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Resilience and sustainability amongst maternity care providers

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Introduction

The preceding chapters have explored a variety of complexities. This chapter turns to the maternity care providers who provide care in this social, political and emotional milieu on a daily basis. The emotional work of maternity care provision cannot be underestimated (Hunter & Deery, 2009). Contemporary maternity environments have an accumulative psychosocial and biomedical complexity and acuity which place increasing stresses for perinatal health providers when supporting women. This is coupled with the growing desire for technological interventions from mothers and families who use the services (McAra-Couper, Jones, & Smythe, 2010). With raising birth rates juxtaposed to financially stretched local services and frequent unrealistic staffing ratios in many services, the potential for unhealthy practices and low levels of resilience in order 'to cope' arise in practice reality. There is evidence of increasing burnout, emotional fatigue, depression and subsequent reduction in work satisfaction in perinatal health workforce (Beaumont, Durkin, Hollins Martin, & Carson, 2015; Cooke, Doust, & Steele, 2013; Curtis, Ball, & Kirkham, 2003; Donald, 2012; Govardhan, Pinelli, & Schnatz, 2012; Yoon, Rasinski, & Curlin, 2010; Young, 2011). This is becoming more evident; for example, the increasing number of midwives choosing part time work and leaving the profession (Hunter & Warren, 2014; Young, 2011). Turning our attention to the psychosocial wellbeing of perinatal health workforce is relevant.

The focus needs to be on developing healthy resilient behaviours that nurture and protect the individual and how maternity systems/organisations can be resilient and facilitate long term sustainability. Although the focus in this chapter is largely on midwives the content, suggestions and implications have parallel concerns with other professions engaged in the perinatal period. This chapter therefore argues for more transdisciplinary long term strategies. Drawing on several studies involving midwives and medical staff the notions of resilience and sustainability are explored. Case studies, based on lived experiences, highlight

the tensions in practice which draw out what is within and beyond the everyday practice realities and gesture to best practice that nurtures and sustains optimal psychosocial resilience in maternity care providers.

Background

The prevalence and incidence of underlying risk factors that create situations of psychosocial vulnerability and feelings of marginalisation amongst perinatal health providers is becoming clearer. Yet there is a relentless expectation to provide more and more with seemingly less and less. This is taking its toll on perinatal health providers to the point where newly qualified midwives report that they are “surviving and not thriving” in their chosen vocation (Fenwick et al., 2012). This raises serious concerns about the sustainability of future services and how current services are configured. This needs addressing urgently to mitigate the potential for adverse outcomes for both the individual health professional and the future of the maternity service as a whole.

Resilient protective factors are now being recognised and researched across disciplines. Despite this it is still challenging to define the concept of resilience and understand the ineffability of how this aspect of human nature reveals itself both in individuals and organisations. It is often a quality only appreciated after it has revealed itself and can rarely (if ever) be predicted. Applied to organisations, businesses and individuals resilience implies that an individual or system needs to be prepared to live with whatever surprise and disturbance occurs (Folke, 2006).

Sustainability and resilience are emergent notions in maternity care workforce discourse. Two midwifery workforce studies define their understanding of resilience and sustainability; a United Kingdom (UK) study defines resilience as ‘the ability of an individual to respond positively and consistently to adversity, using effective coping strategies’ (Hunter & Warren, 2014, p. 927) and a New Zealand (NZ) study defines sustainability as enabling “something to continue to exist, whilst maintaining the mental and physical wellbeing of the agent’ (Gilkison et al., 2015; McAra-Couper et al., 2014). Hunter and Warren’s (2014) study found that being resilient is concerned with dynamism and stability and the capacity to bounce back from times of adversity; qualities regarded as a strength in midwifery. However this raises concerns.

Workforce interventions, such as the growing popularity of 'resilience training' could be espoused as a quick fix solution. The constant need to accommodate, adapt and recover from vulnerable situations in terms of personal wellbeing needs further exploration. Leitch & Bohensky (2014) caution that resilience could be an 'aspirational rhetorical device'. Care is required to ensure constructive help is available when required and is not replaced with a set of formulaic principles in the hope that recovery from times of practice adversity is possible. The subsequent expectation could be construed as exploitative as the message could be "toughen up and get on with your job then you are a real midwife". This obviously is not the intention of the current growth in resilience training workshops, yet this interpretation may have negative implications that cannot be ignored. The 'I can do' stoic mood of many maternity care practitioners may be commendable to a degree but comes at a cost. To cope with whatever, one is 'thrown' into without choice and little opportunity for a reprieve is unsustainable and has the potential for propagating adverse psychosocial consequences amongst maternity care providers.

Resilience amongst maternity care providers

The notion of resilience as applied to professional workforce research has yet to be agreed and studies continue. For the purposes of this chapter several case studies using Coutu's (2002) three principal qualities of resilience provide a starting point for discussion:

- Ability and capacity to accept the harshness of reality
- An ability to improvise and make the best of what resources are available in a given situation and
- The tendency to find meaning in times of adversity

These qualities are illustrated through the use of experiential examples taken from various studies (Crowther, 2014, 2015; Hunter & Warren, 2014; McAra-Couper et al., 2014).

Following this section suggestions for individual and maternity care system psychosocial resilience are offered.

Ability and capacity to accept the harshness of reality

To face the reality of whatever confronts one demands self-awareness and being prepared to meet the worst and deal with it. Childbirth and consequently midwifery is immersed in a world that is inherently unpredictable. Each day can and will bring the unexpected. Most of the time this is an experience of joy and delight, but on occasions there are traumatic

perinatal events which can be harrowing, disruptive and sorrowful (Crowther, 2014). Midwives, for example, have reported post-traumatic stress symptoms (Sheen, Spiby, & Slade, 2015) (also refer to chapter X) and the effects of exposure to perinatal trauma are exacerbated when there is an unsupportive infrastructure (Calvert & Benn, 2015; Crowther, 2015).

Deepa (rural GP) describes how she is thrown into the unpredictable suddenness of a childbirth situation with little expert help nearby. Deepa a New Zealand (NZ) GP has no choice but to accept the harshness of the reality unfolding in front of her:

By the time I got there this wee one didn't have a line in, they'd actually failed on two attempts. The umbilical vein catheter I tried didn't actually work because the umbilical cord had been cut quite short. I did get a line into the back of the hand and we resuscitated the baby and the chopper did come about an hour later after doing major resus. We were 3 hours away from secondary care. Once I'd got the line in I was really quite thankful. She was only 2.3 kilo baby. I have to say that was probably my closest call for a neonatal resus in this area. (Rural GP, Deepa, NZ rural study, Crowther, 2015, p. 31)

The 'can do' mood of rural living often serves communities of practice well. It is about using all the skills and help to hand, as another participant in the same study states it is "all hands on deck". Yet this is dependent on a willingness to work together in teams locally, be focused and recognise and appreciate what expertise is nearby. This is equally true of other environments and with different outcomes including those that are not as positive as this example given by Deepa. Simone (midwife working with a mother in hospital) narrates her story with a very different outcome:

The mother went to the bathroom and didn't come back [long pause] then it was just like white lightening and bright lights and people... [cries] I just didn't think it would come back like this [crying]. But when you contextualize it in relation to the beauty of birth and new life and then death enters. The joy was there because the baby was coming; there was no hint that kind of thing was going to happen...the baby could've died, but it didn't. It's almost like it wasn't the baby's time to die, [whispers] but it was the mother's time. I did not really think on the baby then but now when I look back, it is a miracle. (Midwife working in Hospital setting, Simone; Crowther, 2014, p.174)

To face the reality of a situation is contrary to ignoring or/and unquestioningly persevering in adversity despite personal costs; that would lead to unhealthy resilient behaviour that is

unsustainable long term. Simone spoke about the support she received from peers and other members of the hospital team yet the distress of the events continues to affect her. Deepa and Simone learn to face the situations confronting them and step up to what is required. This is not possible when that demand is unrelenting and support from others is not available. The harshness of the practice reality in maternity care, that can often take an emotional toll on the individual, must be acknowledged and appreciated by the larger team of care providers. The constant need to be prepared, to use what there is locally in all situations and trust local processes and people to communicate and be supportive is essential.

Ability to improvise and make the best of what resources are available

The ability to continually improvise is another quality of resilience. A New Zealand rural midwife finds herself thrown into a situation requiring immediate improvisation during a lengthy transfer to hospital:

The car in front just stopped. I was following them in my own car. She got out leaned on the car and pushed and pushed. So there we were on the side of the road with baby coming. Cars driving past and her bum out to the world! So I throw what I had in my car on the back seat of her car and got her to climb back in onto her knees where she birthed ...in some privacy. I just grabbed whatever I had to hand. No way can you plan for that type of thing I just had to deal with it (Rural caseload midwife, Chris, NZ rural study, Crowther, 2015, p. 30)

Resilience requires the capacity to accept and face the realities of practice, be realistic and optimise outcomes by whatever is available. This requires flexibility and resourcefulness. Chris is able to improvise on the spot, making the most of what is at hand. What she knows and does is revealed in and beyond the everyday taken for granted practice that now unfolds on the side of the road. On this cold snowy day when a baby is born on the back seat of a car with no equipment and no collegial assistance to hand. Chris improvises and delivers the safest skilled care possible in the unexpected situation that she is thrown into. Likewise the practitioner rushing from one task to the other on a busy yet understaffed labour ward needs to improvise and keep care as safe as possible.

As with Deepa above Chris rises to the challenge and adapts. Chris and Deepa have maintained perspective in the face of a potential adverse outcomes and demonstrate a level of skill and expertise. Yet caution is required if the system in which they work is unsupportive. To improvise requires a supportive infrastructure and a leadership that cares and acknowledges these times of heightened stress imposed on the team.

Unfortunately, this is not always the case and the constant need to improvise highlights a system that is unsustainable and unjust. An organisation and its leaders who are overly confident and optimistic may not see how the practice reality is untenable for individual's long term. Sally another New Zealand rural midwife shares her story:

So if I am really exhausted I'll pull off the road and have a sleep in the car. Once you've had your birth you're all kind of hyped up and busy and you've got so much to do and then you get in the car and drive; then tiredness hits. I've got a sleeping bag in the car for when this happens. I am set up for this. I've woken up with all sorts of people staring into the car at me. There was a dustbin man at one small town. I had obviously parked my car in front of someone's drive. I was in a pub carpark at one point, I had no idea, but I was so tired I didn't care. (Rural caseload midwife, Sally, NZ rural study, Crowther, 2015, p. 45)

Sally's story draws attention to the question of personal safety and self-care. Her ability to improvise is not questioned, the question is "is this sustainable long term? Sally wants to provide continuity of carer for members of her community. Yet is it sustainable for Sally to be sleeping in the back of her car on the way home from providing intrapartum care? The time, inconvenience, disruption to her personal life and the effects on her psychosocial wellbeing need addressing.

It is plausible to assume that perinatal health workers practising in different practice settings strive to provide the best care they within their local contexts. Sally's story highlights the significance of models of maternity care and service philosophies and how they directly influence the experience of those that work within them. The drive to make a particular model of care function and remain philosophically aligned to the current discourse in a region is unrealistic when practitioners are sanctioning unsustainable practices. This is not to undermine continuity of carer provision and its proven benefits (Sandall, Soltani, Gates, Shennan, & Devane, 2015). It is about ensuring sustainable psychosocial and physical wellbeing for all perinatal health workers wherever they practice.

The above examples provide an opportunity to question models of care and how perinatal services function sustainably (or not) and what continues to be hidden within the busyness of everydayness. Maternity care providers in all settings, models of care and regions constantly need to adapt and meet the unexpected. It is vital that the individual sacrifice and expertise is not invisible to the organisations that regulates, manages and pays them. If these organisations/institutions lack compassion, insight and appreciation of what practitioners do it becomes a recipe for fatigue and a system in breakdown leaving communities and practitioners vulnerable threatening long-term sustainability of perinatal care provision.

The skills and aptitude of perinatal professionals to cope, even when exposed to adversity and challenge is impressive. They appear to always be on the way to new ways of doing things, developing systems that work better for their communities; even when support from other agencies appears not to be forthcoming, such as lack of individual control over workloads and staff finding ways to ensure breaks on a busy labour ward. Maternity care professionals consistently move towards coherence in maternity services in whatever way they can, for example how midwives construct robust practice arrangements illustrates how New Zealand caseload midwives self-care (Gilkison et al., 2015). The notion of self-care in midwifery has also been highlighted as central to resilience in UK practice (Hunter & Warren, 2014).

To be resourceful, adaptive and have the skill to improvise are certainly qualities worthy of nurturing but balance is required. Self-care, self-awareness and determining what works and does not work regionally is crucial. There needs to be recognition by practitioners and those that manage them to be aware of when healthy resilience turns into unhealthy resilience. Alexandra (2013) stated that "One person's resilience may be another's vulnerability, and one would not want the concept to be used as a means of reinforcing unethical practices or hegemonies" (p. 2714). Persistent unhealthy coping strategies need addressing. Constantly trying to keep up with demands without a pause for reflection may lead to a rigidity of practice that is then unable to adapt and improvise when needed. The consequence of this may be an inability to find meaning in the work they do when times are challenging.

Tendency to find meaning in times of adversity

Maternity is unpredictable, there is always going to be unavoidable times of adversity for all maternity care providers. Coutu (2002) speaks about the need to build bridges over present hardships and times of adversity in order to make better futures. The result is making the present moment of adversity feel more manageable and less overwhelming. The notion of meaning can be elusive yet finding meaning in what we do is another significant quality of resilience which builds bridges over challenging times. As human beings we continually interpret and make meaning out of all our experiences (Gadamer, 2008/1967). The following example is taken from my personal reflective diary written in the late 90s following an adverse outcome:

I've been involved in an unexpected neonatal death at 3 days old whilst providing postnatal care in the community. It was obviously devastating for all involved. That evening I was called to another birth. It was like swimming through treacle to attend that birth yet I found solace in the mystery of life as another baby arrived. I relished the depth of relationship I had with these new parents. Joy and sorrow danced around me that night yet somehow I was able to remain grounded in the reality of my work. I desperately wanted to know 'why' and seek some meaning. Later colleagues came to my home and supported me, the next day I sat with the grieving parents and we hugged, cried and spoke of the precious time we shared with their baby before he died. I had never known such a depth of connection with other families. The significance of being alive profoundly touched my soul in new ways. I plan to attend the funeral.

The neonatal death provided me with a depth of understanding about childbirth not previously encountered. The events of that sad occasion deeply touched me and others around me. That baby boy's death has taken on a rich and lasting meaning for me professionally and personally. I keep a picture of that baby as a remainder of the significance of being with others in this life and the significance of being a midwife. The event strengthened me and made me less vulnerable to the uncertainties that can meet me as a midwife and revealed deeper layers of sensitivity that made me feel stronger. I realised that whatever I do, however honed my skills are 'things' happen beyond my control and that is bearable. Gaining perspective, seeking out social support and using reflection for self-awareness contributed to my ability to continue and nurture my joy of midwifery practice; attributes that have since been identified in midwifery sustainability and resilience studies (Hunter & Warren, 2014; McAra-Couper et al., 2014).

Creating and nurturing meaning helps practitioners survive professionally and personally. Here Brenda (obstetrician) speaks about the joy of being at an emergency high risk caesarean section for twins and the meaning of that experience has for her:

Seeing that baby surviving in a sack and in an instant changing to being an independent little human being was amazing. It is more than the medical stuff to me it's spiritual. There's no laboratory you could cook that up in! It's the gesture or the action that shows us that there is continuity, there's more purpose to life. The fact that it keeps happening with such continuity is a good symbol to us to keep hoping for better things. Birth is a symbol of the continuity of life and gives us value for our lives, giving birth value. (Obstetrician, Brenda, Joy at birth study, Crowther, 2014, p. 203)

Despite the emergency nature of the events unfolding Brenda finds meaning. To be working at the start of life gifts Brenda insight and purpose in the work she does. Birth for Brenda is informed by spiritual values that may seem surprising to the outsider. Yet it is deeply felt meaningfulness that inspire and sustain maternity care professionals.

A shared philosophy that informs the culture of practice is also crucial and brings meaning to everyday reality. In midwifery this shared philosophy helps shape and interpret situations that would ordinarily be construed as impossible to overcome. For Lisa, a community based midwife working in an area of high social deprivation the rewarding part of midwifery practice is supporting and making a difference to women:

I as one individual can't make a huge difference. . . . and I think you have to have an acceptance that you're not going to change the world, but that you may be able to make a little bit of a shift and a dent in it. . . .(Griffiths, et al., 2013, p.226-7)

Lisa accepts her limitations and finds purpose in the small contributions she can provide to the women in her care despite the enormity of the psychosocial concerns in her caseload. Finding and having purpose is arguably a psychosocial spiritual need nurturing positive resilience individually and organisationally. Lisa sees her work making a 'dent' into their world of social and economic challenges making a difference, however small that difference may be. An aligned philosophical approach amongst midwifery colleagues may provide meaning for when times are challenging (McAra-Couper et al 2014). However, what remains largely hidden is the philosophy and 'what matters most' that provides meaning and

inspiration to all individual members of the perinatal health team beyond the medical and midwifery rhetoric (Crowther, 2014).

Building and sustaining psychosocial resilience

This section focusses on building and sustaining psychosocial resilience in the perinatal workforce through relationships and shared resonance.

Relationships

In relation to the studies cited in this chapter it is apparent that resilience in maternity care is fundamentally built upon a rich tapestry of relationships attuning in a way distinctly different to other aspects of healthcare (Hunter, Berg, Lundgren, Ólafsdóttir, & Kirkham, 2008). The joy experienced in reciprocal relationships with women and families contributes to the meaning of maternity practice and thus promotes healthy psychosocial resilience. When reciprocity in relationships is not possible and challenged, either by models of care or/ and workloads the significance of that part of maternity care is brought into the light. Carol, an Obstetrician, who had moved from one model of care to another (from private obstetric-led caseload practice in the USA to a hospital consultant in a state hospital without a personal caseload in New Zealand) shares her experience:

I don't know the women I don't have that relationship with them. So it is a much more clinical; someone calls me, I need to assess the situation, I need to make a recommendation and get the baby delivered. It's much more clinical and the emotional part of it for me about being excited or happy or satisfied about a birth, that's much less now, it's changed. It was that relationship part of it that was important for me to feel much more emotionally involved in births. Whereas now I would say it's much more clinical; it's my job to get this baby delivered and as safely as possible. Sometimes I feel sad about that sometimes not. I mean it's sort of easier emotionally to just walk in, get my job done and go. But, I sort of miss that emotional part of it too when you have much more invested in these women's lives. (Obstetrician, Carol, Joy at Birth study, Crowther, 2014: p.192)

The loss of reciprocal relationships with the families she works with is missed. She remembers how those relationships were important to her in private practice. Relationships allowed Carol to be more touched by the meaning of birth. Likewise professional relationships (both inter and intra-professional) are equally crucial:

I love being a midwife and learned very early in my career to seek out like minded individuals and also other individuals who I knew would be supportive in certain situations. I also know that others use me for support and that mutuality helps build resilience. (Midwife 9, UK resilience study, Hunter & Warren, 2013: p.931)

This reveals how building resilience requires other's support. Building and sustaining resilience is multifaceted and requires healthy trusting functional relationships. When these relationships break down and professional disputes unfold it is challenging. This is Deepa's (rural GP) story:

There was a patient sitting in an ambulance on the rural hospital grounds. I didn't realise why a chopper was coming. It wasn't until the ambulance control rang the hospital to say the chopper's 10 minutes away for your PPH that I realised it was a PPH. I was aghast because when we looked out the back doors suddenly there was an ambulance with a woman inside who did not have an IV drip in having a PPH. The midwife was in the ambulance. I felt embarrassed as an institution that a midwife had arrived with somebody and I was not involved. What was a barrier to that? I don't know. (Rural GP, Deepa, NZ rural study, Crowther, 2015: p.39)

Living with conflict between maternity professional groups leads to resentment and potential care being unsafe. Stress and potential for burnout amongst perinatal health providers has been shown to be exacerbated by lack of support and isolation (Patterson, Skinner, & Foureur, 2015). This is not sustainable.

It is apparent that whatever the regional situation maternity care provision is about creating trust and good working team relationships. One person or professional group cannot retain all information or have all skills required in every situation. The need to work together is essential. It is unclear why the midwife in Deepa's story remained alone with a woman having a PPH in the medical facility car park. Undoubtedly isolated practitioners are developing unhealthy resilient strategies that only worsen the situation. Any false dichotomies, battles, conflicts, territorial disputes and boundary protection strategies would appear to impede any chance of resilience building.

Challenging communications and professional disputes create potential for misunderstandings and undermines accessibility to supportive local networks (also see last chapter in this book). Good communication and collegial rapport are key to ensuring integrated maternity services that maintain the safety of mothers and babies (Bar-Zeev,

Barclay, Farrington, & Kildea, 2011). Not addressing discord locally, regionally and nationally, gestures towards unsustainability and unrealistic and unhealthy resilience. The consequences of ongoing discord in communities of practice result in professional burnout (Crowther, 2015). Collaboration and cooperation is needed whilst acknowledging professional agendas, local risks and complexities. Hierarchical structures that do not resonate with local needs are not useful and impede progress.

Shared resonance

There is a special resonance or shared mood in maternity felt no-where else in human life that sustains those involved (Crowther, Smythe, & Spence, 2015, 2014). Moods seemingly come from nowhere and everywhere, they are unseen yet they are potent in their affect; the lens through which we interpret our experiences (Heidegger, 1927/1962). Empathic resonance, in other words, how we 'catch the moods of others' filters through organisations because moods are contagious. Relationality and mood are closely linked. For example, reciprocal relationships between women and midwives appear to affect and influence the atmosphere at a birth (Berg, Ólafsdóttir, & Lundgren, 2012). Indeed, moods in maternity can spread rapidly creating barriers and facilitators, rousing intense fear and overwhelming moments of joy (Crowther et al., 2014). To be resilient in these tides of emotional changes requires individuals to be self-aware and have the ability to manage how they feel and what they do.

Organisations that resonate with a positive, yet down to earth realistic agenda can galvanise those that work within them providing the potential for optimising worker performance even when confronted by adversity. A maternity organisation's ability to mutually and reciprocally attune to what matters most in childbirth is thus crucial to healthy resilience and long term sustainable maternity services. The mood of organisations and the individuals who manage them thus determine how integrated a service is and how engaged its members feel. According to Goleman (2014) this requires resonant leadership with a long term sustainable vision for an organisation. Unfortunately, this is not always the case in maternity organisations. Midwife 4 in the UK resilience study acknowledges that it is the organisational system that is failing not her:

No matter how busy or stressful it can be it is important to acknowledge that we are dealing with a 24/7 situation and others will pick up where I

have left offPart of the price for aiming high and 'giving your all' while on duty is that occasionally you can't do the impossible, we must tell ourselves that it is the system that is failing, not us! (Midwife 4, UK resilience study, Hunter & Warren, 2013: p.931)

Feeling continually overburdened in a poorly staffed organisation does not provide the opportunity for practice to be meaningful and joyful. 'Giving your all' and remaining optimistic despite the odds is not sustainable. The harsh reality is that sometimes it is not possible to provide the service you wish to.

I would contend that discordant resonance weakens the long-term sustainability of a service. When dissonance from organisational values arises, tension and emotional exhaustion can occur (Edwards, 2009; Hunter, 2004; Murphy-Lawless, 1998; Yoon et al., 2010). Equally, misaligned practice philosophies amongst midwifery colleagues has been shown to be unsustainable (McAra-Couper et al 2014). Even highly motivated practitioners may choose to leave in order to ensure their own wellbeing if their work becomes overly busy, purely rule based, meaningless and lacking congruence in what they value. This could leave a service bereft of healthy resilient role models and the potential for unhealthy resilience to become the norm and contaminate an entire organisation.

Self-assessment and identification of risk

In the sustainability literature it is understood that the environment and the individual are in a reciprocal relationship; one cannot flourish without the other. Resilience is thus also about balance: between the organisation and personal. Without such balance psychosocial resilience is unsustainable. Examine the maternity care in your region and ask yourself:

- Is there any inter-professional conflicts?
- Is there any fears of discord and censure?
- Are there maternity care provider retention/recruitment issues in your region?
- Are users of maternity services excluded from maternity policy/guideline decisions at local and national levels?
- Are some members of the maternity care provider team excluded from maternity policy/guideline decisions at local and national levels?
- Is any single professional group dominating the others in policy, guideline and protocol development?
- Are there some maternity care providers treated with disrespect and unappreciated for their contributions?
- Is there a paucity of locally accessible emotional and psychosocial support to help practitioners work through times of adversity?

- Is the service constantly busy and/or set up in a way that is leaving no time to have conversations and share among colleagues?

If the answer to any (or all) of the above is 'Yes' then urgent work is required to ensure a sustainable healthy psychosocial resilient service. The following questions are focused on (you) the individual maternity care provider.

- Are you self-directed, self-determined in the way you work and how you work?
- Do you share the core values of maternity care provision in your hospital or region?
- Do have healthy self-care strategies?
- Do you have passion and enjoy the work you do?
- Do you nurture/build relationships (social and professional; including across professional groups)?

If the answer to any of these is 'no' then self-exploration of your personal current working practices and situation is necessary. The above exercises would be beneficial to do with others, preferable a multi-professional discussion group.

Recommendations for practice and research

Various individual practice and service system characteristics and qualities need addressing to ensure psychosocial healthy resilience. The following table summarises the psychosocial resilience qualities and two principal attributes for building resilience.

Qualities of psychosocial resilience	Attributes for building and sustaining psychosocial resilience
<ul style="list-style-type: none">• Ability and capacity to accept the harshness of reality• An unusual ability to improvise and make the best of what resources are available in a given situation and• The tendency to find meaning in times of adversity	<ul style="list-style-type: none">• Reciprocal healthy relationships• Shared resonance

Some techniques/approaches have been reported to promote healthy psychosocial resilience: self-determination, self-care, self-awareness and nurturing the love, joy and passion for practice. The foundation for these are relationality and shared resonance requiring a transdisciplinary approach.

Relationality builds psychosocial resilience

Reciprocal relationships are crucial, this includes multi-professional collegial networking. Developing strategies that promote collaborative working; for example local multi-disciplinary meetings that include GPs, obstetricians, midwives and other members of the perinatal team are essential. As an example in the NZ rural study GPs and paramedical staff met regularly to discuss and share about recent transfers; however the local midwives were not invited – Inviting the midwives into these types of meetings would be one simple initiative that promotes collaborative learning, debriefing and support. Nurturing cross-professional sharing could include development of optimal communication pathways using technology (e.g. tele-emergency systems) for more remote members of the maternity care provider team. Other strategies can include peer group support, clinical supervision which provide opportunities for debriefing in a safe context away from the situation or employment structures (Deery, 2005).

Professional isolation and tendency to build individual professional territories serves neither women and families or members of any professional group. Safety and sustainability is born of healthy relationships, collaborations and open pathways of communications that are not conflictual are essential. Collaborative multi-disciplinary approaches are required locally and at secondary level, along with collaborative learning opportunities. Such initiatives allow cohesive common understandings and contextual meanings (McDonald, Jackson, Wilkes, & Vickers, 2012). The process of sharing and collaborative learning engenders transformative learning and reflexivity. Another strategy to promote wellbeing and reduce burnout is the use of mindfulness techniques. Mindfulness is being explored in relation to healthcare providers and shows promise (Goodman & Schorling, 2012), yet may not be acceptable to everyone. What is clear is that one strategy will not be suitable in all contexts and for all individuals.

The starting point is simply getting to know one another and oneself and honouring differences. This holds the possibility to be powerful and transformative bringing meaningful interpretations to perinatal health professionals across working and personal lives. Each member of the perinatal team has their own concerns, values and needs who may feel unappreciated and misunderstood. These are equally significant. What is called for is a focus that is not polarising. For example, the indeterminate psycho-social and spiritual dimensions

to childbirth are often left silenced in contemporary maternity, yet they are ever present (Crowther & Hall, 2015). Examining meaningful holistic experiences in and around childbirth reveals how obstetricians and midwives are not so different (Crowther et al., 2014).

Relationships matter

The centrality of relationships in maternity are indeterminate and not easily measurable. The midwifery holistic model of care that is built upon relationships is often at odds with the structured determinate knowing that provides kudos to medical disciplines. This can leave midwives feeling marginalised and vulnerable and out of synchronisation with the dominant 'mood' of contemporary maternity organisations. This can produce discordance in an already stressful clinical environment. Yet relationships matter to all members of the perinatal health team even if not overtly stated in the same holistic language. Nurturing relationships and a shared resonance requires a new approach to perinatal health care. An approach that engenders collaborative decision making and working beyond the containment of individual professional groups. An approach that requires all stakeholders, both at local and national levels, to sit together and work through the issues. This is not a new idea. Robertson (2008) argued for a more collaborative model in maternity. She contended that functional teams of practitioners of more than one discipline would provide higher quality of services. It is reasonable to believe that this would facilitate sustainable practice and healthy psychosocial resilience. Stock and Burton (2011) contend 'sustainability is also inherently transdisciplinary' (p. 1091). Transdisciplinarity through emergent co-participative conversations breaks down barriers and may lead to strength based improvements in retention and recruitment. Although this approach is more challenging in the short term the long term gains in terms of safety, sustainability, optimal childbirth experiences, wellbeing and psychosocial resilient communities' of practice is a possibility worth pursuing and requires further examination.

Conclusion

The intention of this chapter is not to further problematize the situation but contribute to a more transdisciplinary thinking and development of services. Maternity care providers face a host of challenges it is imperative that their individual needs are recognised, identified and appropriate strategies employed. Maternity care providers need to be treated fairly, be heard, be valued, enjoy open non-hierarchical communications, feel safe and experience

wellbeing. This chapter does not present all there is to know about psychosocial resilience amongst maternity care providers. The insights and suggestions presented are from personal and professional experiences as well as involvement in several of the studies cited. The examples and subsequent recommendations provide no guarantee of healthy psychosocial resilience; they do however offer possibility for it to flourish. Finally, the focus has been on the concerns related to maternity care providers working and living in high and medium income regions of the world. The realisation of psychosocial resilience amongst maternity care providers within low income regions remains little understood. Those maternity care provider's perspectives and daily practice realities remain largely hidden behind significantly harsher complex challenges than those highlighted in this chapter.

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