years one of the six that I've had I would recommend would be able to go into independent practice, the others just haven't got the people skills, haven't got the midwifery skills, even if they were mentored it would be a big burden on their mentor.

It takes a certain type again, that's what I've opened my eyes to as well. We can't make everybody want to work this model and there is confidence and confidence.

Similarly, mentoring may not be for every experienced midwife. Some willingly accepted that role while others found it extremely demanding, especially on top of their own work, and so avoided it. As the comments of this mentored new graduate make plain, someone in her position often has little idea, not only of what the job of an independent midwife is about, but what it means to be mentored and what it demands of the mentor.

I had no idea of what I was asking [my mentor] to do when I asked her to mentor me. Thankfully she did, because she had done it before. So she had some really good structures in place and it was easy.

Her mentor make a similar observation.

I don't think anybody knows what they are asking for when they are asked to come into self-employment, what they are actually asking of another employed midwife. I knew, because I had mentored before.

The demands and stresses on both parties are such that relationships can falter.

I know some people who have come into independent midwifery and been mentored, whether it is straight out of school or after some time in the hospital, and I know of a few relationships that have broken down or haven't worked.

As well as the formal mentor, it seemed that the other midwives in a practice performed important ancillary roles in this regard. When a mentor was unavailable due to

circumstances or simply needing time for their own personal wellbeing, others stepped informally into the breach in various ways.

I have my main identified mentor ... So she was the one person that I could always rely on. And then because there were seven or eight other midwives working here, they kind of took on that role as well. I could ask them for things. If [my mentor] was unavailable or if I knew she was tired, I could always rely on one of the other ones to come and help me, or answer my questions, or just whatever I needed.

By way of concluding this section, I want to note that the sense I developed with caseloading midwives regarding mentoring seemed to exemplify a different world view than that represented by the institutional approach solely focused on “doing time”. The former seems to be part of a wider philosophy that demands an active ongoing engagement with learning and development. Certainly it is more individualised since effective mentoring begins with recognising the capabilities and potential of the individual and the quality of the mentor. As Holland (2001) points out, mentoring is an evolving process that has an essential place in the development of midwifery. It demands, therefore, ongoing discussion and debate.

5.3.3 Attributes and Characteristics

Given that I have deliberately chosen to employ a broad definition of human capital to include traits and abilities, it is necessary to also consider the attributes and characteristics that those interviewed saw as beneficial for an independent midwife to possess. That said, it is always hard to create a list of the characteristics best suited to a particular occupation. As one interviewee noted, midwives display a wide range of attributes and while some of these might seem preferable for doing this job, many midwives cope without them or with only some of them, and any commonly held attribute is likely to be possessed to varying degrees by individuals. In this light, the following discussion merely seeks to offer those characteristics and attributes identified in the interviews as of some benefit for a caseloading midwife to possess.

Like the non-standard knowledge workers in an earlier LMD study (Firkin et al., 2002), a sense of passion for what you are doing was evident among the midwives. For this group there seemed to be a deeply rooted sense of vocation as well. Some recalled that their desire to be a midwife had existed since they were children or realised that, regardless of what happened in between, they would ultimately end up being midwives. Though she starts out in a describing it in a muted way, this interviewee conveys the sentiment of many others.

I suppose it was a calling, but it wasn't an overwhelming calling, I just, you know I knew I was in the right place and have now been doing it for 17 years and have continued to grow and believe that it is my calling and that there isn't really anything else on earth that I want to do.

Combining a passion for what one does with a sense of vocation appears to be necessary to help cope with the particularly demanding nature of caseloading midwifery in general and independent practice in particular.

Allied to this is a particular philosophical disposition. While all midwives are trained in the philosophy of continuity of care and a client-centred approach, caseloading midwifery offers the greatest opportunity to practice such a philosophy. I will later consider this as the cultural capital of midwifery. It seems that as part of the philosophy there was a perception that midwives were givers – to other women and between themselves. Indeed one practice was premised on the core principle of generosity. As will be evident from parts of the report, many caseloading midwives, particularly younger ones, are keen to place some parameters around their ‘giving’. However, to an outsider, it remains a defining feature of the profession.

Other characteristics that were felt to be useful for successful caseloading midwifery by those interviewed included adaptability and flexibility, being organised, and possessing a high level of knowledge and skill. The interviews also revealed, in various ways, that two important attributes were the ability to cope with high stress and demands and integrate these with a midwife’s personal life. This might be done by maintaining a balanced perspective, being able to say no, enjoying free time and/or by seeing the work as part of a lifestyle.

A final ‘attribute’ that all felt was essential was having an adaptable and supportive family. The importance of this ‘family attribute’, on the edges of which there are extended family members and very close friends, is only signalled here as it is canvassed more fully in Section 5.5.

5.4 Cultural Capital

Cultural capital, as developed in the context of the model of entrepreneurial capital, is adapted from Bourdieu (1986). He identifies cultural capital as having three states. Since one of these, the institutional state, can be incorporated into human capital, it is the remaining two states which are of greater interest in this context. The objectified state of cultural capital concerns “cultural goods (pictures, books, dictionaries, instruments machines etc)” (Bourdieu, 1986:243). These have a material character and can thus be owned simply by utilising economic capital. However, for them to be appropriated or consumed as they were intended, that is, for their symbolic value to be realised, presupposes the embodied state of cultural capital which comprises “long lasting dispositions of the mind and body” (Bourdieu, 1986:243-244). Harker (1990:34) identifies some of these as “the body of knowledge, the tacit understandings, the style of self-presentation, language usage, values etc” that are shared among groups.

From this starting point, de Bruin (1999) opens up the idea of cultural capital further. Whereas Bourdieu emphasises its class nature, de Bruin pays attention to the notion of ethnicity and argues that although people from outside the dominant culture are often at a disadvantage, they still possess embodied cultural capital that is shared with others because of common ethnicity. Rather than focusing solely on how a lack of dominant cultural capital disadvantages groups, de Bruin highlights how the cultural capital shared by these other groups can, under certain conditions, provide positive resources and the

basis for opportunity. Cultural capital can thus be seen to have the potential to be utilised in an entrepreneurial sense to provide goods and services in particular ways and forms that are preferred and valued by groups. Going one step further, Aldrich and Waldinger (1990:112) open up the term ethnic to include those collectives whose “members have some awareness of group membership and a common origin and culture, or that others think of them as having these attributes”.

Cumulatively, these various shifts constitute something of an appropriation of the notion of cultural capital from Bourdieu’s (1986) usage. It is a positive transition, I would contend, that allows for the possibility that a range of groups can possess cultural capital in various forms that have entrepreneurial potential. I want to now argue that midwifery constitutes just such a group and to suggest what the cultural capital of midwifery might comprise and how it operates in an entrepreneurial sense.

If the genesis of contemporary independent midwifery is recalled from the earlier brief recounting of its history, the consumers and midwives who fought for legislative changes can be seen as an ethnic group in Aldrich’s and Waldinger’s (1990) terms. They have a common origin within that genesis and a sense of belonging because of their commitments to changes premised on a particular culture. That culture represents the drawing together of particular values, beliefs, attitudes, skills, practices and knowledge that individual practitioners embody in their work. As such, it entails a particular disposition and perspective to childbirth that, as well as viewing normal pregnancy and childbirth as healthy processes, has amongst its philosophical tenets the twin pillars of partnership and continuity: “Midwifery care takes place in partnership with women. Continuity of midwifery care enhances and protects the normal process of childbirth” (NZCOM, 2002d). Such philosophical orientations underpin and guide consequent practices. Collectively, these orientations to maternity care make up, what I call here, the cultural capital of midwifery. This capital is shared by client and practitioner, and is embodied in the practice of the latter.

Like any business, midwifery needs customers that want to purchase or utilise the services/products they provide and must position itself relative to others in that marketplace. The cultural capital of midwifery plays important functions in an entrepreneurial sense in relation to these issues. Firstly, it serves as the key linkage between consumer and practitioner. The existence of people on both the supply and demand side of the equation – created by consumers and midwives sharing the cultural capital of midwifery – opens up the possibility, facilitated by legislative changes, for that market to be created. Much of this has also become true of caseloading midwives within institutions since consumer demand has forced a revision of the standard ways of working even within such settings. Secondly, the cultural capital of midwifery differentiates midwifery-based maternity care from other styles, most notably the medical model. It thus provides the basis for the establishment and maintenance of a specific market within the wider maternity care marketplace. The comments from this midwife sum up the role that the shared cultural capital of midwifery plays.

There is a sense out there in the community of who we are, so women self-select in some ways to come here. So that gives us a huge advantage that we’ll tend to be working with

women who are aligned to way that you want to provide care. So for women who say want to have an obstetrician, want to have an epidural as soon as they want to go into labour, want to formula feed their babies, they would be unlikely to be attracted to come here, just by the nature of the environment really. And so it means that because there is an enormous amount of satisfaction of doing this job and doing it well, you want to work with people you can partner.

If the philosophical disposition towards childbirth is the substance of the cultural capital of midwifery, then the model of partnership articulated by midwifery offers a unique mechanism by which it gains, maintains and grows entrepreneurial value. Though alluded to above, this is worth exploring in a little more detail. In the process I draw on the work of Guilliland and Pairman (1995).¹⁸ As will be obvious from the preceding discussion, both here and in other parts of the report (see, especially, Chapter Four), partnership has always been a part of the re-emergence of midwifery. It can be seen to operate on two closely inter-related levels – at the personal/practice level and at the organisational/political level. The particular approach to partnership adopted by midwifery stands in stark contrast to “the usual expert distancing practices of most professions” (Guilliland and Pairman, 1995:20) since alongside the partnerships that individual pregnant women develop with their midwives, consumers are active partners in the policy processes and decision making systems which steer, develop and oversee midwifery as a profession. The review process (see Section 5.3.1) is an integral part of this. Partnership, as an ongoing and reflexive process, evolves alongside and as part of the re-emergence of midwifery. That is, women as consumers shape the notion of partnership which is, itself, part of the model of midwifery they are also contemporaneously shaping. Since “women’s participation has given midwives a public, legal and socially sanctioned mandate for practise” (Guilliland and Pairman, 1995:19) midwives, for their part, have acted to develop a profession in such a way that “all of its organisational, regulatory, disciplinary, and educational functions are defined and implemented in partnership with women” (Guilliland and Pairman, 1995:20).

The implications for an entrepreneurial capital model of independent midwifery is that the provision of midwifery care is continually renegotiated by both parties with each intimately and necessarily implicated in the ongoing process. Since any business would clearly fail if demand disappeared, they must consequently have some connections to their market and be getting feedback from it in order to modify their product/service according to demand. However, this is usually by distant and infrequent market research mechanisms or crude demand feedback. With midwifery, consumers are involved directly in the ‘production’ and ‘marketing’ processes, shaping the service to their demands whether at the level of policy and organisation or at the intimate moment of birth.

Having made the argument for the importance of the cultural capital of midwifery to the entrepreneurial possibilities of midwifery I want to add two interesting observations. The first concerns the rise, since midwives have been permitted to practice independently,

¹⁸ Here I must acknowledge that I have arbitrarily divided what I call the cultural capital of midwifery into philosophy and partnership when the two are actually intertwined (see Pairman, 1998). This has been to assist in my explication of the idea of cultural capital and its place in the entrepreneurial nature of independent midwifery.

in the numbers of people opting for a midwife as their LMC. The proportion making this choice is currently around 70 percent (NZCOM, 2002c). However, this cannot be entirely explained by the cultural capital of midwifery for two reasons. Firstly, following midwives being allowed to practice independently the numbers of GPs performing deliveries have dropped considerably (National Health Committee, 1999). Secondly, as was noted by some of those interviewed, many people still do not have a true appreciation of what midwives do, how they work, and what their philosophical disposition is. Thus, if the decision to be cared for by a midwife is to be based on an informed choice, rather than a lack of options, then midwifery needs to expand the public's knowledge of their philosophy. In this way the value of the philosophical side of their cultural capital will be maximised.

The second issue I wish to note is that the partnership aspect of the cultural capital of midwifery is in an ongoing state of evolution, something that is evident in the engaging dialogue on the issue of partnership in the New Zealand College of Midwives Journal (see, for instance, Benn, 1999; Daellenbach, 1999; Pairman, 1998; Pairman 1999; Skinner, 1999). While some are critical of, and experience some difficulties in, presenting midwifery in such a manner, others want to position it as a dynamic perspective that serves as an individually responsive basis for developing models of care.

5.5 Social Capital

Social capital has been defined in a number of ways (for a review see Adler and Kwon, 2002). I have elected to follow what Portes (2000a; 2000b; 1998; 1995) terms, a consensus position. He conceptualises social capital as the ability to secure resources, or benefits as he prefers to call them, as an outcome of people's membership in social networks or other social structures. Social capital is most commonly used in an entrepreneurial context to describe "network-mediated benefits beyond the immediate family" (Portes, 1998:12). That is, the benefits and resources that accrue from the entrepreneur being part of and utilising a wide range of relationships (Aldrich and Zimmer, 1986; Birley, 1985). A second way that social capital can be used is to conceptualise how those within a family contribute to entrepreneurial activity undertaken by a family member. An exclusive focus on the social capital between spouses or partners has been developed elsewhere (Firkin, 2001a; Firkin et al., *in print*) but it can also apply to other family members such as children and those who form part of extended family relations (e.g. Rowe and Hong, 2000). In order to clearly differentiate this dimension of social capital it has elsewhere (Firkin et al., *in print*) been referred to as familial social capital; it could just as readily be considered familial capital.

Importantly, as Portes and Sensenbrenner (1993: 1338) observe, "the same social mechanisms that give rise to appropriable resources for individual use can also constrain action or even derail it from its original goals". In line with the greater balance that is consequently emerging in the literature and research, I attempt to highlight some of the negative outcomes of social capital alongside the positive.

5.5.1 *Familial Social Capital*

Familial social capital plays a very large part in independent and caseloading midwifery. Critical to the management of the home-work nexus for caseloading midwives appears to be a supportive family, especially in respect of their partner or husband. While one of the midwives who were interviewed managed to work full-time and be a single parent, somewhat disproving the prior assertion regarding the importance of a supportive partner or husband, the immense struggles and difficulties she experienced and overcame are perhaps an example of the exception that proves the rule. By way of trying to replace the support that a partner could offer in such circumstances, this woman tried all sorts of approaches to ensuring her children were looked after when she was called out. As she observed, some worked, others didn't – though none of these seemed to have any adverse outcomes – and all the time there was an ongoing anxiety. Eventually her children were old enough to look after themselves and proved more than adequate to the task. The importance of family is more directly reinforced by the experiences of another midwife with children who felt she could not continue in a caseloading role when her marriage broke up. Although the flexible workday routines she was able to follow would have been well suited to the needs of school age children, it was the unpredictable nature of the on-call component that created problems since there was no-one who could be with her children if she had to attend a delivery overnight.

From the interviews, it was clear that a partner or husband is a crucial source of support, both in emotional and practical senses. Thus, it is their adaptation to their wife's or partner's new role, as much as the midwife's herself, that is important.

It is your husband. If I am looking in and I am seeing the pressure, it is how the husband adjusts. ... The first year it seems fine, they are supporting their wife into practice and it is novel and its new, and then the reality hits on how it affects their lifestyle.

This is just as true of couples without children as is illustrated by this younger midwife who is building a relationship. She moved directly into independent midwifery from her training.

[It] has been a huge thing for my partner and I to adjust to ... We hadn't had any discussions on how that would impact on us. We have many now. I think we have kind of got used to it now, but it is four and a half years down the track, so it takes a while. ... You know, we are trying to build the foundations of a relationship that might eventually one day result in a family, and that takes a lot of time and effort in itself. You have to be around for that. So that is quite interesting.

As another example clearly shows, the challenges for partners or husbands are increased when children are involved. This midwife was married with two young children at the time of her shift. She had been qualified for some time and had considerable experience in various hospital settings. The issue for her was the process by which her husband came to recognise that in order for her to do her job, he had to accept a shared responsibility in the care of their children.

I've been doing independent now for nearly nine years and it took him well into the fifth year to figure out that he actually had that responsibility. And I think that that for him was really huge because he was just as responsible for my kids as I was ... up until that point in time ... I would say to him I've got a lady in labour, you need to come and pick the kids up. Oh no I can't I've got work ... [But] see he's a builder and he's a self-employed builder so he has that ability to come and go ... [Finally, now,] he can see and understand

that responsibility ... Once he got that, things flowed a lot easier. ... So it actually took him a lot longer I think to get to the point to where he was comfortable with the job that I did, you know I did.

Another midwife summed up the changes that a partner or husband must come to accept.

You can't go off and play golf, because there are kids to be picked up. You might be on the golf course but you have got to have a mobile phone because she might ring you up because she has had a client go into labour and now he has got to pick the kids up. You can't just go off to the rugby club with your mates and get plastered or whatever it is because she has got two women due at the moment, you see what I mean. ... You have to be a team.

The process by which partners and husbands took on certain roles and responsibilities was an ongoing one it seems, as this midwife observes.

We have at times had to renegotiate how we do it as a family to make it work

As is clear, then, caseloading midwives need their husbands and partners to have much greater and more active roles, especially in respect of the care of children. They were not only someone who was there when the midwife was called out in the middle of the night but they might be required to provide all sorts of care at other times given the unpredictability of this work. Thus, husbands or partners might be expected to play a greater role in relation to sports, functions and the like if the midwife is working.

I think I had a far greater expectation of his absolute availability in terms of parenting the children, to be fair he's always risen to the occasion.

Of course, the nature and degree of these demands depends on the age of children. For this reason one woman waited until her children were teenagers before moving into a caseloading role.

A basic premise here is that the husbands are actually able themselves to perform these roles. As was noted in one of the preceding quotes, the midwife's husband had the flexibility to take over caring for their children because he too was self-employed. Other interviewees indicated that their husbands had work that allowed a degree of flexibility. Where this was not possible, midwives had to develop other strategies.

Clearly, then, with and without children, partners provide a range of practical and intangible support and resources for caseloading midwives. It is important, however, not to portray what husband's and partners did in terms of a role reversal. I did not get the impression that these men had simply assumed a full househusband-like role. As one midwife put it,

I wouldn't say that [my husband] ever took on the housework ever.

That said, their involvement clearly exceeded what is usually expected of men in these circumstances – which may help explain the difficulties some had in making the transition (as noted above). Also, while I did not interview the partners or husbands, the midwives made it clear that they (their husbands and partners) at times felt quite negatively about the dynamics of living with a caseloading midwife, as these comments show.

He's had frustrations at times. ... [He] thought that in fact what [the husbands] should do was go off at 4 o'clock in the morning and not return for 36 hours and leave the women

to it. ...[He says] "In our house it is really clear, there is you, there is the women you care for, there is your professional demands, then there is the kids, then there's the dog, then there's me!"

The tensions and difficulties in developing and maintaining new roles in relation to each other and the care of children clearly represent negative aspects of the development and utilisation of familial capital.

Given that all the midwives were women and their partners male, this provides an interesting juxtaposition of roles compared to the knowledge workers in the NSW Report (Firkin et al., 2002). The women in the latter group structured their NSW to allow them to care for their children and fulfil that primary role. Midwives also did this to a degree through the ability to alter the caseloads they were taking over time to reflect other circumstances in their lives. One of the interviewees had just moved into a caseloading role and to enable her, her young son and her husband to adjust she had opted for a smaller caseload which she would gradually increase. Similarly, over the years one of the more experienced midwives had coped by doing just this on an ongoing basis.

You need to work through your family issues first and sort that out. For me it was like balancing my caseload. I balanced my caseload not to take more, and more and more. I mean you could, you could just go up and up and up. I chose to balance it in the beginning between what allowed me more time with my family, but also I could meet the standard that I expected of myself, and the service that I expected to provide to women.

However, no matter how small caseloads were, the nature of the work always meant that midwives were on call and so still needed the support of partners. In contrast, none of the husbands of female knowledge workers in the NSW Report (ibid) had to assume the same degree of involvement that the partners and husbands of the midwives did.

Some interesting contrasts can also be made between the experiences of the independent midwives interviewed in the study and those of male and female entrepreneurs examined in an earlier phase of the LMD Research Project (Firkin, 2001a; Firkin et al., *in print*). In this latter group, self-employed men often relied on their wives or partners for various forms of support. Emotional support was prominent, as was the additional responsibilities that partners and wives often bore to make up for the inability of the self-employed person to be as actively involved in family life while they established and maintained a business. As well, men often relied on their wives or partners to carry out certain ancillary but vital functions in the business, such as doing the accounts, often without payment. Sometimes the income a wife or partner could generate in outside work while a new business was being started was very important. Interestingly, the women who ran their own businesses did not make the same demands on their partners, both in degree and nature. Certainly the financial support of husbands or partners as the primary income earners allowed them to start their businesses and then run them in a more low key fashion. In this respect they mirrored one of the midwives who was interviewed who noted that she had "never seen her income as essential" to the household. This different orientation seemed to explain their lower need for emotional support. It also needs to be considered in light of the fact that they often started and organised their business to accommodate the demands of family and so combine paid and unpaid work. Their partners were not involved in any ancillary fashion with the women's businesses.

Independent midwifery represents a case that lies somewhere between these two scenarios, thereby crossing gender lines. Like the other women's businesses, midwives' did not involve their partners and husbands in any ancillary fashion in the business. However, for the midwife to cope with and succeed in practice, she needed to have the emotional and practical support of a partner.¹⁹ While obviously true when children are involved, it begins with the relationship between the midwife and their husband/partner since both must cope with the demands that independent midwifery makes on the midwife's time and the unpredictability of this way of working. When children are involved, partners must be able and willing to care for children when their (mid)wives are called away or out and accept that disruptive element in their own relationship. The goodwill of the children is also needed. Although midwives did acknowledge and report adjusting their caseloads at various points in their lives to accommodate their personal and family circumstances, this reduces but does not eliminate call outs and the like, and the ongoing need for familial support.

The other members of the family who have only so far been indirectly referred to are the children. They, too, have to live with the demands of having a mother who is a caseloading midwife. For many, this is the only lifestyle they have known.

My little one was nine months old when I went into the job, so has known me doing nothing else but this, the other one was three and a half or four, so again he really doesn't know much different to what I am doing now.

Though I did not speak with any of the midwives' children, the interviewees reported that generally their children accepted these circumstances.

The kids resent sometimes the fact that they might want something, especially when they have been growing up, and I have had to say I can't go, or I can't do that today because I've got whatever, but they have just learnt to live with it, like all sorts of things in our lives.

Occasionally, though, there were mixed reactions. In one case, when directly asked by their mother, two siblings had very different reactions.²⁰ One just accepted it and had no real problems while the other hated the lifestyle and the disruptions and hassles that had resulted. Whether it was grudgingly, willingly or unknowingly given, the acceptance by children of this lifestyle was an essential ingredient to being able to work as an independent midwife.

5.5.2 *General Social Capital*

Bridging the familial domain of social capital with the broader network aspect, there are family in extended relationships and then close friends whose emotional support and practical help at times can also be critical.

I'm very lucky in that I have very good family support to help me care for my daughter and stuff like that so I am very lucky in that respect and I have got lots of really

¹⁹ While it is true that some midwives used partners to screen calls, because the partners did not actually engage in the business activity (give advice, make appointments etc), this is not considered an ancillary role.

²⁰ This questioning of the children, it should be noted, was not prompted by the research.

supportive people around me. If I didn't have that I think it would be a lot harder for me. I don't know that I would be doing it.

Close friends, it seems, come to understand (for the most part) the unpredictable nature of caseloading midwifery and integrate it into their relationship with the midwife and her family.

Midwives' wider social networks more generally also form part of their support networks. They can also be sources of work. Here the overlap between social and cultural capital becomes interesting. People in a midwife's social network may understand the cultural capital of midwifery and thus provide support and help – such as looking after children for instance. Some may share in that cultural capital – as opposed to simply knowing or understanding its content – meaning that these people might become clients, or at least become supporters/advocates in the larger socio-political context.

Similar distinctions within the professional network of midwifery, again based on the mediating effect of shared cultural capital, can also be made. Not all midwives adhere to a single cultural view – as is evident in the resistance experienced within the profession to independent midwives entering institutional settings (see Section 8.1). In terms of networks and social capital, this means that like any large group independent midwives will tend to selectively find support and help within a subset of their profession.

Like any professional and self-employed person, networks form an important resource for independent midwives. They provide professional support in practical and emotional ways and are a source of outside expertise. Networks are also necessary for successfully negotiating aspects of midwives' work and, importantly, can be sources of work. The collective or practice that midwives belong to forms the first network that they are part of and is a particularly important source of support. They are explored in more detail shortly. Beyond their immediate practice or collective midwives belong to groupings that service their needs in terms of claiming and reimbursements and that also draw the members together for educational purposes. The size of the professional group within New Zealand means that midwives know many others and so they form networks within this context, something fostered by the NZCOM as the professional body.

Midwives also have associations with various other health professionals. These may be practitioners they prefer to utilise, and who often reflect similar philosophical dispositions.

So we, we have relationships with GP's and with physios and with naturopaths and all of the other people that you might need, so you are able to refer easily.

This also applied to midwives use of specialists. Like others, this midwife also noted that they spent time and effort developing sound relationships with the staff of units that they delivered in. Associations with other health professionals might also be the source of referrals

Then you get obstetricians perhaps who will still refer to me ... Some doctors still refer because they just don't do any obstetrics whatsoever.

Social networks are also important as they provide a source of work, especially during the initial phases, but also at any stage.

A lot of it is down to word of mouth. ...It is word of mouth that is the best form of advertising.

The networking that occurs when you're a mother yourself, so you're a mother yourself within a community, so you it's a very good way to begin midwifery, that you're a mother of young children so you'll meet women at playcentre, Parents Centre, all of the things that you do and then you become identified as a midwife and so women who you meet within the community will choose you as a midwife and it seems to be, and it certainly how I began, and it seems very organic.

As one midwife found, when she moved to a new area to live and work, these social networks can be quite difficult and take some time to establish. For the others, the communities they lived in were often where they worked as well and so they could utilise these established relationships. Client networks also became established over time as women used the same midwife for subsequent births and they passed on the name of their midwife to family and friends.

Oh, so and so looked after my sister or wife. ...I've had a lot of sisters, three sisters, four sisters, I've had mothers and daughters, I've had aunts, best friends, cousins that type of thing. I had one family that has referred probably about 20 women to me in total, including having you know, 2 daughters, no 3 daughters come through, the mother had 2 kids with me, the aunty had one, I've had the sister-in-law, etc, etc so you do tend to get families.

Though the above example describes networks based on age cohorts and across generations, just relying on the former can have problems over the longer run. Given that she is happy to reduce her potential caseload to allow her to attend to other work responsibilities, this midwife is not too concerned by the problems she is encountering in this regard.

My clients have all had three or four babies and I've looked after them. They are stopping having their babies now.

This signals a possible negative outcome of becoming too reliant on too small a network of clients. None of the other midwives were so confined in their practice that they experienced such a problem.

5.5.3 *Collectives and Practices*

As the previous section shows, wider social capital emerges from various relations and connections that midwives develop over time. Within these, a much more intimate network must be separately acknowledged. This is the practice or collective that each of the midwives belonged to. Even for those engaged as employee caseload midwives a form of practice was central to their work. In her study of self-employed midwives, Guilliland (1998:108) reveals the importance of this relationship in the finding that "some 87 percent of midwives identified they had a formal partnership or co-operative arrangement with another midwife". Though their partnerships extended beyond just one other midwife into what I term collectives or practices, these partnerships were extremely important for the midwives who were interviewed. It is perhaps helpful to view the variations in practices and collectives by means of a continuum. At one end there are

practices that have facilities and are highly organised in terms of processes and policies. Members in these might pay rent for use of the facilities; some might actually be the owners of these!. The other end is occupied by collectives with no facilities and very loose or limited processes and policies.

No we're not, we are not actually a practice as such, there is nothing written down to say we're in practice, but we work in conjunction with each other and all our letterheads ... and our flyers list all of us as [a collective of] independent midwives but we are not affiliated by joint accounts or anything like that or have gone into business together, nothing like that.

In recounting the early days of independent practice, one interviewee recalled the inclination for midwives to work independently while, now, the tendency is for them to work in groups. This was borne out in the interviews with each independent midwife part of some form of practice or collective. Two motivations can be found for such a trend. On the one hand working alone can be extremely isolating and demanding, and so the opportunity to work with others allows for contact with, and the support of, other midwives. Secondly, there was a desire to establish a separate identity for midwifery once its practitioners were able to practise independently. Both business and philosophical motives prompted this position.

Most midwives who were working independently when we first started self-employment were renting space because they had picked up their clients from doctors, GP rooms. Most of them rented space from GPs. So that way you didn't have that separation when you put yourself in the marketplace. ... How do people know what a midwife is? ... The next strategy was, how do we market?

Consequently, this midwife pooled money with some others and purchased a facility to work out of. It gave them the separation and profile they were seeking but was only the beginning.

Collectives take a long time to actually get to the point where they are working, I don't think they work 100 percent, but you know 95 percent of the time.

In fact, the interviews revealed that collectives and practices were dynamic and evolving entities that demanded quite a lot from their members in various ways. They are intriguing groupings as each midwife occupies a dual position within them since membership of the practice or collective does not change their status as an independently self-employed practitioner.

You are an individual but you are still seen under an umbrella.

Each of these umbrellas represent a collective identity that begins with the more general midwifery philosophy and then takes on a unique constitution determined by its members that affects its form and organisation. Importantly, the fact that individual practitioners belong to a group means that the good and bad aspects of their practice become associated with the group.

While it is common to view groupings in terms of their business practices and the like, this does not appear to be of primary importance for midwives. Indeed most confessed to not having much interest in the business mechanics of the groups and they seemed to keep the machinery of their umbrella organisations to a minimum. Again, though, it is often a

reflection of the group. Intriguingly, on top of the guiding business and practical principles that one practice put in place, they also established an unusual basis for their group.

Our principles are around things like we are absolutely generous. So generosity was the number one principle that we also have a principle of saying yes. ... So if you're called by someone else, even though we have a partnership system, say your partner is away and you call another midwife, basically she will say yes to you. ... Sounds very simple now, but that was something that took quite a lot to actually get to.

While every practice would approach it differently, it seems from the interviews that generosity is a principle common to many groups and caseloading midwifery in general. Without it, independent practice would be even more demanding.

The common role for practices and collectives was, in various ways, to provide the members with support both in emotional and professional terms, and in a practical sense by providing cover for time-off. The former can be in an ongoing or informal basis, but all those interviewed reported that the members of their practices and collectives also met regularly. As to the latter, in various places in the report the issue of cover and its importance will be discussed. Groups provided this in various ways since all had the facility to provide it in an ad hoc fashion and more formally. The latter was organised to varying degrees. Some were highly organised – for instance by developing rosters, rotating support partners, insisting on compliance and so on. Others were much less organised – say with time-off available but sporadically used and people tending to cover for a few selected others within the larger group. The manner of organisation was also reflected in how payments were organised for births and care provided by a covering midwife for someone who was having some time-off. Most had come to the conclusion that precisely reimbursing a covering midwife made for difficult and meticulous accounting. Consequently those who were interviewed opted for one of two models. The first was based on half shares so that neither was disadvantaged – that is the midwife who missed the birth of a client they were caring for would still get some income from the event and the covering midwife would get some compensation for the work they did. This seemed to be more common amongst the interviewees. Secondly, midwives opted for the 'swings and roundabouts' approach where no money changed hands with the underpinning assumption being that what one midwife provided for their partner would at some point be returned given the nature of workflows and time-off.

Groups were characterised by in- and out-flows as midwives joined and left independent practice. Various reasons for these are canvassed in different contexts throughout this report. In one case geography was a major force in drawing a number of independent practitioners together. While the members condition the form of the group they belong too, it is also important to note that that form has positive or negative impacts on potential members. In later sections it will become evident that newly graduating midwives are increasingly interested in the structure and organisation of groups, especially in terms of time-off and the like, as part of their evaluation of groups they might join. From the other side, some principles for the introduction of new members might form part of the group's constitution. For instance one group decided that:

We would have some complete agreement about new members coming in and we would all have to be 100 percent wholehearted about it or with some consensus decision making. It would be very easy for people to leave and we would always make it very easy for midwives to leave our collective.

Recruiting for practices and collectives took place in various ways. Obviously midwives who were looking to move into an independent role approached groups but groups also offered positions in their practices and collectives to both new graduates or more experienced practitioners. New graduates could come to the notice of groups when they spent time with them as students. The relatively small size of the midwifery profession, which is even more pronounced within regions, means that midwives can develop some appreciation of how others practise – as individuals and collectives – and be aware of who is looking to move and which practices have openings. As one midwife noted, however, it is often hard to realistically know how another midwife practices and to judge how well they might fit in with a group and their philosophy. Having compatible people as part of the group is beneficial for obvious reasons. It is also important because it can be quite difficult to move people out and to do so can reflect badly on the group.

5.6 Economic Capital

Economic capital is taken to refer to financial assets of any form that are directly convertible into money (Bourdieu, 1986; Jary and Jary, 1995) and will be considered in two ways in relation to caseloading midwifery. Firstly, there is the economic capital required for setting oneself up in independent midwifery practice. This is quite small compared to other forms of self-employment and may, in part, be due to the fact that the business resides predominantly in the knowledge, skills and expertise of the practitioner. Thus, set up costs for purchasing equipment are minimal and the only other costs may be for renting space to work from. While some additional equipment may be necessary for home births, other births take place in fully equipped facilities provided via the public health care system. Membership of practices and collectives can provide members with much of what they might initially need. In addition to equipment and facilities, they also provide an established presence which serves as a source of clients and thus income.

The second way in which economic capital needs to be considered in relation to midwifery concerns income. Midwives are publicly funded for the care they provide and reimbursed according to a set schedule that is made up of a progressive system of payments for ante-natal, birth and post-natal care. Such funding arrangements have implications for midwives' income. For example, unlike other forms of self-employment, the midwife cannot negotiate the rate individually and directly with the funder or client, nor can they charge the client anything additional. The only way they can adjust their income (up and down) is to juggle the numbers of women they care for at any time, though this has flow on effects into their personal life.

A further major issue regarding income concerns the ability of midwives to support themselves during the initial period of self-employment. This is the result of the funding arrangements which underpin independent midwifery practice, and that are characterised by a system of progressive payments and delays in reimbursement.

It was a little bit difficult because also there is six weeks, there was six weeks before you got paid once you put your claim in, so and also you didn't get paid anything until they actually birthed.

As well, the bulk of the total payment is for care at the time of birth, which obviously occurs some months after care had been commenced. While having income difficulties during the start up phase of a business is true of any self-employed person and payment delays, for all manner of reasons, are characteristic of any contracting arrangement, the payment system for midwives accentuate these difficulties. Similarly, while midwives need to cope with this system throughout their self-employment, its effects can be felt most acutely at the outset as described by one midwife recalling the early period of her independent practice.

I think I did realise that it was going to be like that, but eventually you could see the light at the end of the tunnel, there was money there, but I just had to get there first, so I tried to just work my way around it and that's why I had to do the shifts at [the hospital].

A midwife who moved directly into an independent position had not really considered these issues.

I hadn't really thought about it. I was green. I just kind of, I don't know what I thought I was going to do. It was a pretty quick realisation that I didn't have any income and wasn't going to have for some months. So I went on to this special benefit that the government offers, a bit like the dole, but it was \$40 or \$50 a week which was good, and very gratefully accepted. ... So the contract that I was on meant that I was getting paid when women delivered, so for the first eight months of setting up the business I didn't have an income and luckily I had a partner who was earning enough that we just kind of scraped by really.

Others realised that income would be a problem for a time until they were established and so approached the problem in various ways. One midwife continued full-time in her hospital position as she built up her practice, winding the former down as she wound the latter up in her own time.

Another midwife who was in the process of moving into independent practice when interviewed was also establishing this by seeing private clients on her days off. Like any business, it takes time to build up clients in independent practice. A peculiarity of maternity care, however, is that in the early stages of pregnancy the midwife does not see them that often. Although, as already discussed, these factors in combination with the funding arrangements of the maternity system generate some income-related problems, they also allow some other compensatory employment.

I did really fully go into independent practice because when you start, you're only seeing the women monthly if their due, I think I started in about the February or March but the first women was due in July but most of them were due in September ... but you are only seeing them monthly so what you do between the rest of the time so that's when I was mainly full-time [at the hospital].

As the care demands increase it becomes more difficult to manage the balancing act. Though coping with these competing demands is difficult, the midwife who moved directly into independent care from her training clearly did not have the opportunity to manage her income with this approach.

5.7 Physical Capital

Physical capital is made up of the “tangible assets necessary for the operation of the business” (Greene and Brown, 1997) or, in other words, facilities and equipment. Like economic capital, very few physical capital demands are placed on those entering independent practice. A midwife who went directly from her training into independent practice makes this abundantly clear.

I turned up on my first day. I had no equipment, nothing.

The other midwives in her practice shared theirs with her until she was in a position to purchase her own. As is apparent from the preceding section, the income difficulties she experienced for a time meant that this expenditure had to wait. Even so, she went on to note that the outlay was not large.

Essentially, independent midwives require some equipment and a place to see women. Collectives and practices may give access to both. They or their members may have the necessary tools of the trade which they share with newcomers, either on a long term basis or until they have purchased their own. Groups can also provide premises and rooms, or have arrangements in place to hire or rent them. And of course, midwives can use their own homes to see clients though some concerns regarding this were raised in the interviews (see Section 8.2.3). A vehicle is an essential tool of the trade. Even some of the employee caseloading midwives used their own cars for which they were reimbursed). Similarly, the cellphone, a ubiquitous feature of the caseloading midwifery lifestyle, is indispensable. Some used a computer to do paperwork and keep accounts. Computers and cars turned to use in self-employment might come from the existing physical capital that a person possessed prior to moving into a caseloading role.

Finally, the physical capital demands are reduced by the fact that the business of birth often occurs in facilities provided and maintained by others and funded through the public health purse. Interestingly, the midwife does not have to rent or pay for these. That said, some births take place in people’s homes and those midwives who do home births require additional equipment that will demand some financial outlay for individuals or a practice.

5.8 Conversion

Though not a form of capital, the notion of convertibility is an integral component of the entrepreneurial capital model and so needs some brief explanation. Quite simply, this notion establishes that each form of capital can be transformed from and into other forms of capital. They can also be held and used in concert. While some instances of conversion may be fairly straightforward, others can occur across considerable periods of time and be the outcome of a complex, multifarious and contingent process.

In the broadest terms, the obvious direction and end product of conversion in this context, as with other self-employment, is towards turning the various forms of capital and their component parts to entrepreneurial advantage and thus generate an income from independent midwifery. While the process of conversion can be seen operating in many places in the preceding discussions on various forms of capital, particularly as other forms

of capital are transformed into economic benefit, I will offer some specific examples to illustrate this more explicitly. In a general sense, shared cultural capital provides the basis for the business of independent midwifery and can thus be transformed into financial gain. In a more specific example, we see the conversion of social capital – via intimate networks of midwives in the shape of collectives and practices already imbued with cultural capital since they share the cultural capital of midwifery – into economic capital. For instance, the new independent midwife may benefit from what the practice or collective already has in place or available and thus save money on expenditure. They might also benefit from the fact that an established group attracts clients.

Mentoring provides some interesting examples of how the conversion process can operate in different ways since it can be premised on various arrangements. For instance there may be a direct payment for mentoring. Alternatively, as one interviewee described it, a mentor might reduce their workload to half the number of clients they would normally take thus allowing more time and availability for the mentoring role. The new midwife would take a full caseload but would not receive a full income as they would reimburse their mentor for their loss of income in taking on such a role. This then acts as a form of payment for mentoring. Either circumstance demonstrate an economic investment being made to enhance one's human capital so that independent practice becomes viable. In the instances of mentoring discussed in the interviews, the mentoring relationship grew out of social capital heavily infused with cultural capital. Thus, the mentor is known to the new midwife and conducts this process for the benefit of the individual and the profession as a whole. The end product is the same – an enhancement of human capital which can be transformed to economic advantage – but the process is more nuanced.

5.9 Summary

The application of the model of entrepreneurial capital to caseloading midwifery has had three broad outcomes. Firstly, it has provided a detailed account of the mix of entrepreneurial capital unique to independent midwifery – that is, the resources that have entrepreneurial value to a midwife and that she needs to possess, acquire or convert in order to take on this role. How entrepreneurial capital can vary over time and circumstance has also been considered. Some of the key points of the discussion can now be summarised.

Human capital was important in various ways. Over and above their registration, the midwives who were interviewed showed an ongoing commitment to education and training and regular formal reviews of their practice. As well as certain physical attributes – such as stamina – other characteristics beneficial for this way of working and similar to those outlined in the earlier NSW report (Firkin et al., 2002) were identified from the interviews. Mentoring serves as a very specific way that midwives augment the human capital of new graduates so as to allow them to directly enter a caseloading role. The view that not all new graduates may be suited to entering directly into a caseloading role might be read as highlighting the complex human capital needs for this. The cultural capital of midwifery emerges as a very distinctive and extremely important feature of caseloading midwifery. It is constituted by the notions of partnership and its associated philosophy of care, which serve as foundations and guiding principles for the 'business' midwives are

in. Importantly, it is shared by consumers and professionals alike and operates at the individual and socio-political level. As partners, midwives and pregnant women shape the care that is given and received on both a day-to-day basis and in wider terms. Since it is unlikely that cultural capital would be seen operating to such an extent in many entrepreneurial situations the example of midwifery offers a very rich albeit unusual case. In various forms, social capital proved to be extremely important for caseloading midwives. Familial social capital, especially in terms of the supportive attitudes and activities of a partner or husband, is vital for allowing the midwife to carry out her work. This is particularly true when there are children. The collectives and practices that midwives belonged to were a second major source of various forms of support. All sorts of other networks – for instance, socially based, as well as those within and outside the profession or health sector – were also important in numerous ways. Though of lesser overall importance than in other businesses, economic capital is interesting given the funding arrangements for midwives and the impacts this has on them. Of least importance was physical capital with collectives and practices often providing much of what a midwife needed. Their existing possessions (e.g. car, phone and home) could also be easily re-deployed for these purposes. Finally, some examples of the way that different forms of capital were converted into other forms were given. These include, for instance, how social and cultural capital can be converted to economic benefit.

A second outcome of combining the model of entrepreneurial capital with a study of midwifery has been to very effectively illustrate what that model can bring into relief when analysing any particular form of entrepreneurial activity. In the case of midwifery, the model has shown the importance of human, cultural and social capital over financial and physical resources. The latter pairing are more often seen as crucial factors in self-employment. Given that most midwives are women, this approach has also allowed the influence of gender to be easily explored alongside the examination of resources. Finally, exploring midwifery in terms of entrepreneurial capital has added to the model in several ways. This includes the addition of a corporeal dimension to the category of human capital. As well, midwifery has provided a rich discussion of the idea of cultural capital as developed from the work of Bourdieu in the model.

6. The Transition into Caseloading Midwifery and Beyond

6.1 The Transition into Caseloading Midwifery

In the earlier NSW report (Firkin et al., 2002), the transition into alternative working arrangements was considered within the framework of push or pull factors (Bururu, 1998). Push factors are those associated with poor employment alternatives, often the result of weak labour markets, and mean that people are forced into such a move. Other factors, such as personal circumstances, may also exercise a push towards this type of work. By contrast, pull factors are concerned with the attractiveness of the alternative. Of course, it is possible to conceive of both push and pull factors working in combination to promote change. While it did not seem that any of the midwives interviewed were pushed into caseloading roles, though some sense of this can be ascertained, it is possible to interpret their decisions from the perspective of pull factors. These are discussed more fully shortly.

Restricting the discussion to the traditional parameters of push and pull factors, however, does not do justice to the complex nature of the evolution of caseloading midwifery. Rather a much broader approach is needed. It begins with an acknowledgement of the prominence of the 1990 legislative changes and the surrounding socio-political struggles. Independent midwifery emerged immediately from these changes while caseloading midwifery within institutions took a little longer to develop and can be seen as a result of the former shift which set up consumer expectations.

It is important as part of a broader approach to also acknowledge the different experiences of midwives making the transition into caseloading midwifery. The section examining the make-up of the sample split the group of interviewees into two broad categories, depending on when they made their transition relative to 1990 – that is, as either early or later transitions. At this point the early transitions are further divided among two sub-groups. There are, firstly, those midwives already working in a domiciliary fashion and who simply took the opportunities to expand and enhance their work. That said, these changes still represented a very significant shift, as:

from the late 70's to the 80's there were about 12 domiciliary midwives in Auckland, in New Zealand and we worked under the 1934 Social Services Act which meant that you had to have a doctor oversee the birth ... A doctor would just maybe give his name to the birth. It was still very much a midwifery one, midwifery led. ...So from being one of a group of 12 there are now in Auckland nearly 400 midwives in independent practice and I think that when I first started working there were 5 of us so it has been interesting.

The second type of early transition involved hospital based midwives moving into independent practice. While existing domiciliary midwives may have used the legislative changes as opportunities to evolve their existing practice, the moves by hospital based midwives show a necessarily more deliberate and active twin dynamic. One aspect of this was the entry into self-employment. The other was concerned with efforts to establish a

very different way of working for midwives. As is evident in much of the report new phases of both aspects are still emerging.

Differentiating between the two types of pioneer independent midwives – those who evolved from domiciliary roles and those who transitioned from hospital employees – is important not only for emphasising their slightly different experiences of this initial period of change but also because it allows another, more prickly, issue to be acknowledged. As midwives worked at various ways to organise the delivery of independent midwifery care they came to realise that those entering the business were competing with the existing but evolving domiciliary midwives. It took some time to develop unitary rather than divisive approaches.

Outside midwifery, both groups of pioneers were confronted with resistance from the medical profession to their efforts to establish independent midwifery and thus offer competition to the medical provision of maternity care. This is really just signalled here as another factor in the early transitions as it has been more fully dealt with earlier in the report (see Chapter Four). Such resistance to independent midwifery was evident in various ways (and continues to exist). For instance, difficulties in access to facilities initially limited full independent practice.

Taking various factors together – that is, people's background, circumstances and attitudes along with the wider socio-political context – generates a range of very individualised transitions into independent practice. These are characterised by the different ways and timeframes that people made the transition into a caseloading role. Some opted to move completely from one to the other. Others chose a staggered or delayed approach. For example, one of those interviewed combined part-time work in a hospital with some shared care of pregnant women with GPs before committing fully to independent midwifery once midwives were accorded access to hospital facilities. She continued to provide shared care until recognising that the very different approaches of medicine and midwifery made this extremely difficult for her and the women she shared the care of. At the same time, demand for fully independent midwifery care was escalating and so greater opportunities were possible if she made the full transition.

Such a growth in demand was the result of women coming to understand and want care during pregnancy and birth consistent with midwifery philosophy, itself the result of the considerable efforts of the pioneer midwives (and the consumer movement) to not only establish their own practices but to consolidate midwifery as a whole. For instance, one midwife noted that in those early days,

most midwives who were working independently when we first started self-employment were renting space because they had picked up their clients from doctors, GP rooms. Most of them rented space from GPs.

However, this meant that midwives were not differentiated from doctors who up until then had been the primary providers of maternity care. As recounted by one of those interviewed, the process whereby midwifery became almost invisible is extremely important to understanding what earlier midwives breaking into independent practice had to overcome. As she tells it, even when women went

into a hospital and there were midwives, because it was in a hospital, most of the grandmothers generation referred to them as nurses, so the label midwife still wasn't put on there. "Oh the nurse looked after me" they would say. ...When the law did change back in 1940 so GPs could access payments for providing maternity services, that was when GPs entered it. That next generation of women, they went to the doctor and then the doctor started to turn up at the birth and they would say, "Oh yes there was a nurse that looked after me". And if you asked them and really get to it, it was a midwife, and it was a midwife that caught the baby nine times out of ten – the doctor never arrived. But we got lost, we got hidden, we have always been there, we are the second oldest profession. But we have been desocialised, so how do we win our market?

Not unexpectedly it was also a period of deskilling, as has been discussed elsewhere in the report, with both the medicalisation of childbirth and the nursification of midwifery having considerable negative effects on midwifery as philosophy and practice. So, not only did midwives have to re-establish their profession – their philosophical base as well as specialist expertise and knowledge – they also had to educate the public about this. In addition they had to cope with and overcome the resistance of other professional groups, in particular doctors – who were a powerful community – and nurses. As part of establishing a profile that would achieve these objectives some midwives joined together with others to work. These groups took a variety of shapes and forms. Combining resources enabled midwives to have their own facilities, relationships of support, and to increase their profile. Of course not everyone necessarily approached the process in this manner. However, the development of practices or collectives of many forms (see Section 5.5.3) now appears to be an increasingly prominent and central part of independent midwifery according to those interviewed.

There are both similarities and differences – both in subtle and more marked ways – in the experiences of the group who made later transitions, and the issues they confronted, as compared to the pioneers. A core similarity is that both early and late transitions were characterised by the attraction that caseloading midwifery offers to better practice midwifery according to what I have earlier called the cultural capital of midwifery. As such, midwives are pulled into caseloading roles in order to meet the desire to more closely practice a particular philosophical disposition to maternity care. While interviewees from both groups commonly reported the degree of push provided by hospital settings becoming increasingly untenable places to work, this was initially based on these philosophic considerations – wanting to provide a particular form of care – but for the later movers was augmented by the nature of these environments – understaffed, stressful and so on. This was equally true of those moving into employee caseloading positions.

For the later movers, the socio-political context also remained an issue. However, with the major obstacles overcome, this most often took the form of degrees of resistance within and outside the professions as well as periods of intense scrutiny of midwifery, and occasional challenges to any increased autonomy. Building up an image and understanding of midwifery was part of what the early independent midwives were involved in not only from a philosophical position but also for the practical purposes of getting work. Thus, for the latter purpose they might have visited doctor's surgeries, trusts providing social and medical services, and any organisations where women attended and where midwives were welcome. While the later movers enjoyed the more general fruits of

these efforts, they still had to build up an individual client basis. Obviously, over time, their reputation, repeat clientele, and being known by other midwives who passed on referrals were key factors. Their involvement in the community and extended family could also provide clients as it became known that they were midwives. This is one source that was useful for some of those who were starting out. Otherwise they relied on the generosity of the existing midwives in the practices and collectives they were part of who passed on clients they could not see because of existing commitments. Being part of a collective also provided a marketing presence for attracting clients.

Unlike the pioneers, those making the transition later were able to move into established groups, rather than actually having to form practices and collectives. That said, the possibility of forming new groupings still exists. In seeking to join a practice or collective not only are midwives interested in the overall philosophy but also in what arrangements they have for time-off and support. A midwife who was about to enter independent midwifery nicely sums up what she was looking for in a practice.

Midwives that are reliable, that are well known, that have got a good name ... and the fact that they got a sort of structure that works and was fairly well established in the area of Auckland that they're working in.

She also observed that joining an established practice had obvious advantages over setting up alone.

Just like having rent to pay and things like that and other overheads that will be required I felt that it was probably more beneficial to do that than to go out on my own and try and set up a practice.

Collectives seem useful in providing premises, equipment and, as noted above, a beginning source of clients. They are also sources of support for independent practice, and can provide advice on running a business or being self-employed (for instance, getting appropriately skilled support people like accountants). While midwives who were spoken to considered themselves at various points along a continuum of business skills and acumen, independent midwives, if they are to make a living, have to adopt some business practises or perhaps came to rely on a member of their collective for these. Thus, while some admitted to very little interest in or attention to such matters, others were actively engaged in what they saw as a business approach. Regardless of their approach to the business side of independent midwifery, all still emphasised being midwives first and foremost.

The practice of mentoring newly qualified midwives opens up the possibility of independent practice early in a career rather than as an option only for more senior midwives. It may be that midwives become independent practitioners as soon as they register and never practise any other way or work in institutions. Though she was unsure whether she would continue in independent practice once she had a family, mentoring had allowed one of those interviewed to work this way immediately after qualifying.

Other experiences of the same midwife are also worth noting. She clearly demonstrates how difficult it is to imagine this very different way of working.

I had no idea really. ... I really had no idea, and I don't think you can. I think as a student you get, not necessarily protected, but you don't see the bigger picture until you

are the one that is responsible for the bigger picture. I just really had no idea of what I was doing, getting myself in for, asking others to do for me. I learnt pretty quickly what it was all about. It was quite different to my expectations and I don't think I really have many expectations. I knew midwifery for what I had experienced as a student, which was something very different in reality.

Even a year as a core midwife could only provide so much preparation as the next midwife's comments reveal.

Yeah I had some idea, but not compared to what it is actually like when you get out there and practice.

Thus, experienced midwives might have a better idea of what independent midwifery is going to be like, though one of those interviewed noted that no-one can really imagine the demands and responsibilities that are involved. As well, personal circumstances can be very influential in shaping the transition. One midwife, though she had been working as a midwife for about eight years up to the point of transition, found that having two small children made for a difficult adjustment. Similarly, being a single parent provided significant challenges for another midwife during the transition. She found that the support of colleagues often didn't quite match the assurances that had been given prior.

Only one midwife expressed the view that she hadn't really anticipated a move into independent practice. After having a child she thought that any return to work would probably be in a hospital setting part-time. However, encouragement from another midwife who was already self-employed saw her eventually take the plunge. She was able to look after that midwife's clients while she was away and slowly build up her own client base, a situation that was very helpful as she coped with returning to work and combining paid and unpaid work. Her case also shows less planning in respect of the move than others though, as is obvious in various parts of this section, the nature and degree of planning varied on a case-by-case basis. The remarks of the newly qualified midwife who entered independent midwifery directly (as quoted earlier) show very limited planning in respect of the transition. This case is also interesting in that it introduces a unique aspect of the transition to independent midwifery for a newly qualified midwife, that of mentoring (see Section 5.3.2).

Before considering the likelihood of those who were interviewed making some sort of transition out of a caseloading role, it is helpful to consider the transition into a caseloading role as an employee. Similar motivations as for those who became self-employed prompted this move. There was of course the desire to more closely follow the philosophical basis of midwifery. As well there was dissatisfaction with the institutional situation and approach as these two sets of comments illustrate.

Working in the hospital these days is just crap, it is disgusting. They are so short-staffed, they are so unsupported, the pay is ridiculous.

Mainly I wanted to do it because I didn't like the disjointed task-oriented way of working in the postnatal/antenatal wards ... As a midwife and you'd end up doing a lot of nursing tasks ... At the end of the day what you are there for is to try and help the woman breast-feed and bond with the baby. And you'd go home and some days I would sit down and I'd work out on my hand how often, how long I'd actually done breast-feeding help for x number of women I was looking after in something like 5 minutes a day.

Thus, although they remained employees within an institution they worked in very different ways compared to traditional core midwifery roles. The attraction of an employee role over self-employment lay in being able to avoid various other challenges. They did not have to find clients, exist without an income for a time, nor worry over managing the business side of things. Thus, it provided some middle ground for those who did not want or did not feel they could cope with these additional demands, but allowed them the opportunity for independent-style practice and the inherent challenges and benefits (discussed more fully in Section 6.3). Interestingly, new or recently qualified midwives are not considered for the employee-based caseloading services where midwives who were interviewed worked, despite the cautious support from the employed caseloading midwives to such an approach and to the idea that some sort of mentoring scheme could be provided within this context. It also stands in stark contrast to the provision of mentoring for new graduates in independent settings.

6.2 The Return Transition

As was done in the NSW Report on knowledge workers (Firkin et al., 2002), the midwives were asked about the possibility of a return transition. That is, what was the likelihood that they would move out of caseloading midwifery either by returning to a core midwifery role or leaving midwifery all together. One midwife had already done the former. Following the break up of her marriage she moved from a caseloading to core position as she could not manage the on-call component. Interestingly she felt that she was probably due a break given the stress and demands of the job. That said, after a couple of years away she now would like to return to a caseloading position. To do so, however, would require that she develop some arrangements for the care of her children overnight and at weekends or if called away.

Another of the employed caseloading midwives was about to transition to self-employment. She had made what could be seen as a gradual move over many years into what she considered her ultimate goal of independent midwifery. Various personal circumstances had prevented her from doing this until now. Her decision was based on a desire to face new challenges – for instance, in her practice and in having to learn how to run a business – and because she was unhappy with the organisation and structure of the caseloading system she worked in as an employee. In order to facilitate the transition she has chosen between positions that she had been offered, carefully looking at what practices could offer in philosophical, emotional and practical terms. To ease the financial strain she had begun to see clients in her own time.

Apart from one of the midwives who had only had a caseloading role for a few months, all the others had been in their caseloading position for at least two years. For a couple who had many years experience there seemed little if any chance they would change from midwifery or from independent midwifery specifically. In comparison, another very experienced midwife talked of looking for other options both within and outside the profession, though she had few specific plans or ideas and certainly would not simply move back into a hospital after all these years of working independently. She was driven in this regard by the demands of being on-call. A similar drive was in the mind of a

younger but still quite experienced independent midwife and she too was considering a range of options.

I'm not going to do this forever and a day. I'm still reasonably young enough that I think that I've got at least 5 years plus to get to 50 and I don't want to be when I hit 50 doing this job. I don't want to be getting out of bed at 3 o'clock in the morning. So now I'm planning what am I going to do and what are my options out there. ...Teaching is an option I've got ... I might decide to do something completely different. I might become a real estate agent, I don't know...

Like the other midwife considering a change, she had transitioned into independent midwifery with two young children. Managing both children and a caseloading role were circumstances that the younger midwives thought might prompt a change of work-style. One, who was an employee caseloading midwife, realised that self-employment would be too demanding at that time. Like the others, she too was reluctant to return to hospital work but it remained an option. Thus, being in an employee position offered a compromise. She certainly felt that the base she was establishing now would serve her well at some point in the future when she had a family. As another younger midwife observed there were many possibilities within midwifery.

I'm not ruling out working in a hospital, although I don't think I would be as happy there, or as satisfied. But it might be a necessity. I don't think, even if you were taking on one or two clients a month as opposed to say the four or five that seems to be the general number, you are still on call. You don't know when women are going to have their babies. The demands are just as high whether you are looking after one or five. In terms of looking after a little wee baby, I just think that somebody needs to be there with it, one of its parents. So I hope that our financial situation is one that allows at least one of us to be home, and for us both to be doing work that we enjoy. And for me at the moment that is independent midwifery. Lots of midwives try to do it with families but it doesn't always work. The good thing about this job is that there are lots of different avenues you can go down. There is postnatal stuff, there is doing locum work, there's the hospital, there is things like antenatal classes, places where people can go after they have had babies to help with breastfeeding, establish patterns, there is just such a vast number of areas that you can get involved in. So that is nice.

Regardless of the options they might choose to manage personal circumstances with paid employment, there was always the sense among these younger midwives that caseloading midwifery would be the way they preferred to practice.

Mixed opinions, admittedly of a personal nature, were offered about the flows associated with caseloading midwifery; that is, the movements into and out of these sorts of roles. Some thought that, while many midwives moved from core roles into some form of caseloading work, there was little movement the other way, from caseloading into core roles. Certainly those of many years experience who were interviewed had not returned at any stage to a core role. Others thought that there was more movement both ways and the comments above indicate that some people would tailor their work, regardless of its nature, to their personal circumstances. This greater fluidity may be another feature of the contemporary midwifery labour market. As one interviewee observed:

Often students say to me I've got to decide what I'm going to do, be an independent or hospital midwife. I say you actually don't have to decide, remember its just a job, you don't have to sign up for life to be an independent midwife and I think that's quite healthy, because as I said before it suits different people and different times in your life.

Some interesting trends regarding flows into caseloading midwifery can be discerned from available data sets. Research by Pairman and Massey (2001) of a small group of graduates from two direct entry midwifery training programmes shows a trend towards entering caseloading roles as people progress in their careers. Such a trend means that not all newly qualified midwives are entering caseloading roles initially. Of the group studied by Pairman and Massey (2001), in terms of their first midwifery positions around 43 percent went directly from their training into a caseloading role while the others went into core midwifery positions. These percentages were reversed when current positions were considered. Thus, while many newly qualified midwives went into and remained in core positions thereby gaining experience in the secondary maternity service, some of these having gained such experience then moved into caseloading roles. While showing net flows, what such aggregate figures hide, of course, are the precise number who moved in each direction. Thus, we are unable to know, for instance, how many (if any) midwives may have moved out of a caseloading role into a core role. Nor do we have any information on the movements internal to the category of caseloading midwife which incorporates both hospital-based employee schemes and self-employment.

As Pairman and Massey (2001) studied midwives who had trained under the direct entry scheme, their data can be considered with data presented earlier (Table 3, page 23). Pairman and Massey (2001:18) found that 71.6 percent of their respondents intended to practise caseloading midwifery in the future: “Those already working this way were likely to continue and those who weren’t were significantly likely to state that they intended to caseload in the future”. The earlier data shows that, regarding employment types for different groups of midwives, direct entry midwives are more likely to be in a caseloading role than midwives more generally. Thus, a trend towards caseloading forms of practice is reinforced. As noted earlier, for direct entry midwives, caseloading is becoming a standard form of work if proportions are used as a measure.

Pairman and Massey (2001) have also researched factors which serve as influences on movement within midwifery roles for a group of direct entry midwifery graduates. Their data, presented in Tables 4 and 5 provide an interesting adjunct to the discussion. Tables 4 presents data on the influences on choices of original positions after qualifying and the current position (noting that they may not always be different) while Table 5 lays out the various reasons given for choosing different practice roles in their original positions. They provide an array of factors that influence such decisions and transitions. While their list is made up of more factors than can be discerned from this research, many of them do mirror those described by interviewees in the study and discussed in preceding parts of the current section or in the report more generally. The influence of practice style on the choice of a caseloading role is undeniably strong, both for the group of midwives interviewed in this research and those surveyed by Pairman and Massey (2001).

A final point concerns the mention, in a quote from an interviewee reproduced earlier, of not wanting to be an independent midwife “when I’m 50”. Another more experienced midwife noted that doing this type of work – with its inherent on-call demands – got harder as she got older. Such comments or experiences raise an interesting issue when

combined with data from the New Zealand Health Information Service (2000, cited in Pairman and Massey, 2001: 19) showing that over 72 percent of midwives working in New Zealand are over 40 years of age. Such an ageing midwifery population has implications for the midwifery workforce generally and especially when considered alongside comments that suggest that the demands of caseloading, and independent midwifery in particular, become harder to cope with over time.

Table 4
Influences on choice of first or current positions for various sub-groups (by percentages)

<i>Reason</i>	<i>Position</i> <i>Sub-group</i>	First Position All cases %	First Position Those with more than one position %	Current Position Those with more than one position %	Current position Those whose current position is the same as their first position %
Practice style		31.94	26.67	33.33	35.35
Compromise/Expedience		12.17	17.14	6.67	7.07
Family		10.27	6.67	12.38	14.14
Financial		10.27	16.19	8.57	6.06
Geographical		9.37	7.62	12.38	7.07
Professional development		7.59	11.43	10.48	6.06
Supportive work environment		6.00	1.9	6.67	9.09
Conditions of employment		5.84	4.76	6.67	9.09
Orientation to independent practice		4.18	2.86	0.95	6.06
Experience		1.14	2.86	0.00	0.00
Travel		1.14	1.9	1.9	0.00

Table 5
Reasons given for choosing particular roles as first positions (by percentage)

<i>Reason</i>	<i>First Position</i>	Core Midwife %	Employee Caseloading Midwife %	Self-employed Caseloading Midwife %
Mirrored my preferred practice style		3.70	33.30	44.40
Allowed me to work regular hours		48.15	N/A	N/A
I wanted to work in a hospital		48.15	N/A	N/A
I wanted to work as an independent midwife		N/A ¹	66.60	55.56

Notes: 1 – Answer not used in this category

Source

Adapted from Pairman and Massey (2001: 19-20) Figures 3, 4 and 5.

6.3 The Advantages and Disadvantages of Working as a Caseloading Midwife

By way of drawing the discussion on the transition into caseloading midwifery to a close, it seems appropriate to consider the advantages and disadvantages of working as a caseloading midwife generally, and as a self-employed midwife more specifically. It may have been just as reasonable to place them in the next section given that the structure and organisation of caseloading midwifery is always in tension with and affected by certain positive and negative factors which produce both benefits and drawbacks. However, the arbitrary placement of this discussion in relation to the transition seems equally appropriate since the consideration of advantages and disadvantages is likely to have played a part in any decision to take up a caseloading role and remain in it. Such factors may also play a part in the evaluation of any return transition.

6.3.1 Advantages

Prominent among the advantages of working as a caseloading midwife was the inherent flexibility of such a role. Thus, while such work had certain negative characteristics these were offset, to a degree, by the midwife being able to manage many aspects of workflows so as to fit in with other aspects of her life. This could occur on an immediate basis through the scheduling of appointments for instance.

I actually have more time to myself, my time is mine to organise, I have the use of this room and we have another clinic ... I have two clinics here a week and one [there] so my time is mine to do with what I want. If I need to have a quiet afternoon because I have got commitments elsewhere I can do that. That is a real advantage for me as well.

Such flexibility was true, even for those who were employees.

Flexibility can also be on a longer term basis through workload management, that is how many women were cared for in any time period. Though she took what is considered a full-time caseload by the NZCOM, this midwife found it manageable in relation to the other parts of her life.

I've always looked at it as a part-time job. I've got other jobs that I do just as much as I do this and they just tend to coincide with each other. Because I don't, you know I'm still a mother, I'm still a housewife, horrible word housewife, I'm still a wife etc, etc. You've still got friends, you've got other things to do. ...I can still go and watch my kids play rugby on the weekend, I'm manager for one of their teams, we do martial arts three times a week, I still do that and its very rare that I miss those. I have a lifestyle that I go out and do whatever I want to within reason.

The degree of flexibility, then, can be tied to workload. While caseloads determine income, a balance needs to be achieved.

It all depends upon how many women you take. If you take four women your job is going to be a lot more flexible than if you take eight.

Associated with the issue of flexibility were the senses of freedom, control and autonomy that caseloading midwives had over how they worked. These factors were also prominent among the knowledge-work contractors interviewed in earlier research (Firkin et al., 2002). Like caseloading midwives they especially prized having flexibility over the management of time, particularly for the opportunities it allowed to better and more

creatively integrate paid work and home life (Firkin et al., 2002:58). Though the work of caseloading midwives was also seen as challenging, diverse and intense this was viewed positively, as enriching. A similar evaluation of contracting was made by the knowledge-workers (Firkin et al., 2002). For some midwives, such positive reframing extended to how the necessary transparency of independent practice was viewed.

Working in this way as part of a group you can't hide out so your practice is very transparent. You get your, your practice gets observed, so we see that as an absolute benefit.

A very important advantage of working as a caseloading midwife was that it allowed the full expression of midwifery's philosophy, what I have previously termed the cultural capital of midwifery.

Providing continuity in care in whatever form that might be. That is the ideal midwifery philosophy throughout New Zealand.

While not every midwife will be able or want to completely adhere to that philosophy, it is the ideal and the midwives who were interviewed were strong advocates of such a position. They found it an important and positive part of their work to be able to provide care in this manner.

To do all aspects of care and feel confident that you could provide care that was really good.

Being able to have continuity and get to know people and do what I am doing now is where I would far rather be, it makes my job a lot easier for me.

Alongside continuity of care, a client-centred approach is part of midwifery philosophy – allowing the midwife to connect more intimately with the women and families she cares for – as is viewing childbirth as a normal rather than illness-based experience. Being able to practice according to such a philosophy created a further benefit or advantage for working this way – caseloading midwifery work was very commonly described as an extremely satisfying way of working for those interviewed, on both a personal and professional level.

In addition to such benefits, a couple of self-employed midwives made some interesting observations about the advantages of no longer working in the traditional hospital environment.

I chose to work twelve hour shifts when I worked in the delivery unit so I worked full-time ... I worked three twelve hour shifts a week. That was set so it was usually week about, seven to seven in the morning and then the next week I would do seven till seven at night. I actually find what I am doing now is far less taxing on my time and physically my tiredness. Even though I am on call for my women which means they could deliver their babies and need me at any stage of the day or night and my phone is always on, actually not having to go and have set days where I am working all night I am finding a lot easier so that is a real advantage for me. ...working where I worked I speak basically from that experience of working in very, very short-staffed circumstances, incredibly high stress, very low staff morale, so there were lots of other stresses and factors that made my working environment and my working time there a lot more difficult. Working how I am now is a lot easier and a lot less stressful for me.

I was a nurse for six years [so] I've done my fair share of nights. I mean I think one good thing like we all hate nights, all of us, everyone hates nights. The good thing about independent practice, you don't know when you're going to get called out in the night and that's the best thing. Its much easier to get a phone call and get out of bed and go, than lie there thinking oh no I've got to get up at three in the morning, oh no I can't sleep.

You know, if you know that that's happening its much more difficult to deal with than if you know you have to get up and go, that's it done.

While employee caseloading midwives remained part of hospitals, their way of working was so radically different and their degree of independence so marked that they too felt the benefits of no longer being so closely a part of traditional institutional structures and practices.

Though there was some dissatisfaction about the static rates of reimbursement over many years, there was still a sense that midwives could earn a reasonable income. For caseloading midwives working as an employee, the benefit of a stable income without the fluctuations and delays inherent in self-employment were a definite advantage. Regular scheduled time-off was also seen as an advantage of being an employee, though many practices had or were working towards similar arrangements. Being able to practise more in keeping with midwifery's philosophical position but not having to cope with the demands of becoming and being self-employed were also seen as advantageous by employed caseloading midwives.

6.3.2 *Disadvantages*

In the earlier research on knowledge-work contractors the single most prominent disadvantage of contracting or self-employment was the uncertainty associated with this way of working, most particularly in relation to the unsettled and unpredictable nature of workflows (Firkin et al., 2002:62). Although some sense of uncertainty was evident for those entering independent midwifery as they built a caseload, for midwives who had established practices there did not seem to be any problem with getting sufficient work. Indeed the opposite appeared to be the case.

For independent midwives the most commonly identified disadvantage was the negative effect on families, a symptom of the highly intrusive nature of this work. The impact on families is felt in terms of relationships and children. In respect of the former, one midwife observed that,

There is quite a lot of fall out in relationships and marriages.

She observed that research had found that the relationships of around half of those in their final year of study were affected by their choice of work. This was especially true of those in less established relationships. It was because caseloading midwifery demands so much of the midwife that it requires different things of a partner and a relationship.

If I am looking in and I am seeing the pressure, it is how the husband adjusts ...it usually hits them in the second year. The first year it seems fine, they are supporting their wife into practice and it is novel and its new, and then the reality hits on how it affects their lifestyle.

More detailed discussions in relation to the roles played by partners, and the impacts on them, are undertaken in Section 5.5.1 and, to a lesser degree, in Section 8.4.

Children, too, are affected by having independent midwives for mothers. Wherever possible, midwives recognised the significance of events for children and the importance of their presence. Consequently, these were often treated as times worthy of special attention.

What we've all noticed, the 8 of us that work together, is that things around our children are quite critical and that things like children's performances, children's events that those are things and that children's birthdays are things that we would always prioritise and take time-off for and most women were mothers themselves also understand that.

However, despite their best efforts it was not uncommon to hear midwives say that they had missed some of their children's activities and events – school, sport and other pursuits – over time. Some felt that they had managed things reasonably well despite the demands of their work. One midwife recalled that even catching babies on Christmas Day hadn't been a total disaster for the family.

They don't care as long as the food there and the presents are there and I'm there for some of the day. Generally what has happened is that it has worked out really well. You know I've been there to cook the dinner, go out do the delivery, come home and sit down for the meal, because they're all sitting down kinda thing. So its worked out really well. things like.

Even though things generally worked out, it is fair to say that over time the demands of such a job can take their toll.

It is perhaps appropriate at this point to note how two children, themselves, viewed having a caseloading midwife as a mother. Their comments were reported to me by their mother, a midwife. Each held opposed views that likely capture the range of experiences of other children. When asked about how having a midwife as a mother had affected their childhood one replied,

it's like my life's been an adventure you know, you never know what's going to happen and sometimes you gonna do one thing and then it all gets cancelled and when we were little where knew where every park was in Auckland because we could come with you for visits and then we would nip off to parks.

The other child held a very different view of it all. She said,

it was terrible, your mother never does what she says she's going to do, you're been a totally unreliable mother and its ghastly.

One midwife with many years experience in independent practice summed up this negative aspect of their work by noting an ironical feature of their work:

I feel that I have given away the same degree of participation in my children's growing up as the women I'm supporting to participate in their children's upbringing, and I am constantly telling them of the value of it, and not to go back to work so soon, and that you never get their youth back, and yet that is what I am doing.

Beyond partners and children, the negative impacts of caseloading midwifery were also felt by extended family and friends.

You know, my grandmother in particular I am really close to and she has had a hard time understanding why I can't come and be with her as much as I used to be. Friends have learnt to understand that this is what I do, and I think as our priorities start to change a little bit with our age probably, and our jobs, that they are a little bit more understanding of my work than they were and the kind of work that I do. But it is difficult. Christmas for example. You know like we have big family Christmases and everyone fights and doesn't talk to each other for the next eight months and then we prepare for the next Christmas. But there is an expectation that I will be there for those days and I am not for a lot of the time. Or they come here and I am on call and I get called out and have done for just about every function that we have had. But that is just how it is. I guess people learn and just have to accept that that is the way it is, and they do. My friends say things like we'll make dinner for you and I say, oh yeah, we'll see.

The implications for a social life seem particularly important for younger people. One midwife who was interviewed thought that two promising new graduates might be attracted to work in her practice. However, she was surprised to find that both were unwilling to give up aspects of their lives to work in independent practice.

They were really clear that they would not go into independent practice. They wanted to go out, they wanted to get drunk, they wanted to have a life. And what they saw, and it was really interesting feedback for us, was they didn't see that we had a life. That the life that we had, had midwifery as the central part of our existence and they didn't want to do that. They wanted to meet boys, you know.

One of the younger midwives in independent practice and who was interviewed describes the gradual realisation of the level of negative impact this way of working would have on her personal and social life.

No longer being able to just wander out of Auckland for the weekend or for the week, for the night; no longer being able to go out and enjoy a glass of wine with my friends at dinner. Those were things that I really enjoyed doing before and I am only young so they were a big part of my life and they are not anymore.

The following scenario, described by another midwife, further emphasises this effect. It involves her efforts to try and organise a party for a friend's birthday.

I was going to plan this surprise, and I didn't have anyone due for three weeks. It would be fine, just one day. I got up at 6.00am in the morning and cooked all this food, the guests were arriving at 9.30am and he was arriving at 10.00am - he didn't know, and I got called out at 9.15am. I came home at 3.00pm in the afternoon and the place looked like a bomb had hit it. There wasn't a soul there, they had all gone off to somewhere else, and I sat down on the couch and burst into tears because I just thought, what am I doing.

Ultimately then, as the same midwife and others came to realise,

I think that family and friends do have get used to it, people are very used to me, well I might be there but you can't be sure I'll ever turn up or stay the whole time.

However rational this may seem, it doesn't take away the disappointment of not being able to be present at, or stay for the whole duration of, special events.

As is obvious from the preceding discussion, not only is caseloading midwifery extremely unpredictable, it is also very intrusive. Clearly this takes the form of people being unable to attend events, or having to leave them early but it can also take the form of the less profound but insidiously more disturbing interruptions of the phone.

The nature of cellphone is that people can call you and what you are doing will get interrupted on occasion.

My phone never gets turned off so if it rings at 2.00am or 3.00am that's my job.

My phone rings 24 hours a day.

I go to the movies and have to leave the cellphone on and everyone looks at you like bloody cellphones.

The other night I didn't answer the phone here, it went 13 times after 6 o'clock and so it's a really big invasion on that personal time.

The relief is very obvious when one knows that the phone is not going to ring, such as when midwives are having a day or weekend off.

Its great when you're on a weekend and the phone doesn't ring.

Though it perhaps is an extreme example, the following experience of one of those interviewed well illustrates the intrusiveness of this line of work, made all the more possible by the cellphone.

And someone phoned me last year and she said, "Look I'm in a restaurant and I'm just worried about Listeria, do you mind if I just go through the menu for you? So now this is the menu..." ... So I said to her, "I'm in a restaurant as well!" ...[But] she went through this entire thing, and the people I'm sitting with are going wow.

There is a sense, then, that midwifery can take control of the life of a midwife unless she is aware of what is happening and active in response. Associated with this intrusiveness is the demanding nature of caseloading midwifery, not just in how it affects the midwife's personal life but in the way it brings huge responsibilities and stresses. An important way of handling the intrusions and helping blend work and family life was through regular time-off. Though most of those who were interviewed were part of practices where regular time-off was now available (although this was only being trialled in one practice), a lack of access to such relief was seen as an all too common negative aspect of independent midwifery.

Another observation made about independent midwifery is that it can be very isolating. Midwives essentially work by themselves in providing care, even in the middle of large institutional facilities (though they do work with another midwife for homebirths).

The isolation type stuff that puts [midwives] off, because there is a lot to be said about working in a team, like in a hospital, working with your mates, being on shift and that sort of thing. When you are an independent midwife it is quite a lonely and isolating existence.

A sense of isolation was also a significant disadvantage for the knowledge workers interviewed in the NSW Report (Firkin et al., 2002). For midwives there were various forms that this could take. There was, for example, a degree of isolation from a wider social setting by the nature of the work (being called out etc). As well, there was an isolation from professional support and sharing as well as isolation from the social side of a communal work setting, both due to predominantly working as independent practitioners. As one midwife observed, this may have been one of the impetuses for setting up group practices or collectives.

When you first started out you got a lot of individuals, one midwife here, one midwife there, nowadays there is much more of a tendency for midwives to come together in groups and to work in groups, and certainly that is what we do in our practice is work in groups. We still take our own clients but we come together once a week for regular meetings and regular support time really.

Certainly many midwives spoke positively about how these groups provided professional and personal contact and support.

7. The Structures and Organisation of Caseloading Midwifery

While a whole host of arrangements were considered in the NSW Report on knowledge workers (Firkin et al., 2002), the caseloading midwives who were interviewed in this study fell into two main groups. (though obviously there will be variations in how these are played out). These are employee caseloading midwives and independent or self-employed midwives. Many of the differences between these two forms have been and will be described in other parts of the report. Therefore, this section will briefly summarise these alongside a more detailed exploration of other structural and organisational aspects of caseloading midwifery.

7.1 Independent Midwives

All the independent midwives who were interviewed worked as part of collectives and practices though the nature and structure of these differed (for more detail see Section 5.5.3). Regardless of these differences each midwife emphasised that they were independently self-employed thereby making them solely responsible for generating and managing the business aspects of their individual practice. That said,

It's a relatively easy business to start up because it's only you. You don't have to pay out anybody else and so its quite easy to set up and if you've got a midwife whose been in it for a wee while showing you and explaining to you what you need to do in kicking off as you go along, it actually is quite easy.

Most reported that they used specialists, such as accountants, for this side of their self-employment.

Because being an independent midwife is stressful enough just doing the midwifery stuff, without all the extras - pay someone to do it. It is tax deductible. ... I always say get a good accountant.

As one midwife noted, such is the specialist nature of their work that an accountant who understands the business is important.

I did start with an accountant ...[but] he had never looked after a midwife before and it was just awful. It just turned out, it just turned yukky and so I spoke to my colleagues and they told me to go to the midwife's accountant that they go to and it was just great. I walked in there, she knew what my job was, she knew what I could claim, she knew what I should be doing to pay more back, and why haven't you done those - why haven't you done that, she adjusted my tax that he'd done already ... and saved me about \$1500.

Such independence within a collective or practice resembles the health professionals interviewed as part of the NSW Report on knowledge workers (Firkin et al., 2002) who had also formed collectives. However, it is quite different to the looser associations, collaborations and networks that other knowledge workers were part of. These lacked the coherence of the midwifery collectives and practices. That said, these collectives and practices were not as structured as the formal partnerships established by some knowledge workers which removes that element of independence.

Since independent midwives are paid by government for their services they must claim reimbursement for the care they provide. This means that they are part of a large bureaucracy and it seems that the associated demands have only grown over time. None of those spoken to seemed particularly enamoured of the administrative side of their work, but without fulfilling these obligations they will not get paid. Even, then, there is a delay while payments are processed. In order to ensure a regular income there is a need to be periodically attending to claiming and the like. In general, the payment system sets them apart from many of the knowledge workers interviewed in the earlier research (Firkin et al., 2002). As self-employed contractors, midwives work for many clients but are dependent for payment on one body (which is ultimately the government). As well, there is a staggered formula for payments with the bulk being made for the birth.

From one perspective, the payment system is intriguing in that a midwife earns exactly the same amount of money for the care she provides as does a doctor. This is a rather unique and egalitarian situation for a group dominated by women and outside of the medical profession.

Being dependent on one non-contestable source of income structured in a particular way, while ensuring that payments will be made, has drawbacks, however. For instance, should a midwife be no longer able to care for a woman – most often because her pregnancy is no longer considered normal and thus outside the level of care a midwife can provide – the midwife will be paid for the care she has provided but will lose the major portion of the fee. It is not possible to fill the gap, as it were, with another woman at the same stage.

There are also issues with the level of reimbursement. The original funding arrangements at the time of the legislative changes were generous in reimbursing midwives for the continuous, first-hand care they provided, especially around delivery.

If we take the labour thing, a midwife would be with somebody for 12 to 15 hours. When GP's were doing it they still had a midwife from the hospital involved, they would come rushing in, put the gloves on and catch the baby, so the funding was a set fee for 2.5 hours of attendance, and anything over that 2.5 hours was exorbitant, exorbitant overtime. If a GP was there for five hours for some reason, they got this exorbitant overtime. So when midwives became autonomous they didn't have any other funding scheme to put them under so they put them under this scheme. So, if you were with somebody for ten hours, you could claim heaps of money and of course this just blew the budget so they had to stop it.

Subsequent changes driven by these fiscal imperatives, not foreseen as a consequence of the legislative changes, have meant some significant changes. Importantly, there have been few increases to provisions in the ensuing years.

So, now, you just get paid a set fee, so when a client is in labour you get \$950, it doesn't matter whether it is 2 hours or 22 hours that you are there. ... They changed the funding in 1996 when they attacked the budget ... we haven't had a pay rise, in fact we have had a pay decrease since we started out in this business.

Thus, since midwives have no control over what they are paid for the care they provide and cannot charge additional payments, altering the number of women they care for at any

particular time is the only way for midwives to influence their income. Given the static nature of their reimbursement schedule over many years, and faced with rising personal and business costs, if a midwife wants to maintain her relative level of income it becomes necessary overtime to increase the numbers of women being cared for on average.

However, it must be remembered that the numbers of women cared for affect not only income levels but workloads as well. Thus, using this mechanism to maintain income also increases the demands on midwives. Besides being used to influence income, adjusting the numbers of women who are being cared for can also be used to have periods of low or high workload depending on other circumstances – such as allowing for study or having and caring for children and so on. Over a year some midwives would have busier and quieter months comparatively. Others had settled on numbers that they consistently care for and that they are comfortable with. Those interviewed seemed to all be averaging a care ratio around the NZCOM guidelines of four to six women per month.

7.2 Employee Caseloading Midwives

The work of caseloading midwives employed in institutions has many similarities with independent self-employed midwives. They both provide continuity of care through midwives taking on caseloads and caring for women at all stages of their pregnancy including birth and aftercare. Though some would argue that the commitment of hospital-based systems to regular time-off makes for a fundamental difference between the two groups, regular time-off is an increasingly important feature of the practices where those interviewed worked (though as is later discussed there are variations on how this is organised). Although hospital-based caseloading midwives have two days off, they still are on-call 24 hours a day outside these times. The major differences centre on the business aspects of the services. Firstly, of course, those in employment are paid a wage and have paid sick leave and holidays. Self-employed midwives have very different payment arrangements and must budget for leave and holidays. As well, hospital based caseloading midwives have no part in the recruitment of clients, provision of facilities and equipment, and the general running of the business which are the responsibilities of the hospital. One of the hospital-based midwives makes the comparison on these issues, starting by noting that they didn't have to find clients. She also notes,

initially setting up, you wouldn't have a wage until those people reached a certain point in their pregnancy or delivered. You'd have to have a part-time job or I think it would be quite hectic setting up. Whereas in the hospital you get fluctuations in referrals and if you didn't reach your target then it didn't matter, it's the hospitals job to promote the scheme, you didn't have to go out and tout for trade. You had a guaranteed salary.

Though many institutional services provide cars for travelling, in other services the midwives use their own cars – like independent midwives – but unlike them they are reimbursed. Hospital-based caseloading midwives also have access to the considerable support services in the institution – though, as we shall see, these relationships are being re-worked – while independent midwives must establish their own networks of support. Over and above these obvious, often tangible, differences and despite the major similarities it also appears that there may still be some less easily identified but no less important distinctions between the two approaches. Though she cannot see them herself,

one of the hospital-based caseloading midwives described some of the comments she receives from independent midwives. This may help to demonstrate the nature of these less distinct qualities.

Personally a lot of the independent midwives that I meet with, ... you know rub shoulders with, already regard me as an independent midwife. And I don't know why, and I have to keep saying to them, "No, no, no I'm a Domino". "Oh no", [they say], "but you work like us, you must be an independent". ... I don't know looking at how the other [hospital-based] midwives work and how I work, I don't actually see a great difference.

A couple of other interesting observations regarding hospital-based caseloading midwives can be recounted. The first relates to their being reminded that they are part of an institution despite the very different way they work. On the one hand, as one midwife put it, the hospital,

realised it was really the only service that ... was able to provide, that even answered the expectations of Section 88 and what used to be Section 51. ...but it's the only service that ... provides, that actually comes anywhere near the expectations of the Act, you know for all intents and purposes, so they have to keep it going.

Consequently,

they're even talking of growing it. Extending it and getting more independent, more Domino Midwives working, but they are actually having trouble filling the current.

Despite these realisations, the hospital also saw it as an expensive service and one that could always be cut back or abandoned for fiscal reasons.

The second issue regarding employee-based caseloading schemes involves the implications of recent changes to legislation. Whereas the prior legislation saw the hospitals designated as the LMCs, the new Section 88 of the New Zealand Public Health and Disability Act (2000) means that caseloading midwives, although employees, are now the LMCs. The impact of this will mean that the hospital system no longer has any automatic right of care over clients. One of the midwife explains the implications.

The doctors in the hospital at the moment and the way it has been historically has been that around ward round change time, they would come and knock on the door see the colour of the rooms you know, the patient you are looking after had to be an orange patient women they'd come and knock on your door and come in and introduce themselves to the woman and write a plan in the notes, well its not actually their responsibility to do that anymore and they are only invited in if you want to consult or refer because you have a problem.

Such a change is quite radical for the hospital system and, as she notes, will take some time to evolve. What it does do is situate the hospital-based caseloading midwives more closely with their independent counterparts.

7.3 Some Common Issues

7.3.1 Intensification and Enrichment

Midwives from both groups talked about the intensification and enrichment that working in a caseloading way brought. Being solely responsible for the care of a women and the birth of her child was both a demanding and rewarding role in many ways.

Though each obviously lies in tension with the other, such a dynamic was a large part of the attraction to this style of work. It is accentuated by having to balance the care of one woman across a pregnancy and birth, with the care of a number of women in those circumstances. As one midwife described it,

At any one moment I've got someone who is six weeks pregnant to someone that could be going into labour or someone who is two weeks down the track with a breast infection, I've got a huge range of stuff that I am constantly having to make decisions about and it is more challenging and more intense but more enjoyable.

Not only did it allow the midwife to work in a way that is consistent with their profession's philosophy, but doing so meant that they formed close relationships with the women and families they worked with. However, tensions were also at play in the stress of the personal and professional responsibility each bears, being available at all hours, and the clash of personal and professional lives.

7.3.2 *Monitoring*

Unlike the knowledge workers in the NSW Report (Firkin et al., 2002) who reported that monitoring of their work was limited to feedback on their output, the midwives who were interviewed were all engaged in much more reflexive and wide ranging monitoring of their practice. Certainly, like these other workers, the quality of midwives' work was monitored in an ongoing way and at an individual level by consumers as part of the care relationship. This can provide the basis for sorting out issues when they arise.

If I found there was a complaint about me, I would be upset that somebody hadn't come and at least attempted to talk to me about it ... A lot of this stuff can be sorted out, one-to-one, or a resolutions type mediation or something.

Feedback is also sought on a more formal basis through questionnaires that are given to each consumer to complete and then collated by the NZCOM. However, as is indicated in the last quote, on top of these feedback mechanisms, like any other health professional midwives were responsible for their practice and open to formal complaints.

There are fourteen avenues of ways to complain about your midwife. You know how many ways there are to complain about a lawyer - about three. We're up there with the doctors, the doctors are the same. So it can be very stressful.

Unfortunately, there is a very negative emphasis in this sort of monitoring.

The other thing is that the Health and Disabilities Commissioner is a complaints driven organisation. You are not going to get a letter from the Health and Disabilities Commissioner saying well done, we think you are fabulous. People can go and complain and he is obliged to investigate it.

Rather than all complaints finding their way to the Commissioner or their professional body, the NZCOM has developed a lower level process where complaints are received, the case is reviewed, and a separate committee tries to resolve the issues. This committee often meets in the home of the complainant.

In addition to these monitoring mechanisms, practices and collectives provided a degree of peer-based monitoring. Like many of the knowledge-based workers in the LMD report (Firkin et al., 2002) midwives often sought feedback from their colleagues as to the quality of their practice. While this can be in respect of specific cases, it can also be on a

more general level. It can occur in formal ways, like practice meetings, or more informally.

Alongside such feedback though, there were other broader forms of monitoring. For instance, midwives provided considerable amounts of data which was collected and analysed (in the case of those interviewed by an intermediary agency that also performed other support functions like managing the claiming process). The refined data gave midwives important aggregate information about their practice and outcomes.

Perhaps the most substantive efforts in respect of monitoring are regular formal reviews. Though not mandatory for all midwives, membership of certain intermediary support organisations is premised on participating in such reviews. There are different forms that this review can take, with the main difference centring on whether consumers form part of the process. All those who were interviewed were committed to the review process. Taking part in a review is a large undertaking involving not only the half-day attendance but a great deal of preparatory work. It is also a wide ranging process that not only examines the midwife's practice in relation to the standards set by the NZCOM, but also engages her in constructive critical reflection on her work. As a result, the midwife sets goals in various areas. These obviously will include areas such as practice development and education and training, but, as one midwife noted, can extend to other related issues. Her review noted that she needed to be better at her self-care especially in relation to time-off – a perennial issue among independent midwives – as the feedback from clients was that she was placing herself under too much stress by constantly being available. As a result she had structured some more regular time-off into her schedule, and made potential clients aware of this at the outset. Other midwives talked of planning what study they would be doing as a result of their reviews. Although the knowledge workers interviewed in the NSW Report (Firkin et al., 2002) represent a diverse group of professionals, none indicated that they participated in anything resembling such a process, though some noted that they would be bound by the standards of professional bodies that they belonged to.

7.3.3 *Technology*

As was noted in the introduction, midwifery is a profession that is 'heavy' in knowledge but 'light' in technology. This is not meant in a pejorative sense but merely highlights the facts that, as one interviewee put it:

There is technology within the hospital that we use but we try not to use it an awful lot, but it is there. Technology is there to be used when appropriate, but the skills of the midwife are in herself, in her eyes, her hands, her ears, her knowledge.

Thus unlike the knowledge workers who featured in the previous research (Firkin et al., 2002) midwives used technology in a limited way both in their work and in support of their businesses. Even this low level of usage varied among individuals.

The one piece of technology common to all the caseloading midwives is the ubiquitous cellphone, which was seen as an indispensable tool in doing their work. Obviously, midwives could receive calls from clients – for instance, alerting them to the start of labour or seeking advice. As well, midwives could contact clients – say to advise them

that they are tied up at a birth and thus reschedule appointments – other midwives for support or advice, and services such as hospitals. Each could be done regardless of the time, where the midwife was, who she was with, and what she was engaged in doing. The obvious downside is that it is clearly a highly intrusive tool.

I've had that many damn phone calls in the toilet its pathetic.

Since, as the above quote shows, it can ring at any time, anywhere and regardless of circumstances, in many ways the cellphone is the means whereby traditional time and space boundaries – in respect of employment and home for instance – are broken down in the work of caseloading midwifery. Thus, it is the symbol of the intrusion of work into home, though as some interviewees noted it also allows home to intrude into work. This midwife gave her children a cellphone so that they could contact her, especially in an emergency.

However hard I tried they'd always be some last minute phone call about this that and the other. ...Like you know where's me socks type of stuff.

While other non-standard workers reported that although technology had opened up possibilities in terms of working, it also had negative consequences (Firkin et al., 2002:75), the nature of maternity care means that work often intrudes via the phone at all hours and that a phone call can signal the start of a much larger intrusion.

In short, technology, in the form of the cellphone, represents a means whereby caseloading midwifery becomes a form of teleworking, as defined by the Danish Board of Technology, since it allows the midwife, “for a considerable period of time, [to be] physically distanced from, and in electronic communication with, the place, the customer or the organisation to which their work effort is directed” (cited in Mangan, 2000:45). (That said, it is acknowledged that domiciliary midwives practised long before cellphones existed). However, in opening up this way of working, caseloading midwives are also confronted with, and must manage, the negative aspects of teleworking.

By way of closing this section on technology and midwifery, it is perhaps apt to report the remarks of a student at a school where one midwife went to talk about her profession. In response to a question about what they thought a midwife was, one pupil responded:

Oh you are somebody who walks round with a cellphone.

7.3.4 Business Legislation, Policy and Compliance Issues

A set of issues raised by the group of knowledge workers (Firkin et al., 2002) was the effects – both positive and negative – of legislation and policy for those working in non-standard ways. The areas of concern included employment law, health and safety legislation, ACC, tax rates and compliance costs and demands. People in NSW spoke of a lack of flexibility in law and policy, questioned its inappropriateness in respect of small businesses, and sought a better responsiveness to cater for their growing numbers. While the midwives who were interviewed often mentioned the bureaucratic demands of their claiming systems the wider issues as outlined were not raised. This lack of attention to such concerns may in part be, as the report signals more broadly, the result of midwives'

effort and energy being directed at the development of independent midwifery practice. Thus, their concerns of a more political orientation centred on the evolution of midwifery within an, at times, hostile and certainly challenging environment rather than issues relating to the business side of their endeavours.

8. Managing Caseloading Midwifery

This section canvasses a number of issues relating to how caseloading midwives manage aspects of their practice. It is broken down into two broad areas. Firstly, how midwives cope with being outsiders in two respects is explored. Obviously, they are seen as outsiders within many of the facilities where they deliver babies. Intriguingly, independent midwives appear in many respects to be outsiders within some quarters of their profession. The second area of focus concerns how midwives manage the home/work nexus. As well as discussing this issue more generally, the specific themes of time and space management, with the former including a discussion of how time-off is managed, are addressed.

8.1 Managing Insider/Outsider Relationships

While some midwives perform homebirths (which technically still makes them an outsider in the home of another) this section deals with how independent midwives manage working within hospitals and units where they birth. Caseloading midwives who are employed by the very organisation whose facilities they deliver in are not subject to these distinctions since, although they operate very differently from other midwives and staff in the hospital setting, they continue to be viewed as insiders in comparison to independent midwives. Indeed, they are often viewed as highly skilled professionals within the hospital system. They also work only within one setting thereby reducing the stress of moving between different facilities as experienced by independent midwives. In contrast, however, those employee caseloading midwives who work for other organisations are included in this discussion since they too are seen as outsiders since they must deliver in the facilities of organisations where they are not employees. Beyond obviously being an outsider in terms of not being an employee of organisations that they none-the-less have to inhabit for times, there is a hidden dimension in that independent midwives can be seen as outsiders by some within their own profession. Though they are in some respects intertwined, for simplicity I will deal with these issues separately.

At its most basic, the position of an outsider is clearly demarcated in the need for independent midwives to gain access agreements allowing them to deliver in a hospital or unit. Though these used to be highly individualised by hospital or unit, recent changes have seen a standardised approach introduced. The granting of access represents a minor challenge compared to working within these environments. While the degree of difficulties varies on a case-by-case basis, in each setting the outsider not only has to learn the bureaucratic side of things – protocols, procedures and the like – but also has to negotiate a particular cultural setting. Although this midwife had spent time working as an employee of a hospital, the move into a caseloading role had meant she delivered elsewhere. Consequently,

I am now working at ... completely new places for me, they all operate completely differently: I have got like different paperwork to do at each place, I've got different formats of the way things go and different protocols at each place so it can get a bit confusing and there are lots of different things to learn from each place. So for me it has

been a really big challenge and a really big transition going from somewhere where I knew exactly the way things went to somewhere where it works completely differently.

In contrast, other midwives identified the benefits of delivering as an independent midwife in the hospital or unit that they had previously been employed in. Already being known and familiar with the place could obviously ease problems. However there are negatives as well. The very poor view that one midwife had of her former place of work meant that she deliberately avoided working there.

Midwives described the process of becoming established within hospitals and units as demanding and stressful.

It is quite exhausting going into different places and finding different protocols. That can be quite exhausting, especially to a new midwife.

Thus, it can make an already exacting job ever more so. These two examples clearly illustrate the extremes that this can be taken to.

I used to have people ringing me after I had been there for twelve hours with someone in labour, I would get home and go to sleep and somebody would ring and say oh you have left a bit of rubbish on the floor, come and pick it up. And I would just think that is mad, you know, that is mad.

I had a woman ... she needed her discharge summary done which simply means doing that on the computer, well I was at [my] clinic on a Tuesday all day from like 7:30 in the morning until 8:00 at night and I wasn't going to go [back] to do a stupid piece of paper – they could tell that she was well, I was catching up with her the next day. Well you would think that I had committed the biggest crime. I had four phone calls from [the] hospital saying that this was unacceptable, getting our staff to do this, I mean when we are there we do things like answer the phone, we do all of those things for them, yet they can't do a simple discharge for me. And if it had been any other day, I would have been there and done it, but it was out of my control and at 8 o'clock at night I wasn't going to go there and do it. ... there was one midwife that was happy to do it – she rang me and I said I was quite happy to do it the next time I was [there] and she told me, "No, no, no its fine I'll do it" – and so that's where it all started. ... I think that was the issue, that a midwife who had been there a lot longer said, "What are you doing, you can't do that for the independent midwife". And so she decided that that was unacceptable, so rang and said "This is unacceptable, blah, blah".

So difficult can this phase be that one midwife turned down the opportunity to change practices just to avoid having to start all over again negotiating entry as an outsider into new facilities.

The age, experience and reputation of a midwife certainly seemed to be factors that affected the process of acceptance. Thus, younger midwives often experienced more difficulties. The midwife called back to pick up some rubbish clearly identified her age and junior status combined with the fact that she had gone directly into independent midwifery as contributing to the difficulties she experienced. Like others, she realised that over time being an accepted outsider becomes easier. Along the way diplomacy, being proactive in building up relationships, and the support of colleagues can help. Demonstrating that you are a skilled practitioner also speaks volumes though there is a continual sense that,

You had to prove yourself before they'd take you seriously almost.

The way that midwives approach the process is also important and many talked of being active in learning protocols and ways of doing things as well as getting to know staff. Reinforcing the fact that the experiences of outsiders vary on a case-by-case basis, this midwife notes that on the whole people in the hospitals have been supportive. She also recognises another important factor in the process.

And I am lucky that I have supportive colleagues because I know that if I am not sure about something they are only a phone call away. So that was a really important thing for me choosing to go into this job too that I had really good support because I knew I would be going to really unfamiliar environments and it is very different from place to place.

Interestingly, for the knowledge workers interviewed previously (Firkin et al., 2002) similar factors – in their case the skills, expertise, experience and credibility of the outsider – were felt to be the keys to overcoming resistance.

Those who made the shift into independent midwifery soon after the legislative changes may have been able to still work in familiar settings but they faced a different sort of exclusionary force that centred on the newness and rather revolutionary nature of independent midwifery. It took various forms. While resistance outside the profession was to be expected (and continues), the newly independent midwives can be seen to have been made outsiders within their professional group. Thus, as one of those interviewed recounted it, midwives in senior positions within hospitals would obstruct them in many ways, telling them what they could and couldn't do. This was not just confined to senior levels either.

When we first came into the workforce a lot of the antagonism was from our midwives colleagues because they were threatened by us.

While the caseloading midwives who were interviewed agreed that such a situation had improved, probably in response to the much larger numbers of independent midwives now in practice, there was disagreement over the degree of the improvement. Some saw little evidence of overtly negative attitudes, while others found that they persisted.

Sometimes you do detect a bit of sort of not animosity but a bit of a unsettled kind of feeling. I'm not quite sure why that it is. ... I know even from working as a CHE midwife, there was a lot of people around me all the time that would be very quick to judge or criticise independent practitioners coming in and I never really saw why that was necessary and there is still a lot of that going on. I think maybe that people feel a bit threatened or a bit challenged and maybe that is uncomfortable for them and maybe it is a power thing as well, it could be a bit of a power struggle maybe. I don't know, it is strange but there is certainly a lot of that around.

Positive shifts in the acceptance of independent midwifery certainly seem to be occurring, as this quote shows, but it can be a long, slow and uneven process. In contrast, although the knowledge workers interviewed in the NSW study (Firkin et al., 2002) didn't experience a sense of being an outsider within their own professions, they still encountered being excluded within a workplace in many of the same ways as midwives.

An interesting observation made by some interviewees in respect of the insider/outsider issue is that independent midwives need to stop considering themselves as passive in relation to the hospitals and units they deliver in. This persists, one interviewee commented, because midwifery had for so long been based on an employee-

employer relationship and, as such, midwives were bound by the policies and protocols of their employers. As independent midwives, that relationship is changed in obvious and less apparent ways. As to the latter, now midwives must come to see themselves as not bound by the organisations whose facilities they use. This midwife explains what she means.

When you were previously like a midwife that has come through a system of where you have always been employed, so you have always had a employer that has told you what to do, then it is natural for you to think that is what it is you do and not to actually look deeper and think about what you are actually accountable for. Sometimes policies can actually be so stupid that they are actually dangerous and there has been cases where midwives have actually ended up having to defend themselves, and it is no defence to say well the institution says you should do it, its like well do you think it is okay, and its like well no I don't. That is no defence. That is not a professional stance.

Thus, what is evolving is a professionalism based on a sense of autonomy and an accountability to the women who engage them that has clear and provocative implications for the insider/outsider relationship. At the least, it means that midwives need to confront issues at odds with their stance. Consequently they need to be included in and proactive towards the policy process.

8.2 Managing the Home/Work Nexus

8.2.1 Managing Time

The temporal aspects of caseloading midwifery can be viewed in what I refer to here as the short and longer term. The former has a more unpredictable quality to it and will be examined shortly. The latter, by contrast, offers the promise of more stability. This approach to managing time applies equally to midwives taking caseloads as employees and those independently self-employed. The main difference is that the employees do not have a recruitment imperative. That is they don't have to ensure adequate workflows as they get paid a salary and it is the responsibility of the institution to recruit clients. They have to manage time, in the short and long term according to the current number of women they are caring for up to an accepted maximum. The self-employed midwife is responsible for her own recruiting and can vary her caseload.

The longer run management of time involves the planned provision of care across the whole caseload. While each case is unique, in general terms the frequency of visits builds as the birth approaches. A midwife needs to balance her caseload by having a mix of clients at various stages of pregnancy and thereby, requiring differing levels of care. The numbers of clients therefore directly influences the workload. The longer term management of a caseload thus allows midwives to have some control over the structure and organisation of their time through the organisation of appointments and the like. Those who were spoken to usually conducted clinics and appointments during the day, though some did occasionally allow for a few of these in the early evening. Though, given its nature, it could obviously be done at any time, paperwork of various forms can also be seen as another activity allocated to particular time periods. One midwife reported knowing of colleagues who had a day of administration timetabled per week. This aspect of time management means that midwives can provide for the needs of the women they

are caring for as well as have a reasonable degree of flexibility over how they use some of their time. Each midwife is responsible for organising their own such arrangements, and in doing so balancing their personal needs with those of their clientele. Like the knowledge workers in the NSW Report (Firkin et al., 2002), all indicated in various ways that they enjoyed the flexibility this allowed. Similarly, it seemed that midwives used the flexibility of their work arrangements to introduce a sense of normal working hours into what could often become much more abnormal.

In the shorter term caseloading midwifery centres on the need to provide care at all times for clients. Birth happens when it happens, not always when it is planned or predicted, and most babies are born out of business hours.

You haven't got anyone due so you should be fine to go out for a few drinks, but you can't risk it ...[I had] no-one due, but ... that lady was 29 weeks pregnant and she went into labour. Eleven weeks early so you just, just never expect it. The job keeps you very humble, you just don't know what's around the corner

The birth experience itself is varied and unpredictable and midwives are engaged in it from the outset and are committed to being physically involved for the later periods. This has implications for the personal and family life of the midwife. The effects are also felt in midwives' working lives since it means that there are often interruptions to what I have presented earlier as a rather orderly picture of their ability to organise the other packages of their work time. As a result, appointments often have to be rescheduled and others will have to cover for colleagues called away. As simple evidence of this, three of the midwives who were interviewed, had to reschedule our appointments due to unexpected births. However, such are the flow on effects for everyone concerned following such disruptions or re-organisations that some simply decide to press on with the scheduled work.

I try and just keep going with my clinic, even if I've been up since like three or one in the morning. [If] she has delivered I try and get somebody to take over the beginning of my clinic, until I can get there, then I'll just go right through to the end of the day as best I can. Because otherwise you've got to fit all of those women in on a different [day] and [still] ... you've got postnatal visits or you've got something on in your day, so somewhere you've got to fit all those women somewhere else. And some of them you actually do want to see that week, so that's when it gets a bit difficult, so I just try and go all the way through.

Of course, in solving one set of problems she is forced to place additional demands on herself.

Ironically, some who had worked in hospital settings found the unpredictable nature of late night or early morning call outs much more preferable to scheduled night shifts.

When I was a nurse for six years I've done my fair share of nights [and] everyone hates nights. The good thing about independent practice, you don't know when you're going to get called out in the night and that's the best thing. Its much easier to get a phone call and get out of bed and go, than lie there thinking oh no I've got to get up at 3 in the morning, oh no I can't sleep.

Of course, the need to provide care extends beyond the birthing process and the unpredictable temporal element of working as a caseloading midwife also includes being

available to receive calls from clients about concerns and questions. While more will be said about this in consideration of the home-work nexus, it is appropriate to note here that it is probably the most acutely felt temporal intrusion, especially since many of the calls are not of an urgent nature. A number of reasons were given for their availability becoming abused. Some felt that it was a side effect of midwives working hard to establish themselves by being all-things-to-all-people; some thought that it was a reaction to the very different nature of the relationship fostered between midwife and woman as compared to the usual doctor-patient relationship; others considered it might have something to do with midwives being recognised as outside the traditional medical framework; some wondered if, perhaps, it was a gendered matter: women working with women. It is likely to be a combination of each and all of these in various ways. Consequently, many midwives while never discouraging the use of this availability, also sought to educate their clients in what is and is not appropriate and to remind clients that they too are people, with needs and wants and, importantly, with families themselves.

For the knowledge workers interviewed in the NSW Report (Firkin et al., 2002), it was workflows that often dictated the temporal organisation of work. That is, these workers had to work hard and long hours when work was available as they were often unsure when the next job would arrive. Though in not quite the same sense – since all the midwives spoken to had a steady clientele and source of work – the flows of work were an important determinant for midwives as well. This is particularly so when the planning possible via the long run is sabotaged by the unpredictability of the short term and midwives are having to cope with hectic periods and then quieter spells.

8.2.2 *Managing Time-Off*

Many of the knowledge workers in the NSW Report (Firkin et al., 2002) spoke of some difficulties securing time-off in terms of a holiday and/or sick leave. For midwives similar difficulties were sometimes reported but in the more frequent situation of having regular time-off from work. These issues were easily resolved for those caseloading midwives who were employees since regular time-off, sick leave and holidays were all part of their employment packages. Problems still arose, however, since as one midwife noted, to provide these meant that those still working had to cover for those absent for whatever reason. This had been a factor in her decision to move into independent midwifery.

You end up covering them and that just makes it really untenable ... [Recently] I had one of those days, actually three of those days when I was on-call for eight [midwives] and I think from the Tuesday night until the Friday morning at 8 o'clock I actually been in my house nine hours. And I think I had delivered three or four women that were not mine and I was just going home to sleep at 8 o'clock on the Friday morning ... when one of my women walked in, in labour, so I stayed. ... OK while in independent practice I know that I will be covering the other midwives if they have been up or on a weekend off, but its not going to be anything like covering four or eight midwives.

Given that caseloading midwifery is structured around a nine month timeframe, it is reasonably easy for midwives to schedule in holidays – accepting the need for foresight and planning – by not booking clients who were expecting to deliver during periods they wanted off. Of course, the obvious problems are that births can fall outside scheduled

times and delivery dates are often revised after scans but by which time the person is under the care of a midwife. For those whose due dates fall close to periods of planned leave midwives tended to explain the situation at the outset, with a likelihood that their chosen midwife might not be available. If they still chose to go ahead then regular appointments with the lead and a back up midwife were arranged so that both the alternate midwife and the consumer could become familiar with each other. Being part of collectives or practices meant that other midwives could be identified as contact people for the clients of colleagues who were away. Given the demand for midwifery care and the ability to commit to clients due after a holiday, well before any holiday was taken, the fear of losing and not re-establishing work that many of the knowledge workers in the NSW Report (Firkin et al., 2002) talked of in respect of holidays were not issues for the midwives.

Like any self-employed person, sickness was a difficult issue but the tendency towards midwives being part of practices and collectives meant that colleagues were used as back-up, though re-arrangements of appointments and the like might still be necessary so as not to overload them.

The question of more regular time-off was probably of more intense interest to midwives than the knowledge workers in the NSW Report (Firkin et al., 2002). Though these workers were often under pressure to work they could often make time for themselves or their families, and the nature of their businesses usually meant that they were not on-call 24 hours a day, seven days a week. The on-call nature of midwifery work meant not only that midwives needed to be available but that they could often be needed to work. One midwife recalled the rather extraordinary circumstances of an early period in independent practice.

I remember working one year where I never had a day where I didn't have something. I had a day when I didn't do some work but it wasn't like a day off where I had the phone off or anything. I was still available.

Though she might not have been called on or called out every day when she 'didn't have something', simply having to be available places severe limitations on what one can do, when and where it might be done, and certainly has major implications for wellbeing.

Two sorts of time-off can be discerned for the purposes of this discussion. Firstly, there is a short period of time when a midwife might want or need to be unavailable. Midwives often talked of happily covering the phones for one another at these times in a very fluid and adaptable system of support that recognised the impacts of independent midwifery on a person's life.

If I think that I'm going to go out ... or I'm doing something that's really important ... then I'm happy to ring up one of the others and say I need just a couple of hours off tonight ... and get cover.

Important and relevant as this is, of greater interest here are the periods of time-off lasting a day or two – the equivalent of a 'weekend' if you will.

Like some others, one midwife believed that midwifery had created some of the problems in this respect as it set about establishing itself.

I think maybe midwives have made a rod for their own back about being so available and we actually need to set parameters that we don't go outside.

Of course many of the experienced midwives simply came to accept the lack of time-off as part of the job. Their connections with other midwives did allow for the sharing and swapping of cover on an informal and irregular basis, but the demands of a younger generation of midwives and the opportunities afforded by the emergence of collectives and practices meant that more formal and regular arrangements could be developed. Even for the seasoned campaigners, used to the demands of midwifery, being part of arrangements that allow for regular time-off brought benefits.

Its great when you're on a weekend and the phone doesn't ring.

While the structure and organisation of these collectives and practices has been dealt with elsewhere, the impact for time-off can be explored here.

The approaches to organising time-off within practices and collectives ranged from very formal arrangements where time-off was scheduled and taken on a regular basis and provided by means of cover from a partnered midwife through to the availability of time-off at periodic intervals that may or may not be taken up. The former was important to some who wanted a degree of certainty and predictability in their arrangements and desired a system that encouraged a balance between their work and personal life. Those who favoured the latter wanted a sense of this but were also drawn by the need to be there for their women.

I tell my women that I have every alternate weekend off because it gives me an out, so if I do want a weekend off its there and I just have to ask my colleagues. But usually I would only take a weekend off if I had something special on or usually its an evening, its not usually a whole weekend. ...if [my partner is] out at work and I am here on my own on Saturday night, I don't want my women labouring with my backup, I'd rather be there with her.

The experiences of a long-standing independent practitioner appear to bear this out. She also introduces another issue into the mix. The collective she was part of very early on established a principle of regular time-off, though most outsiders would find what they considered reasonable to be far from so.

The reason that we got together as a practice was to enable us to have time-off and so we could actually at that time we thought taking one weekend off every six weeks was reasonable, so we would be on call 24 hours a day, 7 days a week and we would work out a roster a year in advance and let women know when it was we would be off and also make sure that women met the midwife who would be backing up around the time that we were likely to be off.

However, for a variety of reasons this did not work as well as expected.

We constantly sabotaged it, the one weekend off every six weeks, because if you had someone who was due because the nature of continuity of care means that you form a relationship and the relationship is that you, that the birth becomes the critical part of the experience. And it is also the best pay. ... So the birth was you know was big money that you couldn't miss out and it still is it still.

One outcome of having others cover for time-off, then, is the question of how to apportion the income in circumstances where the LMC is not available. This raises certain tricky issues. It must be remembered that a birth provides a substantial part of the midwife's

income for the care of a pregnant woman. To lose a portion of their income because they were having time-off might discourage them from taking this time. However, the time and care of the midwife who does deliver also needs to be recognised. Consequently some practices and collectives had formal arrangements where the income is split, for instance. Others adopt the swings and roundabouts model, relying on the goodwill of each midwife, delivering for free but expecting the same in return. For employee caseloading midwives, being paid a salary eliminated any need to establish protocols for sharing out payments where cover was provided.

Having regular time-off requires greater organisation and planning. Clients need to be made aware of this practice and accept it as part of their care and get to know who might be caring for them as an alternative. It requires that midwives reinforce with clients that they, too, have families and lives to live. As has been seen elsewhere in the report, it also raises interesting questions about continuity of care and legislative requirements. Consequently, midwives need to work with consumers to provide a service that still honours the broad philosophic tenets that underpinned the establishment of caseloading midwifery but that reduces to reasonable levels the demands on midwives' lives. In striving for the latter I heard nothing in the interviews that challenged the former. Indeed midwives were continuously aware of, and seeking to resolve, this tension in ways that ensured their philosophy was upheld.

8.2.3 *Managing Space*

The work of caseloading midwives can take place in many spaces, first and foremost, because midwifery knowledge and skills are embodied in the practitioner. As a result, midwives can attend births at clients' homes – though not every midwife chooses to do so – as well as hospitals and birthing centres. It also allows the care on either side of birth to take place in various locations – at the client's home, at a clinic either hired by the midwife or that belongs to a collective or practice, or in the midwife's home. The administrative side of midwifery could also be done in various locations.

Apart from clinical considerations, the decision concerning where to birth usually belongs to the mother guided by professional advice. It will also depend on the practice of the midwife as not all elect to do home births for various reasons. Which hospital a mother might choose is also very much their decision since maternity care is not “zoned” as other healthcare is.²¹ As midwives need to live in proximity to the hospitals where they wish to deliver, clearly they are not able to deliver at them all. Thus they tend to select a limited number of facilities and then favour a smaller selection of these where they feel most comfortable. Those caseloading midwives employed by a hospital are restricted to delivering at that hospital but those employed by other organisations are able to choose where they deliver as an independent midwife would.

²¹ For example, because I live in greater Auckland if I break my leg I will go to the Accident and Emergency clinic at the public hospital serving the area where the accident occurred. If I need surgery then I will be admitted to a ward at the hospital that is looking after acute admissions for that day or the area I live in. The two may not be the same. Maternity care is not bound by these geographic restrictions though most people opt for services that are close to where they live (for obvious reasons).

Aside from the birthing process, midwives used various spaces to conduct other aspects of their care and business. A couple of the collectives and practices had premises that members used to see clients. Others hired rooms that they used regularly for clinics. These types of arrangements were, by and large, the most common and favoured venues for seeing clients. Those interviewed presented mixed views on conducting care in clients' homes and, in particular, in the midwife's own home. In respect of the former, practical issues were just some of the considerations.

I try not to go to their homes because you can imagine the travel involved in that. I don't even give that as an option, only if transport is a problem.

Those who were caseloading midwives for organisations did not use their own homes at all, but then nor did many of the other midwives. Even those who did expressed some care and circumspection in this regard.

I'll often see women at home in the evenings. ...but I do actually prefer to see women out of my home as it just sort of keeps it a bit separate, and then I quite like some women coming to see me at home too, so its yeah. ... I do have a sense of wanting to keep it quite, on one level to keep it quite professional, and over the years I'm aware of wanting that boundary and people have tried to describe it within midwifery, calling it a professional friendship and I don't know whether its that but I am aware that there is quite an intimate relationship that occurs and it also needs to occur in a way that has some boundary around it and some safety for everybody. So when someone comes to your home, even though I am going to her home, so the women who I will get to see me at home will often be women that I have looked after three, four, five times and its quite a different sort of relationship.

Another midwife, who interestingly was the only one of those interviewed to run a clinic from her home on a regular basis, expresses some similar sentiments.

But you've also got to be pretty careful in this situation you don't know who, if somebody rings you up on the phone you don't know and ... they want to come into your home, so in a way you've got a bit of invasion there that they can come into your home and you need to be really careful about that, but they come right into my home ... you don't know who is on the end of the phone and so that is something that you need to be careful of. ... If it's a booking and she says oh I'm a friend of so and so, then if I've looked after her well I know that they'll be ok, but if somebody rings up and says, sometimes its just the things they say, I just get a feel for it and then what I say is oh well I can't book you at home today are you able to come and see me at my clinic and they say yes and if I get there and think oh, I'll just say oh well I'll come and see you next time and I just need to look after myself too.

This midwife also acknowledged the implications for her partner's privacy (in terms of his personal and work life) by having people in their home on a regular basis.

Those who did not use their homes were perhaps seeking to maintain some spatial limits or boundaries on their work. As has been pointed out, however, the integrity of personal spaces, even if they were not used for work, were frequently breached by the intrusion of on-call demands and the ubiquitous cellphone. Despite this, these efforts at physical separation seem an important part of how individuals sought to manage those aspects of their work that were within their control. The broader and more general features of how they integrated work and home are now discussed.

8.2.4 *Integrating Home and Work – Configuring a Lifestyle*

Caseloading midwifery, particularly for those engaged in self-employment, appears to offer a lot of potential for successfully combining home and work. Such an idyllic possibility is suggested in the experiences of one midwife as she recounts one of her children's memories of going to work with their mum.

When we were little we knew where every park was in Auckland because we could come with you for visits and then we would nip off to parks.

It is also borne out by the comments of a midwife who had transitioned into independent midwifery not long after the legislative changes and who thought, rather naively now she recognises, that it might be the ideal way to balance these two areas.

So I had these two little kids and I think I had this vision that my children would be able to come with me wherever I go antenatally or postnatally as it was supposed to be a child friendly, consumer friendly job.

As she notes, however, this didn't work out anything like her imaginings.

It didn't work out that way, obviously. Having my kids ... scream around here, you can't concentrate on what you are doing and I honestly do believe that I probably put women off ... they wanted people to concentrate solely on them ... and if they don't have that focused time and feel that you are there for them, then you've lost the plot altogether.

While independent midwifery doesn't easily allow quite so close a cohabitation between these worlds, as will be seen it does offer some accommodations between them. That said, it also poses some significant and acute difficulties. How midwives chose to negotiate the home-work nexus differed between individuals. What is being offered here is an overview of the particular benefits and challenges as seen and experienced by the midwives who were interviewed. Since even those engaged as employees talked of the flexibility that their work schedules allowed compared to other core midwifery roles within institutions, much of what follows applies to them as well. However, some differences exist in that the self-employed often have less regular time-off, thus affecting how home and work interact, how this was managed, and the benefits and tensions that result.

Critical to the management of the home-work nexus for caseloading midwives appears to be a supportive family. While children obviously play a part, the key is a partner who is both emotionally and practically supportive. This is a strong theme running through all the interviews and can even be drawn out of the experiences of one midwife who coped as a single parent, but who faced immense challenges without having a partner or husband. Much of this has been explored in Chapter Five (see, especially, Section 5.5.1) so only a summary of the main points as they pertain to managing the home-work nexus is offered here.

Given the nature of this work and its unpredictable and demanding make up, independent midwifery can have a negative impact on the forming and sustaining of relationships. As a consequence some midwives may not enter or remain in independent practice. For those who do move into or elect to remain in this form of work once they are in a relationship there are considerable challenges for them and their partners, which are only exacerbated when children are involved. Essentially, partners or husbands have to accept that midwifery plays a huge part in their partner or wife's life. This has flow on

effects into their social and family life. Although husbands or partners may not be directly involved in the midwife's business, they are intimately a part of it in many regards. For instance, to allow the midwife to work at all hours they must accept greater responsibility and involvement in the care of children. Things that the midwife and her partner wish to do as a couple can also be affected. Developing a relationship that can accommodate these affects is challenging and an ongoing process. As was clear from the interviews, however, this does not mean a complete role reversal with the men assuming all childcare and domestic responsibilities. Rather it is a greater sharing of these responsibilities between partners, though this still represents a challenge to the usual gender-based organisation of unpaid work. For children, they too must accept the intrusive nature of their mother's work. While many will not know any other way of life and most accept it as the way things are, some view it quite negatively.

Against the demands placed on family by caseloading midwifery in general, and independent midwifery in particular, there are positive opportunities in terms of managing the home-work nexus offered by these ways of working.

There is nowhere where I can get the flexibility, the enjoyment, the money, just the whole package is great. Yeah, there are certain aspects that really bug me, but you know, that's life.

A similar view was expressed by another midwife.

You do get more time together because you can pick and choose the hours you work. So on the one hand you get freedom, but on the other hand you get other restraints.

It is necessary then, to consider how the negative side of caseloading midwifery has been offset by the advantages. For instance, one midwife noted that the ability to organise your work day meant considerable benefits in looking after children compared to any hospital based position. Another talked of how the flexibility can augment, rather than just negatively affect, one's life.

Its nice that you can think like I say, oh lets go out for lunch today then whip out for lunch and just for an hour or so I go out for lunch and still be able to fit your women in around, slot the women in your day that works for you, so in a way you can work it to your advantage as well. ... so in that way the job being flexible is really nice. Like I've crossed out Friday, Saturday, Sunday, Monday so that I can move house.

It is also important not to overplay the disruptive elements of this sort of work. Certainly, without question, phone calls were considered intrusive and excessive at times but with efforts these can be managed. The matter of being called out also needs to be kept in perspective as does the fact that the numbers of call-outs reflect the caseload in any month. While it can be disappointing to be taken away from an important or enjoyable event by work, when most midwives reflected on this they readily conceded that it did not actually occur that often.

You go to the movies or you go to whatever and if you get called you get called. And most of the time you don't get called.

So my experience is that I have always gone to bed or gone out for dinner, done whatever I am going to do and the nature of cellphone is that people can call you and what you are

doing will get interrupted on occasion, but you don't get as interrupted as you think you might.

An important issue in respect of managing the home-work nexus is that of time-off, something dealt with earlier (see Section 8.2.2). In this regard there is a sense from the interviews that the pioneer independent midwives in particular, together with their families, have made considerable sacrifices to establish independent practice. Hence, there are some rather extreme observations regarding their experiences:

My husband says midwifery comes before anything else.

[They have] sacrificed [their] family and children, dropped everything at the alter of midwifery.

As has been noted frequently through the report, midwives are continually reflecting on their practice in both a personal and larger sense. Thus caseloading midwifery, and independent practice in particular, is continually evolving. What may have suited those who made the first transitions into independent midwifery may now not suit newly qualified midwives. Consequently, the latter groups are constantly seeking to develop ways of practising that better suit their needs and the times they live in. Importantly, such a process involves not just the midwife but her family as well – this includes not only their partner and children, but also extended family and close friends. They are thus seeking to foster a more balanced approach to their personal and work lives. A significant part of this involves agitating for, and organising, regular time-off. To many on the outside of independent midwifery one weekend off per month, as is being trialled by one group – that is, a weekend when you are not on-call and will not be disturbed for any reasons – may not seem much to ask for. But it offers a period of time when family truly can come first since everyone knows that there will be no phone calls intruding into, and no anxiety that the midwife will be called away from, what is happening. Having regular time-off requires greater organisation and planning and means educating clients that midwives too have families and lives of their own. One collective adopted a proactive approach in this regard.

We've all got the same letter and at the top we just say I live with my partner and blah, blah, blah and then we go into the bit that says, please help us by saving our personal and family time by keeping calls to a minimum and only if its urgent out of these hours and turning up to clinic times and if you can't turn up, please ring and just things like that.

As has always been the case, midwives in practices and collectives continue to provide a range of less formalised cover to allow their colleagues to attend important functions and events or just have some brief respite.

If I think that I'm going to out to a big hoolie and just going to have a whale of a time, then I'm happy to ring up one of the others and say I need just a couple of hours off tonight, or I'm doing something that's really important, and get cover.

This provides an important and ongoing way to balance home and work demands. One midwife noted that her practice was especially careful to ensure such time-off for events involving children.

What emerges from the interviews that draws together the rather fragmented aspects of the discussion thus far is the idea that independent midwives are trying to fashion lifestyles that integrate the various components of their lives – personal, family and work. This often occurs as the result of strategies – and here, following Felstead and Jewson (2000:148), I employ the term ‘strategy’ to capture emergent patterns which might or might not involve deliberate planning and premeditated intent and are the outcome of “conscious planning, or emerge in a cumulative and unreflexive way”. Thus, the structuring of time-off without interruptions is a clear case of a deliberate response to intrusions.²² The need to just accept rather than worry over always being on call, and how it might interfere with your life, is likely to entail a more gradual process of incremental change and may emerge over time in a less conscious way. As one midwife put it:

One of the mistakes that people make is that they say I’m on call so I can’t go out or I can’t do this. You get to a point where you just carry on your life. You do what you do. You go to the movies or you go to whatever and if you get called you get called. And most of the time you don’t get called.

Though the interviewees occasionally resorted to notions of trying to ‘balance’ work and home, as Thompson and Bunderson (2001:17) put it, “balance imagery suggests that there is some appropriate distribution of hours that an individual should achieve among the domains of work, family, community, religion, recreation and so forth”. As these authors go on to say, such an approach ends up limiting the interaction of work and non-work to a zero-sum time allocation exercise which ignores or misses other dimensions and the complexity of the processes. In the case of independent midwifery, for instance, how much is required to balance being called out at 3 am on a Saturday morning and not returning to your home for 24 hours? Or what is required to balance up being called out of a school prizegiving?

Another metaphor that was also prominent in the interviews may, consequently, be more useful. The alternative I want to highlight is the tendency among some of the midwives to talk about developing a *lifestyle* and *integrating* the aspects of their life together. One of those interviewed made this very explicit.

I believe that this is a part-time job, because if I allowed it to take over too much time and energy, I would never continue doing this. This is part-time and I take my phone wherever I go, but I really don’t care about it. ... I know that there are midwives in Auckland that take ten ladies a month and for me that would be just horrendous, I take roughly five a month and I can still go and watch my kids play rugby on the weekend, I’m manager for one of their teams, we do martial arts three times a week, I still do that and its very rare that I miss those.

Though she talks of midwifery as “part-time”, she does in fact take what is considered a full-time caseload, and her terminology seems more intended to help make sense of how she sees work and its place in her life more generally. The evolution of a lifestyle, that

²² See Felstead and Jewson, (2000:120-142) for a discussion of various technologies of the self characteristic of home-located workers. Some of these practices are used to mark off time and spaces as being work or home designated. Others help the person regulate or organise switching between work and non-work activities. Certain strategies can be useful in stopping homelife disrupting work and work intruding into homelife.

integrates work with the midwife's home, family, personal and social life is evident in many other comments from midwives, representing a strong consensus among those interviewed.

It is very much a lifestyle, my phone never gets turned off so if it rings at 2.00am or 3.00am that's my job.

It just becomes integrated into your life.

I have a lifestyle that I go out and do whatever I want to within reason.

Eventually that just becomes part of your life.

I mean that this is a choice that you make, it's a lifestyle that you choose.

I always used to say it is not a job it is a lifestyle

In constructing a lifestyle that integrates work with other aspects of a person's life, it is important to recognise that in the case of midwifery it is women's work that conditions this process. As is evident from the earlier discussion, partners needed to be active and facilitating in any such process. So too do children, while extended family and friends can also play a part. However, two things are of over-riding importance. Firstly, there is the nature of caseloading midwifery practice, much of which cannot be changed and which is out of the control of the midwife. Secondly, there is the midwife's evaluation of, and response to, this. Loosely employing Thompson and Bunderson's (2000) terms, it seems that these women 'anchor' their identities in the paid work domain and that their work is 'identity affirming'. That is, "over the range of instances wherein [work and nonwork] identities bump into one another, one will emerge as central" (Thompson and Bunderson, 2000:28). In this instance it is their paid work that exerts a central and influential role in managing the interaction of work-nonwork conflict. This runs counter to the usual dominant influence exerted by the male's work.

In the previous report on NSW among knowledge workers (Firkin et al., 2002) the notion of a work-life mosaic was introduced to try and capture the way in which people integrate work and non-work aspects of their lives. Mosaics imply the combining of pieces, many of which may be very different in size, shape, colour and composition. The edges of some pieces are sharp and clear while others are less so. In a mosaic some of the joins can be close and neat and others more dispersed. We can visualise a person's life as comprised of different pieces, just as a mosaic is. That is, people combine different activities – described in different lexicons as work and non-work activities or as paid and unpaid work – each with various characteristics. Some of these combinations of activities would fit neatly together and others require more effort or concessions in order to make them fit. The distinctions between components can be very clear in some places and less distinct in others.

By way of moving the theoretical discussion on from the idea of a work-life mosaic I now turn to the work of Norbert Elias. What the midwives described regarding the integrating of work and home in a lifestyle manner can be seen to fit with his

configurational approach, “a model of interdependence, a field of tension ...that is created between that phenomenon and the directly opposing one” (Tabboni, 2001:16). Thus, what happens in one area needs to be considered in relation to the other and tension and interdependence are essential ingredients of each and the whole. Importantly, the perfect or ideal integration may never be achieved. Rather, it is an ongoing and reflexive process. The benefits of adopting a configurational approach are that it maintains something of the mosaic nature of our lives – that they are composed of various activities – while better conceptualising the dynamic nature of the process across time whereby we try to integrate these components, the nature and relationships of which, since they are always in tension with one another, may change.

In the instance of caseloading midwifery, the phenomena and its opposite can be crudely described as work and home. I hope that the bulk of this report has illustrated in various ways the interdependence and tension between these fields and, consequently, the various ways that midwives and their families are constantly at work in the process of configuring lifestyles.

A similar process, though not always necessarily to the same degree, was alluded to by some of the knowledge workers in the NSW Report (Firkin et al., 2002). Nor was it as obvious or distinct in these interviews. However, many of these people were also trying to develop a lifestyle that somehow integrated their personal, home, family and social life with the new working arrangements they had adopted. It seems that to examine new ways of working may necessitate exploring new ways of living.

9. Conclusion

The purpose of this report has been to present the findings from research among a group of caseloading midwives that sought to consider their experiences in terms of NSW. As such, there may be little that is new or insightful in relation to midwifery per se, especially given the level of research interest in the New Zealand approach to caseloading midwifery. However, I hope that the eye and vocabulary of an outsider together with a focus on NSW may offer alternative perspectives and accounts of this profession and way of working that insiders may still find interesting. As is evident in the length and detail of the report, caseloading midwifery has certainly proved to be a very rich and productive case study for illuminating various aspects of NSW and related phenomena. In conclusion, I want to highlight the main findings in three ways. Firstly, I will summarise the discussion built around the model of entrepreneurial capital. Secondly, a comparison will be made between the experiences of caseloading midwives and those of knowledge workers – considered in an earlier report on NSW (Firkin et al., 2002) – in various key areas. Finally, I want to point to what I consider to be two other important issues to arise from the study.

9.1 Entrepreneurial Capital and Caseloading Midwifery

The application of the model of entrepreneurial capital to caseloading midwifery has had three broad outcomes. Firstly, it has provided a detailed account of the mix of entrepreneurial capital unique to independent midwifery – that is, the resources that have entrepreneurial value to a midwife and that she needs to possess, acquire or convert in order to take on this role. How the mix can vary over time and circumstance has also been considered.

Human capital is important in various ways. Over and above their registration, the midwives who were interviewed showed an ongoing commitment to education and training and regular formal reviews of their practice. As well as certain physical attributes – such as stamina – other characteristics beneficial for this way of working and similar to those outlined in the earlier NSW report (Firkin et al., 2002) were identified from the interviews. Mentoring serves as a very specific way that midwives augment the human capital of new graduates so as to allow them to directly enter a caseloading role. The view that not all new graduates may be suited to entering directly into a caseloading role might be read as highlighting the complex human capital needs for caseloading midwifery. On the other side, the blanket ban on any new or recent graduates entering caseloading roles within institutional settings perhaps ignores the variance in human capital that people possess and the possibility that some may be better and, thus, adequately equipped for such a role.

In various forms, social capital proved to be extremely important for caseloading midwives. Familial social capital, especially in terms of the supportive attitudes and activities of a partner or husband, is vital for allowing the midwife to carry out her work. This is particularly true when they have children. The collectives and practices that

midwives belonged to were a second major source of various forms of support. All sorts of other networks – for instance, socially based, as well as those within and outside the profession or health sector – were also important in numerous ways. Though of lesser overall importance than in other businesses, economic capital is interesting given the funding arrangements for midwives and the impacts this has on them. Of least importance was physical capital with collectives and practices often providing much of what a midwife needed. Their existing possessions (car, phone and home) could also be easily re-deployed for these purposes. Finally, some examples of the way that different forms of capital were converted into other forms were given. These include, for instance, how social and cultural capital can be converted to economic benefit.

The cultural capital of midwifery emerges as a very distinctive and extremely important feature of independent midwifery. It is constituted by the notions of partnership and its associated philosophy of care, which serve as foundations and guiding principles for the ‘business’ midwives are in. Importantly, it is shared by consumers and professionals alike and operates at the individual and socio-political level. Thus, as partners, midwives and pregnant women shape the care that is given and received on both a day-to-day basis and in a wider sense. Since it is unlikely that cultural capital would be seen operating to such an extent in many entrepreneurial situations this case offers a very rich albeit unusual example. By very clearly illuminating how cultural capital operates in an entrepreneurial sense, it allows it to be more easily identified in more usual circumstances.

Being able to identify in such detail what I have termed the cultural capital of midwifery is an important feature of the report since it represents part of a second set of outcomes from exploring midwifery in terms of entrepreneurial capital. These centre on what has been added to the model by this process. On top of the contribution made to enhancing the idea of cultural capital as developed from the work of Bourdieu in the model, there is the addition of a corporeal dimension to the category of human capital.

A final outcome of combining the model of entrepreneurial capital with a study of midwifery has been to very effectively illustrate what that model can bring into relief when analysing any particular form of entrepreneurial activity. In the case of midwifery, the model has shown the importance of human, cultural and social capital over financial and physical resources. The latter pairing are more often seen as crucial factors in self-employment. Given that most midwives are women, this approach has also allowed the influence of gender to be easily explored alongside the examination of resources.

9.2 Comparing Caseloading Midwives and Knowledge Workers

Comparing the experiences of caseloading midwives and knowledge workers as non-standard workers – as researched earlier by the LMDRP (Firkin et al., 2002) – allows some discussion of the more significant similarities and differences to take place. Compared to the diverse contextual influences and their rather diffuse effect on the transitions of most of the individual knowledge workers, the factors that opened up possibilities for caseloading midwifery can be clearly identified and their impact is critical and substantial. Indeed they set up a momentum for change within both consumers and

midwives. While most individual transitions into independent practice were for similar reasons to those given by knowledge workers moving into self-employment, they were also characterised by an over-riding desire to practice in a particular way consistent with the cultural capital of midwifery. As such, earlier transitions into caseloading roles represented significant changes in the profession. Like knowledge workers, most caseloading midwives showed little interest in moving out of non-standard ways of working, though age and family considerations were issues that could affect this.

Midwifery is unusual for offering mentoring as a means to prepare and assist new graduates for direct entry to independent practice. Most knowledge workers did not move into self-employment until they had established networks and/or developed certain levels of experience and expertise in their field. While a few knowledge workers did move straight from study into self-employment, they were not mentored in any way.

Like knowledge workers, caseloading midwives viewed the flexibility of this way of working as a key benefit. They also enjoyed the richer but more intense and challenging work environment with the last two features being viewed very positively. Unlike knowledge workers, none of the midwives who were interviewed experienced the uncertainty over workflows that the former group identified as the most prominent disadvantage. The maternity 'market' was such that midwives often had more than enough work. While the alternative ways of working that caseloading midwives and knowledge workers adopted had positive and negative effects on their family lives, the latter were often felt more acutely. This seemed to be more so for midwives given the demands of caseloading midwifery and its unpredictability and intrusiveness.

The tendency for independent midwives to be part of collectives and practices mirrors the ways that other health and social service workers, interviewed as part of the knowledge workers' study, organised themselves. In the main these workers operated as part of fairly loose collectives, itself a contrast with those knowledge workers who were in groups of some sorts, usually in the form of more traditional partnerships. At the other end of the spectrum some were part of informal 'virtual' networks.

Some of the knowledge workers were described as dependent contractors. That is, they were solely or almost exclusively reliant on one organisation for their work. While independent midwives clearly provide services to a number of clients, their payment arrangements make them dependent, in a similar sense, on one source of income. These payment arrangements have other implications which very much separate them from other contractors. For instance, they cannot set their own charges and these had remained unchanged for some considerable time. Nor can they charge over and above the set levels of reimbursement. Thus, the only way for them to vary their income is to alter the number of clients they look after in a period. Of course this has flow on effects into other aspects of their work and home lives. The staggered nature of the payment system – both in terms of time and the varying amounts for different stages of care – also has impacts not always shared by others, though all self-employed people struggle with delays in payment and the like.

As compared to the majority of knowledge workers who were subject to monitoring only by their outputs – the quality and timeliness of these for instance – midwives were subject to much more intensive and extensive monitoring. This could occur as part of, for example, formal reviews, informal peer review within practices, and the day-to-day feedback that was encouraged from clients.

Given that one of the criteria for selecting midwives as a case study was their low involvement with technology, generally and in comparison with the knowledge workers, it is unsurprising that this played only a small part in their work. That said, items like cellphones were valuable for allowing greater integration of paid and unpaid roles, though it could be just as easily argued that they also permitted greater intrusions of work into home. Unlike the knowledge workers, midwives had very little interest in business legislation and policy, and compliance issues. Such a difference could be explained in a couple of ways. Firstly, they tend as a group to recognise but downplay the business side of their work. Secondly, much of their efforts in the wider political realm are targeted at issues related to their practice and not their business.

In relation to insider/outsider issues, while it appeared that midwives had to confront the same sorts of challenges as the contract knowledge workers, in the former's case these seemed to require the negotiation of much more complex and numerous relationships and processes. Consequently, this might have had a bigger impact on them and how they did their work. The resistances independent midwives experienced from within their profession, certainly in the early years after the legislative changes but which persist up to the present to a degree, are very different from anything described by the knowledge workers and represent an added dimension to the insider/outsider issue.

As to the overall management of their working lives, since midwives experienced far less uncertainty in terms of workflows they seemed to be better able to manage their time over the long run compared to many of the knowledge workers. Thus, for instance, holidays were much more easily and readily organised and belonging to collectives and practices meant that there was cover for sickness, though this placed demands on others. In the shorter term, the more demanding and unpredictable nature of their work, meant midwives experienced greater difficulty managing their time with regular time-off the key issue in comparison to knowledge workers. Again collectives and practices provide some solution to this, though how time-off is organised varied considerably. As well, any cover arrangements raise issues of continuity of care, questions of reimbursement, and the need to inform and enlist clients in the process.

While the knowledge workers worked from various locations, many utilised their homes as offices. By contrast, only a couple of the midwives who were interviewed conducted consultations in their homes, preferring instead to use practice rooms or those rented for that purpose, and births took place in maternity units or clients' homes. Despite this, homes were still a place open to the intrusions of work via the phone and many midwives also did administrative tasks there.

As a case study, midwifery offers an important insight into the gender dimensions of NSW. The female knowledge workers with families usually organised their NSW according to the needs of their families. While midwives were also able to do so and enjoyed positive opportunities for integrating home and work, the nature of their work meant that there were limits to both. Their work tended to impact on the household much more and placed greater demands on their male partners or husbands. This was mainly due to its intrusive nature. While phone calls were seen as the most aggravating aspect, they were also the most easily dealt with at the time and most midwives were developing strategies to manage these more generally. Less frequent but far more demanding were the requirements to attend to a client, especially for a birth which might necessitate having to leave whatever they were involved in at any time of the day or night for considerable periods of time.

9.3 Some Final Observations

Two final points I wish to draw attention to concern what a case study of midwifery helps reveal about NSW. The first follows on from the preceding section and considers how midwives integrate work and non-work aspects of their lives. The rise of non-standard ways of working often force or demand different alignments between these two spheres as compared with traditional forms of work. Research into NSW must, therefore, address this. Often, as has been pointed out earlier, a balance metaphor is used but can be problematic. In a similar vein, the earlier research with knowledge workers introduced the notion of a work-life mosaic to try and capture the numerous dimensions of activity – work and non-work or paid and unpaid – that make up people’s lives and how they integrate and manage these (Firkin et al., 2002:15). Some shortcomings of a mosaic approach were evident in the interviews with midwives and served as a further impetus to find theoretical mechanisms to better describe what was occurring. Thus, the idea of an ongoing process of configuring work and home, loosely based on the work of Elias, has been suggested as promising in this regard. However, this does not mean that a configurational approach need necessarily supplant the idea of a mosaic. Rather, it adds dynamic qualities not normally considered part of a static mosaic.

The second point that I want to highlight from the study, and its use of midwifery as an examination of NSW, illustrates the objective and relative nature of this and other such conceptualisations. That is, we can consider whether forms of work are standard or not in relation to the wider labour market and in terms of specific groups. This signals the need to acknowledge the temporal and spatial dimensions of defining ways of working. Thus, determining what is standard or non-standard needs to take account of the location as well as the timeframe under consideration and relevant historical circumstances. Midwifery in New Zealand serves as an exemplary instance of this given that it is organised very differently compared to other countries, and that what might be considered standard ways of working have shifted from independent practice at the turn of last century to hospital-based practice during the bulk of that century. With the re-emergence of independent practice, and then the development of employee-based caseloading schemes, what can be termed standard and non-standard in terms of midwifery is less certain as we enter the new millennium.

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