Midwifery workplace culture in Australia: a national survey of midwives

Abstract

Problem: The midwifery workforce in Australia is impacted by shortages and attrition. Workplace culture affects midwives' intentions to stay in the profession and their capacity to provide woman-centred care for mothers and infants.

Background: Staff attrition in maternity services often relates to midwives' workplace experiences and negative perceptions of organisational culture. Broad-based data are essential to fully understand midwifery workplace culture.

Aim: This study aimed to examine Australian midwives' perceptions of workplace culture, using a specifically developed instrument.

Methods: A national online survey of Australian midwives, within a wider project on maternity workplace culture. Quantitative data were analysed descriptively. Qualitative data were analysed using content analysis.

Findings: Overall, 322 eligible midwives rated workplace culture and 150 provided further qualitative responses. Themes included 'the ability to be a midwife', 'support at work' and 'bullying'. Less than a third of midwives thought their workplace had a positive culture. Many respondents felt disengaged and unsupported by managers and described an inability to use all their midwifery knowledge in medically-dominated environments. Many attributed poor workplace culture to limited resources, poor communication, time pressure and a lack of leadership in their workplaces. Inadequate staffing levels and poor management left many midwives feeling disempowered and despondent about their workplace. Others, however, described highly positive workplace cultures and inspiring role models.

Conclusion: The survey captured a snapshot of Australian midwifery workplace culture. Findings on leadership, workloads, management support and other aspects of workplace culture can inform future workforce planning and policies. A larger study of the midwifery workplace culture is needed.

Keywords

Midwifery; organizational culture; attitude of health personnel; surveys and questionnaires; workplace culture; qualitative research

Statement of Significance

Problem or issue: Australian maternity services face workforce attrition.

What is already known: Studies of midwives in several countries have shown that midwives report powerlessness, dissatisfaction, burnout and limited autonomy to provide woman-centred care.

What this paper adds: A national study of midwives reported that many experienced their workplace culture as negative with limited leadership or support. It demonstrated that midwives' perceptions of workplace culture relates to resources, autonomy, engagement and relationships with peers and managers.

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Introduction

The culture of any workplace is vital to the experience and, ultimately, the output of its workers. More significantly, in maternity services, workplace culture can profoundly affect the experiences and outcomes for not only midwives, but also the women and infants they care for. In Australia, the majority of midwives work in hospitals [1]. In these environments, restructures are common and new models of care require midwives to deliver quality care, often in complex, medically oriented institutions. By comparison, relatively few midwives work in community settings or in homebirth models of care [2]. Recent changes in Australian hospital settings include public/private partnerships, closures of small maternity units and other streamlining structural changes in maternity units. Any change in a workplace can be unsettling and may lead to cultural change, both positive and negative. Midwifery practice has frequently adapted to align with new evidence, technological changes, hospital policy and government directives, all within the context of workplace culture.

Workplace culture is important to sustaining and retaining the midwifery workforce [3-5], with critical implications for how midwives provide care for women and their infants, and the safety and wellbeing of consumers. Workplace culture involves how staff believe in and enact norms and assumptions peculiar to a specific workplace; it embraces collective values, customs and social behaviour. Braithwaite and colleagues explore the many definitions of workplace culture in healthcare settings over time. They synthesise these as 'features of institutional life which are shared across a workplace or organisation, between the members, such as their cognitive beliefs, assumptions and attitudes; and their activities such as their behaviours, practices and interactions'[6] [(p1-2)].

New staff are socialised into workplace culture, either explicitly or indirectly, learning how things are done and what is expected. Often, the culture of a workplace can be 'felt' by the employees who work there and by the consumers using the service [7] who experience not only their immediate

surroundings and care, but also the way staff interact with each other. Workplace culture affects midwives' professional practice, including their ability to 'be with' women [8] and it may influence midwifery students' clinical learning and their attitudes towards the profession [9].

Midwives learn to work in partnership with women by responding to their individual needs. This is particularly facilitated by working in a midwifery continuity of care model: the gold standard of midwifery care, associated with less medical intervention and more positive outcomes for women and babies [10]. However, continuity of care often conflicts with the routines and practices within many midwifery workplaces (especially hospitals), and the majority of institutional maternity models of care. Currently, only a minority of Australian midwives work within a continuity of care model [11]. Working within a more technocratic, medically-oriented model can lead midwives to feel dissatisfied about their ability to do their jobs effectively [blinded reference]. Further, a sense of powerlessness and lack of job satisfaction can lead to midwifery 'burnout' [12], leading to staff attrition. Indeed, a 2018 report of nearly 2000 midwives in the United Kingdom stated 67 percent felt work-related burnout [13].

This paper is part of a wider study to develop a new instrument to examine the culture of Australian midwifery workplaces. The Australian Midwifery Workplace Culture (AMWoC) tool is intended to take account of the diversity of maternity settings in Australia and to address unique aspects of midwifery practice that are not addressed in more general measures of workforce culture. For instance, the Culture of Care Barometer (CoCB) was developed in the United Kingdom to examine health workplace culture, following widespread evidence on the detrimental impact of negative work cultures on the quality and safety of health services [14]. To date, we have not identified any published studies using the CoCB to examine midwifery workplace culture. Some Australian health authorities regularly monitor staff feedback and perceptions of workplace culture. For instance, the biennial New South Wales (NSW) Your Say survey measures staff experiences across all health

services (see https://www.health.nsw.gov.au/workforce/yoursay/Pages/default.aspx), but the questions do not relate specifically to midwifery and the survey reports combine midwives' and nurses' responses. One recent study used a different organisational culture tool, the Competing Values Framework, to assess a maternity service's readiness to change [15]. However, this instrument aimed to categorise the culture profile of an organisation into one of four types and did not contain midwifery-specific items.

More specifically, researchers have explored the concepts of resilience [3,16] and empowerment [17] in midwifery workplace contexts. The Perceptions of Empowerment in Midwifery Scale (PEMS) has been established and refined to quantify aspects of autonomy, empowerment, manager support and professional recognition explicitly within midwifery settings [18-21].

The AMWoC study aimed to take a broader approach to exploring workplace culture; it addresses midwives' perceptions of leadership, morale, professional values, workplace behaviour and management responses to midwives' concerns. The study's first stage found widespread frustration with organisational attitudes that affected midwives' work and hampered their ability to give quality care. This contributed to fatigue and a sense of powerlessness within the workplace [blinded reference]. The study then developed the AMWoC instrument to investigate different dimensions of midwifery workplace culture in Australia. The objective of the current paper is to report findings of a national survey of midwives using the AMWoC instrument. It addresses the question: how does this sample of midwives perceive their workplace culture?

Method

The AMWoC study employed a mixed-methods design to explore midwifery workplace culture in Australia. The first qualitative stage consisted of interviews with 23 midwives [blinded reference]. The second stage consisted of constructing a quantitative instrument to measure workplace culture,

developed with input from midwifery experts, as the base for an online survey of midwives across Australia to assess their perceptions of workplace culture.

Ethics

A University research ethics committee [ETH16-0399] approved the study. All data were collected anonymously with no potentially identifying information about respondents. Commencing the online survey constituted each midwife's informed consent to participate.

AMWoC survey instrument

The AMWoC study previously highlighted the need for quantitative measures to explore aspects of midwifery culture [blinded reference]. We therefore developed the AMWoC survey instrument using a four-phase process: generation of instrument items, content validation by midwifery experts, and a quantitative survey with a representative sample of midwives (reported here). The final phase was psychometric analysis to further refine the AMWoC instrument [blinded reference].

The lead author used and adapted items (statements) from the CoCB [14] with permission from the CoCB project team lead. The CoCB instrument consists of 30 items which had previously been psychometrically tested, and deemed valid and reliable [22]. We adapted the wording of CoCB items, where necessary, to a specific midwifery context. For example, the original phrase '…to do my job well' became '… to care for women and their partners'. Instead of the 5-point Likert scale used in the CoCB, the AMWoC instrument used a 6-point scale requiring participants to choose between a negative and positive response, with no 'neutral' option which can be interpreted in different ways by participants (e.g. undecided, don't care, neutral) [23]. Participants could still indicate a limited

response (*slightly agree, slightly disagree*) or select *not applicable* if the question did not apply to them or their workplace.

The adapted items were validated through discussion with midwifery educators (n=30) and a more formal rating process by seven midwifery academics. These key informants had a wealth of experience in midwifery practice, education, policy development and leadership. This process resulted in a revised instrument with 32 items, some slightly re-worded for clarification. Items were grouped into the seven themes used by CoCB developers: resources, values, management/leadership, teamwork, engagement, role and empowerment.

The AMWoC survey consisted of demographic questions about respondents' qualifications, education and employment; the 32-item AMWoC instrument; and one open-ended question: 'Is there anything else you would like to say about your workplace culture?'

Recruitment

The Australian College of Midwives (ACM) emailed a link to the survey using SurveyMonkey© to their mailing list of members (n=4029) in May 2016. Participation was voluntary and anonymous. The ACM emailed a reminder about survey participation three weeks later. The survey concluded in July 2016.

Setting

The ACM sent the survey link to all ACM members, regardless of where they currently worked: public or private hospitals, community settings, clinics, education institutions or in private practice.

Data analysis

The survey data were cleaned to remove responses from non-midwives, those not currently working in midwifery or who did not respond to any of the AMWoC items. We then transferred them to SPSS v23 for analysis.

We analysed demographic responses descriptively, using frequencies and percentages, identifying the proportion of respondents who rated each AMWoC item ranging from *strongly disagree* (1) through to *strongly agree* (6) (Table 2). We treated the AMWoC data as ordinal and simplified each item into a dichotomous variable indicating a 'positive' response (*agree/strongly agree* vs other response, or *disagree/strongly disagree* vs other response for reverse-scored items). This distinguishes the positive ratings from the negative or uncommitted (*slightly agree or slightly disagree*) ratings. We compared responses from sub-groups of midwives on these or other categorical variables using chi-squared (χ^2) analysis for non-parametric data, with statistical significance set at <0.05.

The qualitative data from the open-ended question were analysed using content analysis [24]. This involves breaking text data down into smaller elements, coding them according to the concepts represented and then grouping the material into themes. This analytic technique aimed to give insights into phenomena by describing the reality through participants' eyes.

Results

Sample

Although 351 individuals responded to the online survey, 29 participants were midwifery students, not currently or recently employed in midwifery workplaces, or did not attempt any of the AMWoC items. This group were excluded from the analysis of AMWoC ratings. Table 1 presents the

characteristics of the remaining 322 who responded to the AMWoC items, together with comparative demographic data from a national survey of the midwifery workforce [1] (n=23,801) where available. Respondents came from all Australian states and territories. A majority worked part-time (53.3%) and the most common work setting was 'all areas', i.e. working with women throughout the spectrum of pregnancy, birth and the postnatal period (46.9%). A relatively large percentage of participants had a postgraduate degree (28.6%). Over 12% facilitated home births within their work.

TABLE 1 HERE

Respondents noted working in 'other' roles, typically combining roles (e.g. in child and family health or special care nurseries); 'other' workplace settings included education institutions/units, neonatal units, rural midwifery units, emergency departments, private obstetric practice, surgical (gynaecological) or residential units. Some respondents recorded 'other' models of care, e.g. education, primary health care, early childhood health, Aboriginal health, community liaison, publicly funded homebirth service or acute ward (general nursing/midwifery). Several respondents had additional non-midwifery qualifications. 'Other' midwifery qualifications included advanced diploma and graduate certificate.

On variables where comparable national statistics are available, the sample appears similar in characteristics such as gender, Aboriginality, main role and working hours. However, a disproportionate number of respondents came from NSW, South Australia (SA) and the Australian Capital Territory (ACT), with consequent under-representation from other states.

Response to AMWoC survey

The original sample of 351 represents 8.7% of the ACM membership, although respondents were typical of the wider midwifery workforce on most dimensions except for state of residence. A few (n=29) did not attempt any of the AMWoC items and were subsequently removed from the data analysis, leaving a final sample of 322. This group did not appear to differ systematically from those who answered one or more AMWoC items in terms of age, state of residence, working hours or model of care. However, the proportion who attempted the AMWoC survey was significantly lower among self-employed midwives (57.1%, χ^2=29.853, 1df, p<0.001) and midwives whose workplaces had few (<250 p.a.) or no births (12.5%, χ^2=4.957, 1df, p=0.026). Midwives working in public institutions were more likely to respond than those in private institutions (χ^2=15.877, 1df, p<0.001).

In the cleaned sample of 322 midwives, 251 (78%) rated all 32 AMWoC items between 1 and 6. The remainder either rated some items as 'not relevant' or skipped them. Table 2 indicates the proportions rating each item 1 to 6 or 'not applicable'; the total number of respondents for each item appears in the right-hand column. Further investigation of sub-groups within the sample (not shown in table) suggest that older midwives (50 and over) were less likely than younger respondents to rate all AMWoC items (70.9% vs 86.9%, χ^2=12.221, 1df, p<0.001), as were those who worked in casual compared with permanent positions (58.5% vs 81.9%, χ^2=11.673, 1df, p=0.001). A higher proportion of midwives who worked in hospital labour wards completed all AMWoC items (88.6%, χ^2=5.919, 1df, p=0.015). There was some variation by professional role in response rates to the AMWoC items, with Registered Midwives and midwifery managers more likely than other roles to rate all AMWoC items (82.1% and 90.9% respectively), although the overall chi-squared results was not statistically significant χ^2=13.669, 7df, p=0.057), given the number of categories in this variable.

TABLE 2 HERE

Quantitative results – AMWoC ratings

Table 2 indicated the proportion of respondents who gave each item a rating between *strongly agree* and *strongly disagree*, or who said that the item was not applicable to them. To simplify these findings, Table 3 presents the proportion of respondents who gave each item a 'positive' rating (either *agree/strongly agree*, or *disagree/strongly disagree* for the five reverse-scored items indicated with *). The remaining respondents gave this item a neutral (*'slightly' agree/disagree*) or negative response. Table 3 groups the items into the seven domains following the CoCB approach [14].

TABLE 3 HERE

Midwives' ratings were relatively low on many items of the survey. Only 11 items achieved a positive rating from a majority of respondents. For the remaining 21 items, the majority gave a negative or neutral rating. Further, the positively-rated items were concentrated in a few domains. The Team domain was the only one where all items (3 out of 3) achieved a positive rating from the majority. In the Values domain, the majority rated five out of the eight items positively. One item in the Role domain was highly rated (*I know exactly what is expected of me in my job*). The Management/Leadership domain included two items with outlier ratings: *I know who my senior midwifery manager is* (91.8% agreed) and *I would like to have more access to resources, training or leadership*. We added the latter item following content validation with midwifery experts and reverse scored it for analysis. However, the researchers debated whether agreement constituted a positive or negative response, given that referred to respondents' wishes (rather than experiences) and that it combined three different factors.

To explore relationships between participant characteristics and their scores for workplace culture, we compared the proportion of positive ratings amongst various sub-groups of the sample. Older

midwives (aged 50 or over) regularly rated items more positively than their younger counterparts, although there were no significant differences in items in the Team domain. Midwives who only worked in public hospitals (n=277) had lower proportions of positive ratings for several items than midwives who worked only in private hospitals (n=32). There was a tendency for full-time midwives to rate more positively than those working part-time. We did not explore patterns of responses within other demographic or employment variables given the small numbers in some of the categories.

Qualitative results – other aspects of midwifery workplace culture

One hundred and fifty midwives answered the open-ended question requesting additional comments on their workplace culture. Many of these comments described issues addressed by one or more of the AMWoC survey items. However, other topics did not fit specifically within the existing items. Content analysis of all open-ended responses identified three main themes: 'support at work', 'the ability to be a midwife' and 'bullying'. These are described below using sample quotes from the participants.

Support at work

The theme 'support at work' embraced two sub-themes: 'teamwork' and 'support from managers'. Forty-eight out of 150 participants mentioned 'support' in responses to the AMWoC survey. Their descriptions ranged from exemplary support from managers and colleagues to little or no support at work. Overwhelmingly, participants described limited support from their organisation and managers, encompassing issues such as problematic implementation of changes in the workplace, support for innovative practice/models, mentorship and maintenance of competency for casual staff. One participant described midwives organising their own support system within the workplace. She said:

> *Support within the midwifery unit is self-arranged: there is no sense of midwifery camaraderie or support that is innate or built into the structure by management* (#210. RM, Victoria)

Participants also described midwives' inability to give quality care to women and families due to a lack of support. One said:

> [We are] *understaffed, over stretched and often unhappy with the 'quality' of care we are able to provide, with often little managerial support or understanding* (#335 RM, NSW)

Fourteen participants described positive support from their managers and colleagues, for example:

> *I have very supportive colleagues, the midwives are* great (#78. RM, SA)

> *My workplace has improved significantly over the last few months since we have a new acting manager who is supportive and respectful – and is doing a great job* (#117. CMS, NSW)

> *It depends on how far up the ladder you go with managers. Immediate above are good, further up it is much less supportive (#81, CMS, WA)*

The ability to be a midwife

The second theme comprised subthemes of 'leadership and management', 'short staffed and busy' and 'medically-focussed work'. Participants perceived that the workplace culture was heavily influenced by those in management roles, that leadership was lacking, and that consequently medical staff had the power over the care given to women. This minimised the importance of midwifery care and the respect midwives perceived from their medical colleagues. They said:

> *While my midwifery colleagues are great to work with, I feel the medical staff aren't on the same page. I feel it's a constant battle to keep labour and birth normal when a woman is low risk* (#274. RM, NSW)

> *The manager is very obstetric and risk-based, there is minimal midwifery vision and leadership* (#189. RM, NSW)

Change is ever so slow, and midwives are clearly in a subordinate position to obstetric and paediatric doctors which means change is hard fought. (#30, RM, ACT)

Participants also described how excessive workloads contributed to low morale and poor workplace culture. Although one AMWoC item specifically addressed staff resources, several respondents took the opportunity to comment further on staffing levels. They said:

We don't get appropriate staff when busy which impacts negatively on our standard of care which is very disappointing (#207. RM, NSW)

Our acuity is high and staffing levels are inadequate to provide optimal care. (#228. RM, Queensland)

I have worked in my current work place for over 4 years with an amazing group of like-minded midwives who shared similar philosophies. However, due to a loss of permanent staff and loss of manager, workplace morale has dived and a poor culture developed with lack of good leadership and a unit of FTE of 6 operating with only 2 permanent midwives - the remainder all agency. (#227. RM, Queensland)

Most midwives try to protect each other but only one per shift so not physical support. Therefore the maternity patients are short changed (#340, RNM, SA)

Bullying

Although the AMWoC items included 'unacceptable behaviour' (item 12), a more explicit focus on bullying emerged strongly in the qualitative responses, with 15 participants mentioning this behaviour. They reported bullying occurring horizontally amongst peers, as well as vertically

between managers and staff, and towards students. Eight described bullying from management and senior management staff. For example:

> *The underlying culture is one that is under-resourced and poorly managed, and has overtones of bullying and detachment* (#210. RM, Victoria)

> *Some of our managers can be bullies and are not dealt with in the appropriate way by their manager, so the culture continues* (#199. Midwifery educator, NSW)

> *Terrible workplace culture where the manager aids and abets staff who undermine and sabotage others (#257, RM, ACT)*

Overall, the open-ended question elicited data that was mostly negative in nature, epitomised by this comment:

> *… my colleagues and peers have very low morale. They seem very dissatisfied, unsupported and burnt-out. They are understaffed, overworked and under-valued. Often getting off shifts late with no breaks and unrecognised for their efforts. They often say 'this place kills you'. Very sad* (#323. Midwifery educator, NSW)

There were four comments from participants that stated how they wanted to leave their job and others that described their workplaces as unpleasant using words: 'bitchiness', 'backstabbing' and 'toxic'. There are clearly many midwifery workplaces in Australia with a suboptimal workplace culture.

Discussion

The study revealed perceptions from midwives working in different settings across Australia about their workplace culture. The initial sample of 351 represented 8.7% of ACM members who

potentially received the invitation to participate and a much smaller proportion of all Australian midwives. However, it appeared representative of the midwifery workforce on several variables, including age, gender, working hours and role (Table 1); it included midwives with varying qualifications, practising Australia-wide in diverse workplaces.

The quantitative and qualitative results indicated midwives' perceptions of many aspects of their workplace culture. Overall, the study showed that midwives valued support from their peers and the camaraderie within their workplace teams. The quantitative ratings revealed that midwives were more likely to respond favourably to statements about colleagues than those about managers or wider organisational structures (Tables 2 and 3). This confirms earlier work on the value of relationships with work colleagues on midwives' work satisfaction, resilience and intention to stay within the profession [3,4,16]. However, participants reported limited resources, powerlessness, lack of information, poor communication and inadequate leadership (Tables 2 and 3). Overall, only 27.9% participants agreed that their workplace had a positive culture.

Although the wording and focus of AMWoC items were largely different from those in the PEMS instrument focusing on empowerment[18], some items were comparable. The proportions with positive ratings in this sample (Table 3) were generally lower than found in a survey of Australian midwives using PEMS. For instance, 46.3% of PEMS respondents agreed that they had autonomy in their practice; 51.9% reported having a supportive manager; 57.4% agreed they had adequate staff education; and 62.1% agreed they had adequate resources for birthing women [21]. The differences may also be because PEMS used a 5-point scale, so these proportions included any affirmative response, whereas our analysis excluded ratings of 'slightly agree' from the 'positive' responses. Further work is necessary to explore how midwives' experiences of broader aspects of workplace culture relate to their sense of personal autonomy and recognition by other health professions.

Qualitative responses in this survey confirmed that several midwives perceived limited support from their managers, and even less from senior management. This is associated with the relatively low ratings in the Management/Leadership and Engagement domains. Midwives reported that their work was hampered by staff shortages, which were not addressed, and the pervading philosophy of the workplace, which was often overwhelmingly medically focussed. These views relate to the negative ratings in the Resources and Empowerment domains respectively. Several reported bullying behaviour in the workplace that contributed to a negative workplace culture. Conversely, there were fewer open-ended comments about great teamwork and exemplary support, possibly because respondents felt these issues had been covered sufficiently in the quantitative AMWoC items where they received more positive ratings. There may have been a tendency for respondents to use the open-ended question to air grievances or concerns about specific issues (especially if not addressed by their quantitative ratings) rather than documenting their satisfaction with others.

Managers have responsibility for laying the foundations of culture in a workplace. Their input into workplace decisions, policies and workforce planning influences midwives' practice with women and the quality of care [25]. Management responses to bullying and other unacceptable behaviour also set the tone within the workplace. The survey results showed that midwifery staff wanted more support from their managers, notwithstanding their more positive perspective on support from other team members. Many respondents reported a lack of leadership, potentially affecting their job engagement. Other studies have espoused the importance of leadership for effective workplace culture [26-28], especially in midwifery [5,29]. A Royal College of Midwives (United Kingdom) survey revealed that 84% of members who had left the profession would return to midwifery if there was a change in the workplace culture, and that 35% of midwives were dissatisfied with the levels of support from their managers [5].

Without visible leadership, midwifery staff may have no clear philosophy or direction to follow and no advocate to consult about issues, worries, career progression or ideas for innovation and improvement. In the current survey, staff perceived that they had limited power or support to change workplace practices for the benefit of women and babies. Other studies have described workplaces where organisational factors deter well-motivated staff from providing good care due to obstructive bureaucracy, policies and procedures [25]. Hospital environments in particular affect midwives' ability to practise as they wish [8,30].

Powerlessness and a consequent lack of engagement at work have been strong influences driving staff to leave their jobs [31,32]. A study of nurses identified that enhancing engagement increased initiative, decreased patient mortality rates and enhanced financial profitability [33]; this may be true in midwifery. Work engagement has certainly been a factor in the delivery of quality midwifery care [34]. Our qualitative data confirmed that some participants expressed feelings of powerlessness and had intentions to leave their jobs due to their inability to provide quality midwifery care.

Some respondents stated that medically dominated workplaces and an overall technocratic paradigm impinged on their ability to 'be a midwife'. Other studies [29,35,36] concluded that the maternity workplace has become highly technological, overtaken by policies promoting medical intervention. This tendency, and participants' perception that others did not share their philosophy, emphasises the need for shared goals and direction in a workplace culture to keep woman-centred midwifery the focus of care.

Bullying behaviour in the midwifery environment was a strong theme in the qualitative data, possibly because no specific AMWoC items addressed it explicitly. Other research has identified extensive evidence of bullying for example [37,38]; it is a prime reason why midwives leave the profession [37]. Bullying amongst staff also affects midwives' ability to feel effective at work and

undermines quality of midwifery care [39]. It is vital that work environments are safe and respectful, and that midwives feel supported and have their emotional needs met [40]. This, again, demonstrates the importance of midwifery leadership, requiring senior staff to tackle bullying behaviour head-on with a zero-tolerance policy. As Dixon-Woods et al. reiterate, ‘good staff support and management [are] fundamental to culture and [are] directly related to patient experience, safety and quality of care’ [25 p.1].

The survey findings revealed that older midwives typically rated workplace culture more positively than their younger colleagues. This result has important ramifications for the future of the profession in Australia. If younger midwives rate their workplaces more negatively, they may be less inclined to stay within the profession, or at least to stay in midwifery workplaces as they currently operate. However, it is unclear how their increasing dissatisfaction will be manifested.

Strengths and limitations of the survey

This national survey has provided valuable feedback on midwifery workplace culture, using the new AMWoC instrument. The online survey process facilitated widespread dissemination across ACM membership, including those in remote areas, and ease of consent and completion for respondents. Within the sample, missing responses were rare. As noted, the response rate was relatively low although the diversity of respondents suggested this sample was generally representative of the Australian midwifery workforce (Table 1). However, the under-representation of young midwives, those in rural or remote areas, and in some states and territories has limited the extent to which the current findings are generalisable to all Australian midwives. The small numbers in some categories of the demographic and employment variables hampered our capacity to undertake sophisticated analysis of the quantitative data. The 12% of respondents who stated that they ‘provided women with the option of homebirth’ far exceeds the proportion of Australian births occurring in the home.

A majority of these respondents worked in public hospitals (including caseload models) which offer home births although most births would be in hospital. These participants may have answered positively to this question but may not personally provide these services.

Further, the participants who chose to respond to the survey may have differed from those who did not, thus creating bias. There may have been less incentive for contented midwives without grievances to contribute, and disgruntled midwives may have been over-represented. Respondents may have interpreted some items on the survey differently, potentially affecting their ratings. The survey occurred in 2016 and response may fail to reflect responses to subsequent changes in NSW midwifery workplaces.

The survey used a new and previously untested instrument to assess workplace culture. However, it was based on an established workplace culture model and its development incorporated extensive input from leading midwifery academics and practitioners to strengthen content validity [blinded reference]. Very few of the respondents failed to engage with the AMWoC instrument (only 23 or 6.6% did not rate any items) and most rated nearly all items. However, several midwives (71 or 22% of respondents who attempted the AMWoC) were unable to give every item a rating between 1 and 6. This suggests that they perceived some items as irrelevant to their practice. Further research could explore the instrument's feasibility for midwives working in specific settings and different models of care.

Basing the AMWoC questions on the established CoCB instrument [22,41] ensured that items were content valid and reliable as measures of workplace culture. However, the CoCB was developed for a broad range of healthcare staff, and we changed some items to be more midwifery-specific. Further, the CoCB items distinguished between management at team level ('my line manager…') and at senior level ('the Trust…'). However, the AMWoC survey did not make this distinction and items just

referred to ‘midwifery manager’, although some respondents attempted to delineate between different levels of management in their open-ended comments.

The diversity of respondents in this survey may have limited the extent to which conclusions could be drawn from the data, especially in terms of workplace setting and model of care. Although the majority of respondents worked in hospitals, smaller numbers worked in community centres, education institutions and elsewhere; some items may not have been applicable or readily translated to other workplaces or models of care.

Conclusion

The AMWoC survey captured a snapshot of Australian midwives’ perceptions of various dimensions of their workplace culture. The results indicate that midwives felt strongly about staff support, engagement and empowerment at work, their experiences of organisational leadership and vision, and workloads. Inadequate staffing levels and poor management have left many midwives feeling disempowered and despondent about their workplace. Whilst many participants described poor workplace culture and morale, others reported highly positive workplaces with peer respect and support, excellent manager relationships with staff and effective teamwork. Additional refinement of the AMWoC survey instrument and a larger study of the Australian midwives would further extend knowledge of the critical dimensions of midwifery workplace culture.

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Table 1: Characteristics of sample, compared with national data on midwifery workforce

	Respondents	Midwifery workforce 2015[1]
Age range		
21 – 29	8.1%	-
30 – 39	13.0%	-
40 – 49	28.9%	-
50 – 59	41.3%	52.3% (50+)
60 – 64	6.5%	
65+	2.2%	
Gender		
Female	98.8%	98.6%
Male	1.2%	1.4%
State/territory of residence[2]		
New South Wales	39.4%	26.2%
Victoria	15.5%	27.8%
Queensland	17.4%	20.3%
South Australia	11.9%	8.6%
Western Australia	8.4%	10.9%

Tasmania	0.3%	2.1%
Australian Capital Territory	4.3%	2.1%
Northern Territory	1.6%	2.0%
Not stated	2.8%	-
Aboriginality		
Aboriginal or Torres Strait Islander	0.6%	1.0%
Language use		
English as first language	98.4%	-
Midwifery education		
Midwifery certificate	17.4%	-
Bachelor of Midwifery degree	23.6%	-
Graduate Diploma	27.3%	-
Masters degree	26.7%	-
Doctoral degree	1.9%	-
Currently studying	0.6%	-
Other degree	1.9%	-
Other midwifery qualification	0.6%	-
Main role		

Registered midwife	69.5%	
Clinical midwifery specialist	12.5%	'Clinician' = 88.4%
Clinical midwifery educator	6.5%	
Clinical midwifery consultant	4.4%	
Midwifery manager	3.4%	5.1%
Midwifery student	1.2%	-
Academic/research midwife	1.2%	5.8%
Other	1.2%	0.6%
Working hours		
Full-time	32.4%	-
Part-time	53.3%	51.9%
Casual/agency	12.8%	-
Currently not working	1.6%	-
Main workplace setting[3]		
All areas	46.9%	-
Ante/postnatal ward	26.4%	-
Labour ward	24.8%	-
Clinic	9.0%	-

Community	7.5%	-
Birth centre	4.0%	-
Other	6.2%	-
Model of care[3]		
Public hospital midwifery care	64.6%	-
Public hospital high risk maternity care	18.3%	-
Midwifery group practice caseload care	14.0%	-
Private midwifery care	10.6%	-
Rural or remote maternity care	3.4%	-
Team midwifery care	1.9%	-
Private obstetrician and privately practising midwife jointly	1.9%	-
Other model of care	4.3%	-
Sector[3]		
Public institution	89.8%	-
Private institution	13.0%	-
Self-employed	0.9%	-
Do you provide women with the option of home birth?		

Yes	12.1%	-
No of births per year in maternity unit/practice		
Over 2000	47.2%	-
1000 – 2000	17.7%	-
500 – 1000	12.7%	-
250 – 500	8.4%	-
Less than 250	11.8%	-
No births at my workplace	2.2%	-
TOTAL N	**322**	**23,801**

1 Australian Institute of Health and Welfare Nursing and Midwifery Workforce Survey, Registered Midwives in employment, Australia 2015 (21), including registered midwives currently employed in midwifery (n=23,801). Blank cells = data not available

2 AIHW data by state/territory exclude those who did not indicate state or who live overseas

3 Respondents could tick more than one response

Table 2: AMWoC survey instrument, proportion of midwives who rated each item, percentages, N=322.

#	Item[1]	Strongly agree	Agree	Slightly agree	Slightly disagree	Disagree	Strongly disagree	NA[2]	*n*
1	I have sufficient resources that I need to care for women and their families well (eg space, adequate rooms, equipment, supplies)	7.5	34.0	15.6	15.6	15.9	10.6	0.9	*321*
2	I feel respected by my co-workers	23.4	44.4	14.4	10.0	5.9	1.9	0	*320*
3	I have sufficient time to care for women and their partners	6.5	21.2	17.1	16.8	20.6	16.2	1.6	*321*
4	I feel good about working in this maternity unit	15.9	33.4	21.3	11.3	10.3	5.9	1.9	*320*
5	My manager treats me with respect	22.0	35.4	16.5	11.8	7.5	5.6	1.2	*322*
6	The maternity unit values the service I provide	12.9	38.6	22.3	7.8	13.2	4.4	0.9	*319*
7	I would recommend this maternity unit as a good place to work	12.6	34.1	21.1	11.7	11.0	6.9	2.5	*317*
8	I do not feel supported by my manager	9.0	12.5	17.4	14.3	25.2	20.6	0.9	*321*

9	I am able to influence the way things are done in my workplace	3.5	17.4	34.7	13.2	21.1	9.8	0.3	*317*
10	We are a well-managed team	8.1	23.7	21.5	17.1	18.7	10.3	0.6	*321*
11	I know who my senior midwifery manager is	41.7	46.4	3.1	1.9	1.6	1.3	4.1	*319*
12	Unacceptable behaviour is addressed appropriately	6.6	25.5	23.6	14.5	16.4	11.6	1.9	*318*
13	There is strong leadership at the highest level in the maternity unit	7.9	15.4	19.2	15.4	22.3	17.3	2.5	*318*
14	When things get difficult, I can rely on my colleagues	21.0	43.3	20.7	7.5	5.3	2.2	0	*319*
15	My managers understand how things really are	8.8	23.8	18.1	10.6	20.0	18.4	0.3	*320*
16	I feel able to ask for help when I need it	17.8	37.7	22.7	10.0	8.7	3.1	0	*321*
17	I know exactly what is expected of me in my job	28.8	50.2	12.5	3.8	4.4	0	0.3	*319*
18	I do not feel supported to develop my potential	14.0	16.2	19.9	16.5	22.1	10.3	0.9	*321*
19	I feel I work in a place with a positive culture (eg collaborative peers, innovative, high morale, supportive management)	7.8	20.1	18.5	15.7	21.3	16.6	0	*319*

20	The people I work with are friendly	29.5	47.3	14.7	5.6	2.5	0.3	0	*319*
21	When we are short staffed, we are given adequate support	1.2	13.4	13.0	18.3	26.1	26.4	1.6	*322*
22	My philosophy of care is shared by the midwives in my workplace	7.5	42.8	21.6	13.1	9.1	4.1	1.9	*320*
23	I cannot change my working hours/shifts easily	10.6	20.6	16.2	16.2	23.4	7.5	5.6	*321*
24	I am supported to make my own decisions about caring for women and babies	6.9	34.4	27.5	13.4	12.8	3.4	1.6	*320*
25	My manager gives me constructive feedback	7.5	29.7	20.6	13.8	15.3	9.4	3.8	*320*
26	Our workplace celebrates when midwives achieve success (eg completes a course, uses innovation to improve practice)	5.6	18.4	25.3	14.7	20.9	11.6	3.4	*320*
27	The maternity unit acts on midwives' concerns	3.4	16.6	29.5	20.4	16.3	11.0	2.8	*319*
28	I get the training and development I need	9.7	36.5	21.1	13.8	11.9	6.6	0.3	*318*
29	I would like to have more access to resources, training or leadership	22.5	41.3	23.1	6.3	5.0	0.9	0.9	*320*
32	I do not feel well informed about what is going on in our maternity unit	6.2	17.1	25.9	21.8	22.1	5.0	1.9	*321*

33	There are positive role models where I work	19.7	43.3	21.9	6.0	6.0	2.5	0.6	*319*
34	My concerns are taken seriously by my midwifery manager	11.0	26.3	20.4	15.0	13.2	9.4	4.7	*319*

1 The original items 30 and 31 duplicated other items in the AMWoC instrument – responses not included.

2 NA=not applicable

Table 3: Summary of AMWoC survey ratings, proportion giving positive[1] rating by domain, N=322

#	Item	Number	%	N[2]
	EMPOWERMENT			
9	I am able to influence the way things are done in my workplace	66	20.9%	316
23*	I cannot change my working hours/shifts easily	99	32.7%	303
24	I am supported to make my own decisions about caring for women and babies	132	41.9%	315
27	The maternity unit acts on midwives' concerns	64	20.6%	310
34	My concerns are taken seriously by my midwifery manager	119	39.1%	304
	ENGAGEMENT			
15	My managers understand how things really are	104	32.6%	319
32*	I do not feel well informed about what is going on in our maternity unit	87	27.6%	315
	MANAGEMENT / LEADERSHIP			

#	Item	Number	%	N[2]
8*	I do not feel supported by my manager	147	46.2%	318
10	We are a well managed team	102	32.0%	319
11	I know who my senior midwifery manager is	281	91.8%	306
12	Unacceptable behaviour is addressed appropriately	102	32.7%	312
13	There is strong leadership at the highest level in the maternity unit	74	23.0%	310
25	My manager gives me constructive feedback	119	38.6%	308
29*	I would like to have more access to resources, training or leadership	19	6.0%	317
33	There are positive role models where I work	201	63.4%	317
	RESOURCES			
1	I have sufficient resources that I need to care for women and their families well (eg space, adequate rooms, equipment, supplies)	133	41.8%	318

#	Item	Number	%	N[2]
3	I have sufficient time to care for women and their partners	89	28.2%	316
21	When we are short staffed, we are given adequate support	47	14.8%	317
	ROLE			
17	I know exactly what is expected of me in my job	252	79.2%	318
18*	I do not feel supported to develop my potential	104	32.7%	318
28	I get the training and development I need	147	46.4%	317
	TEAM			
14	When things get difficult, I can rely on my colleagues	205	64.3%	319
16	I feel able to ask for help when I need it	178	55.5%	321
20	The people I work with are friendly	245	76.8%	319
	VALUES			

#	Item	Number	%	N[2]
2	I feel respected by my co-workers	217	67.8%	320
4	I feel good about working in this maternity unit	158	50.3%	314
5	My manager treats me with respect	185	58.2%	318
6	The maternity unit values the service I provide	164	51.9%	316
7	I would recommend this maternity unit as a good place to work	148	47.9%	309
19	I feel I work in a place with a positive culture (eg collaborative peers, innovative, high morale, supportive management)	89	27.9%	319
22	My philosophy of care is shared by the midwives in my workplace	161	51.3%	314
26	Our workplace celebrates when midwives achieve success (eg completes a course, uses innovation to improve practice)	77	24.9%	309

*Reverse scored item. Proportion giving 'positive' rating calculated after reversal
[1]'Positive' rating=strongly agree or agree (or strongly disagree or disagree for reverse scored items)
[2] Number of respondents who rated item between 1 and 6.