Factors that contribute to midwives staying in midwifery: a study in one Area Health Service in NSW

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CERTIFICATE OF AUTHORSHIP/ORIGINALITY

I certify that the work in this thesis has not been previously submitted for a degree nor has it been submitted as part or requirements for a degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparations of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Candidate

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LIST OF ABBREVIATIONS

ABS	Australian Bureau of Statistics
AHMC	Australian Health Ministers Conference
AHWAC	Australian Health Workforce Advisory Committee
AHS	Area Health Service
AIHW	Australian Institute of Health and Welfare
CMCFH	The Centre for Midwifery, Child and Family Health
COAG	Council of Australian Governments
FNMH	Faculty of Nursing, Midwifery and Health
MGP	Midwifery Group Practice
NHWT	National Health Workforce Taskforce
NSCCAHS	Northern Sydney Central Coast Area Health Service
NSW	New South Wales
UK	United Kingdom
USA	United States of America
UTS	University of Technology, Sydney

ABSTRACT

The aim of this study was to investigate the factors that contribute to midwives in one Area Health Service in New South Wales (NSW), Australia, staying in midwifery. The study was set in the Northern Sydney Central Coast Area Health Service (NSCCAHS), Australia.

A descriptive design underpinned the research. The study was conducted over two phases. Phase One involved focus groups to assess the suitability of a questionnaire for the Australian setting. The questionnaire was previously used in similar research in England. Phase Two was the distribution of the questionnaire and analysis of the data obtained. Both qualitative and quantitative data were obtained in the research, though most data were quantitative in nature. The quantitative data was analysed using descriptive statistics while content analysis was used on the qualitative data.

The study sample consisted of midwives working within NSCCAHS who were employed full-time, part-time or on a casual basis. A total of 392 midwives were surveyed with a response rate of 53% (n=209).

The results provided information on the factors which contribute to midwives staying in midwifery. The top three factors identified for midwives staying in midwifery were: relationships with women, professional identity as a midwife and the practice of midwifery.

This study has implications for Area Health Services and Health Departments in Australia. If midwifery workforce shortages are to be improved Area Health Services and Health

Departments must examine the way in which care is organised and ensure support systems are in place to support advantageous models of care and the midwives who work within them.

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Lastly I wish to acknowledge the midwives who completed this research. At the time in which this study was conducted, midwives within this Area Health Service were feeling the pressures associated with an increasing workload and decreasing staffing levels. For many of the midwives they felt that this was just another form for them to fill in and that nothing would be done as a result of it. I hope those midwives will not be able to say "I told you so" and that instead something is done about the recruitment and retention of midwives. I have read countless accounts of why midwives stay in midwifery; where they get their job satisfaction from and why they would or would not recommend midwifery to others. There were days when I would become extremely depressed as a result of the stories I was hearing. At the times when the negative and extremely sad stories got too much I changed to the positive ones and the encouraging quotes midwives gave about their work. While these positive stories really inspired me, there was one that did so more than any other. This research tells you why midwives in this Area Health Service stay in midwifery, let me share with you the quote that kept me going throughout this extremely rewarding, but sometimes difficult journey:

"*The energy of women and birth is like nothing else and to be part of this is truly special. It does continue to retain a certain mysticism and autonomy, to be a true midwife"*.

CHAPTER ONE: INTRODUCTION

The aim of this thesis, undertaken as part of a Master of Midwifery (Hons), was to investigate the factors which contribute to midwives in one Area Health Service of New South Wales (NSW), Australia, staying in midwifery. While providing knowledge about the factors that contribute to these midwives staying in midwifery, it is hoped that this study will also provide information on the strategies that may be utilised to improve the retention of midwives. Understanding the attitudes and beliefs of practising midwives in relation to their view of work, and the ways to retain them in midwifery, and within the Australian health workforce, is an important strategy to achieve an effective workforce and best possible health care. This study was guided by similar research conducted in England by Mavis Kirkham and her colleagues (Kirkham, Morgan, & Davies, 2006).

The research question was: *What are the factors that contribute to midwives in one Area Health Service in NSW staying in midwifery?*

The main objectives of this study were to:

1. Explore the reasons why midwives select a particular workplace, clinical setting or model of care.
2. Understand the reasons why midwives choose to stay in (1) midwifery; and/or (2) in their current workplace.
3. Explore the issues that contribute to job satisfaction, and the support systems and coping strategies that are important to midwives and keep them in (1) midwifery and/or (2) in their workplace.

The study was set in one of the Area Health Services[1] (AHS) in NSW. There are eight AHSs within NSW, each being responsible for the planning, delivery and coordination of local public health services. Each AHS provides services such as community health services, public hospitals, psychiatric hospitals, emergency transport, acute care, rehabilitation, counselling, and many community support programs (NSW Department of Health, 2007a). One of the eight AHS is the Northern Sydney Central Coast Area Health Service (NSCCAHS). Northern Sydney Central Coast Area Health Services was the setting for this study. There are seven maternity sites within the NSCCAHS.

This introductory chapter will explain this study and briefly outline midwifery in Australia including the history of midwifery in Australia, discuss current shortages within the Australian health workforce and comment on research that has been conducted on turnover within nursing and midwifery. This outline is aimed to briefly provide a context for the study. A more detailed review of the workforce issues in relation to midwifery will follow this chapter. Finally a description of the organisation of this thesis will be outlined.

Significance of the study

While a little is known about why nurses and midwives leave nursing and midwifery, very little is known about why midwives specifically stay in midwifery within the Australian context. Research into this has been conducted in other countries. For example, in 2006, research was published which examined 'Why Midwives Stay' in midwifery in England

[1] An Area Health Service is a similar concept to a Primary Care Trust in the United Kingdom and to Health Districts in some countries.

(Kirkham et al., 2006). This research provided an insight into English midwifery, however, it is not clear whether the same issues apply to midwives and midwifery within Australia. With the permission of the authors of the English study, my study was guided by the English research. The design, methods and results of the English study are discussed throughout this thesis.

Justification for the study

As a clinical midwife at the time this study was undertaken and now as a clinical midwifery educator, I often ask myself why some of the midwives I work with stay in midwifery. Anecdotally I knew that the reasons for midwives staying in midwifery were not the opposite of the reasons for midwives leaving, but there was nothing available to confirm this. I wanted to explore this more deeply as part of my Master of Midwifery (Hons) degree.

For me, I stay in midwifery because I love the job. I am passionate about providing woman centred continuity of midwifery practice to all women and their families. This was my justification, but I wondered whether this was the same for my colleagues.

The 'Why Midwives Stay' study conducted by Kirkham et al (2006) provided the opportunity for me to explore some of the questions I had around midwives in Australia. While my study did not exactly replicate the Kirkham et al (2006) study, it was an important guide and starting point.

Main issues addressed by this study

This section briefly outlines some of the key issues that will be addressed throughout this thesis. These issues include: health workforce, midwifery workforce, midwifery education in Australia, and midwifery patterns of work. These will be discussed in more detail, particularly in the chapter that reviews the relevant literature.

Health workforce

The population in Australia at the end of June 2009 was over 21 million (Australian Bureau of Statistics, 2009a), with the estimated number of employers in the Australian workforce being 10.8 million (Australian Bureau of Statistics, 2009a). There are an estimated 450 000 paid health professionals in the Australian health workforce. Of these, 39% are registered nurses and midwives (Productivity Commission, 2005). There is a level of uncertainty about the exact numbers, the reasons for which will be described in Chapter 2.

The provision of an adequate health workforce is essential to providing Australians with health care. It also ensures that the National Research Priorities, which are established by the national government to drive development, research and investment can be achieved. The national priorities include: achieving a healthy start to life, ageing well, ageing productively, preventive health care and strengthening Australia's social and economic fabric, all of which are dependent on having an adequate health workforce (DEST2003). The Australian health workforce, like the health workforce in many countries, is experiencing significant shortages.

It has been estimated that by 2010 there will be a shortage of 40 000 nurses and 2 000 midwives in the Australian health workforce (Australian Health Workforce Advisory Committee, 2004). This analysis was undertaken more than seven years ago and no further analyses of workforce shortages have been undertaken.

Midwifery workforce

The number of midwives is often tied to the number of births in a specific country or state. In Australia, the annual number of births in 2007 was 294 205 (Laws & Sullivan, 2009). NSW makes up a large proportion of the annual births, for example the total number of births in 2005 was 90 610, an increase of 5.8% from 2004. Of the total births in NSW in 2005, 96.1% (n=85 660) were planned hospital births. The remaining 3.9% of births included: births in a birth centre (2.1%, n=1 830); planned birth centre births with transfer to hospital (1.3%, n=1,128); planned homebirth (0.1%, n=112); planned homebirth with transfer to hospital (0.0%, n=40); and born before arrival (0.4% n=369). The high number of births planned for, and attended in hospital, reflects the fact that the majority of midwives in Australia and NSW are employed by, and work in, the acute hospital setting.

In Australia, as in many countries, midwives are the members of the health workforce who are specifically educated and regulated to provide care to women during pregnancy, labour and birth and the postnatal period. Midwives in Australia are educated to fulfil the International Definition of the Midwife (ICM, 2005). As explained above, maternity services in Australia are primarily provided within the acute hospital setting and are predominantly fragmented in nature. Women receive care from a variety of care providers

including midwives, general practitioners (GPs) and obstetricians (Vernon, 2008). The care providers in the antenatal period are often different to those during labour and birth and in the postnatal period, so it is often the case that a woman does not see the same care provider throughout her childbearing experience. In other words, women generally do not receive midwifery continuity of care.

Midwifery continuity of care is a way or organising and providing care which has been shown to provide women with a known midwife and therefore reduce the incidence of medical intervention (Hatem, Sandall, Devane, Soltani, & Gates, 2008). In Australia during the 1990s there was a shift in Government policy which saw the emergence of new midwifery models of care that would provide continuity with an emphasis on continuity (Brodie & Barclay, 2001). Unfortunately, many maternity services within Australia and NSW are still struggling to ensure a midwifery model of care is available to women accessing the service. Ongoing efforts to change this situation continue across the country including significant changes in the education of midwives.

Midwifery education in Australia

During much of the last 50 years, midwives were trained in hospital-based systems, often in an apprenticeship model. By 1994, all training of Australian nurses and midwives had moved from the hospital settings to the universities. A prerequisite for midwives in Australia had previously been a qualification in nursing, with most courses being one to two years following a nursing qualification. In NSW this changed in 2005 with the

introduction of the Bachelor of Midwifery course. Some Australian states had introduced a Bachelor of Midwifery course before this and some are still moving towards this change. The Bachelor of Midwifery course enables midwives to become registered without needing to be registered nurses first. It is hoped midwifery numbers in Australia will start to increase as a result of this change in registration requirements.

Midwifery patterns of work

Since the early colonisation of Australia, regulated midwives have provided the majority of maternity care to childbearing women (Fahy, 2006). It is recognised, although beyond the scope of this thesis, that Aboriginal and Torres Strait Islander women were lay midwives for centuries prior to European colonisation of Australia in 1788.

The last century in particular, saw increasing numbers of general practitioners (GP) from England and the emergence of the occupation of nursing. Both of these groups soon developed a close alliance which resulted in the eventual cessation of midwifery as an independent occupation (Fahy, 2006) until its revival in the 1970s (Barclay, 1998). The introduction of the Bachelor of midwifery program is one aspect of this revival.

Midwifery in Australia is returning to a profession where the focus involves the provision of continuity of care giver (Homer, Brodie, & Leap, 2008b). Unfortunately, midwifery continuity of care has not yet reached all maternity services within NSW. Most publically-funded maternity care in this state and across Australia is provided in a fragmented way

where women see different midwives and doctors in the antenatal, intrapartum and postnatal period.

While the health department in NSW (known as NSW Health) supports a wide range of midwifery models of care, not all Area Health Services have incorporated these recommendations and not all midwives support or encourage the incorporation of the recommendations. For many women in Australia, including the women within NSW, there is little or no choice when it comes to where they have their baby and who provides them with the care throughout their pregnancy, intrapartum and postnatal periods.

Midwifery models of care that include caseload or midwifery group practice models, have enabled changes in the way midwives work, or to their patterns of work. The change of patterns of work includes the move from a shift-based work pattern to one that is responsive to the needs of a small group or caseload of women. The change in work patterns has implications for the health workforce especially in relation to retention of midwives. Midwifery continuity of care has been linked to an increase in job satisfaction and therefore retention in the midwifery workforce (Sandall, Page, Homer, & Leap, 2008). The link between midwifery continuity of care and job satisfaction will be further explored in the literature review as some of the midwives in this study worked in midwifery continuity of care models.

Overview of the thesis structure

This first chapter has provided background information supporting this study. This chapter has also briefly highlighted some of the major issues within this study which will be further discussed in Chapter Two of this thesis.

Chapter Two provides a literature review which explores the Australian health workforce; the Australian midwifery workforce; recruitment, retention and turnover in the health workforce; workforce planning and workforce development in the health care system; recruitment and retention in the midwifery workforce; strategies to improve retention in the health workforce; strategies to improve retention in the midwifery workforce; and finally examining 'Why Midwives Stay'. While the issues are specifically related to midwifery, literature from other sources is also reviewed and discussed.

Chapter Three describes the design and method of the study. In this chapter, the method used for data collection and the instrument that was used for this study are described. This chapter also outlines the data analysis techniques used and the ethical issues that were considered in the design and undertaking of this study. My role, as employee of the NSCCAHS, researcher, and research degree student is explained.

Chapter Four presents the results of the study. Quantitative and qualitative data are presented. These are synthesised and the top three reasons why midwives stay in midwifery are identified.

Chapter Five is the last chapter of this thesis and provides a discussion which will draw the results and the previous literature together. The limitations of this study will be discussed and the implications for future practice. Within the implications for future practice, some strategies to increase midwifery retention will be mentioned.

CHAPTER TWO: LITERATURE REVIEW

This chapter presents a literature review which explores the Australian health workforce; the Australian midwifery workforce; recruitment, retention and turnover in the health workforce; workforce planning and workforce development in the health care system; recruitment and retention in the midwifery workforce; strategies to improve retention in the health workforce; strategies to improve retention in the midwifery workforce; and finally examining 'Why Midwives Stay' (Kirkham et al, 2006). While the issues are specifically related to midwifery, literature from other sources is also reviewed and briefly discussed.

An initial review of the literature using the keywords: midwifery, retention, recruitment, workforce, job satisfaction industrial relations, and workforce retention was undertaken using the search engines: CINAHL, Journals @ OVID, SociaLit, and Medline. Once primary resources were identified, the reference lists of these documents were examined and secondary resources were located. Local and National Government databases as well as international organisational resources were also utilised to access the latest reviews and reports. Articles obtained from the initial search were reviewed and a total of 78 were included within this literature review. The literature was analysed descriptively in relation to the study objectives.

Due to the inclusion of midwifery within nursing, much of the literature, particularly in Australia, does not differentiate between nurses and midwives. Much of the available data around retention and the workforce focuses only on the nursing workforce with no mention of the difficulties or differences, if there are any, which midwifery has had in retaining its

workforce. Often the documents mean nursing and midwifery when they refer to nursing. This invisibility of midwifery is a limitation of this literature review and has been identified previously as a feature of Australian maternity care (Brodie, 2003). For the purpose of this literature review, where it cannot be seen that midwifery is subsumed under nursing, it has been assumed. While the focus of this study and literature review will be midwifery, it is also important to review the health workforce as a whole. It is the review of the health workforce where this literature review begins.

Australian health workforce

Nursing and midwifery are the largest health occupational groups in Australia (Australian Health Ministers Conference (AHMC, 2004). According to the Australian Bureau of Statistics, the Australian health workforce comprises over 76 different disciplines ranging from nursing and midwifery to medicine, social worker, occupational therapy, and physiotherapy (Australian Health Ministers Conference (AHMC, 2004). The 76 disciplines within the Australian health workforces are all facing difficulties with recruitment and retention.

In Australia, there are several state and national reports that both influence and guide the Australian health workforce. The reports are formulated by a range of commissions, committees and departmental offices including the Australian Government Productivity Commission, Australian Health Ministers Conference, Australian Workforce Advisory Committee, Australian Institute of Health and Welfare, and the NSW Health Profile of the

Nursing Workforce in NSW. Each of the reports provides evidence about the Australian health workforce and will be discussed within this literature review.

In 2002, the Australian Federal Department of Education, Science and Training (now the Department of Education, Employment and Workplace Relations) identified four national research priorities. The national research priorities included having an environmentally sustainable Australia, promoting and maintaining good health, developing frontier technologies for building and transforming Australian industries, and safeguarding Australia. The national research priorities aim to focus the Australian Government's research projects into areas that significantly benefit Australia and Australians. As well as focusing the Australian Government's research projects, the national research priorities aim to encourage collaboration between agencies and disciplines (National Research Priorities Standing Committee, 2007). The provision of an adequate health workforce was identified in the national research priorities as being essential to ensure that the national priority of promoting and maintaining good health could be achieved.

A number of national priorities, in particular, promoting and maintaining good health priority including achieving a healthy start to life, ageing well, ageing productively, preventive health care and strengthening Australia's social and economic fabric, are dependent on having an adequate health workforce (National Research Priorities Standing Committee, 2007). The ability to achieve an adequate health workforce is dependent on a health system's ability to recruit and retain a sufficient workforce with the right number of skills and the right mix, distributed across the right geographical locations (Duffield et al.,

2007). The emphasis on the retention of the health workforce has been significant in the development and conduct of this study.

There are a myriad of factors which influence the demand and supply of health professionals within the Australian health workforce. The factors are often interconnected and multidimensional and are similar across other developed nations. The aspects contributing to the Australian health workforce shortages can be broadly categorised into three themes that is, an escalating demand for health care workers, competition within the labour market, and limited capacity and structures within training facilities to accommodate increasing student numbers (National Health Workforce Taskforce, 2009). While these factors are the leading contributors to the health workforce shortage there are numerous other linked factors which are expected to develop into leading contributors. These include the burden of disease in the Australian population, changes in services delivery, community expectations, workforce expectations, workforce specialisation, and the unintended effects of specific workforce strategies where the specific strategy may create new shortages or shift the shortage from one area to another (National Health Workforce Taskforce, 2009). While it has previously been believed that the Australian health workforce shortages have been solely related to the numbers, or lack of numbers, of health care workers within the system, it is becoming more likely that the problem is a result of both health system and community development.

When considering the health system and workforce numbers as contributing factors to the Australian health workforce shortages there are a number of challenges to consider. The challenges in addressing recruitment and retention in the Australian health workforce starts

with determining the number of employees within the workforce. Establishing the number of employees within the different disciplines is problematic because a variety of different sources are used to calculate the size and distribution of the health workforce. All of the sources used to establish the number of employees within the health workforce have their own strengths and weaknesses. There are three major sources which provide information on workforce numbers and distributions: The Australian Bureau of Statistics (ABS) Census of Population and Housing, The ABS Labour Force Survey, and the Australian Institute of Health and Welfare (AIHW) surveys. Each of the different sources has an individual approach to the way in which they calculate these numbers and the way in which they are presented. For example, the Australian Bureau of Statistics Census of Population and Housing is conducted every five years and collects data on employment status, occupation and industry from all Australians over the age of 15 years. In contrast, the ABS Labour Force Survey includes the surveying of 30 000 private dwellings on a monthly basis, however, it can only be used as a sample due to the limited number involved in the survey.

Another group, the Australian Institute of Health and Welfare, compiles a survey in conjunction with the registration of health professionals. For nurses and midwives, the AIHW has been able to collect data on an annual basis since 2003 when the data collection changed from being collected biannually. The change in collection regimes allows for an annual census of all registered nurses (including midwives) and enrolled nurses in all states and territories of Australian. While the annual collection provides data on the number of registered and enrolled nurses, most jurisdictions do not distinguish between registered and registered and practising clinicians. For many other professions, this data collection is attended on a less regular basis, depending on the registration requirements of individual

professions. The Australian Health Workforce Advisory Committee (2002), in its report into the Australian midwifery workforce for 2002-2012, acknowledged the difficulties and inconsistencies in determining the workforce shortages and workforce predictions, which are currently being faced by the Australian health workforce.

The most recent report exploring the total number of people employed within the Australian health workforce is the report into 'Australia's Health 2008' from the Australian Institute of Health and Welfare. This report recognised that the Australian health workforce has grown by 14% in the five years since the 2001 ABS Census compared with the 10% growth in the overall labour force for the same period. At the time of the 2001 ABS Census there were over 450 000 Australians employed in health occupations. The 'Australia's Health 2008' report (Australian Institute of Health and Welfare, 2008) identified that registered nurses and midwives (categorised as Nursing worker: professional) accounted for 2% (n=203 500) of all persons employed in health occupations (n=10 150 300). The significance of determining the number of employees within the Australian health workforce will be discussed later within this chapter.

The structure of health services within NSW has undergone considerable structural changes over recent years. Both the size and organisational structures have changed, leading to many alterations within the workforce. In 2004, the NSW Health Department took steps to provide better clinical networks and streamline the health services within NSW. At the time there were 17 Area Health Services across NSW. These were realigned, with some services amalgamating, to develop eight AHSs. It was felt that the realignment and amalgamation would increase recruitment opportunities by linking well-staffed with under-staffed

services (NSW Department of Health, 2004). Unfortunately the amalgamations have not solved the problem of workforce shortages and have been very disruptive to many staff.

The Australian Productivity Commission Report (2005) states that commitment, care and the professionalism of the Australian health workforce are contributing factors to the successful delivery of health services across the nation. Retention and the importance of obtaining and then maintaining the Australian workforce are factors which need to be considered, among others, which play a role in the successful delivery of health care services, both within Australia and abroad. The increased size of the Area Health Services along with the amended structure due to the amalgamation of previously separate services could have a dramatic effect on the standard of care provided to the Australian public. Unfortunately, no specific research has been undertaken to quantify these effects in NSW.

Australian midwifery workforce

The registration and regulation of midwives in Australia is currently incorporated with that of nurses. In 2001, Brodie and Barclay (Brodie & Barclay) described the invisibility of midwifery and midwifery legislation in many Australian states and territories. The invisibility of midwifery registration and legislation have contributed to the difficulties in identifying and calculating the actual number of practising midwives in Australia, both nationally and at a state/territory level. With the lack of separate regulation it is also largely unknown how many individuals with midwifery qualifications are actually practising midwifery. Midwifery in Australia is becoming more visible, with four states now having Nursing and Midwifery Acts and the move towards a national Nurses and Midwives Board

in mid 2010. With the introduction of the national Nurses and Midwives Board and national registration, there will be a separate midwifery registry which will enable the calculation of practising midwives in Australia to be easier to establish.

The NSW Nurses and Midwives Board[2] 2008 annual report states that at 30 June 2008 there were 84 507 registered nurses in NSW (an increase of 1.3% from June 2007) and 17 757 registered midwives in NSW (a decrease of 4.2% from June 2007) (Nurses and Midwives Board of New South Wales, 2008). Unfortunately, these figures cannot be taken as a true representation of the total number of practising registered nurses and midwives as it incorporates all those who identify as being registered regardless of whether they choose to work in nursing or midwifery or even if they are working outside of nursing or midwifery but maintaining their registration. It was estimated that in Australia in 2004 there were 39 453 registered or enrolled nurses (including midwives) who were not employed in nursing (Australian Institute of Health and Welfare, 2004). Of these enrolled and registered nurses (and midwives), the majority (63.3%) were not looking for work in nursing or midwifery.

When preparing its report into the midwifery workforce in Australia (2002-2012), the Australian Health Workforce Advisory Committee (AHWAC) (2002), approached the AIHW and requested that the reporting parameters of 'nurses working in midwifery' be altered to 'registered nurses with midwifery qualifications'. This alteration in the reporting parameters reduced the AIHW reported workforce number by more than 2 000 full-time

[2] The Board is the statutory authority responsible for the registration of nurses and midwives, the authorisation of nurses and midwives to practise as nurse practitioners and midwife practitioners respectively, and for the enrolment of nurses in the State of New South Wales.

equivalents (FTE). While providing more accurate data on the Australian midwifery workforce, this calculation still remains less than ideal. Having midwifery qualifications does not mean that individuals are actually practising midwifery.

In Australia, the Federal government is responsible for education and training while the State governments are responsible for employment. Confusion can come from data which are presented regarding health workforce numbers, including the number of registered nurses and midwives. It is easy to see how workforce predictions are difficult to make, and adequate workforce planning is hard to achieve. The difficulties associated with attaining an adequate health workforce are exacerbated by the fact that there is often limited organisation or coordination between the federal and state governments.

Due to the changes in midwifery education mentioned in Chapter 1, New South Wales is starting to see a workforce of midwives who are no longer required to firstly be registered nurses. Prior to 1994 training to become a registered midwife in Australian could only be obtained by registered nurses who undertook midwifery training in the hospital setting. In 1994 there was a move towards university training for registered nurses and with that the introduction of university qualifications for midwives. In 2005, the University of Technology, Sydney introduced the first undergraduate midwifery program in NSW. It is hoped that Bachelor of Midwifery education will continue to grow and develop across Australia (there are now programs in five of the eight states and territories) and address the deficit in the numbers of midwives in Australian health workforce.

Recruitment, retention and turnover in the health workforce

This section presents a review of the literature pertinent to the health workforce. International and national literature will be presented. Recruitment, retention and turnover in the health workforce will be used as subheadings to assist in identifying the issues.

Recruitment

As already highlighted, one of the challenges facing the Australian health workforce is the difficulty in determining the number of workers. The inability to determine an accurate number of workers in the Australian health workforce makes recruitment projections and implementation of retention strategies difficult to plan and achieve. The Australian health workforce aims to provide an effective, safe and high quality of care. In order to achieve this effective, safe and high quality of care, workforce numbers need to match workforce demands. The turnover of staff needs to be monitored to ensure the negative impact of turnover is not affecting the hospital's ability to care for its patients (Hayes et al., 2006). With the unavailability of nursing (and midwifery) staff to care for hospital patients, maintaining and improving health care locally, nationally and internationally will all be affected (Buchan & Aiken, 2008).

The National Health Workforce Taskforce (NHWT) was developed in 2006 as a response to the Council of Australian Governments (COAG)[3] workforce reform package. The NHWT sits within the Australian Health Ministers' Advisory Council (AHMAC) which

[3] COAG is the peak intergovernmental forum in Australia, comprising the Prime Minister, State Premiers, Territory Chief Ministers and the President of the Australian Local Government Association (ALGA).

consists of the health ministers in each of the eight states and territories plus the federal health minister. The NHWT was developed to undertake projects that inform the development of practical solutions on workforce innovation and reform. Specifically, the NHWT is required to develop national strategies to meet the National Health Workforce Strategic Framework outcomes. The National Health Workforce Framework outcomes include: education and training; innovation and reform; planning, research and data; and secretariat support for the Health Workforce Principal Committee (HWPC) who the NHWT reports to, its subcommittees and working parties. Many of the strategies within the National Health Workforce Strategic Framework are directed at recruitment and retention. It is anticipated that the focus on recruitment will help in meeting health workforce shortages.

Strategies previously adopted in Australia to increase workforce numbers have included the recruitment of staff from overseas. International recruitment strategies are currently facing challenges beyond the control of the Australian health system. These strategies are no longer adequate as there is greater difficulty in recruiting staff from overseas due to the current global financial crisis (National Health Workforce Taskforce, 2009). International recruitment has the potential to create retention issues in a health workers country of origin (Buchan & Aiken, 2008). Often international recruitment allows the health worker to move to a country where there is better pay, better conditions, and greater education opportunities. While these conditions are better for the health worker they leave a deficit in their country of origin, often greater than that country can manage (Buchan & Aiken, 2008). Increasingly, it is Australian states which are relying on graduates from outside their

own system of training. In recent consultations, Western Australia and the Northern Territory revealed that they rely on nursing graduates from other states like NSW and Victoria to fill their registered nurse positions (National Health Workforce Taskforce, 2009).

The Australian education and training systems have been used as a strategy for the recruitment of staff within the Australian health system. With the increasing workload demand on the health workforce, and the workforce shortages that are currently being faced, there are less staff able to provide students with supervision and adequate experience within their clinical placements (National Health Workforce Taskforce, 2009). While the supervision of students, and ensuring they obtain adequate experience during their clinical placements is essential if they are to remain within the workforce, this can be seen to add an extra burden to the demands of many registered practitioners.

In Australia, there are currently 29 universities and one college offering undergraduate nursing programs. It is an estimated 13 895 training places exist in 2010, an increase of 57% since 2002 (National Health Workforce Taskforce, 2009). It cannot be expected that with such a large pool of undergraduates that the universities can attend to the supervision of all students when on clinical placements in the workplace and neither are universities adequately funded to provide intensive support. If the nursing profession is unable to find a way to ensure our future health professionals are not better supported during their clinical experience the health workforce is going to continue to struggle (Duffield et al, 2007). Like the nursing workforce, the midwifery workforce face similar difficulties in relation to student supervision while on clinical placement. As the pressures on staff mount,

recruitment of staff becomes increasingly more difficult and retention and turnover continue to challenge. With the increase in workforce demands, it is even more important that the factors which contribute to staff staying in the profession be understood, and acted upon.

While there has been some acknowledgment of the current national shortage of nurses and midwives (Buchan, 2002; Tierney, 2003), a greater emphasis is needed in order to plan effectively for the future of the midwifery profession and the health system in general. Other health professions are facing similar challenges to the nursing and midwifery workforce. For example, the Allied Health Professionals Australia (AHPA) (Allied Health Professionals Australia, 2008) concedes that there is a significant national shortage of allied health professionals in both metropolitan and rural areas. Many allied health professionals are leaving their chosen profession for positions in education and management due to inadequate pay and poor career prospects (Allied Health Professions Australia, 2008).

While the issues of insufficient health workforce numbers, international recruitment and increasing the training positions remain factors important in addressing the health workforce shortage, there are some questions as to whether we actually have adequate numbers of health workers. Adequate numbers of health workers willing to work in the current conditions may actually be the reason for the deficit (Buchan & Aiken, 2008). In the UK, the current workforce shortage is more problematic than experienced previously due to the ageing, or greying, workforce, a potential problem that has been known for some time (Tierney, 2003).

Australia is also seeing the emergence of a growing population and a workforce that is ageing. The Australian General Practitioner (GP) workforce has had an increase in the average age of the GP with 8.3% of practising GPs now being over the age of 55 years. Nursing is similarly ageing. The average age of nurses in the major Australian cities was 46.6 years in 2005, up from 41.9 years in 2001 (National Health Workforce Taskforce, 2009). It is expected that the average age of nurses will continue to increase as many of the current nurses move into retirement (National Health Workforce Taskforce, 2009). A further complication for the nursing (and midwifery) profession is that it is often perceived as being low paying, labour intensive and women's work with limited career opportunities (Buchan, 2002). Even in areas and settings where this is no longer the case, the perception prevails.

The ageing workforce is working shorter hours as it approaches retirement while the emerging workforce has different expectations about work than previous generations. It is acknowledged that Generation Y (those born between 1979 and the 1990s) are intent on making their jobs accommodate to their lives rather than their jobs being their focal point (National Health Workforce Taskforce, 2009). As the youngest members of the current workforce, Generation Y are working fewer hours than Generation X (born between 1964 and the 1970s) and the Baby Boomers (born between 1946 and 1964) who both placed a high priority on career. Again this shift in profile and expectation for work has implications for recruitment and retention (Australian Health Ministers Conference (AHMC), 2004). Further research is still needed on the long term effects of Generation Y on the health workforce, however it is estimated that some workforces are already seeing a turnover rate of over 30%. For example, evidence from New Zealand suggests that 80% of graduate

medical officers are planning on leaving New Zealand within two years of graduation (National Health Workforce Taskforce, 2009).

Retention of the workforce

Along with the issue of the changing profile of the Australian population and therefore the Australian workforce, there are several other issues which need to be considered as contributing factors to the current workforce shortage. An increase in the demographic trends of Australia, including a growth in population as well as the ageing population, the increased prevalence of chronic disease and the burden of disease including an increase in chronic disease and the reduction in the recommended length of stay for many hospital patients, are some of the additional factors which need to be regarded when considering workforce shortages (Duffield et al., 2007; National Health Workforce Taskforce, 2009). As well as the recent focus on rural and Indigenous health, Australia has the added obstacle of a large geographical area with maldistribution of health care workers and health care resources (Australian Health Ministers Conference (AHMC), 2004). Many of the smaller health services are closing down and, in towns where there are health services, the demand is not always being met due to the lack of services for many of the people with chronic diseases. Despite the current workforce shortage and the factors which contribute to the increased demand of the health workforce, strategies need to be examined to help meet and curb this shortage. Recruitment and retention of staff are an important consideration and strategies to address these have been trialed in many hospitals.

Hospitals that were successful at providing quality patient care as well as attracting, retaining and providing job satisfaction for nurses were identified in research that was undertaken in America in the 1980s (Kramer & Schmalenberg, 2005). From this research the terms 'Best Quality Hospitals', 'Magnet Hospitals' and 'Gold Standard Hospitals' were coined. Over the past two decades further studies have expanded on this original work (Kramer & Schmalenberg, 2005). The research by Aiken et al (2002) and others (Brady-Schwartz, 2003; Garon & Ringl, 2004; Lash & Munroe, 2005; Upenieks, 2005) supports these initiatives which have been shown to contribute to increased nurse retention by effective leadership characteristics. A number of studies have examined retention in nursing and these are described in the next section.

Aiken et al (2002), in their multi-site cross-sectional research, concluded that support from the employing organisation and management had a profound effect on the levels of dissatisfaction experienced by nurses in sites across the United States of America (USA), Canada, England, and Scotland and Germany. In order to assess organisational/managerial support, the researchers modified a tool known as the Nursing Work Index to present 49 attributes which related to the organisation. Over 10 300 nurses from medical and surgical units were surveyed in the Aiken et al (2002) study which established that reports of low quality care were three times more likely to be made in hospitals where there was low staffing and less support for nurses than in hospitals with high staffing ratios and higher levels of support. It was also reported that organisational and managerial support was directly related to nurse retention (Aiken et al., 2002). In their research Aiken et al (2002) discussed the fact that too often the focus for a solution to retention is directed to consultants outside the organisation. Not enough attention is placed on clinicians within an

organisation and the significant contribution they make to the outcomes of inpatient care and the role this has on the ongoing retention of the health workforce (Aiken et al., 2002). Aiken et al (2002) identified that staffing levels alone were not a indicator of high staff retention levels, but needed to be aligned with a supportive practice environment.

Other studies have established that the key strategies to improving the quality of patient care, nurses' job satisfaction and nurse retention levels in hospitals, include having adequate nurse staffing levels and good support from managers and the organisation (Aiken et al, 2002; Bartram et al, 2004; Kleinman, 2004; Parsons & Stonestreet, 2004). While their sample number was limited (n=157), and with a response rate of only 26%, Bartram et al (2004) studied a sample of Australian nurses in relation to job stress and job satisfaction and the implications for recruitment and retention. Several instruments were used including the House and Wells social support scale, the Spreitzer's empowerment scale and a job satisfaction scale adapted from the Job Descriptive Index. The use of each of these instruments was successful in extracting the data required for Bartram et al (2004) to identify the factors affecting the job stress and job satisfaction of Australian nurses. Each of the instruments used by Bartram et al (2004) has been previously used in the health system. Analysis of the results from the Bartram et al (2004) study confirmed that social support from both nursing supervisors and work colleagues lowered job stress and increased job satisfaction. Additionally Bartram et al (2004) were able to conclude that the presence of all four cognitions of empowerment (meaning, impact, competence and self-determination) lowered job stress and increased job satisfaction. While employees who are empowered at work are often more committed to the organisation and experience positive feelings about their work, the presence of the four cognitions of empowerment demonstrate an

individual's commitment to their work. With the presence of job satisfaction and the lowering of job stress, workplaces are likely to see a reduction in the need for recruitment and an increase in their retention rates.

Turnover of staff

While the turnover of staff within the health workforce has been examined extensively, the definition of turnover and the way it is recorded is varied within much of the research (Hayes et al., 2006). When discussing turnover of staff within this literature review, it is not possible often to make a distinction between turnover as a result of someone leaving their job for career advancement reasons, or someone who has left due to dissatisfaction with the profession. Hayes et al (2006) acknowledged that regardless of the nature of turnover there is often a considerable cost occurred by the organisation. The cost varies greatly depending on the specialty in which the nurse works. Generic costs to the organisation include recruitment, orientation, lost productivity and preceptoring of new staff (Aiken et al., 2002).

Turnover of staff within the health care system can be attributed to several factors. Some of the factors contributing to staff turnover include: intent to leave the organisation, burnout, excessive workload and stress. In a study of 243 oncology/haematology nurses across 11 health facilities in Australia (Barrett & Yates, 2002) which looked at job satisfaction, burnout and the intent to leave the specialty, 8.2% of respondents reported having a high intent to leave oncology/haematology nursing in the near future. A further 39.5% of respondents were unsure about their future within the specialty. A reason for the nurses

intent to leave was unfortunately not explored in the Barrett and Yates study (2002), however, nurses did report high levels of job dissatisfaction in relation to overall staffing levels (50.6%) and the time they had to get through their work (48.9%).

A further indicator of intent to leave is the commitment that an employee has to the profession. A study in Korea (Chang, 1999) looked at career commitment as a complex moderator of organisational commitment and turnover. From the 227 participants, Chang (1999) was able to conclude that commitment to the profession was increased when the employee perceived that the organisation was providing good support and information to the employee.

The changing profile of the Australian health workforce and the increasing demand of, and for, health care within Australia make the difficulties of recruitment and retention poignant for all members of the health workforce. Midwives and midwifery are not excluded from these difficulties. Nursing and midwifery face differences in their delivery of practice but they both face many similar difficulties when it comes to recruitment and retention. Autonomy, professional development, participation in decision making, and fair reward and remuneration for work done are strong contributors to recruiting and retaining nurses (O'Brien Pallas, Duffield, & Hayes, 2006). The next section focuses on the issues of recruitment and retention in the midwifery workforce.

Workforce planning and workforce development in the health care system

In any given workforce it is essential to have a comprehensive workforce development strategy in order to enhance that workforce. The issues that have been highlighted in relation to midwifery are part of this strategy but clearly the health workforce in general is much larger and more complex. The Australian Health Ministers' Conference's (AHMC) National Health Workforce Strategic Framework (2004) identifies the need for health workforce policy and planning to be informed by the best available evidence involving innovation, research, information sharing, collaboration and consultation. In order to achieve this workforce the AHMC (2004) has identified seven goals as their vision for a healthy health workforce. The vision comprises a workforce that has a population and health consumer focus; that is sustainable of both service delivery and finances; that is equitable to all members of the community; that is trained and competent; flexible and integrated; employable while utilising both old and new skills; and is valued (Australian Health Ministers Conference, 2004).

The difficulty that many health systems around the world, including Australia, have in providing a safe and sustainable workforce include: the maldistribution of employees and services; the continual change in models of care and the struggle for continual improvement and flexibility (Australian Health Ministers Conference, 2004). In the UK, emphasis has been placed on the importance of integration of workforce and service planning (Buchan, 2004). In clinical practice the emphasis is often placed on curing and treating conditions and illnesses with which patients present. Workforce development and planning must start

to focus on the long term health of the Australian workforce and like clinical practice, needs to start focusing on the prevention of illness rather than the continual treatment.

Recruitment and retention in the midwifery workforce

Autonomy of midwifery practice is a theme often present when exploring recruitment and retention within the midwifery profession. Autonomy of practice has been associated with greater job satisfaction and an enhanced woman-midwife relationship (Sandall, 1995). Autonomy of midwifery practice, however, occurs for very few midwives when the true definition is explored. Many of the definitions which have been portrayed in the literature describe autonomy as being free from control by others and independence of mind, judgment and self (Davis-Floyd, 1997; Pairman, 2006; Stafford, 2001). It is believed that what is meant when looking at autonomy in midwifery practice is the midwife having freedom to make decisions about the care she is providing a woman and her family, while working within the parameters of the service in which she is employed, and with the respect of her colleagues. Davis-Floyd (1997) talks of this as being autonomous in thought as opposed to autonomous in action. Davis-Floyd (1997) suggests, that despite the belief of some midwives that, because they are now predominantly working in hospital-based practices, they can no longer be autonomous. Autonomous thought is the most critical type of autonomy. A midwife who is autonomous of thought is able to direct and influence the system to enable her to provide truly woman-centred care, regardless of whether she is working in a hospital with traditional midwifery care or in a midwifery continuity of care model. Stafford (2001) goes so far as to suggest that the undermining of midwives' autonomy is at the core of many of the recruitment and retention issues in midwifery. Ball,

Curtis and Kirkham (2002) in their UK study, 'Why Midwives Leave', found that midwives wanted their experience, skills and responsibilities to be recognised and valued by management. In their study, 1,975 midwives who had indicated their intent to practise midwifery to the UKCC in 1999 but did not indicate intent to practise midwifery in 2000, received questionnaires. While midwives revealed that their decision to leave midwifery was not made lightly, it was made over a protracted and painful time (Ball et al., 2002). Midwives were asked to give five main reasons for leaving midwifery. The largest group of respondents were those who were simply 'dissatisfied' with midwifery. Unfortunately, the characteristics of the midwives who were dissatisfied was not available, however, of all respondents, 66.7% were aged 45 years or less and 51% had graduated at diploma or degree level. Dissatisfaction was shown to be related to discrepancies between what midwives were trained to do and what they actually found their job to be. A sense of lack of control over their working lives and lack of support from their managers also contributed to midwives leaving the profession. The findings from the Ball et al (2002) study identify the necessity for change in relation to improved working conditions, support and flexibility in order to retain the midwifery workforce in the UK. It is unknown whether this is the same in Australia. It is likely that many of the reasons midwives leave are the reverse of why they stay, however this has not yet been established. The reasons that midwives have given for being dissatisfied with their work and therefore leaving midwifery will be further explored within this literature review.

When reviewing the Ball et al (2002) study, it is encouraging to note that 62% of the midwives who had left midwifery stated they would consider returning if the conditions proved right for them. While it is known that job dissatisfaction, burnout, workload, lack of

autonomy, emotional exhaustion, and organisational/managerial factors contribute to nurses and midwives leaving nursing and midwifery (Ball et al., 2002) these issues are not widely understood in the midwifery context in Australia. My study will give some insight into the factors which keep midwives in midwifery in one Area Health Service in NSW.

Midwifery continuity of care models have been seen as a way to recruit and retain midwives within the workforce because of the increased job satisfaction, increased occupational autonomy and the ability to develop relationships with women (Sandall, 1997; Sandall et al., 2008). A study aimed at comparing midwives' experiences of occupational stress under different occupational circumstances was carried out in the UK between 1994-1996 (Sandall, 1999). The study was conducted at a time in the UK when maternity policy was highlighting the importance of midwifery continuity of care, and there were concerns that continuity of care models were not sustainable because of the increased possibility of 'burnout' (Sandall, 1999). Psychological health was one of the three main points of emphasis for this study. Burnout and occupational stress were assessed using the Maslach Burnout Inventory (MBI). Postal surveys were sent to a 5% random sample (n=1 166) of midwives who had membership to the Royal College of Midwives (RCM). From the random sample, there was a 69% response rate (n=800). Many of the surveyed midwives talked about burnout and scored highly for the prevalence of occupational stress. While the levels of burnout and occupational stress were high, the researcher was able to conclude that midwives working in community settings were more likely to get job satisfaction. Midwives working in community settings received job satisfaction from the relationships they developed with women while midwives working in hospital settings got job satisfaction from their clinical practice and relationships with their colleagues (Sandall,

1999). Sandall (1999) was able to conclude that one of the key determinants of midwives becoming burnt out was the degree of occupational autonomy that they received. The burnout that was experienced by the midwives in the continuity of care model known as team midwifery was related to a lack of control over their workload, a large number of midwives working within the team, and conflict with the manager, rather than the continuity rate and overtime that were experienced. Sandall (1999) concluded that while team midwives have greater autonomy than many hospital-based midwives and greater job satisfaction, if the team is based in the hospital they can also experience increased burnout and therefore desire to leave midwifery. While midwifery continuity of care models known as caseload and based in the community reduced the level of burnout and occupational stress among midwives, the Sandall (1999) study did not explore emotional work in midwifery and the emotional work associated with burnout and occupational stress. Relationships, and the development of relationships, play a large part in midwifery care, with midwifery being described as being "conducted in and through the relationship between the woman and the midwife" (p. xi) (Kirkham, 2000).

Knowledge of 'emotional work' or 'emotional labour' has been under discussion since the late 1970s when Hochschild (1979) first drew attention to the meaning of emotions in the workplace. Emotional labour has been described as being carried out through relationships which are developed between midwives and the women for whom they are caring (Kirkham, 2009). When looking at the reasons for midwives staying in midwifery, it is important to note that the relationships described were all positive, however, not all midwives feel the relationship with women is a positive relationship and very often the emotional work or emotional labour can have a burnout effect. Deery (2009) discussed the

exhaustion many midwives experience when they are caring for a variety of women all going through very different experiences at the same time and the emotional exhaustion which can result from this type of care. The positive relationships which midwives develop and nurture are central to the quality of the care midwives give to women (Hunter, Berg, Lundgren, Olafsdottir, & Kirkham, 2008).

Midwives, as predominantly women 'with women', build and develop relationships with the women and families that they are caring for, as well as the colleagues that they are working with, on a day to day basis. Much of the primary culture within which midwifery practice is encapsulated is the culture based on female skills including the maintenance of relationships and the provision of new life (Kirkham, 1999). The importance of the relationships between midwives and women has been well documented (Brodie, 1996; Homer, Davis, & Brodie, 2000; Hunter, 2004; Kirkham, 2000). Being with women was the core category which emerged from a study by Brodie (1996). Brodie (1996) examined team midwifery and the experience of Australian midwives as they made the conversion from a conventional role, to their new role as team midwives. Through the conversion to team midwifery, team midwives were able to be with women and provide midwifery continuity of care. Midwifery continuity of care enabled a trusting relationship between women and midwives which was highly rewarding for the midwives within this model (Brodie, 1996).

In her study which examined conflicting ideologies as a source of emotional work in midwifery, Hunter (2004) citing Brodie's original work (1996) was identified that midwives working in team midwifery settings work within the 'with woman' model, many midwives who work in the hospital setting feel it necessary to work within a 'with

institution' model of midwifery care. The midwives working within the hospital setting and with the 'with institution' model were more likely to fulfill the needs of the institution with a task focus while midwives who worked in the community were able to focus their attention on the women for whom they were caring (Hunter, 2004). Having a better understanding of the emotional work of midwives has been suggested as a strategy to reduce the current shortage of midwives within the UK (Hunter, 2004).

An increase in the degree of autonomy that a midwife has over her work environment is a characteristic of midwives who have the ability, or opportunity, to work within a woman-centred model of midwifery care (Sandall, 1999). The midwives in Sandall's study had a reduction in the level of emotional exhaustion they experienced. This in turn may reduce the turnover of midwives and increases the retention rate. While the model of care that the midwives work within plays a large role in the level of professional autonomy and reduction of emotional work midwives experience, there are other extrinsic factors which need to be considered when looking at recruitment and retention.

Within the literature there appears to be a focus on midwifery continuity of care models as a strategy for improving the recruitment and retention of staff within maternity services. These models of care however are not the norm in Australia at the current time. Increased job satisfaction as a result of autonomy and professional friendships from working in midwifery continuity of care models definitely contributes to improving the recruitment and retention of midwives. When looking at burnout and continuity of care, Sandall (1997) identified three key principles for reducing the incidence of midwives experiencing burnout. While this study was looking at continuity of care models, not all services are able

to provide this model of care and not all midwives are able to secure work within these models when they were available. They key strategies for reducing burnout were: being able to develop meaningful relationships with women; having occupational autonomy and flexibility to organise work; and good support both at work and at home (Homer, Brodie, & Leap, 2008a; Sandall, 1997). In services that do develop maternity continuity of care models or where these models are not possible, these strategies could be adapted as a retention strategy.

Strategies to improve retention in the health workforce

In order to address and improve retention in the health workforce, there needs to be a coordinated and integrated approach (National Health Workforce Taskforce, 2009). A coordinated and integrated approach requires the consideration and examination of all characteristics associated with the shortage, including the structure of the workforce and educational preparation. Many of the current strategies used are single-dimensional rather than being the multi-dimensional approach required. Where there is no coordinated approach to workforce retention there can be seen to be a flow on in workforce shortages and the moving of shortages from one workforce to the next (National Health Workforce Taskforce, 2009). If only one dimension of the workforce shortage is examined with the focus on either reducing the demand within that sector or increasing the supply, the risk becomes that the overflow will be re-directed to another sector (National Health Workforce Taskforce, 2009). Rather than concentrating on this single approach retention needs to be addressed across all the disciplines.

Magnet Hospitals are an example of a workforce strategy that uses a multi-dimensional approach to workforce strategies and which in turn has been successful in reducing the amount of turnover and therefore increasing the retention of nursing staff. The definition and development of magnet hospitals originated from a policy study in the United States of America (USA) in 1981, commissioned by the American Academy of Nursing (AAN). The study set out to examine characteristics of systems which either impeded and/or facilitated professional nursing practice (Buchan, 1999). 'Magnetism', a term coined in the early 1980s from the policy study, involves having nurse-friendly policies, such as providing bonuses for longevity of employment, being paid for continuing education, premium pay for overtime, an increase in staffing ratios and a share in governance hospital-wide. The policies have proved to be cost effective by pitting them against the lower turnover rate of staff and decrease in agency nurse utilisation (Upenieks, 2005).

To achieve 'magnet' status in hospitals (predominantly in the USA), there must have been an accreditation process that deems that these hospitals have a certain level of excellence in clinical services. While not included in the original research an accreditation process is now required and involves simultaneous evaluation of hospital outcomes and structures as well as evidence of each of several 'forces of magnetism'. According to the American Nurses Credentialling Centre (ANCC) there are 14 characteristics, or 'forces of magnetism', which can be thought of as attributes or outcomes that exemplify excellence in nursing. These are: quality of nursing leadership, organisational structure, management style, personnel policies and programs, professional models of care, quality care, quality improvement, consultation and resources, autonomy, community and the health care organisation, nurses as teachers, image of nurses, interdisciplinary relationships, and professional development

(American Nurses Credentialling Centre, 2007). The development of the 'forces of magnetism' came from analysis of interviews from the original 41 magnet hospitals. The original magnet hospitals were identified from a 'reputational study' which was conducted in the USA between 1982 and 1983. While nominations were received from fellows of the American Academy of Nursing, hospitals also needed to provide evidence of turnover rates, personnel and hospital statistics and vacancy levels in order to be awarded magnet status (Kramer & Schmalenberg, 2005).

The magnet hospital model has shown a consistent level of job satisfaction from its staff (Buchan, 1994; Sullivan-Havens & Aiken, 1999). These hospitals are seen to promote and sustain their nursing workforce and support professional development (Lash & Munroe, 2005). Magnet hospitals have been shown to have less nurse turnover than non-Magnet institutions (Kramer, 1990). Nurses from Magnet facilities have demonstrated a significantly higher level of overall job satisfaction than nurses from non-Magnet facilities. It is also apparent that higher levels of job satisfaction shown in the Magnet group are associated with a greater desire to remain in their current nursing positions (Brady-Schwartz, 2003).

Obtaining Magnet status needs to be seen as a long term solution to workforce shortages. While the advantages of Magnet status have been previously discussed, the process for obtaining Magnet status can be quite lengthy. Demonstrating achievement in the 14 'forces of magnetism', for many facilities, may also prove to be problematic. With the current shortage of an adequate health workforce the reaction is often to produce something quickly and within the current budget. Not only can obtaining Magnet status be lengthy but

the initial investment has financial commitments attached to it. While the successful recruitment and retention strategies aligned with Magnet status provide a hospital with an adequate workforce, the initial measures required to obtain this status may be seen as a deterrent for many hospitals or health facilities. It has been suggested that more research into Magnet hospitals is required (Buchan, 1999).

Magnet workforce management practices for hospitals are now beginning to be introduced into Australia. The Princess Alexandra Hospital in Queensland, in 2004, was the first hospital in the Southern Hemisphere to receive magnet designation. In May 2009, Princess Alexandra Hospital continued to be classified as a magnet hospital becoming the first re-designated magnet facility outside of America. The South Australian Government is dedicated to promoting the magnetism principles throughout its hospitals and in NSW St Vincent's Private Hospital in Sydney is currently awaiting assessment for magnet designation. Magnet hospitals demonstrate a sensible strategy in dealing with the current nursing shortage although this strategy implies some autonomy in setting salary levels that is not seen in Australia. Again it is not known whether similar issues to those described in the magnet hospital studies exist for midwives in Australia. While Australia is to see the emergence of hospitals with magnet designation, more health services need to achieve these characteristics if Australia is to address its nursing and midwifery workforce recruitment and retention issues.

Strategies to improve retention in the midwifery workforce

As discussed earlier, midwifery continuity of care is seen as one of the strategies for improving recruitment and retention in the midwifery workforce. Midwifery continuity of care enables the development of a relationship where trust and confidence are central to pregnant women, their families and the midwife/midwives caring for them and meets one of the key points to reduce burnout identified by Sandall (1997, 1999). An intimate knowledge of the belief system of a woman including her beliefs around labour and birth is essential in developing the professional friendship which is required with midwifery continuity of care (Homer et al., 2008b).

The provision of midwifery continuity of care in the community appears to decrease the level of occupational stress and burnout among midwives (Sandall, 1999). While the work by Sandall (1999) concluded that midwives working within a team midwifery or a midwifery continuity of care model based in the hospital experience increased burnout and therefore desire to leave midwifery, it is important to note that if they were to work in the community their level of burnout and desire to leave midwifery would be reduced. The retention of midwives may be improved as a result of the change of focus in midwifery care from a fragmented midwifery model of care to one that has continuity of carer as a focus. As previously mentioned, research by Sandall (1995) identified midwives have higher levels of job satisfaction when they are able to work in models which support and encourage continuity of care.

As discussed earlier, there are suggestions that the undermining of midwives' autonomy may be the heart of the problem in relation to recruitment and retention of midwives within the UK (Stafford, 2001). Autonomous practice in midwifery can be described as the midwifes ability to self-govern and obtain independence in regard to her practice and the care which she provides a pregnant woman and her family. While autonomous practice helps to develop the professional friendship that needs to develop between and woman and her midwife, the practice needs to fall within the sphere of safe practice. Where the autonomy of the midwife is not honoured or is undermined there exists a situation where midwives leave the profession and the health service is faced with recruitment and retention difficulties. The application of the Stafford (2001) research to Australia has not been tested.

Midwifery leaders and senior midwives within the maternity services often participate in a 'with institution' model of practice and younger midwives often perceive the practices of senior midwives as being that of a 'gate-keeper' (Hunter, 2005a). The 'gate-keeper' approach is seen as one where less senior midwives need approval from more senior midwives who are protecting the profession (Hunter, 2005a). For effective recruitment and retention to take place, it is essential that both senior and junior midwives acknowledge the type of model of care which is needed to ensure that their practice is best achieved and the care of the women is maintained.

Examining 'Why Midwives Stay'

In response to lack of information and uncertainty as to why midwives stayed in the workforce, Kirkham, Morgan and Davies (2006) conducted research in England into 'Why Midwives Stay'. As one approach to retaining midwives in the New South Wales midwifery workforce, a similar study was undertaken and described in this thesis. The English study will now be described in detail.

The Kirkham et al (2006) research was carried out in two phases. Phase One can be further divided into two parts. Initially, preliminary questionnaires were randomly distributed asking age; qualifications and; place of work. Two further questions were then asked:

1. What are the main reasons why you continue to practise as a midwife?
2. Would you be willing to be interviewed by a midwife researcher, at a time and place convenient to you, about your reasons for continuing to practise midwifery?

The second part of Phase One of the study included semi-structured interviews of those who consented. Data collection occurred during both parts of Phase One of the research, with a grounded theory approach to analysis being taken.

Phase Two involved the distribution of questionnaires. The study sample was a 5% random selection of midwives in the UK who had notified the Nursing and Midwifery Council (NMC) of their intention to practise as midwives in 2002/3. Sampling and distribution of the population and the questionnaires was attended by the NMC on behalf of the research team.

Initial flaws in the original sample were identified when the first questionnaires in Phase One were returned. Rather than a random sample of midwives being selected it became apparent that a sample by date of birth had been selected. This was rectified and a new sample was distributed. At the completion of Phase One, which was where preliminary questionnaires were distributed, the funding body requested the initial method be amended. Analysis of only midwives from England was requested.

Sampling flaws were also identified in Phase Two of the research where two samples were requested; sample one was of the original 5% sample and the newly requested second sample was a further 400 midwives who expressed intent to practise in early 2002 but who had been practising as midwives in England for greater than six years. These two samples would allow for comparisons to be made between sample one being a random sample and sample two being those midwives deemed to be 'stayers'. On return of the completed questionnaires, it again became apparent that a random sample only had once again been selected with many midwives included who had been qualified for less than six years.

The response rate in Phase One of the study was 34%. This improved for Phase Two of the study where there was a 62% response rate. Reminders were unable to be sent for Phase One due to the initial delay as a result of the sampling error and then a copy of the address labels was not kept. For Phase Two, a reminder was not sent.

Kirkham et al (2006) reported that 94% of respondents strongly agreed or agreed with the statement 'I enjoy my job'. For 53% of respondents, this was one of the top three reasons for staying within midwifery. The second and third reasons midwives gave for staying in

midwifery were ‘I am proud to be a midwife’ and ‘I work in an area of practice I want to work in’. When questioned about job satisfaction, the top four responses all related to the women the midwives cared for. Ninety six percent of midwives either strongly agreed or agreed with the statement they get job satisfaction from ‘feeling they make a difference to clients’. From the study, Kirkham et al (2006) was able to identify seven factors which encouraged midwives to stay. These were:

1. Relationships with childbearing women and making a difference to them
2. Feeling supported and valued by colleagues
3. Feeling supported and valued by managers
4. Adequate resources, especially staffing, to underpin good practice
5. A degree of autonomy, control and flexibility within their work
6. Finding their personal niche within midwifery
7. Working hours to suit individual circumstances

In summary, the ‘Why Midwives Stay’ study in England was attended in response to lack of information and uncertainty as to why midwives stayed in the workforce. The English research used two phases to initially develop the ‘Why Midwives Stay’ questionnaire and then collected data using this questionnaire. The results identified seven factors which encouraged midwives to stay in midwifery. It was hypothesised that similar responses might be received from Australia midwives and my study explored this possibility.

Summary

While the global issue of retention within the midwifery workforce is a topic of focus at the moment, there appears to be little understanding of the area. Many assumptions are made that pronounce the reason midwives stay as the mirror image of why they leave, but anecdotally, as a practising midwife, I believe that this is not always the case. In order to obtain a better understanding of the reasons for midwives staying in midwifery and in their current place of employment, it is essential that the currently practising midwives are questioned about what keeps them in their place of employment and in midwifery. This study aims to examine these issues in one Area Health Service in NSW. The next section describes the methodology that will be used.

CHAPTER THREE: METHOD

A descriptive design underpinned this study. It was felt that a descriptive design was most appropriate, as it allowed for an exploration, description and portrayal of the reasons why midwives stay in both midwifery and in their place of employment and could use both qualitative and quantitative data and analysis (Burns & Grove, 2005). A descriptive design also allowed for the frequency of responses to be explored and examined (Burns & Grove, 2005). The study was a two phased project, which used both focus groups (Phase One) and a questionnaire (Phase Two), and included both qualitative and quantitative responses.

This chapter initially outlines the research question and the objectives of the study, followed by discussion of the ethical considerations of the study and a description of the instrument used to collect the data. The chapter is then divided into Phase One and Phase Two. Under each of the phases is an outline of the setting, sample and data collection methods used within that phase.

Research question

The study aimed to address the lack of understanding in relation to retention in midwifery. The research question is:

What are the factors that contribute to midwives staying in midwifery: a study in one Area Health Service in NSW

The study objectives are to:

1. Explore the reasons for midwives selecting a particular workplace, clinical setting or model of care;
2. Understand the reasons why midwives choose to stay in (1) midwifery; and/or (2) in their current workplace; and
3. Explore issues that contribute to job satisfaction; explore the support systems and coping strategies that are important to midwives and keep them in (1) midwifery and/or (2) in their workplace.

Project planning

Planning took place before the study commenced. Initial discussions with the Area Director of Nursing and Midwifery commenced at the end of 2006. Part of these discussions included an invitation to the Area Director of Nursing and Midwifery to attend a Midwifery Workforce Seminar held at the University of Technology, Sydney (UTS) in November 2006. Present at the workshop was Mavis Kirkham; Professor of Midwifery at Sheffield Hallam University in the UK, who had recently published the study into 'Why Midwives Stay', as previously discussed.

In January 2007, an invitation was extended to the researchers by the Area Director of Nursing and Midwifery to attend the Area Directors of Nursing (DoN) monthly meeting. A short presentation was made at this meeting and unanimous support was given for this Master of Midwifery (Hons) study to be undertaken within the AHS. Request for ethical

approval was submitted to the NSCCAHS Human Research Ethics Committee (approval number 0701/001C) in January 2007, preliminary approval was granted in February 2007, with only a few minor clarifications needed and final approval granted in March 2007. Ethics approval from UTS was granted in June 2007.

The table below provides an overview of the methods used for this study, a detailed description of each phase follows.

Table 1: Overview of the phases of the study

	Phase One	***Phase Two***
Purpose	To review the questionnaire used in the English study and adapt to the Australian context	To determine the factors that contribute to midwives staying in midwifery
Setting	Four maternity units in NSCCAHS	All seven maternity units within NSCCAHS
Sample	Self selected sample of midwives at the four sites (n=36)	All practising midwives (n=392)
Data Collection	Focus groups	Self administered surveys
Data Analysis	Qualitative content analysis	Descriptive analysis qualitative content analysis quantitative descriptive statistics

Ethical considerations

Ethics approval was obtained from the Area Health Service involved in the study (NSCCAHS). I was employed as a clinical midwife in one of the maternity units of NSCCAHS, however the Chief Investigator (my supervisor) and other investigators had no affiliation with, or financial involvement in, NSCCAHS. This could be seen to be an ethical issue however, I worked as a clinician alongside the midwives in the unit and was not in a managerial role.

In Phase One of the research, where focus groups were conducted, the Chief Investigator (Caroline Homer who is also one of my supervisors) facilitated the sessions in the setting where I was employed. Focus group data involved hand-written field notes and tape recordings. For reasons of confidentiality, the names, roles, hospitals and any other identifying information pertaining to the midwives were deleted from the transcripts. Only the Chief Investigator and I had access to the original tapes and transcripts. While the hospitals are able to be identified from the data, individuals and the hospital in which they work are not identifiable.

Maintaining respondent confidentiality in the survey was a priority. Respondents were provided with a study number. The list that linked study number to midwife was stored separately to the data in a password-protected computer database at the Centre for Midwifery, Child and Family Health (UTS) and was only available to the research team. This process ensured that participants could not be identified.

Completion of the voluntary questionnaire was taken as implied consent. Respondents were provided with envelopes to conceal the questionnaire results from the collectors. Completed and collected, questionnaires are stored in locked cabinets at UTS. No names were attached to the questionnaires - study numbers were allocated as an important component for follow-up reminders.

The instrument

The instrument used for this study was an amended version of the 'Why Midwives Stay' instrument developed for the English study. The instrument used for the English study was a 17 page questionnaire comprising questions which were analysed both quantitatively and qualitatively. Questions were divided between eight sections. The questionnaire was developed as part of the English study and has not been used in any other study into the retention of midwives in midwifery. Phase one of my study involved the amendment of this questionnaire to suit local conditions. The instrument amended in Phase One of this study, included seven sections with a variety of different approaches to data collection. Sections A, B, C, F and G used a combination of open and closed ended questions as a method of obtaining data. Sections D and E, used a five point Likert Scale to obtain data from strongly agree to strongly disagree for each of the statements provided.

The sections of the original questionnaire were:

Section A: Current employment – This section included 11 questions which asked predominantly quantitative questions. The questions in this section asked about midwives

current employment status and work environment as well as questions relating to the midwives' qualifications.

Section B: Working hours – This section included 14 questions which asked predominantly quantitative questions. The questions in this section asked the midwives about their current pattern of work and why they work in that way, as well as questions related to the midwives' contracted working hours and actual working hours.

Section C: Why do midwives stay? – There were two questions in this section. The first question had 25 statements which the midwives scored on a five point Likert Scale from strongly agree to strongly disagree. Midwives were asked to score each statement and then rank their top three responses. The second question in this section included 22 statements which the midwives scored on a five point Likert Scale from strongly agree to strongly disagree. Midwives were asked to score each statement and then rank their top three responses.

Section D: What keeps you going? – There was one question in this section. The question in this section had 23 statements which the midwives scored on a five point Likert Scale from strongly agree to strongly disagree. Midwives were asked to score each statement and then rank their top three responses.

Section E: How could your job be improved? – There was one question in this section. The question in this section had 26 statements. In this question respondents were asked to tick

only the statements which applied to them. Midwives were then asked to rank the three statements which they thought would have the greatest impact on their job.

Section F: Future plans – There were 12 questions in this section. This section had a mixture of qualitative and quantitative questions. The section asked midwives whether they planned on staying in midwifery or changing the hours they work. Midwives were asked about their future plans in midwifery and whether they would recommend midwifery to others. In this section midwives were also asked about the advice they would give to people considering midwifery.

Section G: Midwives who have left – This section was only for midwives who were no longer working in midwifery. In this section midwives were asked about their current position including the title of their current position and the hours that they work.

Section H: About you - This was the final section in the original questionnaire. This section had 11 questions which asked questions about the demographics of the midwives. The age, sex, race, education, and qualification of midwives were asked. The final question of the questionnaire was a qualitative question which provided space for the midwife to provide any further information they wish about why they stay in midwifery.

The amendments made to the sections and the questions will be described later in this chapter as part of Phase One.

Phase One

The purpose of Phase One was to review the questionnaire which was used for the English study and determine its appropriateness for the Australian midwifery context. Once approval for use of the questionnaire from the English researchers was received, as the researcher, I considered responses and altered the terminology for the Australian setting. An example of this is the use of the phrase 'bank midwives' in England and 'casual midwives' in Australia. It was for the approval and discussion of these amendments that focus groups were then conducted. The use of focus groups in Phase One allowed midwives at four of the seven maternity units within NSCCAHS to provide input and feedback on the amended questionnaire. Focus groups were the most appropriate method of assessing these changes as they allow midwives to participate in a non-threatening, permissive setting (Burns & Grove, 2005).

Copies of the amended questionnaire were distributed to the midwives participating in the focus groups and collected at the end of the session. As it was the comments that were sought around the terminology and appropriateness of the questionnaires, the midwives in the focus groups were asked not to fill in the questionnaires at this time and to wait for Phase Two. Amendments which were made are discussed later in this chapter.

Setting

Phase One of the research was conducted in four of the maternity settings within NSCCAHS. Details of these settings are:

- Manly Hospital – selected as it is one of the smaller maternity services and has 185 hospital beds and an average of 752 births per year.
- Royal North Shore Hospital – selection was based in it being the largest hospital within the AHS with 574 hospital beds and an average of 1 975 births per year.
- Ryde Hospital – was included as it is a midwifery-led unit. The midwives here have no on-site obstetric support. Ryde Hospital has 174 beds and an average of 374 births per year.
- Wyong Hospital – selected to participate in Phase One of the research as it is in the most rural setting of the AHS. Wyong Hospital has 206 hospital beds with an average birth rate per year of 355.

(NSW Department of Health, 2007b)

The activity level of the maternity services is determined by the role delineation[4] of the individual services. Northern Sydney Central Coast Area Health Service (NSCCAHS) extends north from Sydney Harbour across the Hawkesbury River to the far end of the Central Coast and west to Wiseman's Ferry, and comprises 13 local government areas. NSCCAHS came in to existence on 1st January 2005 when Northern Sydney Health and Central Coast Health amalgamated under the 'Planning Better Health' reform of the state government (NSW Department of Health, 2004).

It was decided that the testing and adaptation of the questionnaire would only occur in a sub-sample of the seven maternity units in the Area Health Service. These four, listed

[4] The medical services available to a site vary depending on the role delineation of that facility. In NSW role delineation varies from 1 where there are no birthing services to level 6 facilities which provide tertiary level obstetric care for women and their babies.

above, were selected after discussion with the Area Director of Nursing and Midwifery and the Directors of Nursing and Midwifery from the seven hospitals. Those hospitals selected for Phase One represent a cross-section of the hospitals in the NSCCAHS.

Sample

The study sample consisted of midwives working within NSCCAHS who were employed full time, part-time or casually[5]. Midwives were invited to participate through the distribution of flyers at the hospital where the focus groups were undertaken. There were more female midwives than male midwives who participated in Phase One and for this reason all data presented is done so in a non-gender specific nature to protect confidentiality.

The aim of the focus group was to gain consensus surrounding the terminology changes which were proposed from the original questionnaire. In order to obtain general consensus and to keep the group progressing together, it was decided that we would go through the questionnaire as a group, question by question.

There were between eight and ten midwives at each of the four focus groups. As the research student I attended each of the focus groups. The first two focus groups were also attended by the Chief Investigator of the research in order to assist me to conduct the groups. It was ideal to have between eight and ten midwives in each of the four focus

[5] Casual employees are similar to 'bank' midwives, in the UK, who are not employed on a permanent basis but called in to work when the staffing and activity level require

groups as it is often the case that, if there are less than six participants in any one focus, group adequate discussion is not achieved (Burns & Grove, 2005). The same limitation in discussion was expected in a group that had greater than ten participants. Following a brief description of the study and the part that these midwives would play, information letters and consent forms were distributed. The midwives were advised that they would be audio-recorded to enable the researchers to go back and make clarification of any points or issues. There was uncontested support for this to occur. Signed consent was obtained from each of the midwives before the focus groups began.

Data collection

Each of the focus groups was audio taped with the consent of participants. Hand written notes were also collected at the focus groups. It was decided that support for any changes had to be agreed upon across the four sites.

Phase Two

Once the questionnaires had been amended and piloted they were ready to be distributed to each of the seven maternity settings throughout the AHS. This was Phase Two of the study.

Sample

All clinical midwives permanently or casually employed within NSCCAHS were invited to participate in the study. Consent for this phase of the research was assumed by the return of a completed questionnaire. The midwives were employed both on a full-time and part-time basis and while it was not the initial intent of the research, casually employed staff of NSCCAHS were invited to participate. Casual employees were included because the staff list that was provided did not distinguish between permanently and casually employed staff.

Staff lists were obtained from the Divisional Managers for Women's, Children and Family Health at each site. Each midwife was assigned a study number which was placed on the top right hand corner of the questionnaire. A study information letter was also attached to the questionnaire. The names of the midwives were then written in pencil on the information letters. This ensured that the questionnaires were distributed to the correct midwife based on the study number to which they had been assigned. Study numbers were assigned to each midwife for follow-up purposes, and not for identification reasons.

Six of the seven sites were visited during this phase of the research. The site which was not visited was one of the sites which was visited during the initial phase of the study. Prior arrangements had been made with the educators, clinical midwifery consultants and midwifery managers to visit the sites and provide initial information sessions regarding the research. These sessions were not well attended with the most common reasons given for this being short staffing issues and high unit activity levels.

At two of the hospitals, questionnaires were placed in the pigeon holes allocated to each of the midwives. At the remaining five sites, the questionnaires were distributed by the midwifery manager, clinical midwifery consultant, or educator. While postage paid return envelopes were provided with each of the questionnaires, each unit was also offered a collection box. Five of the sites chose to have a collection box, while it was suggested that the midwives at the other two sites would be more inclined to return the questionnaires in the provided envelopes. When visiting one of the units that had a collection box, it was discovered that this box had either been removed or discarded without any surrounding discussion. While it cannot be guaranteed, it has been assumed that there were no completed questionnaires in this collection box.

Consultation was arranged with the midwifery managers, clinical midwifery consultants and educators and their assistance sought in raising the profile of the study and encouraging staff participation. There were advertising flyers distributed to each of the seven maternity settings and it can be assumed that these remained displayed. A newsletter was distributed to the Area Divisional Manager of Nursing and Midwifery, midwifery managers, clinical

midwifery consultants and educators for display in the workplace. The newsletter outlined the progress of the study and also gave a synopsis on the response rates for each of the hospitals. Regular email contact was maintained with the midwifery managers, clinical midwifery consultants and educators so that this study remained a current issue within the workplace. At the time of data collection, I was employed as a midwife at one of the maternity sites involved in this study. While the response rate at that maternity service may have been higher as a result of me working there, it is not felt that my dual role of employee and researcher made a difference to the responses to the questionnaire.

Data analysis

Both qualitative and quantitative data were obtained in Phase Two, though most were quantitative. A data entry person was employed to enter all the data into an Excel database. Once the data were entered and returned to me it was firstly reviewed to see if there were any obvious mistakes in data entry and secondly a random detailed checking was performed. This involved random checking of the data to ensure that there were no missing variables or variables which fell outside the specified parameters. Once the data entry was checked the quantitative data was imported into SPSS (SPSS, 2006). SPSS is a statistical analysis program which allows data to be both managed and analysed. For a descriptive study like this, cross tabulations, frequencies and descriptions are able to be drawn from the data.

Where the data are presented in tables in the Results Chapter, a dotted line denotes the statements to which 80% or more midwives strongly agreed (SA) or agreed (A) with that statement. The statements with greater than 80 % SA or A response rate are discussed in greater depth than the statements which received less than 80% of midwives strongly agreeing or agreeing with it. The decision to identify results which had greater than 80% of respondents was not based on any statistical equation, it was a pragmatic decision.

Content analysis of the qualitative data was undertaken in conjunction with quantitative analysis. Several processes were adopted for the content analysis including the transfer of quotes out of the Excel program into a word processing program. Once the quotes were placed in the word processing document content analysis was able to occur. Following the completion of the content analysis a thematic analysis was conducted to identify the key factors for midwives staying in midwifery.

Summary

In summary, this study used a descriptive design. The study was a two phased project which used both focus groups (Phase One) and a questionnaire (Phase Two), and included both qualitative and quantitative responses. Phase One included 36 midwives. This phase reviewed the questionnaire which was used for the English study and determined its appropriateness for the Australian midwifery context. Phase Two involved the distribution of the amended questionnaires from Phase One to 392 practising midwives within NSCCAHS. Both qualitative and quantitative data were obtained during this phase of the

research, though most data were quantitative in nature. The quantitative data was analysed using SPSS (SPSS, 2006) while content analysis was used for the analysis of the qualitative data.

CHAPTER FOUR: RESULTS

This chapter reports the results of the study. The results were obtained through analysis of the focus groups and the questionnaire, which is available in Appendix 2. Initially, the results from Phase One will be presented, followed by the results from Phase Two.

Phase One

Phase One included the amendment to the questionnaire. Content analysis was used to analyse this phase. While the terminology and appropriateness of the questionnaire were altered for the Australian context, the layout of the questionnaire was also amended. The section about the midwives themselves ('Section H – About You') was altered in the revised questionnaire to obtain demographic data at the beginning of the questionnaire. Section H of the original questionnaire therefore became Section A of the Australian questionnaire.

The specific amendments made are detailed in Appendix Four. In summary, the changes mainly included re-ordering and re-wording. For example, in the new Section A (previously Section H), ethnic group was removed as it was felt that this was not required for the Australian setting. Ethnic group was felt to be not necessary as the delineation of ethnic background would not provide any additional or relevant information in the Australian setting. Midwives across all four sites questioned the wording for the question which asked 'Has there been a time when you were not working as a midwife since you qualified as a

midwife?' Queries were made about consideration of employment as a child and family health nurse or being on maternity leave. Unanimous support was given for the wording to change from 'working' to 'employed' for this question which allowed for maternity leave but not child and family health nursing work and hence provided greater clarification. In section C, which relates to working hours, one question was altered to include 'hours actually worked' and 'hours contracted to work' as there appeared to be much discussion around what midwives were employed to work and what they actually worked.

Sections D, E and F prompted considerable discussion surrounding the statements in the section about 'Why midwives stay'. Section D, (question QD1) saw the removal of only one statement 'I want to stay registered as a midwife', it was felt that this question was not appropriate within the Australian context at this time as by simply working in nursing, midwives do not lose their midwifery registration. This was replaced with 'I want to work with women and their families' as it was felt that the women were an obvious omission in this question. Some of the other suggestions for inclusion in this question which were not included were 'my colleagues', 'women deserve midwives', 'the need to be needed', 'I enjoy the power/control/ my status as a midwife' and, 'the money'. These statements were excluded for several reasons including that they were the thoughts of only a minority within the focus groups or it was felt that they were covered within another question (QD2) regarding job satisfaction. At the end of each question there is space for an 'other' response where the midwives can specify reasons which may not be listed and it was hoped that some of these minority comments would be made here.

Section D, question QD2 which asked ‘where do you get job satisfaction from in your CURRENT midwifery post?’ did not need any statements removed. Several midwives questioned the importance of having ‘homebirths’ within this option, however, they were advised that it is hoped that this questionnaire will be able to be used for future research of midwives across Australia, some of whom attend homebirths. As with question QD1 (‘what are your reasons for STAYING in midwifery?’), many of the midwives recognised an obvious absence of the women in QD2 (‘where do you get job satisfaction from in your CURRENT midwifery post?’). It was for this reason that an item ‘Interactions with women’ was included. There were two other additions to this question which were; ‘Job flexibility’ and ‘The professional recognition of midwifery’. While job flexibility was an addition I had expected, the professional recognition of midwifery was not. Midwifery as a profession in many parts of Australia does not have the recognition within the health workforce or the community that midwives would like. For many Australian women the midwife (often referred to as the nurse by these women), is the one that cares for them in labour until the obstetrician comes to ‘deliver’ their baby. Some suggestions which were made but not included in the questionnaire due to lack of consensus among all the focus group participants include; ‘control’, ‘interactions with medical staff’, and ‘it is easy – it doesn’t challenge me’.

The focus groups provided further insight into the way midwives perceive their midwifery practice. Midwives confirmed that individual aspects of midwifery work are strongly interlinked, to create the variety in a midwife’s job. Many of the statements in the original questionnaire could easily have been included in several of the questions, given the

responses and comments that the midwives were making. For example, Section E, question QE1 which asked 'Which of the following help you to keep going as a midwife?', was no exception to the way in which aspects of midwifery interlink with each other to create 'Why midwives stay'. Once again, each focus group mentioned the women and their absence from the statement provided for this question. It was felt that the inclusion of the statements 'having job satisfaction' and 'my work environment' would go towards covering this. 'Work colleagues' was extended to include 'work colleagues and a sense of belonging' and 'social drinking' was altered to 'alcohol and other drugs'. Clinical supervision[6] was mentioned as something that 'keeps midwives going'. At present there is a concerted focus on clinical supervision within NSW Health and NSCCAHS. Within the Central Coast sector of NSCCAHS (the northern section of the NSCCAHS) there is research being conducted into the stress levels of midwives and the affects that clinical supervision has on these stress levels. Clinical supervision was however excluded from this section of the 'Why Midwives Stay' section as it was noted that at the time of distribution NSCCAHS did not routinely offer clinical supervision to clinical midwives. Some midwives within NSCCAHS are now regularly receiving clinical supervision.

While this study was conducted across seven maternity units, all of these fall within the one Area Health Service. However, organisation of hospital services and the way in which these services are utilised at the different hospitals differed significantly. This became very obvious once discussion regarding Section F commenced. Section F asked midwives how

[6] Clinical Supervision is a process within which the clinician brings his or her practice under scrutiny in order to more fully appreciate the meaning of their experience, to develop their abilities, to maintain standards of practice and to provide a more therapeutic service to the client. It is not statutory supervision as received by midwives in the UK.

their job could be improved (Section F, question QF1). All midwives agreed that the use of midwifery support workers did not fit within the Australian context and was therefore altered to patient support assistants (PSA), which are employed at each of the hospitals within the Area Health Service. Patient support assistants, in the majority of hospitals within the Area Health Services, work only within the medical and surgical nursing units including the operating theatre and intensive care unit. Patient support assistants are used within the maternity units at Gosford and Wyong Hospitals to assist with manual handling of women on the postnatal wards; cleaning of the birthing suite and wards; restocking of linen; and the transfer of women between the birthing suites and wards where appropriate. Unfortunately the current use of the PSAs ranges from a designated maternity/birthing suite PSA between 6am and 9pm at Gosford and Wyong hospitals to no PSA use at Manly Hospital, where the midwives do these activities.

Additional suggestions made to improve the working conditions for the midwives, not included in the questionnaire, included the improvement of hospital facilities and physical resources as well as a greater access to the multi-disciplinary team including allied health workers. These statements were not included as the questionnaire needed to remain consistent with the English questionnaire and if facilities and physical resources were added the length of the questionnaire would increase significantly. Amendments to statements and the addition of one statement was all that was needed for Section F, with no statement being removed. ‘Some form of clinical supervision’ was the only additional statement made to this section. Amendments that were made for this section were; ‘Less paperwork’ became ‘Less paperwork / computer work’; ‘Greater respect from management’ was altered

to ‘Greater respect from senior management’ and ‘Greater colleague support’ became ‘Greater colleague support / collegiality’. These changes were seen to reflect local situations more readily.

Content analysis of the audio-recordings was not required to make the amendments to the questionnaire Field notes identified that where statements needed amending, consensus was achieved. Following discussion regarding the wording that was being used and any questions which needed to be added, the focus groups moved on to identifying ways that were most appropriate for the distribution of the questionnaire. It was my initial intention to attach the questionnaire to the payslips of all midwives within the Area Health Service. The consensus was that this was not going to be the most appropriate mode of distribution. At each of the four focus groups, midwives commented on their lack of enthusiasm to complete questionnaires which came attached to their payslips. Payslips were felt to be over-utilised when it came to others within the AHS using them for data collection. Each of the focus groups identified what they felt to be the most appropriate mode of distribution for the midwives within their service, this was then considered and questionnaires were distributed as was suggested.

Following the amendments, it was decided that the new questionnaire should be piloted. A group of five postgraduate midwifery research students were targeted as a convenience sample. The questionnaire was distributed to this group. No further amendments were required as a result of this piloting process. Table 2 provides a summary of the amended questionnaire used for the study.

Table 2: Summary of the amended questionnaire for the study

Section	Questions
Demographic data	Gender Age Type of midwifery qualification Highest education level Year of qualification Time not employed in midwifery Reason for time out of midwifery
Employment status and preferences	Hospital currently working in Title of current position Additional jobs held Sector where you mainly work Would you rather work in a different setting Reasons for not working in desired setting
Current working hours	Hours employed to work Hours actually worked Current pattern of work Reason for working part-time
Reasons for staying in midwifery	Reasons for staying in midwifery Where do you get job satisfaction from your current position
Motivation to stay in midwifery	What keeps you going as a midwife
Ways that the job could be improved	How could your job be improved
Future career plans	Have you ever considered leaving midwifery Main reason for considering leaving Do you plan to work as a midwife in the foreseeable future Main reason for not continuing to work in midwifery Do you plan to change the hours you work Explain main reason for changing hours Plans for future in midwifery Level of previous job enjoyability Future prediction of job enjoyability Overall would you recommend midwifery Reason for recommending or not recommending midwifery Advice you would give to people considering midwifery as a career

Phase Two

As described in Chapter Three, all practising midwives (n=392) within Northern Sydney Central Coast Area Health Service were invited to participate in the study. There were 209 respondents to the survey, giving a response rate of 53%.

This section of the chapter is arranged according to the topic areas addressed by the questionnaire. These were described in Table 2 in Chapter Three. The topic areas include:

- Demographic data
- Employment status and preferences
- Current working hours
- Reasons for staying in midwifery
- Motivation to stay in midwifery
- Ways that the job could be improved
- Future career plans

Demographic data

Of the 209 respondents, the highest response rate (91%) was at Wyong Hospital and the lowest (51%) at Gosford Hospital. Table 3 presents the response rates by hospital.

Table 3: Phase Two response rate by hospital site

Hospital	*No. distributed (n=392)*	*No. returned (n=209)*	*Response rate (%)*
Gosford	114	58	51
Hornsby	51	27	52
Manly	36	27	75
Mona Vale	39	21	53
Royal North Shore	108	39	36
Ryde	10	6	60
Wyong	34	31	91

Respondents included a nursing/midwifery unit manager (NUM), clinical midwifery consultant (CMC) and four clinical midwifery specialists/clinical midwifery educators (CMS/CME). Two of the respondents identified as being neonatal nurses, however both were registered midwives who worked in the special care neonatal nursery[7]. One endorsed enrolled nurse[8] returned the questionnaire and this was excluded as the inclusion criteria were for midwives only.

[7] Intensive care and special care nurseries provide comprehensive care for unwell and/or premature babies.

[8] An endorsed enrolled nurse is a second level nurse who provides nursing care, including the administration of medications, working under the direction and supervision of the registered nurse

The majority of respondents were women (99%). Respondents ranged in age from 23 years to 69 years with the mean age being 42 years. The majority were older than 41 years with only 11% aged less than 30 years.

Most respondents had received their midwifery qualification through the hospital-based system (53%) which was usual prior to 1994 and reflects the age of the cohort. Almost half of respondents (45%) had qualified as a midwife before 1989. Only 32% of respondents had a tertiary qualification.

Many respondents had taken time out of midwifery at some point in their career. About half (47%) reported to have had some time out of midwifery since qualifying. This time out ranged from one year to 25 years with the mean being 2 years and 7 months. The most common reason reported for this time out was 'to care for dependent children' (25%). Other reasons given for having time out of midwifery included:

- Travel (n=7) – this included travel within Australia and abroad. Three midwives stated that they worked as a registered nurse during their travels.
- Unable to get work (n=8) – this included two midwives who moved to Australia and were unable to get work at the time, as their qualifications were not recognised.
- One midwife returned to her previous position in nursing.
- After moving to Australia from overseas, one midwife felt disillusioned by the involvement that medical practitioners had in normal pregnancy and birth.
- One midwife felt there was job instability in her unit and therefore sought employment elsewhere.

Table 4: Demographic data of the respondents to the questionnaire

		N *n=204*	*%*
Gender	Female	202	99
	Male	2	1
Age	20-30	31	15
	31-40	58	28
	41-50	75	37
	51-60	34	17
	>60	6	3
Year of qualification	<1975	14	7
	1976-1985	43	21
	1986-1995	62	30
	1996-2005	75	37
	>2005	10	5
Type of midwifery qualification	Hospital	107	53
	University	97	47
Highest educational qualification	Certificate	54	27
	Degree	35	17
	Postgraduate	98	48
	Other	17	8
Has there been a time when you were not employed as a midwife since qualifying?	Yes	96	47
	No	108	53
Years not employed in midwifery ♦	1-5	66	74
	6-10	14	16
	11-20	7	8
	>21	2	2
Reason for time out of midwifery	To care for dependent children	50	24
	To work in a job other than midwifery	29	14
	Ill health	1	1
	Other	18	9
	N/A	106	52

^ Some percentages have been rounded to the closest full number

♦ Only 89 of the 96 midwives who had time out of midwifery responded to this question

Employment status and preferences

All respondents were currently employed in some form or another in the Area Health Service. Midwives were asked to identify which hospital they worked in and could respond with more than one answer. Some staff at Gosford and Wyong Hospitals were employed for the Central Coast Sector (within the NSCCAHS) and worked in both hospitals. These midwives put down both hospitals as their current place of work. For the purpose of determining the primary place of employment, the site which they put down first was the site taken as their primary workplace. The largest number of respondents came from Gosford Hospital which is the second largest of the hospitals within the Area Health Service.

Just over one in six midwives (18%; n=35) reported having additional paid work to their midwifery position. Of the 35 midwives who had other paid positions, two (6%) midwives had more than one other position. Midwives were asked to report on the other positions that they had. The other positions midwives have in addition to their midwifery job include: child and family health nurse (n=1), receptionist (n=1), registered nurse in private practice, GP surgery or ultrasound business (n=6); self employed or working in husbands business (n=5); antenatal or childbirth education including core of life, CalmBirth©[9] and HypnoBirthing©[10] classes and private subconscious mind therapy (n=14); research assistant (n=2); other midwifery jobs (n=3); lecturer (n=1); nanny (n=1) and after hours supervisor (n=1).

[9] CalmBirth© is a childbirth preparation course developed in Australia to teach couples how to learn to access their inner strength and learn relaxation and visualisation techniques.

[10] HypnoBirthing© is a parenting preparation which in the absence of fear and tension, or special medical circumstances, severe pain does not have to be an accompaniment of labour.

Three quarters (76%) of respondents indicated that they worked in hospital-based settings with almost one quarter (22%) identifying both hospital and community settings as their site for work. This latter option included outreach clinics and community-based care (postnatal visits at home). Four midwives (2%) reported only working in the community.

Just over one fifth of midwives (22%) reported that they would rather work in a different setting to the one in which they are currently working. Of these, the majority (84%) would prefer settings that involved different models of midwifery care. Employment status and preference details are summarised in Table 5.

Table 5: Employment status of the respondents in the study

		N *n=200*	*%*
Hospital	Hornsby	26	13
	Gosford	53	27
	Manly	28	14
	Mona Vale	20	10
	Royal North Shore	39	20
	Ryde	5	3
	Wyong	29	15
Do you hold any other paid positions in addition to your midwifery job?	Yes	35	18
	No	165	83
Please indicate where you mainly work as a midwife	Community	4	2
	Hospital	152	76
	Hospital and Community	44	22
Would you rather work as a midwife in a different setting?	Yes	43	22
	No	157	78

^ Percentages may have been rounded to closest full number

Table 6 reports the percentage of midwives from each of the hospitals within NSCCAHS who would rather be working in a different setting. Midwives working at Wyong Hospital were most likely to want to work in a different setting (27%) while none of the responding midwives from Ryde Hospital wished to work elsewhere.

Table 6: Numbers of midwives who would rather be working in a different setting by current place of employment

	Hornsby	Gosford	Manly	Mona Vale	RNSH	Ryde	Wyong
Yes							
n	6	14	6	5	5	0	8
(%)	(22)	(25)	(21)	(25)	(13)	(0)	(27)
No							
n	21	42	22	15		5	22
(%)	(78)	(75)	(79)	(75)	34 (87)	(100)	(73)
Total	**27** (100)	**56** (100)	**28** (100)	**20** (100)	**39** (100)	**5** (100)	**20** (100)

Current working hours

Almost two thirds (61%) of respondents were employed part-time with the remainder being full-time. The most frequently reported reason for working part-time (30%) related to family reasons, most likely, caring for dependant children. The mean number of hours employed to work per week was 28 hours[11]. Just over a quarter of respondents (27%) were

[11] Full-time employment in NSW means that a midwife is employed to work 38 hours per week.

employed to work between 20 and 29 hours per week with another 19% employed to work 30-37 hours per week (Table 7 p.77).

Hours employed to work and hours actually worked were not always the same thing. Midwives who reported on the hours in which they were employed to work did not all report on the hours that they actually worked. Not all midwives who were employed to work a set amount of hours actually worked those hours. The casually employed midwives all worked more hours than they were contracted to work. Midwives who reported actually being employed to work between 15-19 hours and those employed to work between 20-29 hours each worked less hours than they were employed. There were actually more midwives who worked between 30-37 hours than were employed to do so.

Table 7: Working pattern of respondents in the study

		No.	*%*
Hours employed to work	Zero ^	9	4
	1-14 hours	7	3
	15-19 hours	22	11
	20-29 hours	56	27
	30-37 hours	39	19
	>37 hours	74	36
Hours actually worked	Zero^	0	0
	1-14 hours	8	4
	15-19 hours	17	9
	20-29 hours	51	26
	30-37 hours	49	25
	>37 hours	71	36
Pattern of work	Part-time	114	61
	Full-time	73	39
Reason for working part-time	Need to for family reasons	60	30
	Choose to work part-time	55	28
	Unable to negotiate suitable full-time hours	3	2
	Other	6	3
	N/A (full-time)	73	37

^ Some midwives who received the questionnaire were casual employees and therefore were not employed for any regular hours

Reasons for staying in midwifery

Respondents were asked to rate their reasons for staying in midwifery on a five point Likert Scale. There were nine statements which had over 80% of respondents either strongly agreeing or agreeing with the statements. The statement that received the most frequent highest ranking was, 'I enjoy my job' with 98% (n=141) of midwives either strongly agreeing or agreeing with this statement. The second highest ranked reason respondents provided for staying in midwifery was, 'I am proud to be a midwife' with 97% (n=139) of midwives either strongly agreeing or agreeing with this statement. 'I get job satisfaction' being the third highest reported reason midwives gave for staying in midwifery with 95% (n=137) of midwives either strongly agreeing or agreeing. The remaining statements which had over 80% of respondents either strongly agreeing or agreeing were: 'midwifery is preferable to general nursing', 'I want to work with women and their families', 'I work in an area of practice I want to work in', 'I feel privileged to be a midwife', 'midwifery is a job I feel passionate about', and 'for the women I care for'. Table 8 provides a summary of the reasons midwives gave for staying in midwifery.

Table 8: Reasons respondents in this study gave for staying in midwifery

Reasons for staying in midwifery?	No. (agree or strongly agree)	%
I enjoy my job	141	98
I am proud to be a midwife	139	97
I get job satisfaction	137	95
Midwifery is preferable to general nursing	132	92
I want to work with women and their families	129	90
I work in the area of practice I want to work in	129	90
I feel privileged to be a midwife	127	88
Midwifery is a job I feel passionately about	122	85
For the women I care for	122	85
The good days somehow justify you staying in practice	103	72
It is convenient for me to stay	93	65
Because I want to make a difference to midwifery	91	63
My salary	76	53
Working as a midwife gives me my identity	73	51
I worked hard to be a midwife and feel it would be a waste to give up now	68	47
The alternatives to midwifery are not preferable	67	47
I don't consider it work, it's just my way of life	52	36
Midwifery is what I've always done	50	35
Midwifery is a gateway into other things	48	33
Because I do not have to work full-time	45	31
I cannot afford to retrain in something different	44	31
I could not earn this money doing anything else	43	30
To change direction would be very unnerving	39	27
I am not qualified to do anything else	34	24
I feel I would be letting down colleagues if I left	26	18
I feel I am too old to change jobs	23	16

^ Some percentages have been rounded to the closest full number
* Above the dotted line denotes statements to which 80% or more respondents strongly agree or agree

While job satisfaction was the third highest reason midwives gave for staying in midwifery, midwives were separately asked about their source of job satisfaction. Once again, they were asked to rank each response on a five point Likert Scale. There were ten statements which received greater than 80% of midwives either strongly agreeing or agreeing. The three highest ranked sources midwives stated gave them job satisfaction in their current post were, 'I feel like I make a difference to the women' (99%, n=146), 'Interactions with women in my care' (97%, n=143) and 'Interactions with women' (95%, n=141). The other statements which scored greater than 80% response rate were: 'seeing women happy', 'interactions with my colleagues', 'Being an advocate', 'The variety of my job', 'Feeling valued at work by women', 'Being able to normalise midwifery care', and 'Feeling valued at work by colleagues'.

The following table provides results on the statements on job satisfaction that midwives were asked to score on a five point Likert Scale from strongly agree to strongly disagree.

Table 9: Sources of job satisfaction

Where do you get job satisfaction from in your CURRENT midwifery post?	*No. (agree or strongly agree)*	*%*
Feeling like I make a difference to women	146	99
Interaction with the women in my care	143	97
Interactions with women	141	95
Seeing women happy	139	94
Interaction with work colleagues	138	94
Being an advocate	137	92
The variety of my job	132	89
Feeling valued at work by women	130	89
Being able to normalise midwifery care	127	86
Feeling valued at work by colleagues	120	81
Feeling like I make a difference to colleagues	115	78
My autonomy as a midwife	115	78
Being able to provide the care I want to give	110	74
Being in a team who share my philosophies	108	73
Job flexibility	106	72
The professional recognition of midwifery	100	68
Being able to provide continuity of care	86	58
Feeling valued at work by managers	81	55
Training and study opportunities	69	47
My salary	64	43
Working in the community	58	39
The adrenaline rush of the hospital	30	20
I get no job satisfaction in my current role	9	6
Homebirths	7	5

^ Some percentages have been rounded to the closest full number
* Above the dotted line denotes statements to which 80% or more respondents strongly agree or agree

Motivation to stay in midwifery

Midwives were asked to identify where they received motivation to 'keep them going'. Once again, a five point Likert Scale was used to understand the determinants which midwives feel keep them going in midwifery. There were five statements relating to midwives' motivation to stay in midwifery which had over 80% either strongly agreeing or agreeing. Ninety four percent (n=189) strongly agreed or agreed that having a positive outlook was the most important factor to keeping them in midwifery. While making a difference to women and the interactions with women in their care is what gives midwives job satisfaction, the presence of job satisfaction kept 92% (n=187) of responding midwives going. The presence of work colleagues and the feeling of belonging was the third most reported statement midwives identified with as keeping them going in midwifery with 89% (n=179) strongly agreeing or agreeing. Midwives also felt that 'putting as much into the job as you get out' and 'being an experienced midwife' contributed to keeping them going in midwifery. Table 10 provides the responses for each of the statements regarding what keeps midwives going in midwifery.

Table 10: Motivations to stay in midwifery

Which of the following help you to keep going as a midwife?	*No. (agree or strongly agree)*	*%*
Having a positive outlook	189	94
Having job satisfaction	187	92
Work colleagues and a sense of belonging	179	89
Putting into the job as much as you want to get out	174	87
Being an experienced midwife	161	81
Taking positive action rather than grumbling	153	76
My friends outside of work	146	73
My family	138	68
Switching off/keeping work out of home life	133	67
My work environment	129	65
Not taking a victim mentality	129	64
Being busy outside of work	125	62
My partner	123	61
Not working full-time	115	57
Taking exercise	111	55
Having a moan	77	39
Involvement with professional groups	66	33
My manager	58	29
Moving to a different midwifery position	48	24
Burying my head in a book/ studying	45	22
My religious beliefs	39	19
Taking sick leave	21	10
Knowing that I will soon be retiring	15	8
Alcohol and other drugs	13	7

^ Some percentages have been rounded to the closest full number
* Above the dotted line denotes statements to which 80% or more respondents strongly agree or agree

The motivation to stay in midwifery, and the things that keep midwives going, help understand why midwives are staying in midwifery and within their current workplace. This however varied between sites. The next table shows the top three motivations to keeping midwives going based on the hospital where they were primarily employed to work. 'Having a positive outlook', 'job satisfaction' and 'work colleagues' were the top three motivators in four of the seven maternity sites within NSCCAHS. In the remaining three, there was a combination of a positive outlook, job satisfaction, work colleagues and putting in as much as you want to get out.

Table 11: Top responses given for 'What keeps midwives going' by maternity sites

	Having a positive outlook	*Having job satisfaction*	*Putting into the job as much as you want out*	*Work colleagues*
Gosford	1	2	3	
Hornsby		2	2	1
Manly	1	3		2
Mona Vale	3		1	1
Royal North Shore	1	2		2
Ryde	1	1		3
Wyong	1	1		3

Note: The top three factors which keep midwives going are ranked according to the hospital in which the midwives work (1=highest).

Ways that the job could be improved

Midwives were given a list of statements to which they could either agree or disagree with in relation to what would have the greatest positive impact on their job. The top statement to which midwives agreed was 'an increase in salary'. An increase in salary was the only response which had greater than 80% of respondents either strongly agreeing or agreeing that it would improve their job. The next highest responses were increase in the number of midwives at work, less paperwork/computer work, less routine medical intervention with women, and more resources for further education and development. Eighty seven percent (n=145) of midwives felt that an increase in their salary would have the greatest positive impact on their job. Following an increase in their salaries, 73% (n=122) of midwives felt that an increase in the number of midwives at work would impact positively on their jobs. The responses to the statements describing what would have the greatest positive impact on jobs of midwives within NSCCAHS were very evenly distributed following an increase in salary. The following table records factors which midwives within NSCCAHS feel would improve their work environments.

Table 12: Factors which have the greatest potential positive impact on retention

Which of the following would have the greatest positive impact on your job?	*N (agree or strongly agree*	*%*
Improved salary	145	87
A greater number of midwives at work	122	73
Less paperwork/computer work	112	67
Less routine medical intervention with women	107	64
More resources for further education and development	104	62
Greater flexibility in working hours	99	59
Greater respect from senior management (feeling valued)	99	59
More effective management	98	59
Greater recognition of further education and development	95	57
More clerical support	88	53
More support from my manager	72	43
Some form of clinical supervision	68	41
Reduced night shift	53	32
Greater colleague support/collegiality	53	32
Wider use of midwifery support services	48	29
Wider use of PSAs	39	23
Reduced number of working hours per week	38	23
Reduced shift working	38	23
Feeling more valued by women	35	21
Improved relationships with non midwifery colleagues	34	20
Less pressure to undertake further education and development	25	15
Reduced shifts on call	20	12
Community midwives not having to cover hospital shifts	20	12
A move into a different area of midwifery	17	10
Less experienced midwives having a greater respect for experienced midwives	17	10
Less change in midwifery	8	5
Abolish integrated midwifery (that isn't caseload-based)	6	4

* Above the dotted line denotes statements to which 80% or more respondents strongly agree or agree

Future career plans

In the final section of the questionnaire, midwives were asked to report on their future plans within midwifery. Half of the respondents (51%) had either considered leaving midwifery in the past or were currently planning on leaving midwifery.

While the majority of data collected were analysed quantitatively, midwives were given the opportunity to include written comments in relation to their future plans in midwifery. The previous section has presented results from the analysis of the numerical data alone; the following section will present findings from analysis of both the numerical data and written data.

Fifty one percent (n=105) of midwives were considering leaving midwifery or had considered leaving midwifery in the past. Analysis of the reasons midwives gave for having considered leaving midwifery showed several themes including wanting change, management issues, lifestyle matters, and professional issues.

Wanting change

Seventeen percent (n=17) of midwives who spoke of either planning to leave midwifery or previously planning to leave midwifery were doing so as they wanted a change in their workplace. For example, respondents said that they:

"Need a change" (87)[12]

"Not enjoying my work…" (156)

While many of the responses were limited in their explanation, the explanations were usually linked to careers that were associated with midwifery. For example:

"Have just applied for a child and family health position…" (3)

"Move to community nursing" (130)

"To study medicine" (273)

Wanting change as a reason for either currently or previously considering leaving midwifery included midwives desire to no longer work shift work and the desire to spend more time with their family. Reasons included:

"….Monday to Friday – no shiftwork" (104)

"…..tired of shift work…" (156)

Management

Of the comments midwives made about either planning to leave or having considered leaving midwifery, 17% (n=18), related to their management. The comments made about support from management in response to midwives leaving midwifery or considering leaving midwifery indicates the overall importance of management to the satisfaction of midwives within their work and work environment.

[12] The numbers at the end of the quotes denotes the study number attached to each of the respondents

Different components of management were described in the comments of midwives, some of these descriptions follow:

> "I feel management have undervalues midwives for a very long time…" (390)
>
> "Undervalued by managers" (78)

These quotes show the importance to midwives of feeling valued by their managers. Being valued not only included being supported by management clinically, but as one respondent described it, also includes being emotionally supported. Respondent 343 emphasised the importance of support from management, talked about bullying by the midwifery unit manager and made a connection between midwife burnout and lack of support:

> "Burnout and lack of support emotionally and clinically by management" (343)

These responses identify the importance of management style in retaining midwives in the midwifery workforce.

As well as the negative effects of lack of support, bullying in the workplace by management was identified as being of particular concern by the respondents. Effects of bullying by management appeared to be cumulative and resulted in midwives being unable to express their overall dissatisfaction with workplace environments. For example, reasons included:

> "Bullying by NUM" (343)
>
> "too scared to complain as manager is a 'bully'" (371)

Another component of management negatively commented on by midwives was being placed in a situation of acting in a managerial role without the appropriate rewards. One midwife explained this as:

> "….doing [our] managers job [and] not being paid as manager" (371).

Overall dissatisfaction with management as a reason for either leaving or considering leaving midwifery was described. The components of being dissatisfied with management included being undervalued, not being supported by management, being bullied, and not being appropriately rewarded when acting up in a managerial role.

Matters of practice

For 11% (n=12) of midwives matters of practice was their inspiration for either currently considering leaving midwifery or having previously considered leaving. Examples that midwives gave included:

> "Too much intervention…" (85)
>
> "Felt disillusioned re the treatment of women and the medicalized care they receive…" (118)
>
> "Stressful times at work…." (19)

Midwives commented on their personal feelings related to their work and their workplace. Midwives expressed their personal feelings as:

> "Depressed and overwhelmed" (415)
>
> "Feeling dissatisfied with job and stressed following [a] legal issue" (101)

The increase of medical intervention and the pressures of the workplace contributed to midwives either currently considering or having previously considered leaving midwifery.

Professional issues

The last theme under which participants described reasons for leaving midwifery related to professional issues. Previously presented demographic data of the respondents show that most respondents (53%, n=107) had received their qualification to practise through the hospital system.

While the availability of tertiary education has been opened up to midwives, due to current midwifery education being within the university system, its effects can also create pressure on midwives to improve their level of education. Even though midwives experienced pressure to undertake further education there appeared to be no time dedicated by the employing maternity service for continued education of midwives. As a result of these pressures, midwives may consider leaving midwifery. One midwife wrote:

> "Over the last 5 yrs I have seen increasing political pressures to be better educated (but not actually giving you study leave!) ... Yes I do regularly think of leaving." (182)

Midwives also felt that the organisation was not on their side and was not supporting them. One midwife felt that the amount of other work that was required got in the way and described this as:

> "Bureaucratic rubbish increasing…" (90)

As midwives and midwifery become more professional, midwives begin to assume an increased responsibility for the care of more complex women and families, which in turn increased the stress experienced by these midwives. In order to manage this stress, some midwives engaged in independent clinical supervision, but at personal expense. The combination of issues associated with the care of more complex women and families, stress and cost, were described as reasons for leaving, or considering to leave, midwifery. The increased care of complex women and stress associated with this was described as:

> "Burnout from difficult client and needing to pay for independent supervision…" (62)

Educational and cost issues have been shown to be some of the contributing factors associated with professional or organisational issues related to midwives leaving, or thinking to leave, midwifery.

The following table gives an overview of the responses that midwives provided in regard to their future career plans.

Table 13: Future career plans of midwife respondents

	N *n=207*	*%*
Have you ever seriously considered leaving midwifery? ##		
• Yes, in the past	68	33
• Yes, I am currently considering leaving	37	18
• No	100	49
Do you plan to continue working as a midwife in the foreseeable future?		
• Yes	166	80
• No	5	2
• Don't know	36	17
Do you plan to change the number of hours that you work in the foreseeable future? *		
• Yes, increase my hours	22	11
• Yes, decrease my hours	31	15
• No plans to change my hours at the moment	153	74
Which of the following best describe your plans for the future		
• I plan to stay in the role that I am in now	146	71
• I would like more clinical responsibility	30	15
• I would like more managerial responsibility	20	10
• I plan to leave midwifery altogether	15	7
• I would like to stay in midwifery but move out of this hospital	19	9
• I would like to move from a casual position into a permanent position	6	3
• I would like to move into midwifery education	27	13
• I would like to move into another area of midwifery	34	16
• I would like to progress, but still retain my role as a clinical midwifery	50	24
During your time as a midwife, do you feel your job has become …##		
• More enjoyable overall	85	41
• Less enjoyable overall	56	27
• Stayed about the same	64	31
In the future, do you think working as a midwife will become…#		
• More enjoyable overall	57	27
• Less enjoyable overall	54	26
• Stay about the same	92	45
Overall would you recommend midwifery as a career to others?^^		
• Yes	167	83
• No	34	17

^ Percentages may not equal 100% as numbers have been recorded to the closest whole number
^^ n=201; #n=203; ##n=205; *n=206

Recommending midwifery as a career to others

When asked if they would recommend midwifery to others, 17% of respondents stated that they would not. However, 83 percent of midwives reported that they would recommend midwifery to others. Midwives were given the opportunity to give an explanation as to why they would or would not recommend midwifery to others. Content analysis was attended for the responses to both whether you would recommend midwifery, or not. This section of the results presents an analysis from the responses related to whether midwives would, or would not recommend midwifery.

Initially this section will present the analysis of why midwives **would not** recommend midwifery as a professional occupation. Four themes emerged from the content analysis of responses related to not recommending midwifery. The four themes were organisational issues, money, lifestyle matters, and matters of practice. Following the responses of the midwives who would not recommend midwifery, the analysis of the responses from midwives who **would** recommend midwifery will be presented.

Midwives who would not recommend midwifery to others

Analysis of the responses from the 17% of midwives who would not recommend midwifery to others identified the themes: organisational issues, money, lifestyle matters, and matters of practice. Each of these themes will be discussed further.

Organisational issues

The organisational issues included a belief that there was little reward and recognition for the work midwives do as well as concerns about working in poor conditions. These factors resulted in midwives perceiving that there was an increase in pressure and demands. Some of the perceived pressure on midwives appeared to originate from the NSW Health Department.

Midwives felt that the expectations placed on their practice exceeded their legitimate role. One midwife wrote:

> "… I also feel (the) Health Dept. are pushing midwives down (the) road of mini-obstetricians" (172)

There appeared to be some conflict in the expected roles of some midwives. While midwives perceived that the health department expects too high a level of performance, families of the women with whom the midwives worked expected a 'servant role' from them. While the expectations from the health department were perceived to exceed the legitimate role of the midwife, the women's expectations of midwives were seen to be less than their legitimate role. This was seen as being disrespectful at times. As a result, midwives were caught between the pressures to exceed and the pressure to lower their legitimate role performance. One midwife expressed this tension as:

> "… many patients and their husbands and families treat us like servants and this is not respectful" (413)

The legitimate role of the midwife was not only in conflict as a result of pressures from the health department and the women, but was also because of the tasks which they were expected to conduct. Midwives felt that the education they had received exceeded the education required to perform some of these tasks, for example:

> "I have a master's degree and I mop blood/faeces off the floor!" (344)

When midwives expressed their dissatisfaction at the expectations placed on them and the difference they experienced between training, expectations and reality, there was lack of support for these concerns. The lack of support shown to midwives added to their grievances. Midwives reported being faced with differing expectations, education levels exceeding that required to perform some tasks, and their concerns being disregarded. One midwife said:

> "…. (there is a) lack of support when complaints are made" (344)

In summary, organisational issues that combined to result in midwives leaving or considering leaving midwifery included work pressure and role conflict. Role conflict was compounded by a lack of response to midwives' expressions of dissatisfaction with their work and role.

Money

Money or salary was one of the major reasons midwives gave for not recommending midwifery to others. Many of the comments midwives made regarding money and their pay focused on issues around the low salary they received. When talking about money,

midwives felt that they were underpaid for the work they do. A number of midwives made comments such as:

> "… (the) salary needs to be improved." (129)

Not only did midwives feel underpaid they also felt that their pay did not justify the amount of work and responsibility they were expected to carry out. They reported:

> "…. Too much responsibility and stress for the pay." (334)
>
> "… the financial rewards for the profession are unjustifiably low." (397)

Salary, and the financial reward midwives received, seemed to play a significant part in how midwives feel about their jobs and the future of their work. This result is supported by the quantitative data which had salary as an important consideration in improving the job (Table 11, p.85).

Lifestyle matters

There were numerous responses which related to the lifestyle of the midwives and their families. Midwives felt that the demands of shift work, combined with the salary and the unfriendly hours of work, contributed to why they would not recommend midwifery to others.

Midwives felt that the shifts they work added to the level of exhaustion they experienced. Both physical and emotional exhaustion were reported. The midwives commented on the level of exhaustion with statements like:

"…[I] find shift work exhausting" (330)

"Shift work is a hard slog" (9)

"It's emotionally and physically draining" (156)

As well as experiencing physical and emotional exhaustion as a result of the shifts that they worked, midwives commented on the unsocial hours associated with shift work, with statements like:

"Why opt for a career involving shift work (esp night shift)" (46)

"… there are plenty of other careers with …. friendlier hours" (359)

The combination of shift work, exhaustion and unfriendly hours together formed the lifestyle matters which resulted in midwives not recommending midwifery to others.

Matters of practice

Midwives spoke about the service in which they worked and the way they practised within this service. The management of the services were described as inflexible with midwives expressing concerns about midwifery moving away from the promotion of wellness and normality to a practice based on medicine and a medical model. Midwives expressed these concerns by writing:

"… inflexible senior management and policies and medical administration in Australia will always oppress true and good midwifery practice and maternity care" (397)

"Managers/hospitals want everything their way in their favour!" (409)

"Midwifery has forgotten the woman…" (390)

While midwifery managers were seen as being inflexible they were also described as being unsupportive with the services being "top heavy". For example, they were seen as:

"…no support from managers…" (409)

"To[o] many chiefs not enough Indians" (278)

While the lack of support from midwifery managers was one contributing factor as to why midwives would not recommend midwifery, the path midwifery is taking clinically, was another reason. Midwives felt that midwifery was becoming far more medicalised with an increase in medical intervention and caesarean sections mading statements such as:

"Becoming far more high risk, intervention, increased LSCS[13] rate…" (45)

"The way it is going….midwives will become post-operative nurses…." (334)

"… (it is) obstetric nursing more than midwifery care!" (93)

While midwives felt that their work was becoming more medicalised they also felt that they were being pushed into areas of midwifery where they did not wish to practice. When commenting on midwifery in relation to the area of practice in which they worked, midwives wrote:

"I would only recommend it [midwifery] if working as a ward based midwife was not the only avenue of work." (326)

"…. I see midwives being forced to work in delivery suite…." (182)

[13] LSCS is an acronym for lower section caesarean section

Midwives who would recommend midwifery to others

Analysis of the responses from the 83% of midwives who would recommend midwifery to others identified the themes: women and their families, job satisfaction, matters of practice, lifestyle matters, and sustaining the future.

Women and their families

The impact of midwifery on women and their families was a contributing factor as to why midwives would recommend midwifery to others. Midwives commented on midwifery as a career which made a difference to women and their families' lives. Statements which midwives used to describe the difference midwifery made to families included:

> "The amazing highs you get when you make a difference … seeing that change when a woman births and realises she can do anything and you helped her get there" (398)
>
> "It's good to go to work and know you make a difference to the women and their families" (294)

Not only did the midwives feel as though they are making a difference to the lives of women and their families, they also saw themselves as being a positive support. When referring to the positive impact they have on families, midwives wrote comments like:

> "It is a very important role in terms of being a positive support to parents" (13)
>
> "…there is not a more rewarding job than sharing the beginning of a new family with a couple" (305)

The midwives also felt that through their midwifery role they were able to provide women and their families with the best care. Midwives found their work to be invaluable and profound while they often felt that they were putting in more than what was necessary. This was highlighted with comments such as:

"Pursuing best care for women and families is invaluable" (26)

"Terrific work. Great variety… People focused. Profound!" (312)

"I feel I am adequately paid but I often give much more care than is necessary, just because I love my job" (410)

Job satisfaction

In the quantitative data, job satisfaction was the third highest reported reason midwives gave for staying in midwifery. When it came to reasons they gave for recommending midwifery to others, midwives once again wrote about the importance of job satisfaction. Midwives commented on the high level of job satisfaction they get from their job as well as the love they had for midwifery. The comments from midwives about job satisfaction included:

"IMMENSE job satisfaction…" (188)

"…would rather do a job for its satisfaction than for its salary" (122)

"I love my job!!" (50)

While many midwives wrote of job satisfaction on its own, some also spoke of certain aspects of job satisfaction.

"…it provides great job satisfaction and continuity of care" (34)

"(it provides) job satisfaction with autonomy" (104)

Midwives also wrote about the personal satisfaction they received from midwifery outside the satisfaction that they receive at work. Examples of the comments midwives made regarding the personal satisfaction they receive from midwifery include:

"Great job that creates many opportunities for personal satisfaction" (163)

"I have always found a great deal of satisfaction and value in my role" (13)

Job satisfaction remains one of the major contributors to keeping midwives in midwifery as well as having current midwives recommend the profession to others. Job satisfaction was encouragingly reported not only in their work lives, but in their personal lives as well.

Matters of practice

The model of care in which the midwife works plays a large part in how midwives view their role and profession. The midwives wrote comments like:

"…working in group practice…is very rewarding…" (319)

"The scope of practice is interesting and varied" (101)

While midwives who would not recommend midwifery based on matters of practice spoke of the increasing intervention rates, those who would recommend midwifery saw their job as being autonomous. This was highlighted in comments like:

"Midwifery is an area where autonomy is encouraged and valued…" (14)

"…great job satisfaction in a highly autonomous job…" (331)

Lifestyle matters

Lifestyle matters are evident for both midwives who would recommend midwifery and those who would not. Midwives who would recommend midwifery to others spoke about the flexibility of midwifery. For example, midwifery was seen as:

> "Flexible" (147)
>
> "Flexible hours" (209)
>
> "Flexible in hours and shift work" (94)

While flexibility was important to the midwives it appeared to be of greater importance to the midwives who also had their own children. In relation to the flexibility of midwifery with a family that included children, midwives wrote:

> "Shift work is often more flexible with a family" (196)
>
> "Flexible hours with self rostering work around your family full or part-time" (70)

The ability to work flexibly as well as managing their work life around their personal lives was very important to the midwives. Midwives enjoyed the fact that midwifery could provide them with this flexibility.

Sustaining the future

For some midwives it was very important to ensure that younger midwives entered into the profession. The current average age of midwives from this cohort in NSCCAHS was 42 years with the average age of the current midwives increasing. Some midwives wrote:

> "…it seems our current stock of midwives are becoming older, so we need replacement" (67)
>
> "The profession needs educated dedicated younger midwives" (142)
>
> "we desperately need more midwives" (371)

While midwives were concerned with the average age of midwives they were also concerned that maternity wards may start to introduce registered nurses and enrolled nurses into their units. This was expressed in this example:

> "Because decrease numbers of midwives will lead to the increase risk of introduction of general nurses and enrolled nurses…" (216)

With the average age of midwives increasing and a potential introduction of registered nurses into maternity units, there was also a concern that the community as a whole are not aware of midwifery or what midwives do. One midwife expressed this in her comment:

> "I believe people need to be more aware of what midwifery involves…" (395)

The following table (Table 14) provides a summary of the characteristics of this cohort of midwives from NSCCAHS based on whether they would or would not recommend midwifery to others.

Table 14: Characteristics of midwives who would recommend midwifery as a career to others compared with midwives who would not recommend midwifery as a career

	Would recommend midwifery n (%)	*Would not recommend midwifery n (%)*	*Total n (%)*
Pattern of Work			
• Part-time	98 (86)	16 (14)	114 (100)
• Full-time	53 (76)	17 (24)	70 (100)
• Casual	2 (100)	0 (0)	2 (100)
Age Range			
• <30	26 (84)	5 (16)	31 (100)
• 30-39	42 (89)	5 (11)	47 (100)
• 40-49	59 (77)	18 (23)	77 (100)
• 50-54	19 (83)	4 (17)	23 (100)
• >55	21 (91)	2 (9)	23 (100)
Hospital			
• Hornsby	22 (88)	3 (12)	25 (100)
• Gosford	45 (82)	10 (18)	55 (100)
• Manly	19 (70)	8 (30)	27 (100)
• Mona Vale	17 (85)	3 (15)	20 (100)
• RNSH	32 (84)	6 (16)	38 (100)
• Ryde	6 (100)	0 (0)	6 (100)
• Wyong	26 (87)	4 (13)	30 (100)
Year Qualified			
• <1980	26 (87)	4 (13)	30 (100)
• 1980-1989	45 (80)	11 (20)	56 (100)
• 1990-1994	18 (75)	6 (25)	24 (100)
• 1995-1999	27 (87)	4 (13)	31 (100)
• 2000-2005	41 (84)	8 (16)	49 (100)
• >2005	9 (90)	1 (10)	10 (100)

Note: Not all respondents answered all questions

Summary

Following analysis of all the data three themes were able to be identified as the reasons for midwives staying in midwifery. Relationships, professional identity, and the practice of midwifery are the three main themes which have been identified through analysis of data, from midwives within NSCCAHS as to the reasons why they stay in midwifery. Each of these three themes will be discussed further within the Discussion Chapter which follows.

CHAPTER FIVE: DISCUSSION

Introduction

This study aimed to understand the factors that contribute to midwives in one Area Health Service in NSW staying in midwifery. The reasons midwives gave for selecting a particular workplace, clinical setting or model of care were explored. The results were able to identify the reasons midwives gave for staying in midwifery and in their current workplace.

Results of this study identified three main reasons why midwives stay in midwifery. These reasons were: midwifery relationships; professional identity as a midwife; and, the practice of midwifery. When midwives spoke of relationships as their reason for staying in midwifery, they spoke of relationships with the women and their families and the colleagues they worked with. When they spoke of professional identity, midwives made statements about the privilege of being present when women gave birth and the professional pride they had of being a midwife. The practice of midwifery related to the elements of the job which midwives enjoyed. The elements of the job which midwives found important to keeping them in midwifery included: the variety of the job; normalising midwifery care; job satisfaction; finding the job preferable to nursing; and, working in an area they want to work in.

Initially, this chapter of the thesis will provide an overview of the results. Then, how the results from this study relate to the English 'Why Midwives Stay' study will be discussed (Kirkham et al., 2006). The three reasons midwives gave for staying in midwifery will be

addressed and are used to structure and guide this chapter. Following discussion of why midwives stay in midwifery, the reasons they choose to stay in a particular workplace and what keeps them going will be presented, drawing on relevant evidence from the literature.

Overview of the results

Demographic data

The characteristics of midwives from this study cohort within NSCCAHS were reflective of nurses and midwives as a whole. The average age of midwives from this cohort within NSCCAHS was 42.6 years. In Australia, the average age of nurses and midwives continues to increase. In 2006 the reported average age of nurses and midwives in Australia was 43.3 years (Australian Institute of Health and Welfare). In the English study, the average age of midwives was 44.2 years. In England the Nursing and Midwifery Council (NMC) reported that of the midwives on their register, 43.8% were aged between 40 and 49 years (Kirkham et al., 2006). The largest percentage (37%) of midwives in my study were aged between 41 and 50 years. There are similarities between the average age of midwives in this study and the average age of midwives in both the English study and the UK as a whole.

The average age of midwives in this cohort is reflective of the year midwives obtained their midwifery qualification and the type of qualification. Fifty eight percent of midwives (n=119) obtained their midwifery qualification before 1996. While the average age of midwives in this study and the English study are similar, the year of qualification varied with 77% (n=373) of midwives in the English study qualifying before 1996. The number of

midwives obtaining their midwifery qualification, in this cohort, before 1996, is not only reflective of the average age of midwives in this cohort, but it is also reflective of the number of midwives obtaining their midwifery qualification in the hospital setting. University education for midwives was not introduced in NSW until 1994 and 53% (n=107) of midwives in this cohort obtained their training in the hospital setting. This finding is in line with the average age and the year qualified.

One of the challenges of recruiting and retaining an adequate midwifery workforce stems from the original meaning of midwifery as being 'with woman' and midwifery being very much about women's business. With the history of midwifery in Australia deeply entrenched in nursing and the historical perception that nursing is women's work (Buchan, 2002), recruitment and retention can be difficult. With the knowledge that there are more female midwives in midwifery than males, it is not surprising that of the midwives within this cohort 99% were female.

Nearly half of the respondents (47%; n=96) had had some time out of midwifery since qualifying. Of the midwives who had time out of midwifery, 24% (n=50) had that time out to care for dependent children. In the English study, one third (n=161) of midwives had had time out since qualifying with 59% (n=93) of them having time out to care for dependent children. While a larger percentage of midwives in England had taken time out to care for children, in both countries the percent is relatively high and remains the leading reason for time out of midwifery.

The demographic data obtained from this cohort of midwives within NSCCAHS has proven to be reflective of midwives (and nurses) as a whole. Not only in Australia, but in England as well, midwives (and nurses) are of the same age, qualified at similar times, have had significant time out of midwifery and had their time out of midwifery for similar reasons.

Employment status and preferences

There are seven maternity sites in NSCCAHS and respondents came from each of the sites. Of the midwives who responded to the questionnaire, 18% (n=35) held positions other than their midwifery job. This number is higher but similar to the responses from the English study where 12% (n=59) have other jobs in addition to their midwifery job. Many of the additional jobs midwives held related to women and the provision of pregnancy care. The majority of midwives who had positions outside their current midwifery job, in this study and the English study, had additional employment in midwifery, nursing or education fields.

The findings indicated that 22% (n=43) of midwives, would rather work in different settings. Midwives from Wyong Hospital were most likely to wish to work in a different setting (27%, n=8), while no midwives at Ryde Hospital wished to work in a different setting. The main reason midwives gave from wishing to work in a different setting was to have a greater access to different models of midwifery care. Within the Australian health system there are typically four types of maternity care available to women. Traditional midwifery care, where women receive care by midwives in hospital antenatal clinics;

shared pregnancy care between general practitioners/obstetricians and midwives; private obstetric care and midwifery continuity of care models are the options of care available to women in Australia. There are several organisational variations in the models of midwifery continuity of care which is available to women, but their underlying philosophies remain the same. The provision of care by midwives across the antenatal, intrapartum and postnatal period where there is a consistent and supported philosophy and organisational structure are the key elements of midwifery continuity of care (Homer et al., 2008b). The midwives at Ryde Hospital who did not wish to work in a different model all work within a midwifery group practice model where they provide caseload care[14] to a small group of women. The Ryde Midwifery Group Practice is a midwifery continuity of care service based at Ryde Hospital. The Ryde Maternity Group Practice was developed in association with the local community (Tracy, Hartz, Nicholl, McCann, & Latta, 2005).

While the midwives working in the Ryde midwifery group practice worked in a continuity of care model, they were also able to provide women with continuity of carer. The difference between continuity of care and continuity of carer is the opportunity for women to develop relationships with a midwife they have previously met, and whom she believes she knows, in a model of care that provides continuity of carer. Midwives working in midwifery caseload models also have a greater opportunity to develop meaningful relationships with women and their families as a result of the way in which they practice and often have greater job satisfaction and now it seems that in this cohort of midwives are also more likely to stay in their current setting. These findings are supported by previous

[14] "Caseload care is a model of midwifery practice provided by one or two midwives that focuses on continuity of carer through pregnancy, labour and birth and early pregnancy" (Homer et al., 2008b)

research, by Sandall (1995) and Kirkham (2000), which supports midwives in autonomous practice

Current working hours

All the midwives who responded to this study were employed within NSCCAHS, nine were employed casually. Of the midwives who were employed on a permanent basis, 61% (n=114) were contracted to work part-time. It is estimated that in 2004, 50% of Australian nurses were working part-time (Australian Institute of Health and Welfare, 2006). The midwives in the English study reported a 55% part-time employment rate. Currently in Australia, 46% of the Australian female workforce work part-time (Australian Bureau of Statistics, 2009b). The prevalence of part-time employment can be attributed in part to the fact that nursing and midwifery are women-dominated careers (Buchan, 2002). With 24% (n=50) of midwives having had time out of midwifery to care for dependent children, it can be concluded that when these midwives return to work, they do so in a part–time capacity. In comparison to the statistics on part-time employment in Australia, the percentage of midwives in this study working part-time, was greater than the national average, this could also be contributed to the high feminisation of the midwifery workforce. In the 2006 Australian Bureau of Statistics (ABS) census it was reported that the occurrence of part-time employment had increased in Australia from 20% in 1986 to 32% in 2006. At the time of the 2006 ABS census, almost half of Australian female employees worked part-time (Australian Bureau of Statistics). The ABS indicated that the reason women were working part-time was as a result of several reasons. One of the reasons the ABS gave for the increased uptake of part-time employment was the availability to many parents (particularly

mothers) of combining work with raising their young children (Australian Bureau of Statistics, 2009c).

Factors that would have the greatest positive impact on midwives' jobs

An improved salary was the only statement which had more that 80% of midwives either strongly agreeing or agreeing that this would have the greatest positive impact on their job. In Australia, the Federal government sets the minimum wage but state-based awards govern the salary for different professions including nursing and midwifery. In 2010 the Australian Federal Minimum Wage (FMW) is set at $A14.31 per hour or $A543.78 per week. Nurses and midwives in Australia, are paid a base salary that increases every year until they have been registered for eight years. On top of their base pay they receive additional salary (loading) depending on the shifts they work. Anecdotally, midwives in NSW are among the highest paid midwives in Australia. The base pay in NSW for a first year registered midwife is $A23.99 per hour or $A911.90 per week, increasing to $A33.70 per hour or $A1280.70 per week for a midwife who has been practising for eight or more years.

In 2006 in Australia, the mean starting salary for bachelor degree graduates was $A40 000 per annum. The bachelor degree graduates in this analysis are nursing (which includes midwifery), medicine, education, law and pharmacy. The mean starting salary for nursing bachelor degree graduates was $A38 000. The highest starting salary was seen in medical graduates ($A50 000) with nursing being the lowest (http://www.anf.org.au/pdf/Grad_Stats.pdf). These data are national and it is likely that NSW nursing (and midwifery) graduates fair somewhat better. In addition, as most

respondents in my study were already nurses when they became midwives, their starting salary as midwives would have been considerably higher due to incremental salary increases with length of service.

Reasons for staying in midwifery

Over 80% of midwives either strongly agreed or agreed with nine statements as reasons for them staying in midwifery. The findings from the English study identified six statements where over 80% of midwives either strongly agreed or agreed. In both this study and the English study, the three statements that received the highest percent of midwives either strongly agreeing or agreeing were exactly the same, that is, 'I enjoy my job' Not only is the leading reason midwives from both studies gave for midwives staying in midwifery the same, the percentage of midwives selecting the same statement was identical in each study (98%).

When exploring the results from both the quantitative and qualitative data, it was evident that the enjoyment midwives get from their job is interlinked with their job satisfaction. The statement which received the second highest number of midwives either strongly agreeing or agreeing with it was 'I am proud to be a midwife'. In my study, 97% (n=139) of midwives strongly agreed or agreed with this statement while in the English study, 93% (n=439) of midwives strongly agreed or agreed with the statement. Being proud of the work they do was strongly represented in the data obtained from the midwives in this study. Midwives felt that their professional identity as a midwife was extremely important and being proud of what they do was a part of their identity. The third statement which had the

highest percentage of midwives strongly agreeing or agreeing with it was 'I get job satisfaction'. In my study 95% (n=137) of midwives strongly agreed or agreed with this statement and in the English study 89% (n=419) of midwives strongly agreed or agreed with the statement.

From the results in both this study and the English study, it can be concluded that the positive statements related to midwives staying in midwifery outweigh the negative statements. The negative statements which midwives did not consider as reasons for staying in midwifery included: 'I feel I am too old to change jobs' and 'I am not qualified to do anything else'. Interestingly, in both this study and the English study just over 70%, (72% and 73% respectively) of midwives feel that 'the good days somehow justify you staying in practice'. In the English study, 73% of midwives felt that the good days somehow justified them staying in practice was seen to highlight some underlying tensions in clinical practice. The underlying tensions in clinical practice are often a result of the professional relationships midwives have with each other. In many cases midwives do not support each other and this has been borne out in research from the UK (Deery, 2009). A combination of a lack of support from each other and the demands of the organisation can lead to an increase in the emotional exhaustion and stress of midwives (Deery, 2009). With many of the reasons midwives gave for staying in midwifery being related to the relationships they have with both the women they are caring for and their colleagues, it could be suggested that the strength of these positive relationships outweigh the negative aspects sometimes faced.

Midwives in both this NSW study and the English study identified the same statements as being the reasons for them staying in midwifery. Despite the differences in cultures and clinical practices, it is evident that for many midwives they are staying in midwifery because they enjoy their job, they are proud of what they do and they get job satisfaction.

The source of job satisfaction was not only explored as one of the reasons for midwives staying in midwifery but was also further examined to assist in identifying what midwives mean when they state they have job satisfaction. Midwives were asked to indicate their agreement with a list of statements about their source of job satisfaction. Ten statements received over 80% of midwives either strongly agreeing or agreeing with them as a source of job satisfaction. Four of the top five statements related to the women that the midwives are caring for directly. These statements are: 'feeling like I make a difference to women', interactions with the women in my care', 'interactions with women', and 'seeing women happy'. The source of job satisfaction for the midwives in this study was the same as the midwives in the English study. Of the top ten statements for the midwives within this study, nine were the same as the top ten statements from the English study. The results demonstrated that midwives get an immense amount of job satisfaction from feeling as though they make a difference to women.

The idea of midwives making a difference to the pregnancy and birth experiences of women has multiple meanings or interpretations including that of professional servant. Cronk (2000) discusses the role of the midwife as one of a professional servant and describes the professional servant role being in place when a professional is providing a service to someone else. As employees of an Area Heath Service midwives in this study are

in fact professionals and employees contracted to serve the women who enter the maternity service for pregnancy, labour or postnatal care. In the UK, and here in Australia, the health system in which we work has abolished the traditional role of the midwife as the professional servant and encouraged a system where everyone, except the mother, knows best. The study reported here was unable to determine the meaning behind what midwives describe as 'making a difference' to the women they care for. It is hoped that the meaning of making a difference is not one where the midwife knows best therefore makes a difference by telling the woman what is best for her, but instead is one where the midwife is able to assist and facilitate the informed decision making of the woman and her family.

Relationships

Midwives describe their relationships with women and colleagues as key reasons for them staying in midwifery. For many midwives the relationships they develop with women, through their clinical practice, are the keystone of midwifery (Kirkham, 2000). The themes which relate to the importance of the relationship with women, from the results of this study, were: a desire to work with women and their families; interactions with women and generally for the women for whom they provide care. It is the relationships, not only with the woman, but her partner and family, that are important components of the relationship entered into by the midwife. While the desire to work with women is described here as being a result of the relationship which midwives develop with women, it can also be related to the preference some midwives have for midwifery over nursing, and therefore the elements of midwifery as a job. While it is difficult to determine what midwives mean

when they state that they have a desire to work in midwifery, there were other midwives who stay because they want to work with women and their families.

Working with women and their families was important to midwives who felt that they were able to make a difference and have meaningful interactions with the women. Previous research has suggested midwives working in midwifery continuity of care models develop deeper and more meaningful relationships with women (Foureur & Sandall, 2008; Sandall, 1997). The meaningful relationships which midwives and women form throughout pregnancy, birth and in the postnatal period have previously been given the title of professional friendship; partnership or a professional service (Cronk, 2000; Kirkham, 2000; Pairman, 2000; Sandall et al., 2008). From the cohort of midwives described in this study, I propose that the best description is one of a professional friendship. For midwives, professional friendships are about the development of trust, sharing of information about one's self, providing information and advice and being there when the woman makes decisions regarding the path she chooses to take in regard to her pregnancy and birth (Pairman, 2000). It is through the relationship that is developed that midwives often feel confident enough to work autonomously and is the origin of job satisfaction. From this research, the three top reasons midwives gave for staying in midwifery related to the woman, with two reasons being directly related to the interaction between woman and midwife. For midwives within this study, the interactions with women were not only a reason for staying in midwifery but also a source of job satisfaction.

In this study midwives, who identified interactions with women as one of the key sources of job satisfaction, and therefore their motivation for staying in midwifery, could be viewed

as representative of all NSW midwives in that they worked in both traditional hospital settings and caseload midwifery models as well as working in both full-time and part-time capacities. As this study used a pre-developed tool to obtain the reasons for why midwives stay in midwifery, it was not possible to explore further the reasons midwives had for their selection of statements elaborating on why they stayed. Further research exploring some of these meanings may deepen our understanding of what midwives perceive these statements to be about and how these relationships can be developed and sustained in a public health system.

Professional friendships with women were not the only relationships midwives spoke about as being important to them in relation to why they stay in midwifery. Colleagues, and the interactions midwives had with their colleagues, were also identified as reasons for staying in midwifery. It has previously been suggested that the relationships midwives form with their colleagues can be encased in stress as a result of the high levels of emotional work and emotional labour that is associated with midwifery (Deery, 2009). While there may be high stress levels among midwifery colleagues as a result of the emotional work associated with midwifery, the physiological birth process will be enhanced if a mutually respected collegial relationship is developed among all practitioners involved in the care of women (Fahy, Foureur, & Hastie, 2008). Midwives within this study reported on their relationships with colleagues positively and felt that the interactions they had were contributing factors to the reasons they gave for why they stay in midwifery.

Professional identity

When I think of the professional identity of midwives, the first thing I initially think of is the way in which the profession of midwifery is perceived within the health system and the wider community. Upon close analysis it was discovered that the professional identity many midwives consider to be the reason for them staying in midwifery actually relates to the identity they perceived in the eyes of the women, and families, that they care for. Within the theme of professional identity, identified through analysis of data obtained in this study, midwives spoke about the privilege of being a midwife; how they are proud to be midwives and the role they play as advocate for the women. The importance of professional identity is a theme that is interesting to consider and one that would benefit from further research.

With midwives feeling privileged and proud of the work they are employed and paid to conduct, it may be that for many midwives they feel that the reciprocity of the relationship with women is the basis for their professional identity. The reciprocal relationship between woman and midwife involves a two way exchange where there are benefits for both the woman and the midwife (McCourt & Stevens, 2009).

Other research supports reciprocity within the midwife-mother relationship as being the core element of successful midwifery practice while also being responsible for the emotional work faced by many midwives (Fleming, 1997; Hunter, 2005b). If reciprocity is both the core element of the midwife-mother relationship and the source of emotional work

it could also be the reason why midwives within this study state that ‘the good days somehow justify you staying in practice’.

One could question whether the professional identity and what midwives themselves get out of midwifery is more important than the work they actually conduct and the women for whom they care. Is recognition of self more important to some midwives than the journey of the woman? From analysis of the data it is evident that, from this cohort of midwives within NSCCAHS, the relationship they develop with women and the reciprocity and professional identity they receive from this relationship are important factors to why they stay in midwifery. Reciprocity in midwifery practice is not a new concept. In her study into the ‘Invisibility of Midwifery’, Brodie (Brodie, 2003) introduces ‘Professional Capital’. When exploring the issue of midwifery invisibility in Australia, Brodie (2003) believed that the overarching strategy of ‘Professional Capital’ would enhance midwifery professional capacity. Enhancing the professional capacity of midwives in Australia was seen to be achievable through enabling midwives to become more visible, valued and recognised in the provision of maternity services. It seems that the ‘Professional Capital’ of midwives and the reciprocity they achieve through their work as midwives remain important to midwives and continues to contribute to the reasons why they stay in midwifery.

Practice of midwifery

Analysis of the study data showed that midwives identified the practice of midwifery as an important factor, and one that contributes to them staying in midwifery. The clinical

practice of midwifery related to the variety of the job, normalising midwifery care, having job satisfaction, working autonomously, and finding the job preferable to nursing.

The variety of the work that is involved in the everyday practice of midwifery is one of the reasons for midwives staying in midwifery. With variety comes an increase in interest and challenges. Midwives enjoy the mixture this provides them. The English study (Kirkham et al., 2006) also demonstrated that the variety of midwifery work contributes to midwives staying in midwifery. For midwives in both this study and the English one, the variety of midwifery work was not only one of the reasons for them staying in midwifery but was also a source of job satisfaction for midwives.

Job satisfaction was extremely important to midwives in this study and was part of what made up the theme of the practice of midwifery. It was the third highest reason midwives gave for staying in midwifery, with the source of job satisfaction coming from professional interactions with both women and colleagues. Unlike previous research (Sandall, 1999) which has demonstrated that midwives who work in community based models of midwifery care have greater job satisfaction than midwives in hospital based models of care, the midwives from this study in NSW demonstrated that regardless of where they work, it was the development of relationships which provided job satisfaction. While the midwives from both hospital and community settings within this study in NSW demonstrated that the relationship rather than the location of the service is the important factor in achieving job satisfaction, it is necessary to acknowledge that midwives in midwifery continuity of care practices have better accessibility to relationships with women, and through that, job satisfaction (Sandall, 1999). Job satisfaction alone is a very

important component in the clinical practice of midwifery and the reasons for why midwives stay. No one issue can be described as the sole reason for why midwives stay, while job satisfaction for these midwives was extremely important, so was autonomy.

Working autonomously is part of the clinical practice of midwifery which encourages midwives to stay. Midwives in both these studies (Kirkham et al., 2006) felt that the ability to work in a way that was able to protect the normality of birth was extremely important. Previous research (Davis-Floyd, 1997) describes autonomy as either that of mind or practice. For midwives who work within traditional, hospital models of care or midwifery continuity of care models which are based in the hospital setting, the ability to have this autonomy of mind is extremely important. The freedom to make decisions for, and in conjunction with women, while maintaining respect for yourself and your colleagues enhances the clinical practice of midwifery, which encourages midwives to stay. Midwives often comment on the clinical practice of midwifery being preferable to that of nursing and suggest it is the greater autonomy they feel that contributes to their performance.

For many of the midwives in this study, their motivation for staying in midwifery related to finding their job preferable to nursing. The questionnaire did not ask midwives which components of midwifery were more preferable than nursing. Further research would need to be conducted to identify these reasons.

Midwives stay in midwifery for very different reasons to why they leave. Relationships with the women and their families and their colleagues are vital. The ability to provide midwifery continuity of care, and be autonomous in the delivery of this care, contributes to

the reasons midwives give for staying in midwifery. Practising in models of care and areas of practice where they choose to work, increases the job satisfaction midwives have. Midwives enjoy the reciprocity of the relationships with the women and families and believe that colleagues contribute to and enhance these relationships. The factors which contribute to midwives in one Area Health Service of NSW staying in midwifery are the relationships they develop, their professional identity and the clinical practice of midwifery.

The discussion so far has focused on the top three identified reasons for midwives staying in midwifery. As the main reasons for midwives staying: relationships, professional identity and the practice of midwifery cannot be examined exclusively. While many of the issues which form these themes overlap they can also be described individually as reasons for staying. Job satisfaction, autonomy of practice, working with women and working in an area other than nursing were all strong issues which were raised in this research. Midwifery practice does not revolve around one stand alone aspect but in fact requires all of these individual elements in order for midwives to provide optimal care to women and their families.

Despite the distance between the midwives in this study and the English study, it appears that the reasons midwives stay in midwifery are the same. The meaning of the word midwife emanates from middle English *mid* meaning with and the old English *wif* meaning woman. The women are at the core of why midwives stay in midwifery. The themes identified through this research resonate with this meaning. Developing relationships, having a professional identity with the women and their families, achieving reciprocity through the professional identity, and practising in a way which supports them to support

women, enable midwives to practice to the true meaning of a midwife, allowing midwives to work *with women*.

Limitations

While new knowledge was obtained about the factors that contribute to midwives staying in midwifery, it is important to acknowledge the limitations of this study. While both qualitative and quantitative data were obtained, the major source was quantitative. Where quantitative data was obtained it was done with tick boxes. The use of quantitative data and tick boxes for this study was a limitation. The study was conducted in one Area Health Service in NSW which has seven maternity sites. While the Area Health Service includes both a large metropolitan maternity service and a small regional service, it may not be seen as representative of all maternity sites or midwives within NSW. With a response rate of 53%, it may have been that the most unhappy midwives within this Area Health Service did not respond to the questionnaire. The study was conducted in the NSW public hospital system and therefore does not cover midwives working within the private hospital sector or in private/independent midwifery practice.

Time and size limitations of the Master of Midwifery (Honours) degree did not allow for the inclusion of midwives not working in clinical roles, including midwifery managers. The limitation of representation precludes generalization of the findings across the NSW midwifery workforce.

The tool used was adapted from the Why Midwives Stay study in England. Formal reliability and validity analyses have not been undertaken using this tool. Therefore, it is possible that the instrument is not measuring what it actually set out to measure. Despite this, the face validity of the instrument is high and the findings 'made sense' in the context of the questions asked.

Implications for practice

This study was conducted to examine the factors that contribute to midwives in one Area Health Service in NSW staying in midwifery. The midwives identified that the reasons they stay in midwifery are; the relationships they develop, professional identity and the practice of midwifery.

There is evidence to suggest that the midwifery continuity of care models support the development of the midwife/woman relationship. From this study, it can be concluded that midwives who work in midwifery continuity of care models have a greater opportunity to develop meaningful relationships with women and achieve job satisfaction. When there are meaningful relationships, with women and colleagues, midwives are more likely to stay in both midwifery, and in the maternity setting where they are employed. The development of midwifery continuity of care models enables midwives to work more autonomously and experience the practice of midwifery. The opportunity to normalize midwifery care and practise the full variety of midwifery gives midwives the chance to become autonomous practitioners. When midwives are autonomous they experience greater job satisfaction.

The midwives within this study placed a large degree of importance on the relationships with women and families for whom they provide care. The midwives enjoyed the relationship that they had with the women and the reciprocity they experience as a result of the relationship. In order to support these relationships, it is important that midwifery continuity of care models are available to facilitate the relationship.

Given that continuity of care provides this opportunity, managers need to work towards providing support to midwives who wish to work in this way. While it is critical that midwifery managers support all their staff, it is also important that they acknowledge work attended by a midwife and provide recognition where appropriate. The support that midwives receive from their managers is extremely important. When midwifery managers support and provide recognition to midwives for the work they do and the care they provide, midwives feel more valued. It is likely that when midwives feel valued and appreciated, they are more likely to stay within the maternity setting, but this was not explored within this study. Nevertheless, recognition and feeling valued by managers are factors which could improve the job of midwives and therefore contribute to them staying in midwifery.

This study has implications for the organisation of care, models of care, and support systems. Area Health Services and Departments of Health need to consider these issues especially in an environment of acute workforce shortages. Addressing the way care is arranged and how staff are supported may lead to higher retention rates, thus reducing costs to the health sector.

REFERENCES

Aiken, L., Clarke, S., & Sloane, D. (2002). Hospital Staffing, Organization, and Quality of Care: Cross-National Findings. *Nursing Outlook.* 50(5). 187-194.

Allied Health Professions Australia. (2008). Allied Health in Australia: Priorities for health care reform and key professions and organisations. Retrieved 4th May 2009, from www.ahpa.com.au

American Nurses Credentialling Centre. (2007). Forces of Magnetism. Retrieved March 2007, from http://www.nursecredentialing.org/magnet/forces.html

Australian Bureau of Statistics. (2009a). Australian demographic statistics. Retrieved 18th January 2010, from Australian Bureau of Statistics: www.abs.gov.au

Australian Bureau of Statistics. (2009b). Labour Force Australia. Retrieved 17th December 2009, from www.abs.gov.au

Australian Bureau of Statistics. (2009c). *A Picture of the Nation: The Statistician's Report on the 2006 Census*. Canberra. Australian Bureau of Statistics.

Australian Health Ministers Conference (AHMC). (2004). *National Health Workforce Strategic Framework*. Sydney. AHMC.

Australian Health Workforce Advisory Committee. (2002). *The Midwifery Workforce in Australia 2002-2012.* AHWAC Report 2002.2. Sydney. AHWAC.

Australian Health Workforce Advisory Committee. (2004). *Nursing Workforce Planning In Australia - A Guide to the Process And Methods Used By The Australian Health Workforce Committee*. (Report 2004.1). Sydney. AHWAC.

Australian Institute of Health and Welfare. (2004). *Nursing and midwifery labour force*. Canberra. AIHW

Australian Institute of Health and Welfare. (2006). *Nursing and midwifery labour force 2004*. Canberra. AIHW.

Australian Institute of Health and Welfare. (2008). *Australia's Health 2008*. Canberra. AIHW

Australian Nursing Federation. (2009). *Grad*Stats. Retrieved 15th February 2010, from www.anf.org.au/pdf/Grad_Stats.pdf

Ball, L., Curtis, P., & Kirkham, M. (2002). Why do Midwives Leave?, *Women's Informed Childbearing and Health Research Group.* University of Sheffield.

Barclay, L. (1998). Midwifery in Australia and surrounding regions: Dilemmas, debates and developments. *Reproductive Health Matters.* 6(11). 149-156.

Barrett, L., & Yates, P. (2002). Oncology/haematology nurses: a study of job satisfaction, burnout, and intention to leave the specialty. *Australian Health Review.* 25(3). 109-121.

Bartram, T., Joiner, T. A., & Stanton, P. (2004). Factors affecting the job stress and job satisfaction of Australian nurses: implications for recruitment and retention. *Contemporary Nurse.* 17(3). 293-304.

Brady-Schwartz, D. C. (2003). Satisfaction with organizational characteristics, job satisfaction, and intent to leave current positions: a comparison of Magnet and non-Magnet hospital staff registered nurses. PhD dissertation. Cypress, CA: Touro University International.

Brodie, P. (1996). *The experience of Australian team midwives.* Unpublished Master of Nursing (Research). Sydney. University of Technology, Sydney.

Brodie, P. (2003). *Invisibility of midwifery: will developing professional capital make a difference?*. Unpublished Doctorate of Midwifery. Sydney. University of Technology, Sydney.

Brodie, P., & Barclay, L. (2001). Contempory issues in Australian midwifery regulation. [Research]. *Australian Health Review.* 24(4). 103-118.

Buchan, J. (1994). Lessons from America? US magnet hospitals and their implications for UK nursing. *Journal of Advanced Nursing.* 19(2). 373-384.

Buchan, J. (1999). Still attractive after all these years? Magnet hospitals in a changing health care environment. *Journal of Advanced Nursing.* 30(1). 100-108.

Buchan, J. (2002). Global nursing shortages: are often a symptom of wider health system or societal ailments. *British Medical Journal.* 324(7340). 751-752.

Buchan, J. (2004). Nurse workforce planning in the UK: policies and impact. *Journal of Nursing Management.* 12. 388-392.

Buchan, J., & Aiken, L. (2008). Solving nursing shortages: a common priority. *Journal of Clinical Nursing.* 17. 3262-3268.

Burns, N., & Grove, S. (2005). *The Practice of Nursing Research: Conduct, Critique and Utilization* (5th ed.). Philadelphia. Elsevier Saunders.

Chang, E. (1999). Career Commitment as a Complex Moderator of Organizational Commitment and Turnover Intention. *Human Relations. 52*(10), 1257-1278.

Cronk, M. (2000). The Midwife: A Professional Servant? In M. Kirkham (Ed.), *The Midwife-Mother Relationship*. Hampshire. Palgrave Macmillan.

Davis-Floyd, R. (1997). Autonomy in Midwifery: Definition, Education, Regulation. *Midwifery Today and Childbirth Education.* (42). 21-22.

Deery, R. (2009). Community Midwifery 'Performances' and the Presentation of Self. In B. Hunter & R. Deery (Eds.), E*motions in Midwifery and Reproduction*. Hampshire. Palgrave Macmillan.

Department of Education Science and Training (DEST). (2003). *National Research Priorities*. Available from: http://www.dest.gov.au/annualreport/2004/5.htm#Strategic Priority 11. Accessed 18 February 2009.

Duffield, C.M., Roche, M.A., O'Brien-Pallas, L.L., Diers, D.K., Aisbett, C., King, M.T, et al. (2007). *Glueing it Together: Nurses, Their Work Environment and Patient Safety.* Sydney. University of Technology, Sydney.

Fahy, K. (2006). An Australian history of the subordination of midwifery. *Women and Birth.* 20(1). 25-29.

Fahy, K., Foureur, M., & Hastie, C. (Eds.). (2008). *Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research*. Sydney. Elsevier.

Fleming, V. E. M. (1997). Women-with-midwives-with-women: a model of interdependence. *Midwifery.* (14). 137-143.

Foureur, M., & Sandall, J. (2008). The challenges of evaluating midwifery continuity of care. In C. S. E. Homer, P. Brodie & N. Leap (Eds.), *Midwifery Continuity of Care: A Practical Guide*. Sydney. Elsevier.

Garon, M., & Ringl, K. K. (2004). Job satisfaction of hospital-based registered nurses. *Online Journal of Clinical Innovations.* 7(2). 1-48.

Hatem, M., Sandall, J., Devane, D., Soltani, H., & Gates, S. (2008). Midwife-led versus other models of care for childbearing women. *Cochrane Database of Systematic Reviews*, Issue 4. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub2.

Hayes, L. J., O'Brien-Pallas, L., Duffield, C., Shamian, J., Buchan, J., Hughes, F., et al. (2006). Nurse turnover: A literature review. *International Journal of Nursing Studies. 43*(2). 237-263.

Hochschild, A. R. (1979). Emotional Work, Feeling Rules, and Social Structure. *The American Journal of Sociology. 85*(3). 551-575.

Homer, C. S. E., Brodie, P., & Leap, N. (2008a). Getting started: what is midwifery continuity of care? In C. S. E. Homer, P. Brodie & N. Leap (Eds.), *Midwifery Continuity of Care: A Practical Guide*. Sydney. Elsevier.

Homer, C. S. E., Brodie, P., & Leap, N. (2008b). *Midwifery Continuity of Care: A Practical Guide*. Sydney. Elsevier.

Homer, C. S. E., Davis, G., & Brodie, P. (2000). What do women feel about community-based antenatal care? *Australian and New Zealand Journal of Public Health.* 24(6). 590-595.

Hunter, B. (2004). Conflicting ideologies as a source of emotion work in midwifery. *Midwifery.* 20(3). 261-272.

Hunter, B. (2005a). Emotion work and boundary maintenance in hospital-based midwifery. *Midwifery.* 21(3). 253-266.

Hunter, B. (2005b). The importance of reciprocity in relationships between community-based midwives and mothers. *Midwifery.* (22). 308-322.

Hunter, B., Berg, M., Lundgren, I., Olafsdottir, O. A., & Kirkham, M. (2008). Relationships: The hidden threads in the tapestry of maternity care. *Midwifery.* 24. 132-137.

Kirkham, M. (1999). The culture of midwifery in the National Health Service in England. *Journal of Advanced Nursing.* 30(3). 732-739.

Kirkham, M. (2009). Emotional Work around Reproduction: Supportive or Constraining? In B. Hunter & R. Deery (Eds.), E*motions in Midwifery and Reproduction*. Hampshire. Palgrave Macmillan.

Kirkham, M. (Ed.). (2000). *The Midwife-Mother Relationship*. Hampshire. Palgrave Macmillan.

Kirkham, M., Morgan, R. K., & Davies, C. (2006). Why Do Midwives Stay? Unpublished Research. Sheffield. The University of Sheffield.

Kleinman, C. (2004). The Relationship between Managerial Leadership Behaviors and Staff Nurse Retention. [research]. *Hospital Topics: Research and Perspectives on Healthcare.* 82(4). 2-9.

Kramer, M. (1990). The magnet hospitals: excellence revisited. *Journal of Nursing Administration.* 20(9). 35-44.

Kramer, M., & Schmalenberg, C. E. (2005). Best Quality Patient Care: A Historical Perspective on Magnet Hospitals. *Nursing Administration Quarterly.* 29(3). 275-287.

Lash, A. A., & Munroe, D. J. (2005). Magnet designation: a communique to the profession and the public about nursing excellence. *MEDSURG Nursing; Supplement.* (24). 7-13.

Laws, P., & Sullivan, E.A. (2009). *Australia's mothers and babies 2007*. Perinatal Statistics Series no. 23. No. Cat. no. PER 48. Sydney. AIHW National Perinatal Statistics Unit.

McCourt, C., & Stevens, T. (2009). Relationship and Reciprocity in Caseload Midwifery. In B. Hunter & R. Deery (Eds.), E*motions in Midwifery and Reproduction*. Hampshire. Palgrave Macmillan.

Microsoft Corporation. (2003). Microsoft Office Access 2003 (Version 11.6355.6360 SP1). Redmond. Microsoft Corporation.

National Health Workforce Taskforce. (2009). *Health Workforce in Australia and Factors for Current Shortages*. Available *http://www.nhwt.gov.au/documents/NHWT/The%20health%20workforce%20in%20Australia%20and%20factors%20influencing%20current%20shortages.pdf Accessed 18 February 2010.*

National Research Priorities Standing Committee. (2007). *National Research Priorities Report to Government*. Canberra. Australian Government.

NSW Department of Health. (2004). *Planning Better Health; Background Information*. Sydney. NSW Health.

NSW Department of Health. (2007a). About NSW Health. Retrieved March 2007, from http://www.health.nsw.gov.au/aboutus/index.html

NSW Department of Health. (2007b). Northern Sydney Central Coast - Services. Retrieved March 2007, from http://www.nscchealth.nsw.gov.au/services/default.shtml

Nurses and Midwives Board of New South Wales. (2008). *Annual Report*. Sydney. Nurses and Midwives Board of New South Wales.

O'Brien Pallas, L., Duffield, C., & Hayes, L. (2006). Do we really understand how to retain nurses? *Journal of Nursing Management.* 14. 262-270.

Pairman, S. (2000). Woman-centred Midwifery: Partnerships or Professional Friendships? In M. Kirkham (Ed.), T*he Midwife-Mother Relationship*. Hampshire. Palgrave Macmillan.

Pairman, S. (2006). From autonomy and back again: educating midwives across a century. Part 2. *New Zealand College of Midwives Journal.* 34. 11-15.

Parsons, M. L., & Stonestreet, J. (2004). Staff nurse retention: laying the groundwork by listening. *Nursing Leadership Forum.* 8(3). 107-113.

Productivity Commission. (2005). *Australia's Health Workforce*. Canberra. Research Report.

Sandall, J. (1995). Choice, continuity and control: changing midwifery, towards a sociological perspective. *Midwifery.* (11). 201-209.

Sandall, J. (1997). Midwives' burnout and continuity of care. *British Journal of Midwifery.* (*5*). 106-111.

Sandall, J. (1999). Team midwifery and burnout in midwives in the UK: practical lessons from a national study. *MIDIRS Midwifery Digest.* 9(2). 147-151.

Sandall, J., Page, L., Homer, C. S. E., & Leap, N. (2008). Midwifery continuity of care: what is the evidence? In C. S. E. Homer, P. Brodie & N. Leap (Eds.), *Midwifery Continuity of Care: A Practical Guide*. Sydney. Elsevier.

SPSS Inc. (2006). SPSS for windows (Version 14.0.0). Chicago. SPSS Inc.

Stafford, S. (2001). Lack of autonomy. *The Practising Midwife.* 4(7). 46-47.

Sullivan-Havens, D., & Aiken, L. H. (1999). Shaping systems to promote desired outcomes: the magnet hospital model. *Journal of Nursing Administration.* 29(2). 14-20.

Tierney, A. J. (2003). What's the scoop on the nursing shortage? *Journal of Advanced Nursing.* 43(4). 325-326.

Tracy, S., Hartz, D., Nicholl, M., McCann, Y., & Latta, D. (2005). An integrated service network in midwifery: the implementation of midwifery-led unit. [case study]. *Australian Health Review.* 29(3). 332-339.

Upenieks, V. (2005). Recruitment and retention strategies: a magnet hospital prevention model. *MEDSURG Nursing, (Supplement).* 21-*7*.

Vernon, B. (2008). Politics, policy and the press: critical pieces in the maternity reform jigsaw. In C. S. E. Homer, P. Brodie & N. Leap (Eds.), *Midwifery Continuity of Care: A Practical Guide* (pp. 243). Sydney. Elsevier.

APPENDIX ONE: Information Letter

NORTHERN SYDNEY CENTRAL COAST NSW HEALTH

UNIVERSITY OF TECHNOLOGY SYDNEY

INFORMATION LETTER (Questionnaire)

Why Midwives Stay? A study into the factors which contribute to midwives staying in midwifery

WHO IS DOING THE RESEARCH?
My name is Katie Sullivan and I am a Masters (Hons) student at UTS. My supervisors are Linette Lock and Caroline Homer

WHAT IS THIS RESEARCH ABOUT?
This study will examine the attitudes and beliefs of midwives practising in maternity sites within the NSCCAHS in relation to workforce retention. It is anticipated that this project will be the pilot study which will then allow for statewide investigation into this area. This is a replication of a recent large study in the United Kingdom.

IF I SAY YES, WHAT WILL IT INVOLVE?
The study will take place in two phases over two years. The study has already used focus groups at four sites across the area health service to examine and to review the questionnaire which has previously been used in England. The questionnaire needed to be adjusted to the Australian climate and the focus groups helped achieve this. The focus groups also assisted us in determining most appropriate modes of distribution for future work on this study. Now that the questionnaire has been reviewed for the Australian workforce, it is being distributed to midwives working within NSCCAHS as a written questionnaire.

ARE THERE ANY RISKS?
There have been no identified potential risks, however if any are identified appropriate counseling will be offered and provided. There will be no pressure from any of the researchers for participation in this project, participation will be voluntary.

WHY HAVE I BEEN ASKED?
You have been invited to participate in this phase of the study as you are a registered midwife currently working within NSCCAHS where the study is being conducted

DO I HAVE TO SAY YES?
You don't have to say yes.

WHAT WILL HAPPEN IF I SAY NO?
Nothing. I will thank you for your time so far and the next you will hear about this research is when you receive feedback about the outcomes of the study and my thesis is published.

IF I SAY YES, CAN I CHANGE MY MIND LATER?
You can change your mind at any time and you don't have to say why. I will thank you for your time so far and the next you will hear about this research is when you receive feedback about the outcomes of the study and my thesis is published.

WHAT IF I HAVE CONCERNS OR A COMPLAINT?

If you have concerns about the research that you think I or my supervisors can help you with, please feel free to contact us on 9514 2977. If you would like to talk to someone who is not connected with the research, you may contact the Deputy Chair, Coast HREC, on 43 203070, fax 43202477, quoting approval number 0701/001C.

APPENDIX TWO: Amended questionnaire

NORTHERN SYDNEY CENTRAL COAST NSW HEALTH

UNIVERSITY OF TECHNOLOGY SYDNEY

Why do midwives stay?

This study will examine the attitudes and beliefs of midwives practising in maternity sites within the Northern Sydney Central Coast Area Health Service in relation to workforce retention.

SECTION A	**About you**
SECTION B	**Current Employment**
SECTION C	**Working hours**
SECTION D	**Why do midwives stay?**
SECTION E	**What keeps you going?**
SECTION F	**How could your job be improved?**
SECTION G	**Future plans**

This questionnaire is anonymous – only the researchers will see a copy of your responses. The Area Health Service will receive a summary of the results only.

It is estimated that it will only take you 15 minutes to complete this questionnaire

We would be grateful if you would return the questionnaire to the research team by:

Wednesday 29th June 2007

A pre-paid envelope has been included for your convenience, alternatively you can place completed questionnaires in the box provided.

Thank you for your help

SECTION A - ABOUT YOU

Answers to the questions in this section will help us to understand who has answered this survey.

QA1. Are you: *Female* ☐ *Male* ☐

QA2. What is your age? ☐

QA3. Please indicate your midwifery qualification: **[TICK ONE ONLY]**

Hospital Trained ☐ *University* ☐

QA4. Please indicate your HIGHEST educational qualification: **[TICK ONE ONLY]**

Certificate ☐ *Degree* ☐

Postgraduate Qualification (eg Graduate Diploma) ☐

Other **[SPECIFY HERE]** ☐

QA5. In what year did you qualify as a midwife? ☐

QA6. Has there been a time when you were not employed as a midwife since you qualified as a midwife?

Yes ☐ *No* ☐ **[TICK & GO TO QB1]**

QA7. If yes, please indicate below how many years in total you have <u>NOT</u> employed as a midwife since qualifying:

YEARS ☐

QA8. What were your reasons for your time out of midwifery? **[TICK ALL THAT APPLY]**

To care for dependent children ☐ *To work in a job other than midwifery* ☐

To care for dependent relatives ☐ *Ill Health* ☐ *Other* **[TICK & SPECIFY BELOW]** ☐

☐

SECTION B - YOUR CURRENT EMPLOYMENT

This second section contains questions about your current employment.

QB1. In which hospital do you currently work?			
Hornsby Kuring-gai		*Royal North Shore*	
Gosford		*Ryde*	
Manly		*Wyong*	
Mona Vale			
Other			

QB2. Please state the title of your current midwifery job(s):
e.g. casual midwife, clinical midwife ,clinical educator, clinical midwifery specialist

QB3. Do you hold any other paid positions in addition to your midwifery job(s)?

No ☐ *Yes* **[TICK AND SPECIFY BELOW]** ☐

QB4. Please indicate where you mainly work as a midwife: [TICK ONE ONLY]

Hospital ☐ *Community* ☐ *Both Hospital & Community* ☐

Other **[TICK & SPECIFY BELOW]** ☐

SECTION B - YOUR CURRENT EMPLOYMENT

QB5. Would you rather work as a midwife in a different setting?

No ☐ *Yes* **[TICK & SPECIFY BELOW WHERE YOU WOULD RATHER WORK]** ☐

QB6. What are your reasons for not working as a midwife in this setting at the moment?

SECTION C – WORKING HOURS

The following section is about the hours you work as a midwife. Please answer the following questions as they apply to your **current** midwifery job(s).

QC1 How many hours a week are you employed to work as a midwife? **Hours** ☐

QC2. On average how many hours a week are do you work as a midwife? **Hours** ☐

QC3. Do any of the following patterns of work currently apply to you? **[TICK ALL THAT APPLY]**

Part-time ☐ *Full-time* **[TICK & GO TO QC5]** ☐ *predominantly nights* ☐

Rotating Roster ☐ *Annualised hours* ☐ *Team/Caseload* ☐

Casual ☐ *Other* **[TICK & SPECIFY BELOW]** ☐

SECTION C – WORKING HOURS

QC4. Please indicate your reasons for working part-time: **[TICK ALL THAT APPLY]**

*I **need** to work part-time (family reasons)* ☐ *I **choose** to work part-time* ☐

I have been unable to negotiate suitable full-time hours ☐ *other* **[TICK & SPECIFY BELOW]** ☐

Not applicable (full-time) ☐

SECTION D – WHY DO MIDWIVES STAY?

The statements below are reasons that midwives have told us are important to why they stay in midwifery. We are interested in your reasons for **staying** in midwifery.

PLEASE TICK ONE BOX ALONG THE SCALE FOR EACH OF THE FOLLOWING STATEMENTS DEPENDING ON HOW FAR YOU AGREE WITH EACH STATEMENT. IN THE LAST COLUMN ALSO RANK JUST YOUR TOP 3 REASONS FOR STAYING. RANK 1-3 WHERE 1 IS THE MOST IMPORTANT REASON.

QD1. What are your reasons for STAYING in midwifery?	**Strongly agree**	**Agree**	**Not an issue for me**	**Disagree**	**Strongly disagree**	**RANK JUST TOP 3**
I enjoy my job						
I get job satisfaction						
I feel I am too old to change jobs						
I could not earn this money doing anything else						
Midwifery is what I've always done						
I worked hard to be a midwife and feel it would be a waste to give up now						
Because I do not have to work full-time						
It is convenient for me to stay						
My Salary						
I am not qualified to do anything else						
I want to work with women and their families						
To change direction would be very unnerving						
I cannot afford to retrain in something different						
I feel I would be letting down colleagues if I left						
Working as a midwife gives me my identity						
Midwifery is preferable to general nursing						
The good days somehow justify you staying in practice						
I don't consider it work, it's just my way of life						
Because I want to make a difference to midwifery						
The alternatives to midwifery are not preferable						
Midwifery is a job I feel passionately about						
Midwifery is a gateway into other things						
I feel privileged to be a midwife						
I am proud to be a midwife						
I work in the area of practice I want to work in						
For the Women I care for						
Other **[TICK & SPECIFY HERE]**						

SECTION D – WHY DO MIDWIVES STAY?

The following question explores job satisfaction in midwifery. The following statements cover issues that midwives have described as providing them with **job satisfaction.**

PLEASE TICK ONE BOX ALONG THE SCALE FOR EACH OF THE FOLLOWING STATEMENTS DEPENDING ON HOW FAR YOU AGREE WITH EACH AS IT APPLIES TO YOUR CURRENT POST. IN THE LAST COLUMN ALSO RANK JUST YOUR TOP 3 REASONS FOR STAYING. RANK 1-3 WHERE 1 IS THE MOST IMPORTANT REASON.

QD2. Where do you get job satisfaction from in your CURRENT midwifery post?	**Strongly agree**	**Agree**	**Not an issue for me**	**Disagree**	**Strongly disagree**	**RANK JUST TOP 3**
Feeling like I make a difference to women						
Feeling like I make a difference to colleagues						
Interaction with the women in my care						
Interaction with work colleagues						
Feeling valued at work by women						
Feeling valued at work by colleagues						
Feeling valued at work by managers						
Being able to provide the care I want to give						
My salary						
Being able to provide continuity of care						
My autonomy as a midwife						
The variety of my job						
Seeing women happy						
Job flexibility						
Being in a team who share my philosophies						
Homebirths						
Being able to normalise midwifery care						
Being an advocate						
Interactions with women						
The professional recognition of midwifery						
Training and study opportunities						
The adrenaline rush of the hospital						
Working in the community						
I get no job satisfaction in my current role						
Other **[TICK & SPECIFY HERE]**						

SECTION E – WHAT KEEPS YOU GOING?

Midwives encounter things in their work that are difficult. The following section explores some of the support systems and coping mechanisms that midwives have told us are important to them. We are interested in what keeps you going as a midwife.

PLEASE TICK ONE BOX ALONG THE SCALE FOR EACH OF THE FOLLOWING STATEMENTS DEPENDING ON HOW FAR YOU AGREE WITH EACH STATEMENT. IN THE LAST COLUMN ALSO RANK JUST YOUR TOP 3 STATEMENTS. RANK 1-3 WHERE 1 IS THE MOST IMPORTANT SUPPORT.

QE1. Which of the following help you to keep going as a midwife?	**Strongly Agree**	**Agree**	**Not an issue for me**	**Disagree**	**Strongly Disagree**	**RANK JUST TOP 3**
Work colleagues and a sense of belonging						
My partner						
My family						
Taking exercise						
Being busy outside of work						
My manager						
Burying my head in a book / studying						
Taking positive action rather than grumbling						
Taking sick leave						
My religious beliefs						
My friends outside work						
Not having a victim mentality						
Not working full-time						
Having a positive outlook						
Having job satisfaction						
Moving to a different midwifery position						
Being an experienced midwife						
Putting in the job as much as you want to get out						
Alcohol and other drugs						
Knowing that I will soon be retiring						
Having a moan						
My work environment						
Switching off / keeping work out of home life						
Involvement with professional groups						
Other **[TICK & SPECIFY HERE]**						

SECTION F – HOW COULD YOUR JOB BE IMPROVED?

The following issues are those which midwives have told us impact on their job satisfaction.

PLEASE TICK ALL THE ISSUES THAT APPLY TO YOU. IN THE LAST COLUMN PLEASE ALSO RANK JUST 3 MAIN ISSUES THAT WOULD HAVE THE GREATEST IMPACT. RANK 1-3 WHERE 1 WOULD HAVE THE GREATEST IMPACT.

QF1. Please indicate which of the following would have the greatest positive impact on your job:	**TICK ALL THAT APPLY**	**RANK JUST TOP 3**
Improved salary		
A greater number of midwives at work		
Greater flexibility in working hours		
Reduced number of working hours per week		
Reduced night shifts		
Reduced shifts on call		
Reduced shift working		
Less paperwork / less computer work		
Greater respect from senior management [feeling valued]		
More effective management		
Less routine medical intervention with women		
More support from my manager		
Less pressure to undertake further education & development		
Some form of clinical supervision		
Greater recognition of further education & development		
More resources for further education & development		
Improved relationships with non-midwifery colleagues		
Abolishing integrated midwifery (that isn't caseload based)		
Greater colleague support / collegiality		
A move into a different area of midwifery		
Feeling more valued by women		
Less change in midwifery		
Less experienced midwives having a greater respect for experienced midwives		
Wider use of midwifery support services		
Wider use of PSA's		
More clerical support		
Community midwives not having to cover hospital shifts		
Other **[TICK & SPECIFY HERE]**		

SECTION G – FUTURE PLANS

The following questions explore your plans for the future in midwifery.

QG1. Have you ever seriously considered leaving midwifery? **[TICK ALL THAT APPLY]**

No **[TICK & GO TO QF3]** ☐ *Yes, in the past* ☐ *Yes, I am currently considering leaving* ☐

QG2. If you answered '*Yes*' to QF1 please explain your MAIN reason for considering leaving midwifery:

QG3. Do you plan to continue working as a midwife for the foreseeable future?

*Yes [***TICK & GO TO QF5]** ☐ *No* ☐ *don't know* ☐

QG4. If you answered '*No' or 'Don't know'* to QF3 please explain the MAIN reason why you may not continue working as a midwife:

QG5. Do you plan to change the number of hours that you work in the foreseeable future? **[TICK ONE ONLY]**

Yes, increase my hours ☐ *Yes, decrease my hours* ☐

No plans to change my hours at the moment **[TICK & GO TO QG7]** ☐

QG6. If you answered *Yes* to QF5, please explain why you plan to change your hours:

QG7. Which of these best describes your plans for the future in midwifery?	**TICK ALL THAT APPLY**
I plan to stay in the role that I am in now	
I would like more clinical responsibilities	
I would like more managerial responsibilities	
I plan to leave midwifery altogether	
I would like to stay in midwifery but move out of this hospital	
I would like to move from a casual position into a permanent position	
I would like to move into midwifery education	
I would like to move into another area of midwifery **[TICK & SPECIFY AREA e.g. Community]**	
I would like to progress, but still retain my role as a clinical midwife **[TICK & EXPLAIN HERE]**	
Other **[TICK & SPECIFY HERE]**	

SECTION G – FUTURE PLANS

QG8. During your time as a midwife, do you feel your job has become: **[TICK ONE BOX ONLY]**

More enjoyable overall ☐ *Less enjoyable overall* ☐ *Stayed about the same* ☐

QG9. In the future, do you think working as a midwife will become: **[TICK ONE BOX ONLY]**

More enjoyable ☐ *Less enjoyable* ☐ *Stay about the same* ☐

QG10. Overall, would you recommend midwifery as a career to others? **[TICK ONE BOX ONLY]**

Yes **[TICK & EXPAND BELOW]** ☐ *No* **[TICK & EXPAND BELOW]** ☐

QG11. Please expand on your answer to QF10:

SECTION G – FUTURE PLANS

QG12. What advice would you give to people considering midwifery as a career?

Please use the space below if there is anything else you would like to tell us about why you STAY in midwifery:

Thank you for taking the time to complete this questionnaire.

Please use the pre-paid envelope or box provided to return the questionnaire to the research team by:

Wednesday 20th June 2007

APPENDIX THREE: Consent

NORTHERN SYDNEY CENTRAL COAST NSW HEALTH

UNIVERSITY OF TECHNOLOGY SYDNEY

CONSENT

PARTICIPANT (HEALTH CARE PROVIDER) CONSENT

A study of the factors that contribute to midwives continuing to work in midwifery
(HREC APPROVAL NUMBER 0701/001C)

I _____ agree to participate in the research project, A study of the factors that contribute to midwives continuing to work in midwifery (HREA approval number 0701/001C) being conducted by Professor Caroline Homer and Katie Sullivan who is working on the project as part of her Masters of Midwifery (Hons) at the Centre for Midwifery, Child and Family Health at the University of Technology, Sydney (telephone 9514 2977).

I understand that the purpose of this study is to investigate why midwives stay in midwifery and in their current workplace. A questionnaire will be used to collect this information. I am aware it is anticipated that this project will be the pilot study which will then allow for statewide investigation into this area. This is a replication of a recent large study in the United Kingdom.

I understand that this focus group will provide preliminary information on factors contributing to midwives staying in midwifery. The focus group will also look at the language used in the questionnaire and the relevance to Australian midwives. I understand that information obtained in this focus group may be tape-recorded and that hand written notes will also be taken. These results will be used in the final analysis of the data.

I understand that my participation in this research is completely voluntary and that I can withdraw participation at any time, without consequences, and without any reason. I am aware that I can contact Caroline Homer, Linette Lock, Patricia Brodie or Katie Sullivan (9514 2977) if I have any concerns. I understand that information collected from the focus group is anonymous and no identifying information will be kept about me. Withdrawal from the study will not in any way change my relationship with the hospital, other employees or my manager. The study is independent from my managers and no feedback will be given to my managers if I do not participate.

I agree that the research team, Caroline Homer, Linette Lock, Patricia Brodie and Katie Sullivan, have answered all my questions fully and clearly.

I agree that the research data gathered from this project may be published in a form that does not identify me in any way.

_____ ___/___/___
Signature (participant)

_____ ___/___/___
Signature (researcher or delegate)

APPENDIX FOUR: Section Summary

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
Section A	QA1	Section B	Removed	Are you currently working as a midwife?		The Australian questionnaires are only being distributed to currently practising midwives
Section A	QA4	Section B	Removed	Which of the following currently applies to you?		This question referred to self-employed; privately employed and NHS employed midwives and it was felt that this is not relevant in the Australian setting
Section A	QA7	Section B	Removed	What is your current midwifery grade?		We don't have a grading system in Australia like they do in the UK.
Section A	QA8	Section B	Removed	Do you feel that this grade is appropriate for your qualifications and experience?		As Above
Section A	QA10	Section B	Removed	What is the highest grade (or grade equivalent) you have held in midwifery?		As Above
Section A	QA11	Section B	QA1	In what region are you currently working as a	In which hospital do you currently work?	As this questionnaire was being distributed to midwives in one Area

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
				midwife?		Health Service we already knew the region they were working in and were only interested in the Hospital.
Section B	QB1	Section C	Removed	Do you work as a bank midwife?		While we have casual midwives not bank midwives, it is felt that this question will be answered during section A of the amended questionnaire.
Section B	QB2	Section C	Removed	Do you work as an agency midwife?		As Above
Section B	QB3	Section C	QC1	How many hours a week are you CONTRACTED to work as a midwife?	How many hours a week are you employed to work as a midwife?	The change in language made this question more appropriate to the Australian setting.
Section B	QB4	Section C	QC2	On average how many hours a week do you work in TOTAL as a midwife (including contracted hours, bank, agency and extra shift work)?	On average how many hours a week do you work as a midwife?	As Above
Section B	QB5	Section C	Removed	If you work unpaid hours, what arrangements are there (if any) for time back or payment for this?		It was felt that this information was not required to meet the aims and objectives of the research.
Section B	QB6	Section C	Removed	Do you work these hours voluntarily, or is there an		As Above

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
				expectation that staff will work overtime		
Section B	QB7	Section C	Removed	Is this a regular occurrence, or only in cases of emergency?		As Above
Section B	QB8	Section C	Removed	If you work some contracted hours as a midwife, have you negotiated these contracted hours to suit your home circumstances?		It is felt that this question will be answered in another part of the questionnaire.
Section B	QB10	Section C	Removed	Would you still work in your current post if you were not given these work patterns?		As Above
Section B	QB11	Section B	QB9	Are you currently working full-time hours as a midwife?	Do any of the following patterns of work currently apply to you?	It was felt that this question could be incorporated into a question which was already there.
Section B	QB13	Section C	Removed	Do you feel there are any disadvantages of working part-time?		It was felt that this information was not required to meet the aims and objectives of the research.
Section B	QB14	Section C	Removed	Please indicate below your reasons for not working full-time:		It was felt that this information was not required to meet the aims and objectives of the research.

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
Section C	QC1 Statement #9	Section D	Removed	I want to stay registered as a Midwife		The original wording was removed because in Australia at the time of this survey you do not loose your midwifery registration
Section C		Section D	Section D Statement #9		My Salary	This statement was added as a result of the focus groups which were conducted in phase one of the research
Section C	QC1 Statement #11	Section D	QD1 Statement #12	To change direction would be very unnerving	Wording remained the same	The question remained in the questionnaire but moved position on the questionnaire
Section C	QC1	Section D	Statement #26		For the women I care for	It was felt that there needed to be more options related to the women directly
Section C	QC2	Section D	Statement #1	Feeling like I make a difference to clients	Feeling like I make a difference to women	It was felt that the word woman was more midwifery friendly than client
Section C	QC2	Section D	Statement #5	Feeling valued at work by clients	Feeling valued at work by women	It was felt that the word woman was more midwifery friendly than client
Section C	QC2	Section D	Statement #13	Seeing clients happy	Seeing women happy	It was felt that the word woman was more midwifery friendly than client

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
Section C	QC2	Section D	Statement #14	Being in a team who share my philosophies	Job flexibility	Midwives felt that including job flexibility was a source of job satisfaction and that the omission of it would not truly reflect their source of job satisfaction
Section C	QC2	Section D	Statement #15	Homebirth	Being in a team who share my philosophies	
Section C	QC2	Section D	Statement #16	Being able to normalise midwifery care	Homebirth	
Section C	QC2	Section D	Statement #17	Being an advocate	Being able to normalise midwifery care	
Section C	QC2	Section D	Statement #18	Training and study opportunities	Being an advocate	
Section C	QC2	Section D	Statement #19	The adrenaline rush of the hospital	Interactions with women	Midwives in Australia felt there needed to more emphasis on the women they cared for as being a source of job satisfaction
Section C	QC2	Section D	Statement #20	Working in the community	The professional recognition of midwifery	Midwives in Australia felt that the professional recognition of midwifery was one of their source of job satisfaction and should be included in the questionnaire
Section C	QC2	Section D	Statement #21	I get no job satisfaction in my current role	Training and study opportunities	

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
Section C	QC2	Section D	Statement #22	Other	The adrenaline rush of the hospital	
Section C	QC2	Section D	Statement #23		Working in the community	
Section C	QC2	Section D	Statement #24		I get no job satisfaction in my current role	
Section C	QC2	Section D	Statement #25		Other	
Section D	QD1	Section E	Statement #1	Work colleagues	Work colleagues and a sense of belonging	The midwives felt that their work colleagues alone did not keep them going but when it was the combination with a sense of belonging that keep them going
Section D	QD1	Section E	Statement #15	Moving into a different midwifery post	Having job satisfaction	
Section D	QD1	Section E	Statement #16	Being an experienced midwife	Moving into a different midwifery position	
Section D	QD1	Section E	20Statement #17	Putting into the job as much as you want to get out	Being an experienced midwife	
Section D	QD1	Section E	Statement #18	Social drinking	Putting in as much as you want to get out	
Section D	QD1	Section E	Statement #19	Knowing that soon I will be retiring	Alcohol and other drugs	It was felt that the use of other drugs as well as alcohol may be what keeps some midwives going

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
Section D	QD1	Section E	Statement #20	Having a moan	Knowing that I soon will be retiring	
Section D	QD1	Section E	Statement #21	Switching off/keeping work out of home life	Having a moan	
Section D	QD1	Section E	Statement #22	My supervisor of midwifery	My work environment	Australian midwives do not have supervisors of midwifery
Section D	QD1	Section E	Statement #23	Other	Switching off/keeping work out of home life	
Section D	QD1	Section E	Statement #24		Involvement in professional groups	For many Australian midwives involvement in professional groups provides them with the motivation to keep going
Section D	QD1	Section E	Statement #25		Other	
Section E	QE1	Section F	Statement #8	Less paperwork	Less paperwork/ less computer work	In Australia over recent years there has been an increase in the amount of computer work required
Section E	QE1	Section F	Statement #9	Greater respect from management [feeling valued]	Greater respect from senior management [feeling valued]	Midwives in the Australian setting felt that they were supported from their immediate managers and that it was the senior managers who they did not receive support from
Section E	QE1	Section F	Statement #12	More support from	More support from my	As Australian midwives do

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
				supervisor/ manager	manager	not have supervisors of midwifery it was felt that this needed to be removed from this statement
Section E	QE1	Section F	Statement #14	Greater recognition for further education and development	Some form of clinical supervision	Midwives in Australia felt that they need clinical supervision in their working lives to have a positive impact
Section E	QE1	Section F	Statement #15	More resources for further education and development	Greater recognition for further education and development	
Section E	QE1	Section F	Statement #16	Improved relationships with non-midwifery colleagues	More resources for further education and development	
Section E	QE1	Section F	Statement #17	Abolishing integrated midwifery (that isn't caseload based)	Improved relationships with non-midwifery colleagues	
Section E	QE1	Section F	Statement #18	Greater colleague support	Abolishing integrated midwifery (that isn't caseload based)	
Section E	QE1	Section F	Statement #19	A move into a different area of midwifery	Greater colleague support/ collegiality	It was felt that there was a difference between support from colleagues and collegiality
Section E	QE1	Section F	Statement #20	Feeling more valued by clients	A move into a different area of midwifery	

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
Section E	QE1	Section F	Statement #21	Less change in midwifery	Feeling more valued by women	
Section E	QE1	Section F	Statement #22	Less experienced midwives having a greater respect for experienced midwives	Less change in midwifery	
Section E	QE1	Section F	Statement #23	Wider use of midwifery support workers	Less experienced midwives having a greater respect for experienced midwives	
Section E	QE1	Section F	Statement #24	More clerical support	Wider use of midwifery support services	
Section E	QE1	Section F	Statement #25	Community midwives not having to cover hospital shifts	Wider use of PSA's	
Section E	QE1	Section F	Statement #26	Other	More clerical support	
Section E	QE1	Section F	Statement #27		Community midwives not having to cover hospital shifts	
Section E	QE1	Section F	Statement #28		Other	
Section F	QG7	Section G	Statement #1	I plan to stay in the post that I am in now	I plan to stay in the role that I am in now	
Section F	QG7	Section G	Statement #5	I would like to stay in midwifery but move out of the NHS	I would like to stay in midwifery but move out of this hospital	All midwives included in this research were currently employed within the Area Health Service
Section F	QG7	Section G	Statement #6	I would like to move into	I would like to move	All midwives included in

Original Section	Original Question Number	New Section	New Question number	Original wording	Amended wording	Rationale for amendment
				the NHS	from a casual position into a permanent position	this research were currently employed within the Area Health Service
Section G		Removed				
Section H	QH3	Section A	Removed	Please indicate the ethnic group to which you belong		This question was removed as it was felt that it was not necessary for the Australian setting
Section H	QH4	Section A	QA3	Please indicate your professional qualification	Please indicate your midwifery qualification	We know that in Australia most midwives will have been registered as nurses first
Section H	QH6	Section A	Removed	Do you currently have responsibility for the regular care of dependents		This question can be answered in other parts of the questionnaire
Section H			QA6	Has there been a time when you were not working as a midwife since you qualified as a midwife?	Has there been a time when you were not employed as a midwife since you qualified as a midwife?	Midwives whom had had maternity leave were confused as to whether this included them as were midwives who had worked in Child and Family Health